Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC

March 1, 2007 **Vol. 14, No. 6**

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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Key for Icons:

- All Providers
- H: Hospital/Critical Access Hospital (CAH) Providers
- S: Skilled Nursing Facility (SNF) / Swing Bed Providers
- R: Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Providers
- E: Renal Dialysis Facility (RDF)
- C: Community Mental Health Center (CMHC) Providers
- O: Comprehensive Outpatient Rehabilitation Facility (CORF) Providers and Outpatient Physical Therapy (OPT) Providers

The Medicare A Newsline provides information for those providers who submit claims to Cahaba Government Benefit Administrators®, LLC as their Fiscal Intermediary or Regional Home Health Intermediary. *The CPT codes, descriptors and other data only are copyright © 2006 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.*

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Flu Shot Reminder
It's Not Too Late to Give and Get a Flu Shot!
The peak of flu season typically occurs between late December and March; however, flu season can last until May. **Protect yourself, your patients, and your family and friends by getting and giving the flu shot.** Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination. Remember—influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' Web site at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf

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.

Update on CMS Actions to Reverse Invalid Overpayments Generated by Managed Care Informational Unsolicited Responses (MCIURs)—(Invalid MCIURs from the Common Working File (CWF))

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: MM5507
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R262OTN
Related Change Request (CR) #: 5507
Effective Date: January 26, 2007
Implementation Date: April 26, 2007

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare contractors (fiscal intermediaries (FIs), carriers, Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), and/or DME Medicare administrative contractors (DME/MACs)).

Provider Action Needed

This article provides information regarding overpayment recovery actions that may be taken by your Medicare contractor and the circumstances that have caused these recovery actions. We estimate that between 150,000 – 300,000 claims may be affected by these actions. If, due to the conditions stated below, an overpayment recovery action has occurred for your claims, your Medicare contractor is in the process of

correcting the payment. **You need not take any action at this time.** Because these actions will affect Medicare contractors in varying degrees, you should stay tuned to your Medicare contractor's Web site for additional details.

Background

In MLN Matters article SE0681 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0681.pdf), CMS advised providers of certain eligibility system issues related to managed care Medicare beneficiaries. In brief, article SE0681 alerted providers that, in some instances, Medicare may be recovering certain overpayments due to system updates on beneficiary eligibility. When such overpayments are identified, Medicare systems generate a managed care informational unsolicited response (MCIUR), which triggers the overpayment recovery.

During the week of December 17, 2006, Medicare systems were updated with some incorrect managed care enrollment data, which, in turn, caused the systems to create some incorrect MCIURs. Medicare files have now been corrected and CMS is working diligently with Medicare contractors to stop the invalid overpayment recoveries from occurring. In addition, where action to recover the overpayments has already occurred, CMS has instructed your contractor to reverse the action and reissue payment to you.

Key Points

- CR 5507 states that recovery action should stop if it has been initiated and reversed if MCIURs have already affected a recovery.
- Physicians and other providers who bill Medicare contractors need not take any action since contractors will automatically make the necessary adjustments as CR 5507 is implemented.
- Your contractor will post more detailed information on their Web site as CR 5507 is implemented.

Additional Information

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*.

For complete details regarding this issue, please see the official instruction (CR 5507) issued to your Medicare carrier, FI, A/B MAC, DME MAC, and/or DMERC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R262OTN.pdf on the CMS Web site.

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Part C Plan Type Description Display on Medicare's Common Working File (CWF)

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: MM5349
Related CR Release Date: February 2, 2007
Related CR Transmittal #: R1175CP

Related Change Request (CR) #: 5349
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected

Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through CWF eligibility screens (e.g., HIQA, HIQH, ELGA, ELGB, ELGH).

Provider Action Needed

Be aware of the expanded list of Medicare Advantage (MA) plan type descriptions that are being displayed by Medicare's CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in private fee-for-service (PFFS) plans.

A plan directory will soon be published that contains the list of all active Medicare contracts and their corresponding plan type. The directory will be posted at the following URL no later than March 1, 2007: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage

Background

When you query Medicare regarding a beneficiary's entitlement and eligibility, Medicare's CWF system responds with information on the Medicare managed care contract number in which a beneficiary is enrolled, including the plan type description associated with the contract. Currently, CWF largely displays the label "HMO" for these contracts. In many cases, the "HMO" label is incorrect since the list of possible plan type values has grown far larger since the creation of the MA program.

For example, under the MA Part C program, Medicare beneficiaries can enroll in PFFS plans. PFFS plans are very different from the more traditional MA Health Maintenance Organization (HMO) type plan.

PFFS PLANS

PFFS plans generally have no plan specific provider network. Enrollees in a PFFS plan can obtain plan covered health care services from any Medicare FFS enrolled provider in the U.S. who is willing to furnish services to a PFFS plan beneficiary. It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan.

In most cases, a PFFS enrollee will inform a provider before obtaining a service that they are enrolled in a PFFS plan. In addition, the PFFS enrollee will have an enrollment card provided by the PFFS plan identifying them as enrollees in a PFFS plan. The card will specify a phone number and/or a Web address where the provider can obtain the PFFS plan's terms and conditions of participation.

At a minimum, the terms and conditions will specify:

- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures, including:
  - The amount the provider is permitted to collect from the enrollee; and
  - Whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers in the U.S. from whom its enrollees seek health care services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a Web site and also make them available upon written or phoned request.

To be paid by a PFFS organization, the provider must send their bill to the address (or electronic address) provided in the PFFS plan's terms and conditions of participation.

For more detailed information on PFFS plans as they relate to providers, see the "Provider Q&A" downloadable document on: http://www.cms.hhs.gov/PrivateFeeforServicePlans/

Additional Information
If you have questions regarding the plan of a specific Medicare MA enrolled patient, you may wish to contact that plan.

To view the official instruction (CR 5349) issued to your Medicare FI, carrier, MAC, DMERC or RHHI, visit http://www.cms.hhs.gov/Transmittals/downloads/R1175CP.pdf on the CMS Web site.

To review a related article that explains Medicare's CWF Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes go to http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5118.pdf on the CMS Web site.

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Institutional Value Code Changes

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: MM5411
Related CR Release Date: January 19, 2007
Related CR Transmittal #: R261OTN
Related Change Request (CR) #: 5411
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected
Providers who bill fiscal intermediaries (FI), Part A/B Medicare administrative contractors (A/B MACs), or regional home health intermediaries (RHHIs) for Medicare services

What You Need to Know
Value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 are now restricted to use only in paper claims, and are no longer available for use on X12N 837 institutional claim transactions.

Background
The National Uniform Billing Committee (NUBC) has restricted the use of value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 to paper claims only. These value codes are no longer available for use on X12N 837 institutional claim transactions.

Your Medicare FI, RHHI, or A/B MAC will create edits to restrict the use of these value codes to paper claims, and to not allow their use on direct data entry claims. Further, Medicare will ensure that any paper claim data from value codes A1, A2, A7, B1, B2, B7, C1, C2, or C7 are migrated to the appropriate X12N 837 2320 Claim Level Adjustment Segment (CAS) (claim adjustment reason code "PR") for coordination of benefits files.

Additional Information
You can find the official instruction, CR 5411, issued to your FI, A/B MAC, or RHHI by visiting http://www.cms.hhs.gov/Transmittals/downloads/R261OTN.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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Guidelines for Payment of Diabetes Self-Management Training (DSMT)

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: MM5433
Related CR Release Date: January 19, 2007
Related CR Transmittal #: R1158CP & R64BP
Related Change Request (CR) #: 5433
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected
Providers submitting claims to Medicare fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs) for DSMT services provided in institutional settings to Medicare beneficiaries.

Provider Action Needed
STOP – Impact to You
This article is based on CR 5433, which corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings.

CAUTION – What You Need to Know
Medicare Part B covers ten hours of initial training for a beneficiary who has been diagnosed with diabetes, and beneficiaries are eligible to receive two hours of follow-up training each calendar year following the year in which they were certified as requiring initial training. DSMT must be ordered by the physician or qualified nonphysician practitioner who is managing the beneficiary's diabetic condition.

GO – What You Need to Do

See the "Background" and "Additional Information" sections of this article for further details regarding these changes.

