

Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



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This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no cost from our Web site at: www.cahabagba.com



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News from CMS For All Providers

Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS Web site.

Flu Shot Reminder

Flu season is here! Medicare patients give many reasons for not getting their flu shot, including—"It causes the flu; I don't need it; it has side effects; it's not effective; I didn't think about it; I don't like needles!" The fact is that out of the average 36,000 people in the U.S. who die each year from influenza and complications of the virus, greater than 90 percent of deaths occur in persons 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk to your Medicare patients about the importance of getting their annual flu shot--and don't forget to immunize yourself and your staff. **Protect yourself, your patients, and your family and friends. Get Your Flu Shot.** Remember – Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's Web site:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf>



Claims Submitted With Only a National Provider Identifier (NPI) During the Stage 2 NPI Transition Period

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5378

Related CR Release Date: November 13, 2006

Related CR Transmittal #: R249OTN

Related Change Request (CR) #:5378

Effective Date: October 1, 2006

Implementation Date: November 20, 2006

Provider Types Affected

Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries, with Medicare

Provider Action Needed

STOP – Impact to You

Beginning October 1, 2006, and until further notice, claims that you submit containing only an NPI will be returned to you as unprocessable if a properly matching legacy number cannot be found.

CAUTION – What You Need to Know

From the beginning of Medicare's Stage 2 NPI transition period on October 1, 2006, and until further notice, you should submit both NPIs and legacy provider numbers on your Medicare claims to ensure that they are properly processed. During this period, claims submitted with only an NPI that Medicare systems are unable to properly match with a legacy number (e.g., PIN, OSCAR number), may be rejected and you will be required to resubmit the claim with the appropriate legacy number.

GO – What You Need to Do

You should make sure that when submitting Medicare claims with dates of service on or after October 1, 2006, your billing staff submits both your NPI and legacy provider numbers until further notice from CMS.

Background

As previously announced, CMS plans to begin testing new software it has developed to use the NPI in the existing Medicare fee-for-service claims processing systems. (Remember that you will be required to submit claims and other HIPAA transactions with only an NPI beginning on May 23, 2007.)

During the Stage 2 NPI transition period of October 1, 2006, through May 22, 2007, Medicare will accept claims having only NPIs (as well as those having only legacy provider numbers); however, in CR 5378, from which this article is taken, CMS recommends that during this period you submit claims using:

- The provider's legacy number, such as a Provider Identification Number (PIN), NSC number, OSCAR number or UPIN; or
- Both the provider's NPI and legacy number.

Note: Until January 2, 2007, NPIs are not to be submitted on paper claims via CMS-1500 forms. Institutional providers are advised that the NPI will not be accepted on paper claims by FIs or A/B MACs until implementation of the UB-04 on May 23, 2007.

Until testing of Medicare's new software is complete, if you submit Medicare claims with only your NPI:

- 1) They may be processed and paid, or
- 2) If the Medicare systems are unable to properly match the incoming NPI with a legacy number (e.g., PIN, OSCAR number), they may be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

Additional Information

The official instruction issued to your Medicare contractor on this issue, CR 5378, is available at <http://www.cms.hhs.gov/Transmittals/downloads/R249OTN.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the "Contact Us" page of this *Medicare A Newsline*.

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Outpatient Therapy Cap Exceptions Clarifications

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network* (MLN) *Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5271
Related CR Release Date: November 9, 2006
Related CR Transmittal #: R60BP, R171PI,
R1106CP

Related Change Request (CR) #: 5271
Effective Date: December 9, 2006
Implementation Date: December 9, 2006

Note: While CR 5271 also reflects effective and implementation dates in January 2007 for Medicare system changes, the information in this article clarifies existing processes.

Provider Types Affected

Providers, physicians, and nonphysician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and carriers) under the Part B benefit for therapy services

Provider Action Needed

CR 4364, released February 15, 2006, described the exception process to the caps set on outpatient therapy services (physical therapy and occupational therapy). CR 5271, upon which this article is based, clarifies questions (below) that have arisen about this exception process. Thus, the article is meant primarily for informational purposes. It also reminds you that the exception process stops after December 31, 2006.

Background

A brief history may be beneficial at this point. The Balanced Budget Act of 1997 placed financial limitations on Medicare covered therapy services (therapy caps) that were implemented in 1999 and again for a short time in 2003. Congress placed moratoria on these caps for 2004 and 2005, but the moratoria are no longer in place, and the caps were reimplemented on January 1, 2006. However, Congress, through the Deficit Reduction Act has provided that (only for calendar year 2006) exceptions to caps may be made when provision of additional therapy services is determined to be medically necessary. **This process ends after December 31, 2006.**

Review of this exception process

Section 1833(g)(5) of the Social Security Act provides that, **for services provided during calendar year 2006**, FIs, RHHIs, and carriers can, in certain circumstances, grant an exception to the therapy cap when requested by the individual enrolled under the Part B benefit (or by a person acting on behalf of that individual).

Exception processes fall into two categories:

1) Automatic Process Exceptions

Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if they meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 5, (as revised by CR 5271) for exception from the therapy cap for 2006.

2) Manual Process Exceptions

Medicare beneficiaries may request an exception using the manual process for exception from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the criteria for automatic exceptions.

The clarifications to questions generated from CR 4364

Your FI, RHHI, or carrier:

1. Will grant exceptions for any number of medically necessary services for 2006 that meet the automatic process exception criteria, if the beneficiary meets the conditions described in *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR 5271).
2. Will grant an exception to the therapy cap, by approving any number of additional therapy treatment days, when these additional treatment days are deemed medically necessary based on documentation that you have submitted in 2006.
3. Will utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance in which you do not submit all required documentation with the exception request for services provided in 2006.
4. Must reply as soon as practicable to a request for exception for services provided in 2006. They will grant an exception to the therapy cap, approving the number of treatment days that you or the beneficiary request (not to exceed 15 future treatment days), if they do not make a decision within 10 business days of receipt of any request and appropriate documentation.
5. Will allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.
6. Will follow the manual description for allowing exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process for services provided in 2006.
7. Will allow automatic process exceptions when complexities occur in combination with other conditions that may or may not be on the list in the *Medicare Claims Processing Manual* in 2006.
8. Will, when a patient is being treated under the care of two physicians for separate conditions, accept as appropriate documentation either 1) A combined plan of care certified by one of the physicians/NPPs, or 2) Two separate plans of care certified by separate physicians/NPPs.
9. Will update the list of exceptions in 2006 according to the changes provided in this transmittal. You should be aware that they may expand (but not contract) this list if their manual process exception decisions lead them to believe further exceptions should be allowed.
10. Will not require the additional documentation that is encouraged but not required in the manuals.
11. Will interpret a referral or an order or a plan of care dated after an evaluation, as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.
12. Will not deny payment for re-evaluation only because an evaluation or re-evaluation was recently done, as long as documentation supports the need for re-evaluation. A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.
13. Will require clinicians to write Progress Reports at least during each Progress Report Period. Note that required elements of the Progress Report that are written into the Treatment Notes or in a Plan of Care may acceptably fulfill the requirement for a Progress Report. In these instances, a separate Progress Report is not required.
14. Will require, on pre or postpay medical review of documentation, that when the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each Progress Report Period and sign the Progress Report.

15. Will continue to use Medicare Summary Notice (MSN) message 38.18 on all Medicare MSN forms, both in English and in Spanish. This message reads: “ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006, through December 31, 2006. The limits are \$1,740 for PT and SLP combined and \$1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE.”
16. Will continue to enforce local coverage determinations (LCDs).

Final Note: You should keep in mind that claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable.

Additional Information

You can find more information about outpatient therapy cap exceptions by going to CR 5271, issued in 3 transmittals. As attachments to those transmittals, you will find updated manual sections for:

- The *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), §10.2 (The Financial Limitation); (This will be at: <http://www.cms.hhs.gov/Transmittals/downloads/R1106Cp.pdf>)
- The *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), §3.4.1.1.1 (Exception from the Uniform Dollar Limitation (“Therapy Cap”)). (This will be at: <http://www.cms.hhs.gov/Transmittals/downloads/R171PI.pdf>); and,
- The *Medicare Benefit Policy Manual*, Chapter 15, §220.3 (Documentation Requirements for Therapy Services.) This is available at: <http://www.cms.hhs.gov/Transmittals/downloads/R60BP.pdf> on the CMS Web site.

These manual revisions include numerous additional changes clarifications.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

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Fee Schedule Update for 2007 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5417
Related CR Release Date: December 8, 2006
Related CR Transmittal #: R1125CP

Related Change Request (CR) #: 5417
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), carriers, and/or regional home health intermediaries (RHHIs)), for services paid under the DMEPOS Fee Schedule.

Provider Action Needed

This article is based on CR 5417, and it provides specific information regarding the annual update for the 2007 DMEPOS Fee Schedule. Be sure billing staff are aware of this update.

Background

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

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

Payment on a fee schedule basis is required for:

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

Note: DMERCs and DME MACs will use the 2007 PEN fee schedule payment amounts to pay claims for items furnished from January 1, 2007, through December 31, 2007.

Deleted HCPCS Codes

The following codes are being **deleted** from the HCPCS effective January 1, 2007, and are therefore being removed from the DMEPOS and PEN fee schedule files.

A4348	L0100	L6740	L6825	L6872
A4359	L0110	L6745	L6830	L6873
A4462	L3902	L6750	L6835	L6875
A4632	L3914	L6755	L6840	L6880
E0164	L6700	L6765	L6845	L7010
E0166	L6705	L6770	L6850	L7015
E0180	L6710	L6775	L6855	L7020
E0701	L6715	L6780	L6860	L7025
E0977	L6720	L6790	L6865	L7030
E0997 thru E0999	L6725	L6795	L6867	L7035
E2320	L6730	L6800	L6868	
K0090 thru K0097 K0099	L6735	L6806 thru L6809	L6870	

Added HCPCS

The HCPCS codes listed below are being **added to the HCPCS** on January 1, 2007:

A4461	A9279	L1001	L6703
A4463	E0676	L3806	L6704
A4559	E0936	L3808	L6706
A4600	E2373 thru E2377	L3915	L6707 thru L6709
A4601	E2381 thru E2396	L5993	L7007 thru L7009
A8000	K0733 thru K0737	L5994	L8690
A8001		L6611	L8691
A8002		L6624	L8695
A8003		L6639	
A8004			

Payment Rates for Oxygen and Oxygen Equipment

As part of this fee schedule update, CMS is implementing national monthly payment rates for oxygen and oxygen equipment effective for claims with dates of service on or after January 1, 2007. The 2007 national monthly payment rates are listed in the table below. As a result of these changes, CMS is revising the fee schedule amounts for codes E1405 and E1406. Since 1989, the fees for E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

As part of these changes, suppliers must submit claims with both the code for stationary oxygen contents (E0441 or E0442) and the code for portable oxygen contents (E0443 or E0444) when billing for payment for furnishing both stationary and portable oxygen contents for beneficiary-owned gaseous or liquid stationary and portable oxygen equipment.

HCPCS Codes	Amount	Class
E0424, E0439, E1390, and E1391	\$198.40	Stationary Oxygen Equipment (including stationary concentrator, liquid and gaseous equipment) and Oxygen Contents (stationary and portable)
E0431 and E0434	\$31.79	Portable Equipment Only (gaseous or liquid tanks)
E1392 and K0738	\$51.63	Oxygen Generating Portable Equipment (OGPE) Only
E0441 and E0442	\$77.45	Oxygen Contents for Beneficiary-Owned Stationary Gaseous or Liquid Oxygen Equipment
E0443 and E0444	\$77.45	Oxygen Contents for Beneficiary-Owned Portable Gaseous or Liquid Oxygen Equipment

The fee schedules for HCPCS code E0461 (Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used with Non-Invasive Interface (e.g., Mask)) are being revised as part of this update to correct calculation errors and are effective for dates of service on or after January 1, 2007.

Gap-Fill Items

The Medicare DMERCS and DME MACs will gap-fill base fee schedule amounts for each state in their region for the following new and revised HCPCS codes that will be subject to the DMEPOS fee schedules in 2007:

- Inexpensive or routinely purchased DME for codes A8002, A8003, A8004, E2373, E2374, E2375, E2376, E2377, E2388, E2389, E2390, E2391, E2392, E2393, E2394, E2395
- Capped rental DME codes of E0639 and E0640
- Prosthetics and Orthotics codes of L1001, L3806, L3808, L3915, L5993, L5994, L6611, L6624, L6639
- Surgical Dressings codes of A4463
- DME supplies codes of A4559

Additional Information

For complete details regarding this CR please see the official instruction (CR 5417) issued to your Medicare A/B MAC, DMERC, DME MAC, FI, RHHI, or carrier. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1125CP.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

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Notification and Testing of an Integrated Outpatient Code Editor (OCE) for the July 2007 Release

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5344

Related Change Request (CR) #: 5344

Related CR Release Date: November 9, 2006

Effective Date: July 1, 2007

Related CR Transmittal #: R1107CP

Implementation Date: July 2, 2007

Provider Types Affected

Non-OPPS hospitals submitting outpatient claims to Medicare Fiscal Intermediaries (FIs) for services provided to Medicare beneficiaries

Provider Action Needed

This article is based on CR 5344, which informs FIs of the integration and testing of the non-Outpatient Prospective Payment System (non-OPPS) OCE into the OPSS OCE effective July 1, 2007.

Background

This article is based on CR 5344 which informs your fiscal intermediary (FI) of the integration and testing of the non-Outpatient Prospective Payment System (non-OPPS) OCE into the OPSS OCE effective July 1, 2007.