Background

The Balanced Budget Act of 1997 (Section 4105) permits Medicare coverage of diabetes self-management training (DSMT) services when these services are furnished by a certified provider who meets certain quality standards, and CR 5433 corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings. Note that no new codes are being created by CR 5433. Also, deductible and coinsurance apply to these services.

The DSMT program is intended to educate beneficiaries in the successful self-management of diabetes. The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management.

Initial Training

The initial year for DSMT is the twelve-month period following the initial date, and Medicare will cover initial training that meets the following conditions:

- DSMT is furnished to a beneficiary who has not previously received initial or follow-up training under Healthcare Common Procedure Coding System (HCPCS) code G0108 or G0109;
- DSMT is furnished within a continuous twelve-month period;
- DSMT does not exceed a total of ten hours (the ten hours of training can be done in any combination of half-hour increments;
- With the exception of one hour of individual training, the DSMT training is usually furnished in a group setting with the group consisting of individuals who need not all be Medicare beneficiaries, and;
- The 1 hour of individual training may be used for any part of the training including insulin training.

Follow-Up Training

Medicare covers follow-up training under the following conditions:

- No more than two hours individual or group training is provided per beneficiary per year;
- Group training consists of two to twenty individuals who need not all be Medicare beneficiaries;
- Follow-up training for subsequent years is based on a twelve-month calendar after completion of the full ten hours of initial training;
- Follow-up training is furnished in increments of no less than one-half hour; and
- The physician (or qualified nonphysician practitioner) treating the beneficiary must document in the beneficiary's medical record that the beneficiary is a diabetic.

NOTE: All entities billing for DSMT under the fee-for-service payment system or other payment systems must meet all national coverage requirements.

Examples

Example #1: Beneficiary Exhausts Ten Hours in the Initial Year (twelve continuous months)

Beneficiary receives first service in April 2006.

Beneficiary completes initial ten hours DSMT training in April 2007.

Beneficiary is eligible for follow-up training in May 2007 (thirteenth month begins the subsequent year).

Beneficiary completes follow-up training in December 2007.
Beneficiary is eligible for next year training in January 2008.

Example #2: Beneficiary Exhausts Ten Hours Within the Initial Calendar Year
Beneficiary receives first service in April 2006.
Beneficiary completes initial ten hours of DSMT training in December 2006.
Beneficiary is eligible for follow-up training in January 2007.
Beneficiary completes follow-up training in July 2007.
Beneficiary is eligible for next year follow-up training in January 2008.

Coding and Payment of DSMT Services
The following HCPCS codes should be used for DSMT:

- G0108 – Diabetes outpatient self-management training services, individual, per thirty minutes; and
- G0109 – Diabetes outpatient self-management training services, group session (two or more), per thirty minutes.

Payment to physicians and providers for outpatient DSMT is made as follows:

Type of Facility/Provider	Payment Method	Type of Bill (TOB)
Physician/nonphysician practitioner (billing carrier/MAC)	Medicare Physician Fee Schedule	N/A
Hospitals subject to Outpatient Prospective Payment System (OPPS)	OPPS	12X, 13X
Method I and Method II critical access hospitals (CAHs) (technical services)	101 percent of reasonable cost	12X and 85X
Indian health service (IHS) providers billing hospital outpatient	Office of Management and Budget (OMB)-approved outpatient per visit all inclusive rate (AIR)	13X and revenue code 051X
IHS providers billing inpatient Part B	All-inclusive inpatient ancillary per diem rate	12X and revenue code 024X
IHS CAHs billing outpatient	101 percent of the all-inclusive facility specific per visit rate	85X and revenue code 051X
IHS CAHs billing inpatient Part B	101 percent of the all-inclusive facility specific per diem rate	12X and revenue code 024X
Rural health clinics (RHCs)	All-inclusive encounter rate	71X with revenue code 0520, 0521, 0522, 0524, 05225, 0527, 0528, or 0900
Federally qualified health centers (FQHCs)*	All-inclusive encounter rate	73X with revenue code 0520, 0521, 0522, 0524, 0525, 0527, 0528, 0r 0900
Skilled nursing facilities (SNFs) **	Medicare Physician Fee Schedule (MPFS) non-facility rate	22X, 23X

Type of Facility/Provider	Payment Method	Type of Bill (TOB)
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	Payment in accordance with the terms of the Maryland Waiver	12X, 13X
Home health agencies (can be billed if service is outside of the treatment plan)	MPFS non-facility rate	34X

* Effective January 1, 2006, payment for DSMT provided in an FQHC, that meets all the requirements as above, may be made in addition to one other visit the beneficiary had during the same day, if this qualifying visit is billed on TOB 73X, with HCPCS code G0108 or G0109, and revenue codes 0520, 0521, 0522, 0524, 0525, 0527, 0528, or 0900.

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

NOTE: An end stage renal disease (ESRD) facility is a reasonable site for this DSMT service; however, because it is required to provide dietician and nutritional services as part of the care covered in the composite rate, ESRD facilities are not allowed to bill for it separately and do not receive separate reimbursement.

Advance Beneficiary Notices (ABNs)

Providers should also be aware that the beneficiary is liable for services denied over the limited number of hours with referrals for DSMT. An ABN should be issued in these situations and absent evidence of a valid ABN, the provider would be held liable.

However, an ABN should not be issued for Medicare-covered services such as those provided by hospital dieticians or nutrition professionals who are qualified to render the service in their state, but who have not obtained Medicare provider numbers.

Additional Information

For complete details, please see the official instruction, CR 5433, issued to your FI, RHHI, and A/B MAC regarding this change. There are two transmittals related to CR 5433, one which revises the *Medicare Benefit Policy Manual* and one that modifies the *Medicare Claims Processing Manual*. These transmittals are at http://www.cms.hhs.gov/Transmittals/downloads/R64BP.pdf and http://www.cms.hhs.gov/Transmittals/downloads/R1158CP.pdf, respectively.

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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Infrared Therapy Devices—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) *Matters* article entitled "Infrared Therapy Devices," which was published in the February 1, 2007, *Medicare A Newsline*. 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: MM5421
Related CR Release Date: February 9, 2007
Related CR Transmittal #: R1183CP and R62NCD
Related Change Request (CR) #: 5421
Effective Date: October 24, 2006
Implementation Date: January 16, 2007

Note: This article was revised on February 9, 2007, to correct the range of ICD-9 codes shown in bold print. The range is 880.00–887.7. Originally, CR 5421 and the related article incorrectly showed 880.00–887.79 for that range. The CR transmittal number, release date, and Web address for accessing CR 5421 are also revised, but all other information remains the same.

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare carriers, Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME/MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs), for the use of infrared therapy devices for treatment of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Impact on Providers

This article is based on CR 5421. Effective for services performed on or after October 24, 2006, CMS has made a national coverage determination (NCD) stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), **is noncovered for the treatment**, including symptoms such as pain arising from these conditions, of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Background

The use of infrared therapy devices has been proposed for a variety of disorders, including treatment of diabetic neuropathy, other peripheral neuropathy, skin ulcers and wounds, and similar related conditions, including symptoms such as pain arising from these conditions. A wide variety of devices are currently available. Previously there was no NCD concerning the use of infrared therapy devices, leaving the decision to cover or not cover up to local Medicare contractors.

The following requirements are in effect as of October 24, 2006

- **Effective for services performed on or after October 24, 2006**, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) **are noncovered** as DME or PT/OT services when used for the treatment of diabetic and/or nondiabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.

- Claims will be denied with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9 codes:
  - 250.60–250.63,
  - 354.4, 354.5, 354.9,
  - 355.1–355.4,
  - 355.6–355.9,
  - 356.0, 356.2–356.4, 356.8–356.9,
  - 357.0–357.7,
  - 674.10, 674.12, 674.14, 674.20, 674.22, 674.24,
  - 707.00–707.07, 707.09–707.15, 707.19,
  - 870.0–879.9,
  - **880.00–887.7,**
  - 890.0–897.7, or
  - 998.31–998.32.
- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects types of bills (TOBs) 12X, 13X, 22X, 23X, 34X, 74X, 75X and 85X.
- If you submit a claim for one of the non-covered services, your patient will receive the Medicare Summary Notice (MSN) message stating "This service was not covered by Medicare at the time you received it." The Spanish translation is: "Este servicio no estaba cubierto por Medicare cuando usted lo recibió."
- If you submit a claim for one of the noncovered services you will receive a remittance advice notice that reads: "Claim Adjustment Reason Code 50, 'These are non-covered services because this is not deemed a 'medical necessity' by the payer.'"
- Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospital outpatient departments should note that you are liable if the service is performed, unless the beneficiary signs an Advance Beneficiary Notice (ABN).
- DME suppliers and HHAs be aware that you are liable for the devices when they are supplied, unless the beneficiary signs an ABN.

Additional Information

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*.

For complete details regarding this CR please see the official instruction (CR 5421) issued to your Medicare A/B MAC, FI, DME MAC, RHHI, or carrier. There are actually two transmittals associated with CR 5421. The first is the national coverage determination transmittal, located at http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf on the CMS Web site. In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is at http://www.cms.hhs.gov/Transmittals/downloads/R1183CP.pdf on the CMS site.

Disclaimers

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Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

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: MM5456
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R1163CP

Related Change Request (CR) #: 5456
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare administrative contractors (A/B MACs), durable medical equipment regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs)) for services.

Provider Action Needed

CR 5456, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective April 2, 2007. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by CMS, and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national code maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are available at http://wpc-edi.com/codes and are updated three times a year. **The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5456, effective on and after April 1, 2007.**

A new tool has been developed to help you search for a specific category of code, and that tool is at http://www.cmsremarkcodes.info on the CMS Web site. Note that this Web site does not replace the Washington Publishing Company (WPC) site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You can see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5456, located at http://www.cms.hhs.gov/Transmittals/downloads/R1163CP.pdf on the CMS Web site.

For additional information about remittance advice, please refer to "Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers" at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.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*.

X12N 835 Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf. **Note: (New Code 12/1/06)**	No
N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required. **Note: (New Code 12/1/06)**	No
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility. **Note: (New Code 12/1/06)**	No
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE. **Note: (New Code 12/1/06)**	No
N377	Payment adjusted based on a processed replacement claim. **Note: (New Code 12/1/06)**	No
N378	Missing/incomplete/invalid prescription quantity. **Note: (New Code 12/1/06)**	No
N379	Claim level information does not match line level information. **Note: (New Code 12/1/06)**	No

Modified Codes

Code	Current Narrative	Modification Date
M143	The provider must update license information with the payer. **Note: (Modified 12/1/06)**	12/01/06
N181	Additional information is required from another provider involved in this service. **Note: (New Code 2/28/03. Modified 12/1/06)**	12/01/06
N361	Payment adjusted based on multiple diagnostic imaging procedure rules **Note: (New Code 11/18/05. Modified 12/1/06)**	12/01/06
There are NO deactivated codes		

NOTE II: Some remark codes may provide information that may not necessarily supplement the explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Newly created informational codes will have "Alert" in the text to identify them as informational rather than explanatory codes. An example of an informational code:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

The above information is sent per state regulation, but does not explain any adjustment. These informational codes should be used only if specific information needs to be communicated but not as default codes.

X12 N 835 Health Care Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Notes
197	Payment denied/reduced for absence of precertification/authorization **Note: New as of 10/06**	New as of 10/06
198	Payment denied/reduced for exceeded, precertification/authorization **Note: New as of 10/06**	New as of 10/06
199	Revenue code and procedure code do not match. **Note: New as of 10/06**	New as of 10/06
200	Expenses incurred during lapse in coverage **Note: New as of 10/06**	New as of 10/06
201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR). **Note: New as of 10/06**	New as of 10/06

Modified Codes

Code	Current Narrative	Notes
42	Charges exceed our fee schedule or maximum allowable amount. **Note: Changed as of 10/06. This code will be deactivated on 6/1/2007.**	Modified as of 10/06 Effective 6/1/2007
45	Charges exceed your contracted/ legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use group codes PR or CO depending upon liability). **Note: Changed as of 10/06**	Modified as of 10/06 Effective 6/1/2007 **Note: This code replaces code 42 (above) on June 1, 2007.**
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. **Note: Changed as of 2/01 and 10/06. This code will be deactivated on 4/1/2007.**	Modified as of 10/06
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated **Note: Changed as of 2/99 and 10/06.**	Modified as of 10/06

Code	Current Narrative	Notes
107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim. **Note: Changed as of 6/03 and 10/06.**	Modified as of 10/06
136	Claim adjusted based on failure to follow prior payer's coverage rules. (Use group code OA). **Note: Changed as of 6/00 and 10/06.**	Modified as of 10/06
196	Claim/service denied based on prior payer's coverage determination. **Note: New as of 6/06. Changed 10/06. This code will be deactivated on 2/1/2007, beginning on that date, value 136 will be used.**	Modified as of 10/06
A1	Claim/service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). **Note: Changed as of 10/06**	Modified as of 10/06
B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note: Changed as of 2/01 and 10/06.**	Modified as of 10/06
D17	Claim/service has invalid noncovered days. **Note: This code will be deactivated on 2/1/2007 and code 16 will then be used with appropriate claim payment remark code [M32, M33].**	Modified as of 10/06
D18	Claim/service has missing diagnosis information. **Note: This code will be deactivated on 2/1/2007 and then code 16 will be used with appropriate claim payment remark code [MA63, MA65].**	Modified as of 10/06
D19	Claim/service lacks Physician/Operative or other supporting documentation **Note: This code will be deactivated on 2/1/2007 and code 16 will be used with appropriate claim payment remark code [M29, M30, M35, M66].**	Modified as of 10/06
D20	Claim/service missing service/product information. **Note: This code will be deactivated on 2/1/2007 and code 16 will be used with appropriate claim payment remark code [M20, M67, M19, MA67].**	Modified as of 10/06
D21	This (these) diagnosis(es) is (are) missing or are invalid **Note: New as of 6/05. This code will be deactivated on 2/1/2007.**	Modified as of 10/06

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Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change

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: MM5387
Related CR Release Date: January 19, 2007
Related CR Transmittal #: R1160CP
Related Change Request (CR) #: 5387
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected

Non-outpatient prospective payment system (non-OPPS) hospital outpatient departments and ambulatory surgical centers (ASCs) who bill Medicare fiscal intermediaries (FIs), carriers, or Part A/B Medicare administrative contractors (A/B MACs) for colorectal cancer screening flexible sigmoidoscopy, and colonoscopy.

Impact on Providers

Effective for services on or after January 1, 2007, Medicare requires:

1. A 25 percent beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies, and colonoscopies performed in the outpatient departments of non-OPPS hospitals; and
2. A 25 percent beneficiary coinsurance for colorectal cancer screening colonoscopies performed in ASCs.

Background

Section 1834(d)(2) of the Social Security Act, imposes a 25 percent beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies (Healthcare Common Procedure Coding System [HCPCS] code G0104—Colorectal cancer screening; flexible sigmoidoscopy) that are performed in hospital outpatient departments. While this coinsurance has already been applied in the outpatient prospective payment system (OPPS) for OPPS hospitals (effective for services performed on or after January 1, 1999), it will now be applied to non-OPPS hospitals, effective January 1, 2007.

Similarly, Section 1834(d)(3) of the Social Security Act, in part, imposes a 25 percent beneficiary coinsurance for colorectal cancer screening colonoscopies (HCPCS codes G0105—Colorectal cancer screening; colonoscopy on individual at high risk, and G0121—Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk) that are performed in ASCs and in hospital outpatient departments. And while, as above, this coinsurance has already been applied in the OPPS for OPPS hospitals (effective for services performed on or after January 1, 1999), it is being applied to these services performed in ASCs or non-OPPS hospitals, effective January 1, 2007.

Therefore, effective for services on or after January 1, 2007 (as is currently done for OPPS hospitals), FIs, carriers, A/B MACS will apply the 25 percent coinsurance to colorectal cancer screening flexible sigmoidoscopies (G0104) and colonoscopies (G0105 and G0121) that are performed in non-OPPS hospitals, and to colorectal cancer screening colonoscopies (HCPCS codes G0105 and G0121) that are performed in ASCs.