The integration of the non-OPPS OCE into the OPPS OCE:

- Will result in the routing of all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis.
- **Does not change the current logic that is applied to outpatient bill types that already pass through the OPPS OCE software. It merely expands the software usage to include non-OPPS hospitals.**
Note: This new software product will be referred to as the Integrated OCE.

Note: Claims with dates of service prior to July 1, 2007, will be routed through the non-integrated versions of the OCE software (OPPS and non-OPPS OCEs) that coincide with the versions in effect for the date of service on the claim.

The principal reason for the integration of the non-OPPS OCE into the OPPS OCE is the long-standing systems issues related to the non-OPPS OCE software that require corrective action.

Editing that only applied to OPPS hospitals (e.g., blood, drug, partial hospitalization logic) in the past will not be applied to non-OPPS hospitals at this time. However, with the integrated OCE non-OPPS hospitals will be assigned specific edit numbers and dispositions, where in the past, this type of detail was not provided.

OPPS OCE

The current OPPS OCE:

- Processes claims for all outpatient institutional providers with the exception of hospitals not subject to OPPS;
- Performs detailed editing and evaluates patient data to help identify possible coding errors, returning a series of edit flags with claim/line item actions;
- Assigns Ambulatory Payment Classification (APC) numbers based on Healthcare Common Procedure Coding System (HCPCS) codes for payment under the OPPS; and
- Sets a series of indicators/flags based on various coding criteria and sends those indicators/flags to the OPPS Pricer to determine pricing.

Non-OPPS OCE

The current non-OPPS OCE:

- Processes claims for the following non-OPPS hospitals: Indian Health Service Hospitals, critical access hospitals (CAHs), Indian Health Service Hospitals (IHS)/ Tribal hospitals including IHS/ Tribal CAHs, Maryland hospitals, as well as hospitals located in American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands;
- Processes claims from Virgin Island hospitals with dates of service January 1, 2002, and later, and from hospitals that furnish only inpatient Part B services with dates of service January 1, 2002, and later; and
- Does not perform detailed editing and grouping (unlike the OPPS OCE) since it is not required for these hospitals.

CR 5344 provides instructions and specifications for the integrated OCE, which will be used to process outpatient claims for the following institutional providers:

- OPPS providers (hospital outpatient departments, community mental health centers (CMHCs) and for limited services provided in a home health agency (HHA) not under the Home Health Prospective Payment System, or to a hospice patient for the treatment of a non-terminal illness);

- Non-OPPS hospitals (Indian Health Service Hospitals, critical access hospitals (CAHs)), Maryland hospitals, as well as hospitals located in American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands. In addition, claims from Virgin Island hospitals with dates of service January 1, 2002, and later, and hospitals that furnish only inpatient Part B services with dates of service January 1, 2002, and later are edited in the non-OPPS OCE; and
- All non-hospital outpatient institutional providers (HHAs, skilled nursing facilities, rural health clinics, federally qualified health centers, hospices, renal dialysis facilities, Religious Non-Medical Healthcare Institutions, comprehensive outpatient rehabilitation facilities, and outpatient physical therapy providers).

The changes specific to the July release for the new integrated OCE will be issued in a separate recurring CR, which will replace the non-OPPS, and the OPPS recurring CRs for July. As a result, there will only be one recurring CR for each quarterly release of the OCE beginning with the July release.

Implementation

The implementation date for CR 5344 is July 2, 2007.

Additional Information

Integrated Edit/Disposition Table for Hospitals

Note: All edits that currently apply to providers other than hospitals remain unchanged with this integrated product.

CR = Claim Rejection, CD = Claim Denial, RTP = Return to Provider, CS = Claim Suspension, LIR = Line Item Rejection, LID = Line Item Denials

Edit	Disposition	Application to hospitals
01 – Invalid diagnosis code	RTP	Apply to all hospital claims
02 – Dx/Age conflict	RTP	Apply to all hospital claims
03 – Dx/Sex conflict	RTP	Apply to all hospital claims
04 – MSP Alert (v1.0,v1.1 only)	--	Inactive (Do not apply)
05 – E-code as Reason for Visit	RTP	Apply to all hospital claims
06 – Invalid procedure code	RTP	Apply to all hospital claims
07 – Procedure/age conflict	--	Inactive (Do not apply)
08 – Procedure/sex conflict	RTP	Apply to all hospital claims
09 – Non-covered service (other than statute)	LID	Apply to all hospital claims
10 – Svc submitted for verification of denial (Condition code 21)	CD	Apply to all hospital claims
11 – Svc submitted for FI review (Condition code 20)	CS	Apply to all hospital claims
12 – Questionable covered svc	CS	Apply to all hospital claims
13 – Service not paid	--	Inactive – 1/1/06
14 – Non-OPPS site of svc	--	Inactive – 1/1/06
15 – Svc units out of range	RTP	Apply to all hospital claims
16 – Multiple bilateral procedures (edit deleted)	--	Inactive (Do not apply)

Edit	Disposition	Application to hospitals
17 – Inappropriate specification of bilateral proc	RTP	Apply to all hospital claims
18 – Inpatient procedure	LID	Apply to all hospital claims
19 – Mutually exclusive procedure - modifier irrelevant	LIR	Apply to OPPS hospitals only
20 – Comprehensive/ Component proc - modifier irrelevant	LIR	Apply to OPPS hospitals only
21 – Med Visit same day as type T or S w.o modifier 25	LIR	Apply to OPPS hospitals only
22 – Invalid modifier	RTP	Apply to all hospital claims
23 – Invalid date	RTP	Apply to all hospital claims
24 – Date out of OCE range	CS	Use OPPS Date 8/1/2000. For non OPPS, use integration date (planned 7/07)
25 – Invalid age	RTP	Apply to all hospital claims
26 – Invalid sex	RTP	Apply to all hospital claims
27 – Only incidental services reported	CR	Apply to OPPS hospitals only
28 – Code not recognized by Medicare	LIR	Apply to all hospital claims
29 – Partial hospitalization service for non-mental health diagnosis	RTP	Apply to OPPS hospitals only
30 – Insufficient services on day of partial hospitalization	CS	Apply to OPPS hospitals only
31 – Partial hospitalization on same day as ECT or type T procedure (edit deleted)	CS	Inactive (Do not apply)
32 – Partial hospitalization claim spans 3 or less days with insufficient services, or ECT or significant procedure on at least one of the days	CS	Apply to OPPS hospitals only
33 – Partial hospitalization claim spans more than 3 days with insufficient number of days having mental health services	CS	Apply to OPPS hospitals only
34 – Partial hospitalization claim spans more than 3 days with insufficient number of days meeting partial hospitalization criteria	CS	Apply to OPPS hospitals only
35 – Only activity therapy and/or occupational therapy services provided	RTP	Apply to OPPS hospitals only
36 – Extensive mental health services provided on day of ECT or significant procedure (edit deleted)	--	Inactive (do not apply)
37 – Terminated bilateral, or terminated proc w units greater than 1	RTP	Apply to OPPS hospitals only
38 – Inconsistency between implanted device and implantation procedure	RTP	Apply to OPPS hospitals only
39 – Mutually exclusive procedure; allowed if CCI modifier coded	LIR	Apply to OPPS hospitals only

Edit	Disposition	Application to hospitals
40 – Comp/Comp procedure; allowed if CCI modifier coded	LIR	Apply to OPPS hospitals only
41 – Invalid revenue code	RTP	Apply to all hospital claims
42 – Multiple Med Visits same day w same RevCode, w.o CC G0	RTP	Apply to OPPS hospitals only
43 – Transfusion or blood product exchange w.o specification of blood product	RTP	Apply to OPPS hospitals only
44 – Observation revenue code w non-observation HCPCS	RTP	Apply to OPPS hospitals only
45 – Inpatient separate procedure not paid	LIR	Apply to OPPS hospitals only
46 – PH Cond Code 41 not allowed for TOB	RTP	Apply to all hospital claims
47 – Svc not separately payable	LIR	Apply to OPPS hospitals only
48 – Rev Center requires HCPCS	RTP	Apply to OPPS hospitals only
49 – Svc on same day as inpatient procedure	LID	Apply to OPPS hospitals only
50 – Non-covered based on statutory exclusions	LIR	Apply to all hospital claims
51 – Multiple observations overlap in time (Not activated)	--	Inactive (Do not apply)
52 – Observation does not meet minim hours, qualifying diagnosis, and/or ‘T’ procedure conditions (edit deleted)	--	Inactive (Do not apply)
53 – Observation G codes only allowed with bill type 13x or 85x	LIR	Apply to all hospital claims
54 – Multiple codes for the same service	RTP	Apply to all hospital claims
55 – Non-reportable for site of service	RTP	NA to hospitals
56 – E/M or ancillary procedure conditions are not met and line item date for obs code G0244 is not 12/31 or 1/1 (edit deleted)	--	Inactive (Do not apply)
57 – E/M or ancillary procedure conditions are not met and line item date for obs code G0378 1/1	CS	Apply to OPPS hospitals only
58 – G0379 only allowed with G0378	RTP	Apply to OPPS hospitals only
59 – Clinical trials requires diagnosis code V707 as other than primary diagnosis	RTP	Apply to OPPS hospitals only
60 – Use of modifier CA with more than one procedure not allowed	RTP	Apply to OPPS hospitals only
61 – Service can only be billed to the DMERC	RTP	Apply to all hospital claims
62 – Code not recognized by OPPS; alternate code for same service may be available	RTP	Apply to OPPS hospitals only
63 – This OT code only billed on partial hospitalization claims	RTP	Apply to OPPS hospitals only
64 – AT service not payable outside the partial hospitalization program	LIR	Apply to OPPS hospitals only
65 – Revenue code not recognized by Medicare	LIR	Apply to all hospital claims

Edit	Disposition	Application to hospitals
66 – Code requires manual pricing	CS	Apply to OPPS hospitals only
67 – Service provided prior to FDA approval	LIR	Apply to all hospital claims
68 – Service provided prior to NCD approval	LIR	Apply to all hospital claims
69 – Service provided outside approval period	LIR	Apply to all hospital claims
70 – CA modifier requires patient status code 20	RTP	Apply to OPPS hospitals only
71 – Claim lacks required device code	RTP	Apply to OPPS hospitals only
72 – Service not billable to the fiscal intermediary	RTP	Apply to all hospital claims with the exception of CAH Method II billing revenue codes 096X, 097X, and 098X.
73 – Incorrect billing of blood and blood products	RTP	Apply to OPPS hospitals only
74 – Units greater than one for bilateral procedure billed with modifier 50	RTP	Apply to OPPS hospitals only

For more complete details, especially regarding the edits of the integrated OCE, please see the official instruction (CR 5344) issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1107CP.pdf> on the CMS Web site.

Current OCE Web-based training may be found under Medicare Payment Policy training at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

Disclaimers

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Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims – Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the MM5270 article entitled “Reporting of Taxonomy Codes to Identify Provider Subparts on Institutional Claims”, which was published in the October 1, 2006, *Medicare A Newsline*.

MLN Matters Number: MM5243 Revised
Related CR Release Date: November 22, 2006
Related CR Transmittal #: R1114CP

Related Change Request (CR) #: 5243
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Note: This article was revised on November 9, 2006, to reflect changes made to CR 5243. CR 5243 was revised to include a more complete definition for the 2000A loop in the first bullet point at the top of page 4. The article was also revised to reflect the new CR transmittal number, CR release date, and the Web address for accessing CR 5243. All other information remains the same.

Provider Types Affected

Institutional providers who bill Medicare fiscal intermediaries (FIs) for their services

Provider Action Needed

STOP – Impact to You

Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a **taxonomy code** on all claims submitted to their FI.

CAUTION – What You Need to Know

Please use the attachment to CR 5243 (supplied in the “Background” section of this article) to crosswalk the OSCAR (Online Survey Certification and Reporting System) number to the appropriate taxonomy code for your type of facility. The taxonomy code will assist Medicare in crosswalking from the national provider identifier (NPI) of the provider to each of its subparts in the event that the provider chooses not to apply for a unique NPI for each of its subparts individually.

GO – What You Need to Do

Refer to the “Background” section of this article for additional crosswalk information.

Background

Regulations implementing the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 require the use of NPIs by covered health care providers and health plans (other than small plans) effective May 23, 2007. (45 CFR Part 162, Subpart D (162.402-162.414).)

CMS will utilize a Medicare Provider Identifier Crosswalk between NPIs and legacy identifiers (such as OSCAR numbers) to validate NPIs received in transactions, assist with the population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. (See MM4023 at the link provided below for more information on CMS’ implementation of the NPI.) The crosswalk detailed in CR 5243 between the provider’s OSCAR number and the appropriate taxonomy code will assist in this process.

Attachment to CR5243: Reporting of Taxonomy Codes (Institutional Providers)

The following chart supplies the crosswalk from the OSCAR number to the appropriate taxonomy code based on the provider’s facility type.

OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Short-term (General and Specialty) Hospitals	0001-0879 * Positions 3-6 of the OSCAR number	282N00000X
Critical Access Hospitals	1300-1399 *	282NC0060X
Long-Term Care Hospitals (LTCH Swing Beds submitting with type of bill 18X must use the LTCH taxonomy code)	2000-2299 *	282E00000X

OSCAR Provider Type	OSCAR Coding	Taxonomy Code
Hospital Based Renal Dialysis Facilities	2300-2499 *	261QE0700X
Independent Renal Dialysis Facilities	2500-2899 *	261QE0700X
Rehabilitation Hospitals	3025-3099 *	283X00000X
Children's Hospitals	3300-3399 *	282NC2000X
Hospital Based Satellite Renal Dialysis Facilities	3500-3699	Type of Bill 72X and taxonomy code of 261QE0700X and a zip code different than any renal dialysis facility issued an OSCAR number that is located on that hospital's campus
Psychiatric Hospitals	4000-4499 *	283Q00000X
Organ Procurement Organization (OPO)	P in third Position of the OSCAR number	335U00000X
Psychiatric Unit	M or S in third Position	273R00000X
Rehabilitation Unit	R or T in third Position	273Y00000X
Swing-Bed	U, W, Y, or Z in third Position	Type of bill X8X with one of the following to show type of facility in which the swing bed is located: 275N00000X-short term hospital (U); 282E00000X-long term care hospital (W); 283X00000X-rehabilitation facility (Y); or 282NC0060X-critical access hospital (Z)

Be sure to follow the billing instructions (below) contained in CR 5243:

- Report the service facility locator loop (2310E) in an 837-I claim whenever the service was furnished at an address other than the address reported on the claim for the billing or pay-to provider.
- Input the taxonomy code in the 837-I provider loop 2000A (billing or pay-to-provider taxonomy code).
- Submit separate batches of claims for each subpart identified by a different taxonomy code.
- Providers submitting claims for their primary facility and its subparts must submit a nine-digit zip code on their claims.
- Submitters of institutional claims (X12 837-I version 4010A1) that bill and are to be paid for services furnished by a subpart, that do not have a unique NPI separate from that of the main entity or another subpart, the subpart that furnished the billed care must be identified in the billing provider loop (2010AA) of the claim and the entity to be paid in the Pay-to provider loop (2010AB). The taxonomy code of the subpart must also be reported in the PRV segment in the 2000A loop.
- CMS recommends submitting both the OSCAR number and the NPI on claims submitted through May 22, 2007. (Note that failure to report an OSCAR number that corresponds to your NPI could result in a payment delay.)

Implementation Date

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

Additional Information

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” is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf> on the CMS Web site.

CR 5243 is the official instruction issued to your Medicare FI regarding changes mentioned in this article. CR 5243 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1108CP.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

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Laboratory Competitive Bidding Demonstration

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5359

Related CR Release Date: November 1, 2006

Related CR Transmittal #: R50DEMO

Related Change Request (CR) #: 5359

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

Note: This article was previously published as MM5205, based on Change Request (CR) 5205, which discussed the initial phase of implementing this demonstration.

Provider Types Affected

Physicians and hospitals (TOB 14X only) that bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites

Background

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires CMS to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

Key Points

This article and CR 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this article and CR 5359, are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the zip code of the beneficiary's residence.
- Hospital inpatient testing is covered by Medicare Part A and is therefore exempt from the demonstration.
- Physician office laboratory (POL) testing and hospital outpatient testing are not included in the demonstration, except where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.
- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

Required Bidders

Laboratory firms with \$100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for “demonstration tests” provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration.

These laboratory firms will be referred to as “required bidders.”

Passive Laboratories

Small laboratories or laboratory firms with less than \$100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will not be required to bid in the demonstration. These laboratories are considered “passive” laboratories.” Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of \$100,000.

Passive laboratory firms exceeding the annual ceiling of \$100,000 will be:

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.
- Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considered “passive-ESRD” laboratories. Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration tests provided

to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007, through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

Winners

Both required and nonrequired bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled “winners.”

Non-Winners

Both required and nonrequired bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled “nonwinners.” Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Nonwinner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, nonwinner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

Although nonwinner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Demonstration Sites

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary’s zip code of residence.

CMS will provide the contractors with a list of zip codes included in each MSA, which will be used to determine whether a beneficiary’s residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of pap smears, colorectal cancer

screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Implementation

CR 5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

During the first quarter of 2007, CMS will provide Medicare carriers, FIs, and A/B MACs with a national zip code pricing file identifying the zip codes included in the first CBA. Also, in that same timeframe, CMS will provide to the carriers, FIs, and A/B MACs a list of the laboratories eligible to participate in the first CBA demonstration (“winners” and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

Claims submitted by nonwinner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code 96 (noncovered charges);
- Remark code M114 (This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.); and
- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Using these same reason and remark codes, Medicare will reject any laboratory claims with a date of service between April 1, 2007, and March 31, 2010, with a modifier of “90” submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA, regardless of the referring laboratory’s participation status.

Medicare will pay claims during the demonstration period submitted by non-demonstration laboratories for beneficiaries residing in the CBA who receive services outside of those areas (e.g., “snow birds”) according to the laboratory competitive bidding demonstration.

Nonwinning laboratories should know that Advance Beneficiary Notices (ABNs) and Notices of Beneficiary Exclusion from Medicare Benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at nonwinner laboratories.

Line items for demonstration services and for non-demonstration services may be submitted on the same claim.

A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

Medicare contractors will be prepared to begin processing claims under the laboratory competitive bidding demonstration in the first CBA on April 1, 2007. The tentative start date for the demonstration in the second CBA is April 1, 2008.

Remember that required and nonrequired bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

Implementation

The implementation date for this instruction is April 2, 2007.

The official instructions issued to your Medicare carrier, FI, or A/B MAC regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R50DEMO.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

Disclaimers

1. Please note that the demonstration design described in Transmittals R49DEMO and R50DEMO, which provide instructions to Medicare contractors for the implementation of a CMS laboratory competitive bidding demonstration, is a proposed design and has not yet received final approval from the Office of Management and Budget.
2. This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



2007 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5362

Related Change Request (CR) #: 5362

Related CR Release Date: December 8, 2006

Effective Date: January 1, 2007

Related CR Transmittal #: R1122CP

Implementation Date: January 2, 2007

Provider Types Affected

Clinical laboratories billing Medicare carriers, intermediaries, or Part A/B Medicare Administrative Contractors (A/B MACs)

Provider Action Needed

This article and related CR 5362 contain important information regarding:

- The 2007 annual updates to the clinical laboratory fee schedule

- Mapping for new codes for clinical laboratory tests, and
- Laboratory costs related to services subject to reasonable charge payments.

It is important that affected laboratories understand these changes to ensure correct and accurate payments from Medicare.

Key Points

Update to Fees

In accordance with §1833(h)(2)(A)(i) of the Social Security Act (the Act), as amended by Section 628 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the annual update to the local clinical laboratory fees for 2007 is zero (0) percent.

Section 1833(a)(1)(D) of the Act provides that payment for a clinical laboratory test is the lesser of the actual charge billed for the test, the local fee, or the National Limitation Amount (NLA).

The Part B deductible and coinsurance do not apply for services paid under the clinical laboratory fee schedule.

National Minimum Payment Amounts

For a cervical or vaginal smear test (pap smear), §1833(h)(7) of the Act requires payment to be the lesser of the local fee or the NLA, but not less than a national minimum payment amount. Also, payment may not exceed the actual charge.

The 2007 national minimum payment amount is \$14.76 (\$14.76 plus zero percent update for 2007). The affected codes for the national minimum payment amount include the following Current Procedure Terminology (CPT) codes:

88142	88143	88147	88148	88150	88152	88153
88154	88164	88165	88166	88167	88174	88175
G0123	G0143	G0144	G0145	G0147	G0148	P3000

National Limitation Amounts (Maximum)

For tests for which NLAs were established before January 1, 2001, the NLA is 74 percent of the median of the local fees. For tests for which NLAs are first established on or after January 1, 2001, the NLA is 100 percent of the median of the local fees in accordance with §1833(h)(4)(B)(viii) of the Act.

Access to 2007 Clinical Laboratory Fee Schedule

Internet access to the 2007 clinical laboratory fee schedule data file should be available after November 20, 2006, at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the CMS Web site.

Medicaid State agencies, the Indian Health Service, the United Mine Workers, Railroad Retirement Board, and other interested parties should use the Internet to retrieve the 2007 clinical laboratory fee schedule. It will be available in multiple formats: Excel, text, and comma delimited.

Public Comments

On July 17, 2006, CMS hosted a public meeting to solicit input on the payment relationship between 2006 codes and new 2007 Current Procedural Terminology codes. Notice of the meeting was published in the *Federal Register* on May 26, 2006, and on the CMS Web site on June 19, 2006.

Recommendations were received from many attendees, including individuals representing laboratories, manufacturers, and medical societies. A summary of the meeting and the tentative payment determinations can be found at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the CMS Web site. Additional written comments from the public were accepted until September 26, 2006.

Additional Pricing Information

The 2006 laboratory fee schedule includes separately payable fees for certain specimen collection methods (codes 36415, P9612, and P9615).

For dates of service January 1, 2007, through December 2007, the fee for clinical laboratory travel code P9603 is \$0.935 per mile and for code P9604 is \$9.35 per flat rate trip basis. The clinical laboratory travel codes are billable only for traveling to perform a specimen collection for either a nursing home or homebound patient. The standard mileage rate for transportation costs was increased by the Federal Government's Treasury Department to 48.5 cents a mile and this amount is incorporated into the fees for travel codes P9603 and P9604.

The 2007 laboratory fee schedule also includes codes that have a 'QW' modifier to both identify codes and determine payment for tests performed by a laboratory registered with only a certificate of waiver under the Clinical Laboratory Improvement Amendments (CLIA).

Based on comments and data submitted, codes 83037 and 83037QW are priced by crosswalking to code 82985.

Organ or Disease Oriented Panel Codes

Similar to prior years, the 2006 pricing amounts for certain organ or disease panel codes and evocative/suppression test codes were determined by Medicare by summing the lower of the fee schedule amount or the NLA for each individual test code included in the panel code.

Mapping Information

CMS advises the following:

- New code 80178QW is priced at the same rate as code 80178.
- New code 82107 is priced at the same rate as code 83950.
- New code 83698 is priced at the same rate as code 83880.
- New code 83913 is priced at the same rate as code 83907.
- New code 84443QW is priced at the same rate as code 84443.
- New code 86788 is priced at the same rate as code 86645.
- New code 86789 is priced at the same rate as code 86644.
- New code 86901 is priced at the same rate as code 86900.
- New code 87305 is priced at the same rate as code 87327.
- New code 87498 is priced at the same rate as code 87496.
- New code 87640 is priced at the same rate as code 87651.
- New code 87641 is priced at the same rate as code 87651.
- New code 87653 is priced at the same rate as code 87651.
- New code 87808 is priced at the same rate as code 87802.
- New code 87808QW is priced at the same rate as code 87808.
- New code G0394 is priced at the same rate as code 82270.

Laboratory Costs Subject to Reasonable Charge Payment in 2006

For outpatients, the following codes are paid under a reasonable charge basis. In accordance with 42 CFR 405.502 – 405.508, the reasonable charge may not exceed the lowest of the actual charge or the customary or prevailing charge for the previous 12-month period ending June 30, updated by the inflation-indexed update. The inflation-indexed update is calculated using the change in the applicable Consumer Price Index for the 12-month period ending June 30 of each year as prescribed by §1842(b)(3) of the Act and 42 CFR 405.509(b)(1). The inflation-indexed update for year 2007 is 4.3 percent.

Manual instructions for determining the reasonable charge payment can be found in the *Medicare Claims Processing Manual*, CMS Pub 100-04, Chapter 23, §80-80.8. If there is insufficient charge data for a code, the instructions permit considering charges for other similar services and price lists. The *Medicare Claims Processing Manual* is located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS Web site.

When these services are performed for independent dialysis facility patients, *Medicare Claims Processing Manual*, CMS Pub 100-04, Chapter 8, §60.3 instructs the reasonable charge basis applies. However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital outpatient prospective payment system (OPPS).

Blood Products

P9010	P9011	P9012	P9016	P9017	P9019	P9020
P9021	P9022	P9023	P9031	P9032	P9033	P9034
P9035	P9036	P9037	P9038	P9039	P9040	P9044
P9050	P9051	P9052	P9053	P9054	P9055	P9056
P9057	P9058	P9059	P9060			

Also, the following codes should be applied to the blood deductible, as instructed in the *Medicare General Information, Eligibility and Entitlement Manual*, CMS Pub 100-1, Chapter 3, §20.5-20.54, which is available at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>

P9010	P9011	P9016	P9021	P9022	P9038	P9039
P9040	P9051	P9054	P9056	P9057	P9058	

NOTE: Biologic products not paid on a cost or prospective payment basis are paid based on §1842(o) of the Act. The payment limits based on section 1842(o), including the payment limits for codes P9041, P9043, P9045, P9046, P9047, and P9048, should be obtained from the Medicare Part B Drug Pricing Files.

Transfusion Medicine

86850	86860	86870	86880	86885	86886	86890
86891	86900	86901	86903	86904	86905	86906
86920	86921	86922	86923	86927	86930	86931
86932	86945	86950	86960	86965	86970	86971
86972	86975	86976	86977	86978	86985	G0267

Reproductive Medicine Procedures

89250	89251	89253	89254	89255	89257	89258
89259	89260	89261	89264	89268	89272	89280
89281	89290	89291	89335	89342	89343	89344
89346	89352	89353	89354	89356		

Additional Information

For complete details regarding CR 5362, please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to

<http://www.cms.hhs.gov/Transmittals/downloads/R1122CP.pdf> on the CMS Web site.

Instructions for calculating reasonable charges are located in the *Medicare Claims Processing Manual* Pub. 100-04, Chapter 23, §§80-80.8 at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newslines*.