Pertinent details included in CR 5387 are:

- For services beginning January 1, 2007, FIs, carriers, and A/B MACs will base the coinsurance amounts for colorectal screening sigmoidoscopies and colonoscopies performed in non-OPPS hospitals, on the payment methodology currently in place for colorectal screening services and, for those performed in ASCs, on Medicare's ASC facility payment for services.
- FIs, carriers, and A/B MACs will neither search for nor adjust claims for colorectal screening colonoscopies and sigmoidoscopies that have been paid prior to the implementation of this change by Medicare on July 2, 2007, but they will adjust such claims that are brought to their attention.
- While prior to January 1, 2007, both a deductible and a coinsurance applied to these colorectal screening procedures, effective for services on or after January 1, 2007 (as part of Section 5113 of the Deficit Reduction Act [DRA]), the deductible is waived for colorectal screening sigmoidoscopies and colonoscopies performed in ASCs or hospital outpatient departments. (This change is implemented under CR 5127, Transmittal 1004, dated July 21, 2006. A related *MLN Matters*, MM5127, is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf on the CMS Web site.)
- For procedures performed in ASCs, this change applies to the ASC bills, not to the physician bills.
- FIs, carriers, and A/B MACs will change the Medicare Summary Notices (MSNs) notices issued to beneficiaries to reflect this change in the coinsurance/copayment amount. They will use EOB message 61.41: "You pay 25% of the Medicare-approved amount for this service."

Additional Information

You can find more information about the change in the coinsurance payment amount for colorectal cancer screening flexible sigmoidoscopy and colonoscopy performed in hospital outpatient departments and ASCs, by going to CR 5387, located at http://www.cms.hhs.gov/Transmittals/downloads/R1160CP.pdf on the CMS Web site. Attached to the CR 5387, you will find an updated *Medicare Claims Processing Manual* (Publication 100-04), Chapter 1 (General Billing Requirements), §30.3.1 (Mandatory Assignment on Carrier Claims); Chapter 14 (Ambulatory Surgical Centers), §40.2 (Carrier Adjustment of Base Payment Rates); and Chapter 18 (Preventive and Screening Services), §§60.1 (Payment), 60.1.1 (Deductible and Coinsurance); and 60.2.2 (Ambulatory Surgical Center [ASC] Facility Fee).

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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April Quarterly Update to 2007 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

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: MM5502 | **Related Change Request (CR) #:** 5502
Related CR Release Date: February 9, 2007 | **Effective Date:** January 1, 2007
Related CR Transmittal #: R1182CP | **Implementation Date:** April 2, 2007

Provider Types Affected

SNFs and other providers submitting claims to Medicare fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (MACs) for services provided to Medicare beneficiaries in SNFs.

What You Need to Know

Three Healthcare Common Procedure Coding System (HCPCS) codes (96521, 96522 and 96523) that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS), were included in the January 2007 update to the carrier file, but not in the FI file. CR 5502, from which this article is taken, adds these three codes to the FI file.

Please refer to the "Background" section for more information.

Background

Quarterly, CMS updates the lists of HCPCS codes (for both FIs and carriers/DMERCs) that are subject to the consolidated billing (CB) provision of the SNF PPS. This particular update, however, applies only to providers billing Medicare FIs, because in the January 2007 update, these three codes were included in the carrier file, but were omitted from the FI file. CR 5502, from which this article is taken, adds these codes to the FI file only.

The following chemotherapy administration-related HCPCS codes are being added to Major Category III, EXCLUSIONS (Effective for claims with dates of service on or after January 1, 2007):

- 96521 – Refilling and Maintenance of Portable Pump;
- 96522 – Refilling and Maintenance of Implantable Pump or Reservoir for Drug Delivery, Systemic (e.g., intravenous, intra-arterial); and
- 96523 – Irrigation of Implanted Venous Access Device for Drug Delivery Systems.

Remember that:

- With the exception of SNFs, Medicare will not pay providers for services appearing on this list when they are included in SNF CB.
- Conversely, Medicare will pay non–SNF providers for beneficiary services excluded from SNF PPS and CB, even when in a SNF stay.
- SNF CB applies to nontherapy services only when furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.
- FIs and A/B MACs will not search their files for claims affected by this change to either retract payment for claims already paid or to retroactively pay claims, but will adjust such claims that you bring to their attention.

Additional Information

You can find the official instruction, CR 5502, issued to your FI or A/B MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1182CP.pdf on the CMS Web site. In addition, you can view the 2007 Annual Update file for FIs at http://www.cms.hhs.gov/SNFConsolidatedBilling/75_2007_FI_Update.asp#TopOfPage 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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Additional Changes to the 2007 Medicare Physician Fee Schedule Database (MPFSDB)

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: MM5498
Related Change Request (CR) #: 5498
Related CR Release Date: January 24, 2007
Effective Date: January 1, 2007
Related CR Transmittal #: R1161CP
Implementation Date: February 26, 2007

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs)) for professional services paid under the Medicare Physician Fee Schedule (MPFS).

Background

This article and CR 5498 wants providers to know that payment files were issued to carriers based upon the December 1, 2006, "MPFS Final Rule" and Transmittal 1143, CR 5459, "Emergency Update to the 2007 Medicare Physician Fee Schedule Database." (An *MLN Matters*, MM5459, is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf on the CMS Web site.) This CR, 5498, amends those payment files and includes new outpatient prospective payment system (OPPS) payment amounts for codes subject to the OPPS cap and other miscellaneous corrections.

Key Points of CR 5498

The changes to the 2007 MPFSDB are listed in Attachment 1 of CR 5498 and those changes are:

CPT/HCPCS	ACTION
31545	Bilateral Indicator = 1
31546	Bilateral Indicator = 1
70555 – 26	Work RVU = 2.54
76998 – 26	Work RVU = 1.20
77013 – 26	Work RVU = 3.99
77022 – 26	Work RVU = 4.24
77055 – Global	Work RVU = 0.70

CPT/HCPCS	ACTION
77055 – 26	Work RVU = 0.70
93624 – 26	Status Indictor = A Work RVU = 4.80 Transitional Non-Facility PE RVU = 2.31 Fully Implemented Non-Facility PE RVU = 2.67 (Informational Only) Transitional Facility PE RVU = 2.31 Fully Implemented Facility PE RVU = 2.67 (Informational Only) Malpractice RVU = 0.33
96020 – 26	Work RVU = 3.43
G0103	Short Descriptor = PSA screening
S0147	Status Indicator = I
S0180	Status Indicator = I
S0345	Status Indicator = I
S0346	Status Indicator = I
S0347	Status Indicator = I
S2325	Status Indicator = I
S2344	Status Indicator = I
S3855	Status Indicator = I

Note: In addition to the changes listed above, all records subject to the OPPS payment cap are also included since these payment amounts have been changed. These codes can be identified by OPPS indicator = 1.

Providers take note that the Medicare contractors will not search their files for claims affected by these changes in order to retract payment for claims already paid or retroactively pay claims. However, contractors will adjust claims that you bring to their attention.

Additional Information

You can see the official instruction issued to your Medicare carrier, FI or A/B MAC by going to CR 5498, located at http://www.cms.hhs.gov/Transmittals/downloads/R1161CP.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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Use of Nine-Digit ZIP Codes for Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services

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: MM5208
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R1167CP

Related Change Request (CR) #: 5208
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected

Physicians and providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare administrative contractors (MACs)) for services paid under the MPFS and for anesthesia services

Provider Action Needed

STOP – Impact to You

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed in Table 1 (below), if you do not include the full nine-digit ZIP code on your claims for services paid by Medicare carriers or MACs under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services, your claim will be treated as unprocessable.

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed in Table 1, if a valid full nine-digit ZIP code is not present on the Provider Master File Address ZIP code, services paid by the FIs/MACs under the MPFS and for anesthesia services, your claim will be treated as unprocessable.

CAUTION – What You Need to Know

Effective October 1, 2007, for services rendered in the areas defined by the ZIP codes in Table 1, Medicare will require that you provide the nine-digit ZIP code for the location where services were rendered on your claims for services paid by carriers/MACs under the MPFS and for anesthesia services. CMS is implementing this requirement to prevent payment issues generated by ZIP codes that cross payment localities.

Effective October 1, 2007, for services rendered in the areas defined by the nine-digit ZIP codes in Table 1, Medicare will require a valid nine-digit ZIP code on the Provider File Master Address for services paid by the FIs/MACs under the MPFS and for anesthesia services.