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Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5382

Related CR Release Date: November 24, 2006

Related CR Transmittal #: R1118CP

Related Change Request (CR) #: 5382

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Provider Types Affected

Physicians, suppliers and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), or Part A/B Medicare Administrative Contractors (A/B MACs) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

Provider Action Needed

Physicians, suppliers and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), or Part A/B Medicare Administrative Contractors (A/B MACs) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses. Providers may want to be sure their billing staff knows of these changes.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses in calendar year 2007 as required by regulations contained in 42 CFR 405.501 (<http://www.gpoaccess.gov/cfr/retrieve.html>).

For splints and casts, Q-codes are to be used when supplies are indicated for cast and splint purposes. Current Procedural Terminology (CPT) codes should be used as indicated in the CPT section “Application of Casts and Strapping” for the specified CPT procedure codes in the 29XXX series. This payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.

For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician’s office. CR 5282 instructs your carrier, DMERC, DME MAC, or A/B MAC to compute 2007 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician’s Office) using actual charge data from July 1, 2005, through June 30, 2006.

Carriers, and A/B MACs will compute 2007 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2006.

DMERCs and DME MACs will compute 2007 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2005, through June 30, 2006. For these same codes, they will compute 2007 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2006. These tables are:

Dialysis Supplies Billed With AX Modifier

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639
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Dialysis Equipment Billed Without AX Modifier

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Carriers and A/B MACs will make payment for splints and casts furnished in 2007 based on the lower of the actual charge or the payment limits established for these codes. **Carriers, DMERCs and DME MACs** will use the 2007 reasonable charges or the same payment limits to pay claims for items furnished from January 1, 2007, through December 31, 2007. **Those 2007 payment limits are in the table at the end of this article.**

Additional Information

Instructions for calculating:

- Reasonable charges are located in Chapter 23 (§80) of the *Medicare Claims Processing Manual* (Pub. 100-04);
- Customary and prevailing charge are located in §§80.2 and 80.4 of Chapter 23 of the *Medicare Claims Processing Manual* (Pub 100-04); and
- The IIC (Inflation Indexed Charge) are located in §80.6 of Chapter 23 of the *Medicare Claims Processing Manual* (Pub. 100-04). The IIC update factor for 2007 is 4.3 percent.

You can find Chapter 23 of the *Medicare Claims Processing Manual* (Pub. 100-04) at the following CMS Web site: <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>

For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC, or A/B MAC regarding this change. That instruction may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1118CP.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newslines*.

Disclaimers

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2007 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit
A4565	\$7.19	Q4025	\$31.60
Q4001	\$40.91	Q4026	\$98.64
Q4002	\$154.63	Q4027	\$15.80
Q4003	\$29.39	Q4028	\$49.33

Code	Payment Limit	Code	Payment Limit
Q4004	\$101.74	Q4029	\$24.16
Q4005	\$10.83	Q4030	\$63.59
Q4006	\$24.42	Q4031	\$12.08
Q4007	\$5.43	Q4032	\$31.79
Q4008	\$12.21	Q4033	\$22.53
Q4009	\$7.23	Q4034	\$56.05
Q4010	\$16.28	Q4035	\$11.27
Q4011	\$3.61	Q4036	\$28.03
Q4012	\$8.14	Q4037	\$13.75
Q4013	\$13.16	Q4038	\$34.44
Q4014	\$22.21	Q4039	\$6.89
Q4015	\$6.58	Q4040	\$17.22
Q4016	\$11.10	Q4041	\$16.71
Q4017	\$7.61	Q4042	\$28.53
Q4018	\$12.14	Q4043	\$8.36
Q4019	\$3.81	Q4044	\$14.27
Q4020	\$6.08	Q4045	\$9.70
Q4021	\$5.63	Q4046	\$15.61
Q4022	\$10.17	Q4047	\$4.84
Q4023	\$2.83	Q4048	\$7.81
Q4024	\$5.08	Q4049	\$1.77



Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5235

Related CR Release Date: November 17, 2006

Related CR Transmittal #: R1113CP

Related Change Request (CR) #: 5235

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Provider Types Affected

All physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), and Medicare Administrative Contractors (MACs) for subject services

Background

This article and related CR 5235 highlight the fact that section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysms (AAA) under Medicare Part B, effective for services furnished on or after January 1, 2007, as a result of a referral from an Initial Preventive Physical Examination (IPPE) and subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test.

Key Points

Effective for dates of service on and after January 1, 2007, Medicare will pay for a one-time ultrasound screening for AAA, for beneficiaries who meet the following criteria:

- Receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (IPPE). (See MLN Matters article MM3638 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf> for more details on the IPPE.)
- Receives such ultrasound screening from a provider or supplier who is authorized to provide covered diagnostic services.
- Has not been previously furnished such an ultrasound screening under the Medicare Program.
- Is included in at least one of the following risk categories:
 1. Has a family history of abdominal aortic aneurysm;
 2. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime;
 3. Is a beneficiary, who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

Payment

- The Part B deductible for screening AAA is waived effective January 1, 2007, but coinsurance is applicable.
- If the screening is provided in a physician office, the service is billed to the carrier using the HCPCS code G0389: Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening.
 - Short Descriptor: Ultrasound exam AAA screen
 - Modifiers: TC, 26 (modifiers are optional)
 - Payment is under the Medicare Physician Fee Schedule (MPFS).

FIs will pay for the AAA screening only when the services are performed in a hospital, including a **critical access hospital (CAH), Indian Health Services (IHS) facility, a skilled nursing facility (SNF), rural health clinic (RHC), or federally qualified health center (FQHC)**, and submitted on one of the following types of bills (TOBs): **12X, 13X, 22X, 23X, 71X, 73X, 85X**.

- The following table describes the payment methodology Medicare will use for AAA Screening:

Facility	Type of Bill	Payment
Hospitals subject to Outpatient Prospective Payment System (OPPS)	12X, 13X	OPPS
Method I and Method II CAHs	12X and 85X	101% of reasonable cost
IHS providers	13X, revenue code 051X	OMB-approved outpatient per visit all inclusive rate (AIR)
IHS providers	12X, revenue code 024X	All-inclusive inpatient ancillary per diem rate

Facility	Type of Bill	Payment
IHS CAHs	85X, revenue code 051X	101% of the all-inclusive facility specific per visit rate
IHS CAHs	12X, revenue code 024X	101% of the all-inclusive facility specific per diem rate
SNFs **	22X, 23X	Non-facility rate on the MPFS
RHCs*	71X, revenue code 052X	All-inclusive encounter rate
FQHCs*	73X, revenue code 052X	All-inclusive encounter rate
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12X, 13X	94% of provider submitted charges or according to the terms of the Maryland Waiver

* If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI using TOBs 71x and 73x, respectively, and the appropriate site of service revenue code in the 052x revenue code series. If the screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier under the practitioner's ID following instructions for submitting practitioner claims to the Medicare carrier. If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI under the base provider's ID, following instructions for submitting claims to the FI from the base provider.

** The SNF consolidated billing provision allows separate Part B payment for screening services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a 22x bill type. Screening services provided by other provider types must be reimbursed by the SNF.

Implementation

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

Information Regarding Advanced Beneficiary Notices: Medicare contractors will deny an AAA screening service billed more than one in a beneficiary's lifetime.

If a second G0389 is billed for AAA for the same beneficiary or if any of the other statutory criteria for coverage listed in Section 1861(s)(2)(AA) of the Social Security Act are not met, the service would be denied as a statutory (technical) denial under Section 1861(s)(2)(AA), not a medical necessity denial.

If a provider cannot determine whether or not the beneficiary has previously had an AAA screening, but all of the other statutory requirements for coverage have been met, the provider should issue the ABN-G. Likewise, if all of the statutory requirements for coverage have been met, but a question of medical necessity still exists, the provider should issue the ABN-G.

Additional Information

The official instructions for CR 5235, issued to your Medicare carrier, FI, MAC, FQHC, RHC, SNF, or CAH regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1113CP.pdf> on the CMS Web site. The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 18, has been updated to include the requirements to implement section 5112 of the DRA of 2005. The new sections of this chapter address the payment and allowable settings for AAA and the sections are attached to CR 5235.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

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New 2007 Current Procedural Terminology (CPT) Mammography Codes

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5327

Related CR Release Date: September 29, 2006

Related CR Transmittal #: R1070CP

Related Change Request (CR) #: 5327

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Provider Types Affected

All physicians and providers who bill Medicare carriers, fiscal intermediaries (FI), or Part A/B Medicare Administrative Contractors (A/B MACs) for providing mammography services

Provider Action Needed

STOP – Impact to You

As part of the annual HCPCS update, CMS has assigned new 2007 Current Procedural Terminology (CPT) mammography codes for screening and diagnostic mammography services. Effective January 1, 2007, these codes (77051, 77052, 77055, 77056, and 77057) will replace the current CPT codes; however, the CPT code descriptors for the services are unchanged.

CAUTION – What You Need to Know

Failure to submit the correct codes will cause your claims to be returned and not processed.

GO – What You Need to Do

Make sure that your billing staffs are aware of the CPT code changes.

Background

CR 5327, from which this article was taken, announces the assignment of new CPT codes for screening and diagnostic mammography services.

As part of the annual HCPCS update, CMS has assigned new 2007 CPT mammography codes for screening and diagnostic mammography services. Effective January 1, 2007, these codes (77051, 77052, 77055, 77056, and 77057) will replace the current CPT codes; however the CPT code descriptors for the services are unchanged.

The following table displays the new (and old) replacement codes and their description.

2007 Screening and Diagnostic Mammography CPT Codes		
New Code	Old Code	Description
77051	76082	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography. (List separately in addition to code for primary procedure.)
77052	76083	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography. (List separately in addition to code for primary procedure.)
77055	76090	Diagnostic mammography, unilateral
77056	76091	Diagnostic mammography, bilateral
77057	76092	Screening mammography, bilateral (two view film study of each breast)

Be advised that your carriers and FIs will return claims (with dates of service on or after January 1, 2007) that contain the old screening and diagnostic mammography codes. Also, effective January 1, 2007, frequency standards for screening mammography will be applied to the new screening codes (77052 and 77057).

Additional Information

You can find more information about the new 2007 mammography CPT codes by going to CR 5327, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1070CP.pdf> on the CMS Web site.

As an attachment to that CR, you will find revised Chapter 18 (Preventive and Screening Services), Section 20 (Mammography Services) of the *Medicare Claims Processing Manual* (100-04),

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Revised American National Standards Institute (ANSI) X12N 837 Institutional Health Care Claim Companion Document

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5334
Related CR Release Date: November 24, 2006
Related CR Transmittal #: R1116CP

Related Change Request (CR) #: 5334
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries

Impact on Providers

This article is based on CR 5334, which informs your FI, RHHI, or A/B MAC that changes (including National Provider Identifier (NPI) and taxonomy code reporting information changes) are being made to the ANSI X12 837 Institutional Companion Document, which is included with CR 5334 as an attachment.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires that CMS, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services.

The American National Standards Institute (ANSI) X12N 837 implementation guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. Implementation guides for each ANSI X12N transaction adopted as a HIPAA standard can be found at the following Web site: <http://www.wpc-edi.com>

The ANSI X12 837 Institutional Companion Document includes a set of statements, which supplements the requirements (but does not contradict) the X12N 837 Institutional Implementation Guide, and it clarifies Medicare contractor (FI/RHHI/A/B MAC) expectations regarding data submission, processing, and adjudication.

CR 5334:

- Provides your FI, RHHI, or A/B MAC with changes needed to the ANSI X12 837 Institutional Companion Document as an attachment, and
- Instructs your FI, RHHI, or A/B MAC to use these changes (**which include adding a requirement to report, as of May 23, 2007, the National Provider Identifier (NPI) and taxonomy code reporting information**) to revise/update your ANSI X12 837 Institutional Companion document.

The revised/updated ANSI X12N 837 Institutional Companion Document will be available through your Medicare FI, A/B MAC, or RHHI.

Implementation

The implementation date for CR 5334 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your FI, RHHI, or A/B MAC regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1116CP.pdf> on the CMS Web site.

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Unsolicited/Voluntary Refunds

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medlearn Matters* article. This article and other *Medlearn Matters* articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MedlearnMattersArticles/>

Medlearn Matters Number: MM3274

Related CR Release Date: July 30, 2004

Related CR Transmittal #: 50

Related Change Request (CR) #: 3274

Effective Date: October 1, 2004/January 1, 2005

Implementation Date: October 1, 2004/January 3, 2005

Provider Types Affected

All Medicare providers

Provider Action Needed

Providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Background

Medicare carriers and intermediaries receive unsolicited/voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related CR 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.

Additional Information

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Quarterly Provider Update

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all nonregulatory changes to Medicare including Transmittals, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the *Federal Register*.

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update listserv (electronic mailing list) at:

<http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1>

The Quarterly Provider Update can be accessed at:

http://www.cms.hhs.gov/quarterlyproviderupdates/01_overview.asp on the CMS Web site. We encourage you to bookmark this Web site and visit it often for this valuable information.

News from CMS for Hospital/CAH and RDF Providers



Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2007

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5407

Related CR Release Date: November 24, 2006

Related CR Transmittal #: R61BP

Related Change Request (CR) #: 5407

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Provider Types Affected

Medicare certified End Stage Renal Disease (ESRD) facilities billing Medicare fiscal intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for ESRD dialysis services.

What You Need to Know

CR 5407, from which this article is taken, notes that for calendar year (CY) 2007, there are no significant changes to the ESRD composite rate payment methodology; but announces that CMS made two updates: 1) To the drug add-on adjustment to the composite rate; and 2) To the wage index and transition.