GO – What You Need to Do

Make sure that your billing staffs are aware that if you provide services paid by carriers/MACs under the MPFS or anesthesia services in a payment locality whose ZIP code appears in Table 1, below; effective for dates of service on or after October 1, 2007, they must include the nine-digit ZIP code in the claim.

Make sure that if you provide services paid by FIs/MACs under the MPFS or anesthesia services in a payment locality whose ZIP code appears in Table 1, a valid nine-digit ZIP code is present on the Provider File Master Address. If a valid nine-digit ZIP code is not on the file, submit a CMS-855A, the Medicare Enrollment Application, with a valid nine-digit ZIP code.

Background

Reimbursement Based on the Location Where the Service Was Rendered

Where you actually provide services paid under the MPFS and anesthesia services determines the amount of your reimbursement. More specifically, Medicare reimburses you for these services based on the locality, which is determined from the ZIP code that is on the claim submitted to carriers/MACs. The ZIP code on the Provider File Master Address is used to determine the locality on the claims submitted to FIs/MACs.

The ZIP codes that your Medicare contractors use to determine the payment locality come from the CMS ZIP code file, which conforms to the United States Postal Service convention of assigning ZIP codes into dominant counties.

CMS has become aware that some ZIP codes cover more than one payment locality; in some cases, while the service may actually be rendered in one county, because of the ZIP code it may be assigned into a different county. This causes a payment issue when each of the counties is associated with a different payment locality and therefore a different payment amount.

Nine-Digit ZIP Codes

CR 5208, from which this article was taken, corrects this issue. Effective October 1, 2007, you will have to include the full nine-digit ZIP code for anesthesia services and for services paid under the MPFS by carriers/MACs when those services are provided in a ZIP code area that crosses payment localities (see Table 1, below). Note that services on the Purchased Diagnostic Abstract File are all payable under the MPFS, thus the nine-digit ZIP code requirement also applies to those services.

There are some important details that you should know:

Exceptions

There are two instances in which you do not need to submit the nine-digit ZIP code in claims for services payable under the MPFS and for anesthesia services:

- You may continue to submit claims with five-digit ZIP codes if you provide these services in ZIP code areas that do not cross payment localities (not listed in Table 1);
- There is no current requirement for the submission of a ZIP code when the place of service (POS) is "Home" or any other places of service that your Medicare contractor currently considers to be the same as "Home."

As necessary, CMS will provide quarterly updates of the list of the ZIP codes that cross localities.

You should submit your claims for ambulance and lab services using five-digit ZIP codes, as your carrier/MAC will continue to use the five-digit codes for determining payment.

Claims for ambulance services will continue to be priced using five-digit ZIP codes by the FIs/MACs. Laboratory services will continue to be priced by the FIs/MACs using the locality for non-fee based services.

Master Address
FIs determine locality based upon the ZIP code of the provider's physical address, which, including the ZIP code is stored on the provider file as the master address.

Effective July 1, 2007, institutional providers, with a ZIP code displayed in Table 1, will need to submit a valid nine-digit ZIP code on the CMS 855-A when the Provider File Master Address ZIP code is five-digits, the last four-digits of a nine-digit ZIP code are zeroes, or the last four-digits of a nine-digit ZIP code do not match a four-digit extension on the ZIP code file.

Claims Returned as Unprocessable
To re-emphasize, if you provide only a five-digit ZIP code on a claim for services payable under the MPFS and for anesthesia services that you provide in one of the ZIP code areas that crosses localities (and therefore requires a nine-digit ZIP code to be processed), your carrier/MAC will return this claim as unprocessable. Returned claims will have the following remittance advice and remark code messages:

- Adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.
- Remark Code MA 130 – Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- Remark Code MA114 – "Missing/incomplete information on where the services were furnished."

Effective for dates of service on or after October 1, 2007, if an invalid ZIP code is present on the Provider File Master Address for claims payable under the MPFS and for anesthesia services provided in one of the ZIP code areas that crosses localities, your FI/MAC will return the claim as unprocessable.

Table 1 - ZIP Codes that Cross Payment Localities by State

State	ZIP Code			
Arkansas (AR)	71749	72338	72444	
	71953	72395	72644	
Arizona (AZ)	85534			
California (CA)	90265	91362	94303	95377
	90623	91709	94514	95391
	90630	91766	94515	95476
	90631	91792	94550	95616
	90638	93013	94571	95690
	91304	93243	95023	95694
	91307	93252	95033	96056
	91311	93536	95076	95377
	91361	93560	95304	95391
Delaware (DE)	19952	19973		
Florida (FL)	32948	33920	34141	34972
	33440	33955	34142	34974
	33917	33972		

State	ZIP Code			
Georgia (GA)	30011	30135	30223	30519
	30014	30143	30224	30534
	30019	30153	30228	30548
	30025	30178	30233	30559
	30040	30179	30234	30620
	30055	30180	30248	30641
	30056	30183	30268	30650
	30101	30184	30276	30663
	30102	30185	30506	30730
	30107	30187	30517	31029
	30120	30205	30518	30641
Idaho (ID)	83342	83856		
Illinois (IL)	60007	60407	60544	62280
	60010	60410	60554	62286
	60013	60416	60559	62355
	60015	60423	60935	62361
	60021	60431	60940	62366
	60042	60432	60950	62538
	60050	60439	62031	62546
	60051	60447	62044	62553
	60074	60449	62052	62557
	60081	60464	62053	62558
	60089	60466	62054	62630
	60090	60467	62075	62638
	60102	60468	62080	62643
	60103	60475	62081	62667
	60118	60477	62082	62690
	60120	60481	62083	62692
	60126	60504	62231	62801
	60133	60506	62237	62808
	60140	60511	62238	62831
	60142	60521	62253	62877
	60151	60523	62262	62882
	60172	60527	62263	62883
	60178	60538	62268	62907
	60401	60543	62272	62916
Iowa (IA)	51630	52542	52626	
	51640	52573	52761	
Kansas (KS)	66012	66021	66083	66109
	66013	66025	66102	66112
	66018			
Kentucky (KY)	40965	42079	42223	42602
Massachusetts (MA)	01432	01930	02339	02762
	01434	02324		
Maryland (MD)	20601	20736	20871	21776
	20607	20754	21757	21787
	20613	20842	21771	21791
	20714			

State	ZIP Code			
Michigan (MI)	48005	48166	48380	48455
	48041	48169	48428	48462
	48062	48178	48430	49229
	48118	48189	48438	49236
	48137	48353	48439	49240
	48160	48371	48442	49285
Minnesota (MN)	56136	56164	56220	56744
	56144	56219	56257	
Missouri (MO)	63005	63071	64034	64082
	63015	63072	64048	64147
	63020	63087	64061	64439
	63023	63348	64062	64444
	63028	63357	64070	64484
	63030	63535	64075	64492
	63041	63548	64077	64733
	63060	63627	64080	64784
	63069	64024		
Montana (MT)	59030	59847		
Nebraska (NE)	68719	68777	69212	69352
	68755	69168	69216	69358
Nevada (NV)	89061			
New Hampshire (NH)	03579	03813		
New Jersey (NJ)	07735	08512	08530	08558
	07747	08525	08540	08560
New York (NY)	10505	11001	11096	12434
	10541	11040	12167	13750
	10579			
North Dakota (ND)	58030	58053	58436	58623
	58041	58225	58439	58653
	58043	58413	58568	
Oregon (OR)	97002	97064	97128	97231
	97014	97071	97132	97362
	97032	97119	97140	97375
	97056	97123		
Pennsylvania (PA)	17527	18070	19344	19505
	17555	18077	19362	19512
	18036	18092	19363	19520
	18041	18951	19464	19525
	18042	19087	19504	19543
	18055	19310		
South Dakota (SD)	57005	57255	57446	57642
	57026	57260	57457	57645
	57030	57270	57523	57648
	57034	57430	57632	57660
	57068	57437	57638	57717
	57078	57441	57641	57724
Tennessee (TN)	37317	37391	37821	38326

State	ZIP Code			
Texas (TX)	75007	75851	77430	78613
	75019	75856	77444	78615
	75028	75862	77447	78617
	75044	76008	77450	78620
	75048	76020	77474	78621
	75050	76028	77477	78634
	75051	76036	77480	78641
	75052	76051	77484	78652
	75054	76052	77485	78654
	75067	76063	77489	78657
	75080	76065	77493	78663
	75082	76071	77494	78664
	75088	76092	77511	78669
	75089	76108	77520	78727
	75098	76126	77521	78728
	75104	76177	77532	78729
	75115	76262	77535	78734
	75125	77047	77539	78736
	75146	77053	77546	78737
	75148	77082	77550	78738
	75154	77083	77568	78750
	75159	77085	77581	78759
	75182	77099	77583	78933
	75248	77339	77622	78940
	75252	77357	77656	78950
	75287	77365	77665	78954
	75839	77381	77833	79835
	75844	77382	78610	79922
	75847	77426	78612	79932
Virginia (VA)	20120	20135		
Washington (WA)	98019	98072	98177	99033
	98022	98077	98251	99128
	98047	98092	98354	
Wisconsin (WI)	54540			
Wyoming (WY)	82063	82716	82930	83120
	82082	82725	83114	83127
	82240	82731		

Additional Information

You can find more information about the use of nine-digit ZIP codes for determining the correct payment locality for anesthesia services and services paid under the (MPFS) by going to CR 5208, located at http://www.cms.hhs.gov/Transmittals/downloads/R1167CP.pdf on the CMS Web site.