Background

Section 1881(b) of the Social Security Act (as amended by section 623 of the Medicare Modernization Act (MMA)) directed CMS to make a number of revisions to the ESRD composite rate payment system, as well as to the payment for separately billable drugs furnished by ESRD facilities.

For calendar year (CY) 2007 CMS did not propose any significant changes to the composite rate payment methodology, but did make the following updates:

1. An update to the drug add-on adjustment to the composite rate; and
2. An update to the wage index and transition.

Drug add-on adjustment

MMA Section 623 established the ESRD composite payment rate's drug add-on adjustment to account for the difference between 1) payment amounts for separately billable drugs under pre-MMA payments, and 2) the new payment methodology established under Section 623.

The current add-on adjustment is 14.5 percent and includes a 1.4 percent update for 2006. CR 5407 announces that for CY 2007, the drug add-on adjustment to the composite payment rate is 0.5 percent. As a result, the drug add-on adjustment for 2007 will increase from 14.5 percent to 15.1 percent (1.145 x 1.005).

Also, note that there are no changes to the current CMS policy for payment of separately billed ESRD drugs. Therefore, for CY 2007, payment for separately billable drugs furnished by ESRD facilities will continue at average sales price (ASP) +6 percent.

Wage index and transition

CR 5407 also announces an update to the wage index adjustment to reflect the latest hospital wage data, including a budget neutrality adjustment to the wage index for CY 2007 (the second year of the four-year transition period). Consistent with the transition blends, CMS is implementing a 50/50 blend between an ESRD facility's Metropolitan Statistical Area (MSA) based composite rate, and its CY 2007 core based statistical area (CBSA) based rate reflecting its revised wage index values.

Also, for CY 2007, CMS is reducing the wage index floor from 0.85 to 0.80, so after applying a budget neutrality adjustment of 1.052818, the wage index floor is 0.8423.

Additional Information

You can find more information about the ESRD payment for CY 2007 by going to CR 5407, located at <http://www.cms.hhs.gov/Transmittals/downloads/R61BP.pdf> on the CMS Web site. You will find the updated *Medicare Benefit Policy Manual*, CMS Pub 100-2, Chapter 11 (End Stage Renal Disease (ESRD)), §30.5.1 (New ESRD Composite Payment Rates) as an attachment to that CR.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the "Contact Us" page of this *Medicare A Newslines*.

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Clarification on Billing for Cryosurgery of the Prostate Gland

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5376 Revised

Related Change Request (CR) #: 5376

Related CR Release Date: November 9, 2006

Effective Date: April 1, 2007

Related CR Transmittal #: R1111CP

Implementation Date: April 2, 2007

Provider Types Affected

Hospitals submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for services related to cryosurgery of the prostate gland

Provider Action Needed

This article is based on CR 5376, which revises sections of the *Medicare Claims Processing Manual* related to cryosurgery of the prostate, expands revenue codes permissible for billing for this service, and corrects the payment method for Indian Health Service (IHS) facilities. Be sure your billing staff is aware of the revenue code information.

Background

Cryosurgery of the prostate, also known as cryoablation of the prostate (CAP), destroys prostate gland tissue by applying extremely cold temperatures; this reduces the size of the prostate gland.

This article is based on CR 5376 which:

- Relocates the section on cryosurgery of the prostate from Chapter 18, Screening and Preventive Services, in the *Medicare Claims Processing Manual* (Publication 100-04) to Chapter 32, Billing Requirements for Special Services, in the same manual, and
- Expands the revenue codes permissible for billing this service to include 0360 and 0369, as well as 0361.

CR 5376 also changes the manual to clarify the payment method for cryosurgery in Indian Health Service (IHS) facilities. These revised sections of the manual are included as attachments to CR 5376.

Additional Information

CAHs That Elect Method II Must Do So Annually

In addition, CR 5376 revises the *Medicare Claims Processing Manual* by clarifying that critical access hospitals (CAHs) wishing to be paid using the optional method (Method II) for professional outpatient services must make the election to do so annually.

Note: There are no policy changes related to these clarifications.

For complete details, please see the official instruction, CR 5376, issued to your FI or A/B MAC regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1111CP.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

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Cavernous Nerves Electrical Stimulation with Penile Plethysmograph

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network* (MLN) *Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5294

Related Change Request (CR) #: 5294

Related CR Release Date: November 24, 2006

Effective Date: August 24, 2006

Related CR Transmittal #: R61NCD

Implementation Date: January 8, 2007

Provider Types Affected

Physicians and hospitals that bill Medicare fiscal intermediaries (FI) and carriers for performing Cavernous Nerves Electrical Stimulation with Penile Plethysmography in Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures

Provider Action Needed

STOP – Impact to You

Effective for claims with dates of service on or after August 24, 2006, Medicare will not pay for performing Cavernous Nerves Electrical Stimulation with Penile Plethysmography in Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

CAUTION – What You Need to Know

CR 5294, from which this article is taken, announces the results of a national coverage determination (NCD) addressing Cavernous Nerves Electrical Stimulation with Penile Plethysmography performed for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

It states that CMS, after reviewing the evidence, has determined that this test is not reasonable and necessary for Medicare beneficiaries undergoing these procedures.

GO – What You Need to Do

Make sure that your billing staffs are aware of this NCD.

Background

The direct application of electrical stimulation with penile plethysmography (also referred to as cavernosal nerve mapping) may be performed, in nerve-sparing prostatic and colorectal surgical procedures, to assess the integrity and function of the cavernous nerves.

Through either an open or laparoscopic approach, the surgeon can assess the function of the cavernous nerves by stimulating, with an electrical nerve stimulator, the most distal end of the nerve that can be located. A functioning and stimulated nerve will trigger blood flow either into or out of the penis, which can be detected via a penile plethysmography sensor fitted around the penis and connected to a nerve stimulator control unit. If the nerves are intact, cavernous blood flow will cause slight changes in penile girth, which the sensor can detect. The presence (and degree) of a response may be used to provide the surgeon with a more realistic assessment of the chance of the patient regaining potency and assist in choosing appropriate therapy.

Heretofore, local Medicare carriers/FIs had the discretion to cover this test whenever it was determined to be medically necessary for the individual patient, because a national coverage determination (NCD) or national Medicare coverage policy had not been issued. However, on December 9, 2005, a request for review of this test initiated a national coverage analysis.

CR 5294, from which this article is taken, announces the results of this NCD. It provides that CMS has reviewed the evidence and determined that: 1) Cavernous Nerves Electrical Stimulation with Penile Plethysmography is not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures, and 2) this test is noncovered under Medicare (as specified the *Medicare National Coverage Manual* (100-03, §160.26 “Cavernous Nerves Electrical Stimulation with Penile Plethysmography”).

Effective with claims with dates of service on or after August 24, 2006, your FIs and carriers will not pay for these services.

Physicians should use HCPCS code 55899 to bill this for test. Your FIs and carriers will suspend claims containing this code to determine whether this test is the service being billed, and will deny the line item associated with it, using Medicare Summary Notice 21.11 (This test was not covered by Medicare at the time you received it).

You should be aware that your FIs, A/B MACs and carriers will not search for, and adjust, claims for tests that have been paid prior to January 8, 2007, but they will adjust claims brought to their attention. Further, physicians and hospitals should, as appropriate:

1. Issue the appropriate liability notice for Medicare beneficiaries having this test;
2. Include the following language when issuing an Advanced Beneficiary Notice (ABN):
 - Under “Items or Service” Section: Cavernous Nerves Electrical Stimulation with Penile Plethysmography.
 - Under “Because” Section: As specified in section 160.26 of *Medicare National Coverage Determination Manual*, Medicare will not pay for this test as it is not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures. and/or
3. Issue a hospital Issued Notice of Noncoverage (HINN).

If a physician does not issue an ABN, the physician is liable for the service.

Additional Information

You can find more information about payment for Cavernous Nerves Electrical Stimulation with Penile Plethysmography by going to CR 5294, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R61NCD.pdf> on the CMS site. You will find revised §160.26 (Cavernous Nerves Electrical Stimulation with Penile Plethysmography) of the *Medicare National Coverage Manual* (Publication 100-03) as an attachment to this CR.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

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2007 Update of HCPCS Codes and Payments for Ambulatory Surgical Centers (ASCs)

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network* (MLN) *Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5211

Related CR Release Date: July 28, 2006

Related CR Transmittal #: R1013CP

Related Change Request (CR) #: 5211

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Provider Types Affected

Ambulatory surgical centers (ASCs) submitting claims to Medicare carriers or fiscal intermediaries (FIs) for ASC services provided to Medicare beneficiaries

Impact on Providers

This article is based on CR 5211, which updates the 2007 HCPCS codes and ASC payment rates, effective for services furnished on or after January 1, 2007.

Background

Section 5103 of the Deficit Reduction Act of 2005 (DRA) limits ASC payments to:

- The lesser of the Medicare Hospital Outpatient Prospective Payment System (OPPS) payment amount; or
- The ASC payment amount for services furnished on or after January 1, 2007.

Also, §1833(i)(1) of the Social Security Act requires that the list of payable ASC procedures be updated as least every two years.

CR 5211, from which this article is taken, implements the required biennial ASC update, which includes changes made by the American Medical Association for the Calendar Year (CY) 2007 Common Procedural Terminology (CPT). These changes include replacing the ASC two-digit payment group code designation next to the ASC-approved Healthcare Common Procedure Coding System (HCPCS) codes with a “yy” designation for these codes, which will be defined as “the procedure is approved to be performed in an ambulatory surgical center.”

CR 5211 also revises the manner in which ASC payment groups are defined. The number of ASC payment groups that carriers and fiscal intermediaries (FI) currently use to identify ASC payment amounts for individual HCPCS codes is being expanded in order to accommodate the new payment amounts that will be assigned to certain ASC services in CY 2007 under the DRA requirement. The ASC payment groups will now be called ASC PRICER groups.

The additional ASC PRICER groups reflect the DRA-driven payment amounts, which will be included in the ASC PRICER files that carriers, and certain FIs, use to process ASC facility claims.

And lastly, CR 5211 includes payment file retrieval instructions that your carriers and FIs will use to access the final payment files on, or after, the specified retrieval date provided in CMS’s notification.

You should be aware that final ASC payment rates are established after publication of the OPPS final rule and the code change update will be published as part of the OPPS final rule in the *Federal Register*. This publication usually occurs in late October. Shortly after publication, you can reach this rule through a link at <http://www.cms.hhs.gov/center/asc.asp> on the CMS Web site.

Also note that your carriers and FIs will continue to use the wage index values contained in Transmittal 51, dated February 4, 2004, to calculate payment amounts for all type of service “F” Healthcare Common Procedural Coding System (HCPCS) codes until further notice. This transmittal is available at <http://www.cms.hhs.gov/Transmittals/downloads/R51OTN.pdf> on the CMS site.

Additional Information

For complete details, please see CR 5211, the official instruction issued to your carrier/intermediary regarding this change, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1013CP.pdf> on the CMS Web site. Attached to CR 5211 is the ASC List of Approved Procedures HCPCS Code Changes (deletions/additions) for January 1, 2007.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newslines*.

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Common Working File (CWF) Duplicate Claim Edit for the Technical Component (TC) of Radiology and Pathology Laboratory Services Provided to Hospital Patients

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5347

Related Change Request (CR) #: 5347

Related CR Release Date: November 2, 2006

Effective Date: April 1, 2007

Related CR Transmittal #: R1098CP

Implementation Date: April 2, 2007

Provider Types Affected

Radiology suppliers, physicians and nonphysician practitioners billing Medicare carriers for the TC of radiology laboratory services provided to Medicare fee-for-service hospital inpatients. Also affected are independent laboratories billing Medicare carriers for the TC of pathology laboratory services provided to Medicare fee-for-service hospital patients.

Provider Action Needed

Effective April 1, 2007, CMS will install systems edits to prevent improper payments to radiology suppliers, physicians and nonphysician practitioners for the TC of radiology laboratory services during an inpatient stay. The system edits will also apply to independent laboratories for the TC of pathology laboratory services provided to beneficiaries during a covered inpatient hospital stay or provided on the same date of service as an outpatient service. This change applies to claims with dates of service on or after January 1, 2007, where the claim is received on or after April 1, 2007. Please be sure billing staff are aware of these changes.

Background

Current Medicare billing practices allow either the hospital or the supplier performing the technical component (TC) of physician pathology laboratory services to bill the carrier for these services. This policy has contributed to the Medicare program paying twice for the TC service, first through the Prospective Payment System (PPS) to the hospital and again to the supplier that bills the carrier, instead of the hospital, for the TC service.

Effective for claims received on or after April 1, 2007, for services on or after January 1, 2007, CMS will install systems edits to prevent additional improper payments to radiology suppliers, physicians and nonphysician practitioners billing Medicare carriers for the TC of radiology laboratory services during an inpatient stay. The edits will also apply to independent laboratories for the TC of pathology services provided to beneficiaries during an inpatient stay or for the same date of service as an outpatient service.

Key Points

- Effective for claims received on or after April 1, 2007, Medicare will reject/deny a Part B TC or globally billed radiology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay. Such services will also be rejected/denied when they match with a date of service of a hospital inpatient previously processed by Medicare.