You might also want to look at the updated *Medicare Claims Processing Manual*, (CMS Pub 100-04), Chapter 1 (General Billing Requirements), §10.1.1 (Payment Jurisdiction among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services), which you will find 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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News from CMS for Hospital/CAH Providers

Payment of Same Day Transfer Claims Under the Long-Term Care Hospital Prospective Payment System (LTCH PPS)

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: MM5323
Related CR Release Date: February 2, 2007
Related CR Transmittal #: R1172CP
Related Change Request (CR) #:5323
Effective Date: October 1, 2002
Implementation Date: July 2, 2007

Provider Types Affected

Providers submitting LTCH same day transfer claims to Medicare contractors (fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs)).

Provider Action Needed

This article is for informational purposes and is based on CR 5323, which clarifies how to process long-term care hospital (LTCH) same-day transfer claims that have been suspended in the Fiscal Intermediary Standard System (FISS) since implementation of LTCH PPS on October 1, 2002.

Background

CMS recently found that same-day transfer LTCH PPS claims have been suspending in FISS since the implementation of the LTCH PPS on October 1, 2002.

A same-day transfer occurs when a patient is admitted to a LTCH and is subsequently transferred for acute care (or another type facility care) on the same day.

If the patient is admitted to a LTCH with the expectation that the patient will remain overnight but is discharged before midnight, the day is:

- **Counted** as **a total day** (i.e., a cost report day), and
- **Not counted** as **a Medicare covered day**.

In other words, this day will be considered covered and counted for cost reporting purposes, but will not be counted as a Medicare utilization day for the beneficiary.

Currently, same day transfer claims are suspending in the FISS system because:

- The LTCH PPS Pricer cannot accept a '0' day, and
- There is no transfer policy under LTCH PPS.

CR 5323 clarifies how to process LTCH same-day transfer claims that have been suspended in FISS since implementation of the LTCH PPS on October 1, 2002, and instructs that same-day transfer LTCH PPS claims that have been suspended are to be released as of July 2, 2007, and are to be paid with interest applied.

Additional Information
The official instruction, CR 5323, issued to your FI or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1172CP.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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Correction to the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) Pricer

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: MM5455
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R1166CP
Related Change Request (CR) #: 5455
Effective Date: October 1, 2006
Implementation Date: April 2, 2007

Provider Types Affected
Inpatient psychiatric facilities (IPFs) submitting claims to Medicare contractors (fiscal intermediaries (FIs), and Part A/B Medicare administrative contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on CR 5455, which announces that a new version of the IPF PPS Pricer will be released that will account for new diagnosis-related groups (DRGs) effective on October 1, 2006. CR 5455 also

instructs Medicare contractors to add International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code 238.73 (High Grade Myelodysplastic Syndrome Lesions), which needs to receive a comorbidity adjustment of 1.07 for discharges on or after October 1, 2006.

Background

The IPF PPS Pricer (Rate Year 2007 effective October 1, 2006) was not updated to include new DRGs. Although the IPF PPS Pricer only makes a DRG adjustment on 15 DRGs, psychiatric facility claims are still grouped and receive a DRG. Prior to October 1, 2006, there were 559 DRGs (DRGs 1 through 559), but 19 DRGs have been added (DRGs 560 through 579). A table containing DRGs 560 through 579 is included below in the "Additional Information" section of this article. Medicare contractors are currently holding IPF claims received that group to DRGs 560 through 579, and these claims will be released (and paid with interest) once the April 2007 Pricer is in production on April 2, 2007.

The IPF PPS Pricer (Rate Year 2007 effective October 1, 2006) also did not include ICD-9-CM diagnosis code 238.73 (High Grade Myelodysplastic Syndrome Lesions). This code should appear in the Oncology Comorbidity list, and it should receive a comorbidity adjustment of 1.07. After April 2, 2007, IPFs should resubmit claims (with discharges on or after October 1, 2006 through March 31, 2007) that contain ICD-9-CM diagnosis code 238.73 if the cormorbidity adjustment should apply.

Additional Information

For complete details, please see the official instruction, CR 5455, issued to your FI and A/B MAC regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1166CP.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*.

The following table lists DRGs 560 through 579:

DRG	DRG Description
560	BACTERIAL AND TUBERCLOUS INFECTIONS OF NERVOUS SYSTEM
561	NON-BACTERIAL INFECTIONS OF NERVOUS SYSTEM EXCEPT VIRAL MENINGITIS
562	SEIZURE AGE >17 W CC
563	SEIZURE AGE >17 W/O CC
564	HEADACHES AGE >17
565	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT 96+ HOURS
566	RESPIRATORY SYSTEM DIAGNOSIS WITH VENTILATOR SUPPORT < 96 HOURS
567	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W MAJOR GI DX
568	STOMACH, ESOPHAGEAL & DUODENAL PROC AGE >17 W CC W/O MAJOR GI DX
569	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W MAJOR GI DX
570	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC W/O MAJOR GI DX
571	MAJOR ESOPHAGEAL DISORDERS Disclaimer
572	MAJOR GASTROINTESTINAL DISORDERS AND PERITONEAL INFECTIONS
573	MAJOR BLADDER PROCEDURES

DRG	DRG Description
574	MAJOR HEMATOLOGIC/IMMUNOLOGIC DIAG EXC SICKLE CELL CRISIS & COAGUL
575	SEPTICEMIA W MV 96+ HOURS AGE >17
576	SEPTICEMIA W/O MV 96+ HOURS AGE >17
577	CAROTID ARTERY STENT PROCEDURE
578	O. R. PROCEDURE W PDX EXC POSTOPERATIVE OR POST-TRAUMATIC INFECTION
579	O. R. PROCEDURE W PDX OF POSTOPERATIVE OR POST-TRAUMATIC INFECTION

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Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) for Oncology Treatment Payment Adjustment

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: MM5470
Related CR Release Date: February 2, 2007
Related CR Transmittal #: R1170CP
Related Change Request (CR) #: 5470
Effective Date: January 1, 2005
Implementation Date: July 2, 2007

Provider Types Affected

Inpatient psychiatric facilities (IPFs) submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for oncology treatment services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on CR 5470, which states that an oncology adjustment factor should be applied when the oncology procedure code appears in either the principal procedure code field or any of the other procedure code fields. However, the adjustment may not have been applied to some claims. Be sure your billing staff is aware of this issue and takes appropriate action as noted in this article.

Background

Currently, the IPF Prospective Payment System (PPS) Pricer program receives only the 'other' procedure codes from Medicare's Fiscal Intermediary Standard System (FISS). Therefore, if a radiation or chemotherapy procedure code appears in the principal procedure code field, the claim will not receive the Oncology Treatment payment adjustment.

The IPF PPS provides a comorbidity adjustment of 1.07 for oncology treatment, and in order to receive this adjustment, a claim must have:

- An ICD-9-CM code in the range from 140.0 through 239.9, and
- A procedure code 99.25 (chemotherapy) or 92.21 through 92.29 (radiation).

CR 5470 states that the FISS will pass the IPF PPS Pricer all procedure codes, including the principal procedure code and allow this capability back to January 1, 2005, (the implementation date of the IPF PPS).

The oncology adjustment factor should be applied when the oncology procedure code appears in either the principal procedure code field or any of the other procedure code fields.

If an IPF believes that they are entitled to a comorbidity adjustment for oncology treatment, the IPF should resubmit their claim after July 1, 2007, so that they may be reimbursed accurately. Timely filing rules will not apply to claims resubmitted by IPFs as a result of this issue.

Additional Information

The official instruction, CR 5470, issued to FIs and A/B MACs regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1170CP.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 Clinical Laboratory Tests Furnished by Hospitals with Fewer Than Fifty Beds in Qualified Rural Areas

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: MM5493
Related CR Release Date: February 2, 2007
Related CR Transmittal #: R1180CP
Related Change Request (CR) #: 5493
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected

Hospitals with fewer than fifty beds in qualified rural area submitting claims to Medicare fiscal intermediaries (FIs) or Part A/B Medicare administrative contractors (A/B MACs) for outpatient clinical laboratory tests provided to Medicare beneficiaries.

Provider Action Needed
This article is based on CR 5493, which instructs that payment for outpatient clinical laboratory tests to hospitals (with fewer than fifty beds in qualified rural areas) will be made on a reasonable cost basis for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2007.

Background
The Balanced Budget Refinement Act of 1999 provided payment (on a reasonable cost basis) for outpatient clinical laboratory tests to critical access hospitals (CAHs).

Subsequently, a provision in Section 416 of the Medicare Modernization Act (MMA) of 2003 provided for payment on a reasonable cost basis for outpatient clinical laboratory tests:

- To hospitals with fewer than fifty beds in qualified rural areas
- For cost reporting periods beginning during the two-year period beginning on July 1, 2004

This was implemented by CR 3130 (http://www.cms.hhs.gov/transmittals/Downloads/R100CP.pdf). The corresponding MLN Matters article can be found at http://www.cms.hhs.gov/mlnMattersArticles/downloads/MM3130.pdf on the CMS Web site.

The provision (in Section 416 of the MMA) was recently extended (by Section 105 of the Tax Relief and Health Care Act of 2006) for an additional year for cost reporting periods beginning during the three-year period beginning on July 1, 2004.

Therefore, CR 5493 instructs that payment will be made on a reasonable cost basis for outpatient clinical laboratory tests:

- To hospitals with fewer than fifty beds in qualified rural areas,
- For cost reporting periods beginning during the three-year period beginning on July 1, 2004 (i.e., beginning on or after July 1, 2004 but before July 1, 2007).

CR 5493 also instructs your FI or A/B MAC to adjust any affected laboratory claims (those containing lines with revenue code 030X) from hospitals meeting the requirements for reasonable cost payment for such services during this additional year.

Note: Medicare outpatient covered clinical laboratory services are generally paid based on a fee schedule, and Medicare beneficiaries are not liable for coinsurance, deductibles or other cost sharing amounts for these services.

Reasonable costs (for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2007) are determined by, 1) using the ratio of costs to charges for the laboratory cost center; and 2) multiplied by the Provider Statistical and Reimbursement's Report (PS&Rs) billed charges for outpatient laboratory services.

The same rules used to determine whether clinical laboratory services are furnished as an outpatient CAH service apply for outpatient clinical laboratory tests to hospitals with fewer than fifty beds in qualified rural areas (i.e., one with a population density in the lowest quartile of all rural county populations). Condition of participation for hospitals 42 CFR 485.620(a) (http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?YEAR=current&TITLE=42&PART=485&SECTION=620&SUBPART=&TYPE=TEXT) and *State Operations Manual* (Appendix W, Section 485.62(a); http://cms.hhs.gov/manuals/Downloads/som107ap_w_cah.pdf) establish the rules for bed count for CAHs.

Additional Information

The official instruction, CR 5493, issued to your FI and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1180CP.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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Direct Billing and Payment for Nonphysician Practitioner (NPP) Services Furnished to Hospital Inpatients and Outpatients

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: MM5221
Related Change Request (CR) #: 5221
Related CR Release Date: January 26, 2007
Effective Date: April 26, 2007
Related CR Transmittal #: R1168CP
Implementation Date: April 26, 2007

Provider Types Affected

All hospitals, clinical nurse specialists (CNSs), nurse practitioners (NPs), and the employers of physician assistants (PAs) who bill Medicare for hospital inpatient and outpatient services.

Background

Section 4511(a)(2)(B) of the Balanced Budget Act of 1997 amended section 1861(b)(4) of the Social Security Act **to exclude the professional services of NPs, CNSs and PAs from hospital inpatient services**. Accordingly, upon the effective date of CR 5221, NPs and CNSs are authorized to bill Medicare carriers directly for their professional services when furnished to hospital patients, both inpatients and outpatients. The **employer of a PA**, rather than the hospital, **must bill the carrier for their professional services when furnished to hospital patients. Hospitals should not bill for the professional services of a PA, unless the PA is employed by the hospital**.

Key Points

This article and CR 5221 describe the removal of the paragraph in the *Medicare Claims Processing Manual*, Chapter 12 §120.1 that contains outdated policy on payment for NP and CNS services furnished in a hospital setting. The changes are as follows:

- The professional services of NPs and CNSs furnished to hospital inpatients and outpatients may be billed directly by the NP or CNS to the carrier under their respective Medicare billing number or their National Provider Identifier (NPI), once the NPI is effective.

- The employer of a PA may bill the carrier directly for the professional services of the PA furnished to hospital inpatients and outpatients under the PA's Medicare billing number or the PA's NPI, once the NPI is effective.
- Hospitals may bill the carrier for the professional services of an NP or a CNS furnished to hospital inpatients and outpatients when payment for the NP and CNS services has been reassigned to the hospital and when the hospital bills for these services under the NP's or CNS's Universal Provider Identifier Number (UPIN).
- Your Medicare carrier will identify and reprocess any claims submitted by NPs, CNSs, or the employer of a PA that have been denied since January 1, 2006, because the claim listed a hospital inpatient or outpatient setting place of service.
- For claims for dates of service prior to January 1, 2006, the carrier will reopen claims that were denied because they listed a hospital inpatient or outpatient place of service. However, the carrier will only reopen these claims if the NP, CNS, or employer of the PA brings the claim to the attention of the carrier and the carrier will pay these claims for dates of services on or after the January 1, 1998, effective date retroactive to the actual date that the services were rendered.

Additional Information
The official instructions, CR 5221, issued to your Medicare carrier regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R1168CP.pdf on the CMS Web site. A revised Chapter 12, §120.1—Direct Billing and Payment—of the *Medicare Claims Processing Manual* is attached to CR 5221.

If you have questions, please contact your Medicare carrier at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip 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

Health Care Provider Taxonomy Code Updates
The Health Care Provider Taxonomy Codes (HPTCs) are maintained by the National Uniform Claim Committee (NUCC). Codes are updated twice a year. The January publication is effective for use on April 1st and the July publication is effective for use on October 1st. The updates identify active, modified, and new codes and definitions. The HPTC list is available at http://www.wpc-edi.com/codes/taxomony from the Washington Publishing Company (WPC) Web site. Updates will also be available on our Web site at https://www.cahabagba.com/part_a/claims/taxonomy.htm

Resources for the Most Common Medicare Part A Provider Questions

The topics listed below are the most common inquiries received in the Cahaba GBA, LLC Provider Contact Centers (PCCs) for the quarter ending December 31, 2006. This includes the call center in Iowa for home health and hospice providers (1-877-299-4500 and 1-866-539-5592) and for all other Part A providers in Iowa and Alabama (1-877-567-3092 and 1-866-539-5598).