- Effective for claims received on or after April 1, 2007, Medicare will reject/deny a Part B TC or globally billed pathology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay when billed by a physician/supplier. Such services will also be rejected/denied when they match with a date of service of a hospital outpatient bill (bill types 13X and 85X) previously processed by Medicare.
- If providers submit a TC of a radiology or pathology service with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay, the carrier will use Remittance Advice Reason Code 109 “Claim not covered by this payer/contractor.” when denying a service line item.
- Where Medicare systems detect that a Part B TC or globally billed radiology or physician pathology service has been paid and Medicare subsequently receives a hospital inpatient bill for the same date of service, the Medicare carrier will adjust a TC of a radiology or physician pathology service line item and recoup the payment made for that service from the physician/supplier. The Medicare carrier will also adjust a TC of a pathology service for an outpatient claim. The same Remittance Advice Reason Code of 109 will be used in such cases.
- Effective for claims received on or after April 1, 2007, the carrier will deny an incoming Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (noncovered level of care) from and through dates plus one day on a posted hospital inpatient bill. Again, the carrier will use Remittance Advice Reason Code 109. In addition, the Medicare carrier will recoup payment made to the physician/supplier if a subsequent hospital inpatient bill is received for those same services.
- Carriers will not search their files to either retract payment or retroactively pay claims prior to the implementation of CR 5347. However, they will adjust claims if they are brought to their attention.

Implementation

This change will be implemented on April 2, 2007.

Additional Information

For complete details regarding this CR, please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1098CP.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

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Announcement of Medicare Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Payment Rate Increases

The Centers for Medicare & Medicaid Services (CMS) has provided the following *Medicare Learning Network (MLN) Matters* article. This *MLN Matters* article and other CMS articles can be found on the CMS Web site at: <http://www.cms.hhs.gov/MLNMattersArticles>

MLN Matters Number: MM5435

Related Change Request (CR) #: 5435

Related CR Release Date: December 8, 2006

Effective Date: January 1, 2007

Related CR Transmittal #: R1126CP

Implementation Date: January 2, 2007

Provider Types Affected

Providers submitting claims to Medicare fiscal intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on CR 5435, which provides instructions for the calendar year (CY) 2007 payment rate increases for RHC and FQHC services. The RHC upper payment limit increase per visit is \$74.29 and reflects a CY 2007 rate increase of 2.1 percent. The FQHC upper payment limits per visit also reflects a CY 2007 rate increase of 2.1 percent for urban (\$115.33) and rural (\$99.17) areas.

Background

The following provides instructions for the CY 2007 payment rate increases for RHC and FQHC services.

RHCs:

The RHC upper payment limit per visit **is increased**

- From \$72.76 to **\$74.29** effective January 1, 2007, through December 31, 2007 (i.e., CY 2007).

The 2007 rate reflects a **2.1 percent increase** over the 2006 payment limit in accordance with the rate of increase in the Medicare Economic Index (MEI) as authorized by the Social Security Act (§1833(f); http://www.ssa.gov/OP_Home/ssact/title18/1833.htm).

FQHCs:

The FQHC upper payment limit per visit for **urban FQHCs is increased:**

- From \$112.96 to **\$115.33** effective January 1, 2007, through December 31, 2007 (i.e., CY 2007).

The maximum Medicare payment limit per visit for **rural FQHCs is increased:**

- From \$97.13 to **\$99.17** effective January 1, 2007, through December 31, 2007 (i.e. CY 2007).

The 2007 FQHC rates reflect a **2.1 percent increase** over the 2006 rates, in accordance with the rate of increase in the MEI.

Additional Information

The official instruction, CR 5435, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1126Cp.pdf> on the CMS Web site.

If you have questions regarding this issue, contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.

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News from Cahaba GBA, LLC for All Providers



Process Change – No Longer Returning Suspended Claims for Correction Upon Provider Request

Beginning February 1, 2007, Cahaba GBA, LLC will no longer return suspended claims for correction to a provider's Return to Provider (RTP) file upon the provider's request. Until this effective date, Cahaba GBA, LLC will only return suspended claims for correction upon a provider's request in the following circumstances:

- The request is made the same day the provider submitted the claim or worked it out of RTP; or
- The claim is in FISS status/location (S/LOC) S B9000, (except claims that have been reviewed by Medical Review).

If claims are submitted with incorrect, missing or inappropriate information, providers may correct the claims after FISS returns the claims to the RTP S/LOC T B9997. If the claim does not go to the RTP file, providers can still change the information after the claim has finalized (S/LOC P B9997 and R B9997) by submitting adjustments and cancellations, when appropriate.

One of the reasons why this process change is occurring is in preparation for additional data that will be made available through the Comprehensive Error Rate Testing (CERT) program. CERT is a quality assurance program established by the Centers for Medicare & Medicaid Services (CMS) to ensure that contractors are paying claims correctly according to Medicare regulations.

There are currently three different types of data that are calculated through the CERT program for fiscal intermediaries (FIs), with a fourth one (the Provider Compliance Error Rate) to be calculated in the future. The Provider Compliance Error Rate reveals how well providers prepare claims for processing prior to their submission to Medicare before any edits in the Fiscal Intermediary Standard System (FISS) are applied.

Providers, therefore, are encouraged to make sure the information on their claims is complete, appropriate and according to Medicare regulations prior to submitting them to Cahaba GBA, LLC.

In addition to a high Provider Compliance Error Rate, providers are negatively impacted by the consequences of incomplete, inappropriate and missing claim information, which costs time and money by creating the need for staff to re-work or re-submit claims, as well as contributes to Medicare payment delays and cash flow interruption. The Medicare program also is negatively impacted due to increasing the cost to process Medicare claims.

Please ensure that your staff is aware of this process change prior to it taking effect in February 2007. If you have questions regarding this process change, please contact a Customer Service Representative at the appropriate telephone number found on the “Contact Us” page of this *Medicare A Newsline*.



Ask-The-Contractor Teleconferences (ACTs)

In response to feedback from our provider community and the members of our Advisory Groups, Cahaba GBA, LLC is changing the format of the Ask-The-Contractor Teleconferences (ACTs) for Fiscal Year (FY) 2007. The ACTs will be topic-oriented, whereby information will be shared and questions solicited on a specific topic. The FY 2007 ACTs have been organized to address topics of concern within our provider community. Currently for FY 2007, Cahaba GBA, LLC has five ACTs scheduled (see below).

We welcome participation by providers, associations, and other provider groups. You may have an unlimited number of staff participate; however, to allow maximum participation we encourage one telephone line per provider, association, or group.

A tentative schedule of the FY 2007 ACTs follows, with each specific topic. All calls will be held from 1:00 p.m. – 2:00 p.m. Central Time (CT). ACTs will be posted on our Calendar of Events Web page approximately four weeks prior to the event. Once posted, you may register to participate by accessing the Calendar of Events Web page at: https://www.cahabagba.com/apps/course_registration/ia/calendar.jsp

Date	Topic
January 11, 2007	Comprehensive Error Rate Testing (CERT)
January 25, 2007	Benefits Exhaust and No-Payment Billing
February 8, 2007	UB-04
March 8, 2007	National Provider Identifier (NPI)
August 2, 2007	Claim Submission Errors (CSE)

A reminder to providers who participate in the ACTs: To ensure your questions for an ACT topic are addressed during the call, you must submit them in advance by replying to the email confirming your registration for the ACT by the date noted in the email. Questions not received in advance may not be addressed during the ACT.





Implementation of the 2007 Medicare Contractor Provider Satisfaction Survey (MCPSS)

The 2007 implementation of the Medicare Contractor Provider Satisfaction Survey (MCPSS) is quickly approaching. This survey is conducted by the Centers for Medicare & Medicaid Services (CMS) and administered through a contract awarded to Westat, a survey research firm. During this survey, 800 randomly selected providers who submit claims to Cahaba GBA, LLC will be surveyed in seven key areas. Westat began calling providers in November to conduct screenings to ensure the surveys are directed to the appropriate person. Providers who are selected for this survey will then receive a letter in January 2007. However, during the screening, if Westat determines the provider does not have Internet access, they will proceed with conducting the survey during the screening calls.

In July 2007, Westat will provide sanitized survey results to Cahaba GBA, LLC. This is a vital means by which we evaluate how we interact and communicate with our providers. We will use the MCPSS results to improve our processes and communication with providers, and better meet the needs of our providers. To accomplish this, we ask that those providers who receive surveys take time to complete them within the timeframe indicated. In addition, each question on the survey allows providers to supply comments. These are most helpful to us, and provide you with a means to suggest ways for us to improve. All comments submitted by providers are reviewed by Westat, and sanitized to ensure the provider's confidentiality is maintained.

For more information about the MCPSS, access the CMS Web site at <http://www.cms.hhs.gov/MCPSS/> or the Westat Web site, at: <https://www.mcpsstudy.org/>



FAQs About Determining Medicare Advantage Plans Using ELGA/ELGH

Following the November 9, 2006, Cahaba GBA, LLC teleconference titled "The Empowerment of the Eligibility Screens", we received some questions about Medicare Advantage (sometimes referred to as a Health Maintenance Organization (HMO)) plans and how that information is identified using the eligibility screens available via ELGA and ELGH. Below is a summary of the questions we received, and responses to those questions.

Q1. I would like to know if it is possible to find HMO information on a beneficiary like you can Medicare Secondary Payer (MSP) information.

A1. Yes, Medicare Advantage (MA) plan information for all Medicare beneficiaries can be found on page 01 in ELGA, or on page 05 in ELGH. You must consider the effective date (EFF DATE or ENTITL) and the termination date (TRM DATE or TERM) when determining if the beneficiary is currently under a Medicare Advantage plan. In addition, providers should review the option (OPT) code. An option code "C" indicates the services must be billed to the Medicare Advantage plan. An option code "1" indicates the services should be billed to the fiscal intermediary (FI) or Regional Home Health Intermediary (RHHI) as usual.

Q2. Will all Medicare Advantage beneficiaries have a Medicare number to check this eligibility information in ELGA/ELGH?

A2. Yes, all Medicare beneficiaries receive a Medicare Health Insurance Claim Number (HICN), regardless of whether they receive services under the traditional Medicare fee-for-service (FFS) plan, or a MA plan. Using the beneficiary’s HICN, name, date of birth and sex code, all providers can utilize ELGA or ELGH to determine whether the beneficiary has elected an MA plan. The MA plan information is available on page 01 in ELGA, and on page 05 in ELGH.

For additional information about ELGA and ELGH, refer to the “Checking Beneficiary Eligibility” section of the *FISS Reference Guide*, available at:

https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_elig.pdf on our Web site. In addition, please review the article “Tips for Preventing Billing Issues Associated With Medicare Advantage (HMO) Plans” found in the November 1, 2006, *Medicare A Newsline* available at: https://www.cahabagba.com/part_a/education_and_outreach/newsletter/index.htm



Availability of the Provider Contact Center

Medicare is a continuously changing program, and it is important that we provide correct and accurate answers to your questions. To better serve the provider community, the Centers for Medicare & Medicaid Services (CMS) allows the provider contact centers the opportunity to offer training to our Customer Service Representatives (CSRs). The Provider Contact Center in Birmingham, Alabama (1-866-539-5598 and 1-877-567-3092) will conduct training for CSRs on a weekly basis, on Thursdays from 10:30 a.m. to 12:30 p.m. Central Time (CT). Listed below are the days and times the Provider Contact Center will be closed for training. We will continue to notify you of future CSR training dates in the *Medicare A Newsline*.

CSR Training	Dates Time
January 4, 2007	10:30 a.m.–12:30 p.m. CT
January 11, 2007	10:30 a.m.–12:30 p.m. CT
January 18, 2007	10:30 a.m.–12:30 p.m. CT
January 25, 2007	10:30 a.m.–12:30 p.m. CT



Provider Enrollment – Important Information

Several issues have arisen in the past few months that providers need to be aware of. In addition, the Centers for Medicare & Medicaid Services (CMS) has also issued an update to the provider enrollment regulation. These items are addressed as follows.

- I. There have been several CMS-855A applications that were recently rejected as the provider failed to respond to the information request or submitted only some of the information that was requested. Please note that it is very important that the provider furnish complete and accurate enrollment information to Medicare when the application is initially submitted. Failure to do so may lead to processing delays. The following will assist in the submission:
- Ensure all sections and fields of the application are complete. Sections 1A and 1B of the application identify the specific sections that need to be completed based on the submission type. The Cahaba GBA, LLC Web site (www.cahabagba.com) contains checklists that will walk you step by step through completion of the forms. Refer to the contact information below for a link to this site.
 - Ensure all required documents are submitted with the 855. Section 17 identifies the mandatory documents. When in doubt, submit. Although not required, it would be helpful if the CP 575 or other IRS documentation that identifies the legal business name and tax identification number was submitted. As noted in the referenced articles below, the national provider identifier (NPI) documentation from the National Plan and Provider Enumeration System (NPPES) and the electronic funds transfer (EFT) agreement, if the provider is not currently on EFT, are required.
 - When submitting, ensure the 855 contact person is available to address any questions or corrections. The authorized official should also be available to re-sign the form to approve the corrections. The 855 cannot be processed until the approving signature is received.
 - Although the best way to expedite the review is to submit a clean application with all supporting documents the first time. The next best way is to respond immediately to any and all requests for information. If a clarification is needed, submit a letter of explanation with the corrections.
- II. There have been several CMS-855A applications that have recently been returned upon receipt as the acceptability requirements were not met. The requirements for acceptance are as follows:
- Must be signed and dated.
 - Must include an original signature. No stamped, copied, or faxed signatures.
 - Must be on the most current version. Refer to the CMS Web site at: <http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf>
 - The application must be sent to the audit intermediary (AI); not the claims intermediary. The AI is responsible for processing the request.
 - The application CMS-855A must be submitted. The CMS-855B, 855I, and 855R are processed by the Part B carrier.
 - The application, when required, must be completed in its entirety. A full application is required when a provider requests any type of enrollment change, but has not submitted a CMS-855A since the implementation of the Provider Enrollment Chain and Ownership System (PECOS) on July 29, 2002.
 - Change of Ownership (CHOW) applications should not be submitted more than three months prior to the anticipated date of sale.
 - Applications other than CHOWs, should not be submitted more than thirty days prior to the effective date of the change.
 - Applications must be mailed in. Faxed or e-mailed 855s are not acceptable.
 - Applications must be typed or completed in pen.
 - 855s do not apply for home office changes.
 - EFT agreements must also meet the above requirements. If the requirements are not met, the EFT agreement will be returned. Refer to the EFT agreement, which can be found on the CMS Web site at: <http://www.cms.hhs.gov/cmsforms/downloads/cms588.pdf>

- III. Adverse legal history information must be complete and correct. If Section 3, 5B, and/or 6B are answered no, and an action is discovered during the contractor's review, this could result in a denial of the application. The provider will not be asked to correct the application.
- IV. CMS has recently updated the Medicare Provider Enrollment regulation. Providers are now required to submit a complete CMS-855A application if the provider is making any change to its current provider enrollment data and is not in the Provider Enrollment Chain and Ownership System (PECOS). This system includes enrollment data from the 855 application. Note that PECOS was initiated on July 29, 2002. The IRS documentation supporting the tax identification number and legal business name should also be submitted. If a full application is not submitted, the 855 will be returned upon receipt, prior to a review.

Refer to the "Provider Enrollment" articles in the July 1, 2006, through October 1, 2006, *Medicare A Newslines* issues for additional frequently asked questions (FAQs) regarding the NPI, EFT, and submission of the varying types of CMS-855A applications.

Provider enrollment contact and Web site information is as follows:

Contact our Alabama office if your provider is located in the state of Alabama or is a component provider or a national chain organization that has single intermediary status with Cahaba Government Administrators,[®] LLC.

Medicare Part A

Attention: Provider Reimbursement

P.O. Box 361930

Birmingham, AL 35236-1930

Helpline Number (Medicare Provider Customer Service): 866-539-5598

CMS Web site: <http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

Cahaba GBA, LLC Web site: http://www.cahabagba.com/part_a/enroll_update_your_records/index.htm

Contact our Iowa office if your provider is located in the states of Iowa or South Dakota or is a component provider or a national chain organization that has single intermediary status with Cahaba Government Benefit Administrators,[®] LLC.

Cahaba GBA, LLC

Attention: Provider Enrollment

401 Douglas, Suite 410

P.O. Box 7501

Sioux City, IA 51101

Helpline Number (Provider Enrollment/EFT/Provider-Based): 712-293-5764

CMS Web site: <http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

Cahaba GBA, LLC Web site: http://www.cahabagba.com/part_a/enroll_update_your_records/index.htm



Provider-Based Status

The information provided in this article is intended to answer questions that relate to determinations involving provider-based status.

Q1. Our facility plans to voluntarily attest as to the provider-based status of our facility rather than request approval. Does the state agency need to be notified of this?

A1. Regardless of whether the provider chooses to voluntarily attest as to the status of a facility as provider-based, the provider needs to contact the state agency to request approval of this facility as a unit of the hospital. The provider cannot bill for the facility as provider-based unless the facility is on the hospital license. In order to add the facility, the state must ensure that building and other requirements have been met.

Q2. Where can the provider-based attestation statement be found?

A2. The Centers for Medicare & Medicaid Services (CMS) does not have a standard provider-based attestation form. An explanation of the documentation that should be submitted, along with an example can be found in a CMS Program Memorandum dated April 18, 2003, Transmittal A-03-030. Cahaba GBA, LLC has developed a standard provider-based attestation that will assist in requesting approval of your facility. This, along with additional provider-based instructions, and a link to the previously mentioned transmittal, can be found on the Cahaba GBA Web site at: https://www.cahabagba.com/part_a/enroll_update_your_records/enroll_provstatus.htm

Q3. We would like to submit a request for provider-based status. Are there any tips that would expedite the review?

A3. There are several things a provider can do to help expedite the provider-based review:

- The most typical reason for delay is the license. The provider should submit the hospital license that includes the facility for which the request is being made, with the request for provider-based status.
- If the facility is offsite, the additional off campus documentation should be submitted.
- The application needs to be mailed in. Faxed copies are not accepted.
- The application should contain an original signature and date. No faxed, stamped, or copied signatures are accepted.
- Submit the application on the standard application format as addressed in A2, with all fields completed. This will ensure all requirements are addressed and can be verified by the contractor.

Please refer to the “Provider-Based Status” articles in the December 1, 2005, February, June, and October 1, 2006, *Medicare A Newslines* issues for additional information on provider-based status. Note that the attestation statement process is voluntary. If you choose to request formal approval, please submit the attestation statement and support to:

For Part A providers who submit Medicare claims to the Cahaba GBA office in Iowa:

Cahaba Government Benefit Administrators,[®] LLC
Attn: Provider-Based Status
401 Douglas, Suite 410
P.O. Box 7501
Sioux City, IA 51101

For additional assistance, contact our Provider Enrollment Helpline at 712-293-5764.

For Part A providers who submit Medicare claims to the Cahaba GBA office in Alabama:

Cahaba Government Benefit Administrators,[®] LLC
Provider Audit and Reimbursement
PO Box 361930
Birmingham, AL 35236-1930

Questions regarding provider-based status issues for Alabama providers may be submitted by e-mail to:
AlaMedicarePtAProviderBasedQuestions@bcbsal.org



Medicare Credit Balance Quarterly Reminder

This is to remind you to submit the Quarterly Medicare Credit Balance Report. The next report is due in our office postmarked by **January 31, 2007**, for the quarter ending **December 31, 2006**.

The Medicare Credit Balance Report (CMS-838) and certification must be postmarked by the date indicated above. If the information is received with a postmark date later than the date indicated above, we are required to withhold 100 percent of all payments being sent to your facility. This withholding will remain in effect until the reporting requirements are met. If no credit balance exists for your facility during a quarter, a signed Medicare Credit Balance Report certification is still required. Please include your Medicare provider number on the certification form.

To ensure timely receipt and processing, please send the report to the appropriate address listed below.

If you submit your Medicare claims to the Cahaba GBA, LLC office in Des Moines, Iowa, send the report to:

Attention: Credit Balance, Sta. 210
Provider Audit and Reimbursement
Cahaba GBA, LLC
P.O. Box 14537
Des Moines, IA 50306-3537

Or, if sending overnight:
Attention: Credit Balance, Sta. 210
Provider Audit and Reimbursement
Cahaba GBA, LLC
500 E Court Ave STE 200
Des Moines, IA 50309-2019

If you submit your Medicare Credit Balance report to the above address and have any questions, please contact the Medicare Credit Balance telephone line at **515-471-7444**.

If you submit your Medicare claims to the Cahaba GBA, LLC office in Birmingham, Alabama, send the report to:

Medicare Part A Credit Balance Reporting

Cahaba GBA, LLC
P.O. Box 10808
Birmingham, AL 35202-0808

If you submit your Medicare Credit Balance report to the above address and have any questions, please contact the Medicare Credit Balance telephone line at **205-220-1280**.

The CMS-838 and certification form is available on the Centers for Medicare & Medicaid Services (CMS) Web site at: <http://new.cms.hhs.gov/cmsforms/downloads/CMS838.pdf>

If you need a paper copy of the CMS-838 form, contact the appropriate Medicare Credit Balance telephone line listed above.



Consolidation of Local Coverage Determination (LCD) Identification (ID) Numbers – UPDATE

As outlined in the article “Consolidation of Local Coverage Determination (LCD) Identification (ID) Numbers – CORRECTION” which was published October 12, 2006, on the “What’s New” page of our Web site at: https://www.cahabagba.com/part_a/whats_new/20061012_lcdNumbers.htm, Cahaba GBA, LLC began consolidating common LCDs by number. Due to temporary problems with the Centers for Medicare & Medicaid Services (CMS) Coverage Database, Iowa and South Dakota LCDs display “Alabama” in the “Contractor Name” field, when they are accessed through the Cahaba GBA, LLC Web site for Active Iowa/South Dakota LCDs. The LCDs display the correct “Contractor Name” when the LCDs are accessed through the CMS Coverage Database using the following process:

1. Access the CMS Medicare Coverage Database at: <http://www.cms.hhs.gov/mcd/search.asp>
2. Select the blue “Indexes” tab.
3. Scroll down to “Local Coverage.” Under the “List of LMRP/LCDs” heading, select “by Contractor.”
4. Scroll down and select “Cahaba Government Benefit Administrators,® LLC Midwest (00011, FI)” to access a list of the current LCDs.

We apologize for the confusion and temporary inconvenience. We will publish a follow up article when these temporary problems have been corrected.



Automating Local Coverage Determinations

LCD – FI and Outpatient RHHI - IA – Automating Local Coverage Determinations

Note: This article applies to those providers who submit their claims to Cahaba GBA, LLC office in Des Moines, IA.

In an effort to assimilate the review of Local Coverage Determinations (LCDs) and to ensure LCDs remain accurate and current, effective January 1, 2007, our Medical Review Department plans to begin expanding the use of the automated review process to edit current and future LCDs. For current LCDs this process will be implemented over the first quarter of 2007. These edits will be based on those covered diagnoses listed in the “ICD-9 Codes that Support Medical Necessity” section of an LCD. Any claim containing CPT/HCPCs codes billed without the covered diagnoses will be automatically denied.

This automated process results in a more consistent claim review and timely ‘claims processing’ related to services billed without payable criteria on the claim. While most of the LCDs do not specify that covered diagnoses should be primary, some LCDs do have specific coverage instructions related to the covered diagnoses indicated in the policy. In addition, although your documentation may support a covered diagnosis and/or the medical necessity of a service included in an LCD, the automated review process will only recognize that diagnosis if located on the submitted claim. Therefore, to avoid unnecessary denials and costly appeals, providers must ensure the claim contains the coverable diagnoses as indicated by an LCD. If you disagree with the automated denial, your only recourse to receive reimbursement is to request an appeal.

Please update your records and notify appropriate staff of this update. Please refer to our Web site at: https://www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm to view active LCDs. For information regarding the automated review process, refer to the November 1, 2005, *Medicare A Newsline* article, “Automated Edits and the SuperOp Claims Processing Software.” The *Medicare A Newsline* can be found on our Web site at: https://www.cahabagba.com/part_a/education_and_outreach/newsletter/index.htm



Part A Local Coverage Determination (LCD) Update

Our Medical Review department continues to develop Local Coverage Determinations (LCDs) and review existing LCDs to ensure policies remain accurate and up-to-date. As a result, please review the following LCD update.

- **Updates for 2007 CPT/HCPCS**

The LCD revisions listed below are based on the 2007 CPT/HCPCS coding changes. Unless otherwise noted, these revisions apply to Part A providers who submit claims to the Cahaba GBA, LLC office in Alabama and Iowa.

Effective January 1, 2007, the following revised LCDs will be available to view at:

https://www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm

2007 CPT/HCPCS Codes

LCDs	Invalid	Replaced with	Added
Erythropoietin Analogues			Q4081
Paravertebral Facet Joint Block (Iowa Only)	76005	77003	
Paravertebral Nerve Blocks (Iowa Only)	76005	77003	

Please update your records. These policies and other LCDs can be found on our Web site at:

https://www.cahabagba.com/part_a/policies_medical_review/index.htm

News from Cahaba GBA, LLC for Hospital/CAH Providers



Widespread Probe Review Results – Review of Current Procedural Terminology (CPT) 76000 (fluoroscopy, separate procedure, up to one hour physician time, other than 71023 or 71034) with Various Procedures

This article applies to Medicare Part A providers who submit claims to the Cahaba GBA, LLC office in Alabama.

Our Medical Review department recently completed a probe review of outpatient hospital claims billing of CPT 76000 with CPTs 36561 (Insertion central venous access with port, age 5 or older); CPT 47563 (Laparoscopic cholecystectomy with cholangiography); CPT 52332 (Cystourethroscopy with insertion indwelling ureteral stent); CPT 74420 (Urography, retrograde with or without KUB). Educational articles regarding other uses of fluoroscopy were previously posted in April 2006 and May 2006 on the “What’s New from Cahaba GBA” page of our Web site at:

https://www.cahabagba.com/part_a/whats_new/news_cahaba.htm

The review results are as follows:

Providers Reviewed: 23
 Claims Reviewed: 96
 Claims Approved: 0
 Claims Denied: 96
 Charges Reviewed: \$ 38,447.27
 Charges Approved: \$ 0.00
 Charges Denied: \$ 38,447.27

Error Rate: 100%*

* error rate is based on the percent of charges denied divided by the charges reviewed

The medical review decisions were based on the Correct Coding Initiative (CCI), developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in claims. The purpose of the CCI edits is to ensure the most comprehensive groups of codes are billed rather than the component parts, and to check for mutually exclusive code pairs. According to the *National Correct Coding Initiative Policy Manual*, if a CPT code descriptor includes the phrase, 'separate procedure' (as does CPT 76000), the procedure is subject to CCI edits. CMS does not allow separate reporting of a procedure designated as a 'separate procedure' when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

The majority of denials of claims reviewed resulted from the documentation in the medical record not supporting the billing of fluoroscopy as a separate service from the procedure performed on the same patient encounter. In most instances, the fluoroscopy billed was an inherent component of the procedure performed and not separately billable. As instructed in the *Medicare Claims Processing Manual*, Chapter 23, §20.9.1.B, if a separate and distinct procedure (in this case fluoroscopy) is performed independent of the other services performed on the same day, then the provider should add modifier -59 to the secondary, additional or lesser service on the claim. The -59 modifier may represent a different session or patient encounter, different procedure or surgery, different anatomical site or organ system, separate incision/excision, or separate injury area.

Additionally, 16 claims were denied due to a lack of record submission in a timely manner. According to *The Medicare Program Integrity Manual*, Pub 100-08, Chapter 3, §3.4.1.2, if a coverage or coding determination cannot be made based upon the information on the claim, the fiscal intermediary (FI) may solicit additional documentation from the provider by issuing an Additional Documentation Request (ADR) and must notify the provider of the 30 day time-period to respond. If ADR requested information is not received within 45 days after the date of the request, the claim will be denied.

To eliminate reason code 56900 denials, please review the following elements to ensure appropriate and timely record processing:

- Beginning January 1, 2007, Cahaba GBA, LLC will no longer send letters to inform providers of Additional Development Requests (ADRs). Instead, providers will need to access the Fiscal Intermediary Standard System (FISS) to identify claims selected for ADR. Claims selected for ADR can be identified by accessing FISS Inquiry Option 12, and will appear in status location S B6001. Pages 07 and 08 of the claim will contain the date your documentation is due, and the elements of documentation requested.
- Print screen FISS Claim Page 07 and attach it to the front of the requested medical documentation.
- Send requested information to the address on FISS Claim Page 07.
- Do NOT send certified mail or overnight mail.
- Do NOT staple or add tabs to your documentation.
- Include ALL requested documentation outlined on FISS Claim Page 08.
- Submit the above information **via regular mail** by the 30th day, to ensure the FI receives the information prior to the 45th day after the request date.

Although this review only included the use of CPT 76000 with CPT 36561 (Insertion central venous access with port, age 5 or older), CPT 47563 (Laparoscopic cholecystectomy with cholangiography), CPT 52332 (Cystourethroscopy with insertion indwelling ureteral stent) and CPT 74420 (Urography, retrograde with or without KUB), this is not an all-inclusive list of procedures that include a fluoroscopy component. For

additional information regarding the accurate coding and billing of services in adherence with CMS coverage criteria, please review the National Correct Coding Initiative Edits for Hospital Outpatient PPS found at: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage>

As a result of this targeted review, Alabama Part A Medical Review will initiate a 100 percent targeted pre-pay review of all outpatient hospitals (bill type 13X) billing CPT 76000 with CPT 36561, CPT 47563, CPT 52332, and CPT 74420. Also, providers identified through data analysis as driving this aberrancy may warrant provider specific medical review.

News from Cahaba GBA, LLC for RHC/FQHC Providers



Rural Health Clinics- We Want You!

WHO? Based on current data analysis, Cahaba GBA, LLC listserv enrollment numbers are low for **Rural Health Clinics (RHCs) in the state of Alabama, Iowa and South Dakota.**

WHAT? The Cahaba GBA, LLC e-mail notification service.

WHERE? www.cahabagba.com/forms/subscribeForm.htm

- Complete the subscription form and include the following:
 - ◆ Your email address
 - ◆ Your first and last name
 - ◆ Your organization name and type
 - ◆ Your address, city, state, zip code, and phone number
 - ◆ If you submit your claims electronically
 - ◆ Number of employees at your facility
 - ◆ Select the Medicare A and/or Medicare B topics of interest.
 - ◆ Click on “Sign Up For News”
 - ◆ Reply to confirmation e-mail to confirm subscription

WHEN? Don't delay; sign up today! The service is FREE and your e-mail address will not be shared outside of Cahaba GBA, LLC.

WHY? To stay up-to-date on important Medicare regulations, the Cahaba GBA, LLC listserv allows you to receive updates via e-mail on Medicare news, including policy, benefits, claim submissions, claim processing, and educational events.

Don't miss out! Log on to www.cahabagba.com today!

Contact Us

Medicare Customer Service Representatives (CSR)

If you have any questions about this newsletter, please call the Provider Contact Center at the designated telephone number below, anytime Monday through Friday, between 8:00 a.m. – 5:00 p.m. Central Time.

- If you submit your Medicare claims to the Cahaba GBA office in Des Moines, Iowa, call: **1-877-567-3092**
- If you submit your Medicare claims to the Cahaba GBA office in Birmingham, Alabama, call: **1-866-539-5598**

Beneficiaries can talk to a Medicare customer service representative by calling the Medicare Call Center **1-800-MEDICARE (1-800-633-4227)**. The Call Center is available 24 hours a day and 7 days a week.

Medicare A Newline Forum

If you have a Medicare Part A question or issue you would like addressed in the *Medicare A Newline* Forum, please sent your questions to:

Medicare Part A Newline Forum
400 East Court Ave, Station 69
Des Moines, IA 50309

Questions can also be faxed to **515-471-7584** or e-mailed to ianewline@cahabagba.com

Please include your name and telephone number. We also welcome your comments or suggestions on this publication and other Cahaba GBA, LLC customer service activities.

Important Web Sites

Cahaba GBA, LLC's site – www.cahabagba.com

CMS Web site – <http://cms.hhs.gov/>

CMS Medicare Learning Network (MLN) Matters Web site –
<http://www.cms.hhs.gov/MLNMattersArticles/>

CMS Medicare Learning Network Web site – <http://www.cms.hhs.gov/MLNGenInfo/>

CMS Manuals – <http://www.cms.hhs.gov/manuals/>

CMS Transmittals – <http://www.cms.hhs.gov/Transmittals/2006Trans/list.asp#TopOfPage>

Quarterly Provider Update – <http://www.cms.hhs.gov/QuarterlyProviderUpdates/>

The following highlights the educational resources and upcoming events offered by the Provider Outreach and Education (POE) department and the Medical Review department.

To receive immediate notification about new education events posted to our Web site, go to <https://www.cahabagba.com/forms/subscribeForm.htm> to subscribe to the Cahaba GBA, LLC E-mail Notification Service.

How To Register - Information on how to register for the following workshops/teleconferences can be found on our Web site on the “Calendar of Educational Events” page. Our “Calendar of Educational Events” Web page is updated frequently. To check for the most current information, go to:

https://www.cahabagba.com/apps/course_registration/ia/calendar.jsp

✓ **Teleconference Title/Information:**

- ***Uncovering the Errors from the 2006 CERT Report Ask-The-Contractor Teleconference (ACT)***—This ACT will present the highlights of the Comprehensive Error Rate Testing (CERT) November 2006 Report. To submit questions for discussion and response during the ACT, participants must reply to their registration confirmation with the question by 5:00 p.m. Central Time (CT) January 2, 2007.

January 11, 2007 1:00 p.m. – 2:00 p.m. CT

The registration deadline for this educational event is **January 8, 2007**. Registration is limited; therefore, we encourage you to register early to ensure your participation in this event.

- ***Benefits Exhaust and No-Payment Billing Ask-The-Contractor Teleconference (ACT)***—This ACT will focus on the topic of benefits exhaust and no-payment billing. Participants will be provided an overview on billing claims in benefits exhaust and no-payment billing situations. To submit questions for discussion and response during the ACT, participants must reply to their registration confirmation with their questions by 5:00 p.m. CT January 15, 2007.

January 25, 2007 1:00 p.m. – 2:00 p.m. CT

The registration deadline for this educational event is **January 22, 2007**. Registration is limited; therefore, we encourage you to register early to ensure your participation in this event.

✓ **Visit Our Web Site**

Cahaba GBA, LLC’s Web site at <https://www.cahabagba.com/> provides a variety of valuable information for Medicare providers. We encourage you to visit our site.

The Web site is continuously updated with information. Bookmark the Medicare Part A page (https://www.cahabagba.com/part_a/index.htm) for the most current Medicare A headlines.

Cahaba GBA, LLC Learning Corner

- ✓ **Online Courses** are computer-based and can be launched from the convenience of your own desk. All courses are free and open to anyone. Online courses are available on our Web site at: https://www.cahabagba.com/part_a/education_and_outreach/online_courses/index.htm

Course Title	Description
Adjusting and Canceling Claims	Learn how to adjust or cancel claims.
Appeals Process	Learn about the Medicare appeals process.
CERT (Comprehensive Error Rate Test)	Learn about the CERT Program.
Checking Claims Status	Learn how to use the Fiscal Intermediary Standard System (FISS) to check the status of your claims.
Comprehending Medicare Claims Processing	Learn about Medicare claims processing.
Electronic Data Interchange	Learn about the Electronic Data Interchange (EDI) process
Insight into Medicare Coding	Learn the basics about Medicare coding.
Introduction to FISS	Learn the basics of using the Fiscal Intermediary Standard System (FISS) to enter claims.
Introduction to Medicare Cost Report	Learn the basics about the Medicare Cost Report
Medicare Secondary Payer	Learn the basics of Medicare Secondary Payer.
NPI (National Provider Identifier)	Learn about the NPI (National Provider Identifier). Additional Resource: CMS NPI Training Package http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Training_Package.pdf
Overview of Medicare	Learn the basics about the Medicare program.
Provider Enrollment NEW	Learn about provider enrollment and how to apply.
Rural Health Clinic Billing	View a presentation on rural health clinic billing.
Skilled Nursing/Swing Bed PPS Consolidated Billing	View a presentation on skilled nursing facility/swing bed prospective payment system (PPS) consolidated billing.
Verifying Beneficiary Eligibility	Learn how to use the Fiscal Intermediary Standard System to check if a beneficiary is eligible for Medicare benefits.

Please note these courses were designed specifically for providers served by Cahaba GBA, LLC. You can find additional national courses under the Medicare Learning Network at: <http://www.cms.hhs.gov/medlearn/default.asp>

Glossary of Acronyms and Abbreviations for the January 1, 2007, Medicare A Newslines

- A -

AAA Abdominal Aortic Aneurysms
 ABN Advance Beneficiary Notice
 A/B MAC Part A/B Medicare Administrative Contractors
 ACT Ask-The-Contractor Teleconference
 ADR Additional Development Request
 AI Audit Intermediary
 AIR All Inclusive Rate
 ANSI American National Standards Institute
 APC Ambulatory Payment Classification
 ASC Ambulatory Surgical Centers
 ASP Average Sales Price

- C -

CAH Critical Access Hospital
 CAP Cryoablation of the Prostate
 CBA Competitive Bidding Demonstration Area
 CBSA Core Based Statistical Area
 CCI Correct Coding Initiative
 CERT Comprehensive Error Rate Testing
 CLIA Clinical Laboratory Improvement Amendments
 CMHC Community Mental Health Center
 CMS Centers for Medicare & Medicaid Services
 COB Coordination of Benefits
 CPT Current Procedural Terminology
 CR Change Request
 CSE Claim Submission Error
 CSR Customer Service Representative
 CT Central Time
 CWF Common Working File
 CY Calendar Year

- D -

DDE Direct Data Entry
 DME Durable Medical Equipment
 MAC Medicare Administrative Contractor

DMEPOS Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
 DMERC Durable Medical Equipment Regional Carrier
 DRA Deficit Reduction Act

- E -

EDI Electronic Data Interchange
 EFT Electronic Funds Transfer
 ESRD End Stage Renal Disease

- F -

FAQ Frequently Asked Questions
 FFS Fee-For-Service
 FI Fiscal Intermediary
 FISS Fiscal Intermediary Standard System
 FQHC Federally Qualified Health Center
 FY Fiscal Year

- H -

HCPCS Healthcare Common Procedure Code System
 HIPAA Health Insurance Portability and Accountability Act
 HHA Home Health Agency
 HICN Health Insurance Claim Number
 HINN Hospital Issued Notice of Noncoverage
 HSCRC Health Services Cost Review Commission

- I -

IHS Indian Health Service Hospital
 IIC Inflation-Indexed Charge
 IPPE Initial Preventive Physical Examination

- L -

LCD Local Coverage Determination
 LTCH Long-Term Care Hospitals

***Glossary of Acronyms and Abbreviations for the January 1, 2007, Medicare A Newsline
(continued)***

- M -

MA Medicare Advantage
 MAC Medicare Administrative Contractors
 MCPSS Medicare Contractor Provider Satisfaction Survey
 MEI Medicare Economic Index
 MLN Medicare Learning Network
 MMA Medicare Prescription Drug Improvement and Modernization Act of 2003
 MPFS Medicare Physician Fee Schedule
 MSA Metropolitan Statistical Areas
 MSN Medicare Summary Notice
 MSP Medicare Secondary Payer

- N -

NEMB Notice of Exclusion from Medicare Benefits
 NCD National Coverage Determination
 NLA National Limitation Amount
 NPP Nonphysician Practitioners
 NPES National Plan and Provider Enumeration System
 NPI National Provider Identifier

- O -

OCE Outpatient Code Editor
 OGPE Oxygen Generating Portable Equipment
 OPO Organ Procurement Organization
 OPPTS Outpatient Prospective Payment System
 OPT Outpatient Therapy
 OT Occupational Therapy

- P -

PECOS Provider Enrollment Chain and Ownership System
 PEN Parenteral and Enteral Nutrition
 PIN Provider Identification Number
 POE Provider Outreach and Education
 POL Physician Office Laboratory
 PPS Prospective Payment System
 PT Physical Therapy

-R-

RA Remittance Advice
 RHC Rural Health Center
 RHHI Regional Home Health Intermediary
 RTP Return to Provider

- S -

S/LOC Status/Location
 SLP Speech-Language Pathology

- T -

TC Technical Component
 TOB Type of Bill