Along with the topic, we have listed resources providers can use to reduce the number of phone calls to Cahaba GBA, LLC for these reasons:

Total Number of Inquiries Received: 38,944		
Inquiry Topic	**Number Received**	**Resource**
Outpatient Therapy Caps	3,157	"Checking Beneficiary Eligibility" section of the *FISS Reference Guide* (see information published on ELGA page 1 and ELGH page 1). https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_elig.pdf
Overlapping Claims	2,563	"Checking Beneficiary Eligibility" section of the *FISS Reference Guide* (see information published on ELGA pages 1, 2, and 4, as well as ELGH page 3 and 8). https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_elig.pdf Home health providers may also refer to "Avoiding Billing Errors Due To Overlapping Home Health Episodes" quick reference tool at: https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_homehealth_overlap.pdf and the November 1, 2006, *Home Health and Hospice Medicare A Newsline* (pg. 34) at: https://www.cahabagba.com/part_a/education_and_outreach/newsletter/1106_rhhi.pdf
Claims in a Suspended Status/Location (S/LOC)	2,508	"Is Your Claim in Status 'S'? Read This Before You Call Cahaba GBA, LLC" article in the December 1, 2006, *Medicare A Newsline* at: https://www.cahabagba.com/part_a/education_and_outreach/newsletter/1206_fi.pdf Please also refer to the information posted to the Cahaba GBA, LLC Web site at: https://www.cahabagba.com/part_a/whats_new/20061221_rtp.htm

Total Number of Inquiries Received: 38,944		
Inquiry Topic	**Number Received**	**Resource**
Beneficiary Part A and Part B Medicare Entitlement	2,272 2,444	"Checking Beneficiary Eligibility" section of the *FISS Reference Guide* (see information published on ELGA page 1 and ELGH page 1) at: https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_elig.pdf The IVR used by Alabama providers (1-866-539-5598) can also be used to verify Part A and B Medicare entitlement and beneficiary demographic information. For more information about using this tool, please access the instructions at: https://www.cahabagba.com/part_a/contact_IVR_alab.htm
Beneficiary Demographic Information	1,816	

Additional information on the ELGA/ELGH screens is available through the online course "Verifying Beneficiary Eligibility," found at: https://www.cahabagba.com/part_a/education_and_outreach/online_courses/eligibility/index.html A quick reference tool highlighting the key fields in the ELGA/ELGH pages is also available at: https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/quick_elgaelgh.pdf

Providers in South Dakota Will Transition to Noridian Administrative Services, LLC

For South Dakota Providers (Hospital, Skilled Nursing Facilities/Swing Beds, Rural Health Clinics, Renal Dialysis Facilities, Federally Qualified Health Centers, Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Facilities)

Effective March 1, 2007, Noridian Administrative Services, LLC, (NAS) will become the Medicare Administrative Contractor (MAC) for the Medicare fiscal intermediary (FI) providers in South Dakota (SD).

All Medicare SD FI functions, (e.g., claims, adjustments, appeals, inquiries, additional development requests (ADRs), cost reports, provider enrollment, etc.) will be transitioned to NAS, on or before February 28, 2007. This includes all functions that are not finalized and are still pending at the time of the transition. In addition:

- Mail delivery received by Cahaba GBA, LLC, from SD FI providers will be forwarded to NAS beginning February 19, 2007.
- SD FI providers will adhere to the NAS local coverage determinations for claims with dates of service March 1, 2007, and after.
- Electronic Data Interchange security with Cahaba GBA, LLC will be deactivated on April 14, 2007. Therefore, SD FI providers will have 45 calendar days after the transition to connect to Cahaba GBA, LLC to download final reports and electronic remittance advices (ERAs).

As a result of this transition, on and after March 1, 2007, SD FI providers will communicate with NAS for **all** Medicare related business.

For more details about this transition, go to the NAS Web site at https://www.noridianmedicare.com/ and click on the "MAC Jurisdiction 3" link. After accepting the user agreement, click on "South Dakota" under the state information.

Having worked closely with NAS during the transition period, Cahaba GBA, LLC is confident that you will experience a smooth transfer of Medicare business functions.

The associates at Cahaba GBA, LLC appreciate the opportunity we have had working with the SD providers for so many years.

ELGA and ELGH Overview of Key Fields

The February 1, 2007, *Medicare A Newsline* article, "ELGA and ELGH Now Available to Alabama Providers" included the Attachment #1, which provided a summary of the important fields for each page of the eligibility screens. Unfortunately, the attachment, in the paper issues of the *Medicare A Newsline* that were mailed, appeared in the incorrect format. As a result, information was cut off from the right side of the paper copy. Please refer to a corrected print of Attachment #1 in this issue of the *Medicare A Newsline*.

Avoiding Medicare Payment Delays by Preventing Claim Submission Errors

Data analysis for the quarter ending December 31, 2006, revealed two of the top claim submission errors (CSEs) were for reason codes C7010 (hospice overlap) and 30715 (name/HIC mismatch). There were a total of 22,247 errors for these two reason codes during the quarter. This reflects twenty percent of claims that were Returned to Provider (RTP) for correction or rejected for any reason during this timeframe. Although any Part A provider may receive these reason codes, data analysis further shows that the provider types who receive them most often include: hospitals, including critical access hospitals (CAHs); rural health clinics (RHCs); and skilled nursing facilities (SNFs).

Avoiding/Preventing Reason Code C7010

Claims are rejected with reason code C7010 when a beneficiary has elected the hospice benefit and a nonhospice provider submits services to Medicare indicating they are related to the terminal diagnosis. When a beneficiary elects the hospice benefit, they give up the right to fee-for-service Medicare payment for services related to their terminal diagnosis. Therefore, the hospice agency coordinating the beneficiary's care must bill all services relating to the terminal diagnosis to Medicare.

However, the hospice benefit does not prevent a Medicare beneficiary from receiving services that are unrelated to the terminal diagnosis provided by other Medicare Part A providers that are unrelated to the terminal diagnosis. Such services must be billed with a condition code “07” in form locators (FL) 24–30 on the UB-92 claim form (FL 18–28 on the UB-04). These FLs are found on claim page 01 of the Fiscal Intermediary Standard System (FISS). Including this code will allow claims for unrelated services to successfully process in the FISS. Condition code “07” can **only** be used when the services are unrelated to the terminal diagnosis; any other use of condition code “07” may be considered abusive.

To prevent future billing errors for this reason, we encourage you to implement the following billing processes:

- Verify with the beneficiary or their representative what health care services they are currently receiving at the time the service occurs.
- Use ELGA page 2 or ELGH page 8 to determine whether the beneficiary has elected the hospice benefit and whether this election will impact your dates of service. These screens should be reviewed both at the time of admission **and** prior to the submission of each claim to Medicare, as the information can be updated at any time. Please access the “Checking Beneficiary Eligibility” section of the *FISS Reference Guide* at https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_elig.pdf for more information on using these eligibility screens.

In addition, a future IVR enhancement will allow Alabama providers (1-866-539-5598) to check if a Medicare beneficiary has elected the hospice benefit. We will notify you via the *Medicare A Newsline* when this enhancement has been implemented.

Avoiding/Preventing Reason Code 30715

Claims are returned to providers for reason code 30715 when the patient’s name (first/last name or middle initial) submitted on the claim does not match the Fiscal Intermediary Standard System (FISS) eligibility record.

To prevent billing errors for this reason code, we encourage you to implement the following billing processes:

- Obtain and photocopy the patient’s Medicare identification card. Keep a copy of this identification card with the patient’s file.
- Verify the information on the card with the patient or their representative and determine if all the information is still valid.
- At the time of admission **and** prior to submitting each claim to Medicare, verify the patient’s name and the correct spelling of the name on page 1 of ELGA/ELGH.
- Submit your claim with the patient’s name keyed **exactly** as it appears on ELGA/ELGH.
  - Make sure the patient’s name is spelled correctly.
  - Make sure there are no unnecessary spaces before or after the name.
  - Does the patient use an initial for their first name? If so, submit your claim with the initial as the first name.
  - Do not use apostrophes or hyphens.

```
ELGH            CWF PART A      ELIGIBILITY SYSTEM                  ELGHCRO
 01/26/2007  13:59:04   BENEFICIARY INFORMATION                 PAGE 01 OF 08

IP-REC  CN 111222333B  NM PATIEN  IT J  DB 12251910  SX F    INT 00011
PN XXXXXX        AP            REAS   1  REQ  0011
CORRECT CN                NM          IT     DB            SX

A-ENT 12011975 A-TRM 00000000 B-ENT 12011975 B-TRM 00000000 DOD
 PARTB YR  20070101 DED-TBM 13100
FULL-NAME PATIENT.JOSEPHINE.J
PT TBM      178000     OT TBM     178000
```

FULL-NAME: Ensure you report the patient name exactly as it appears when submitting Medicare claims. The name will appear in a "Last name.First name.Middle initial" format.

Example #1: The name appears as OBRIEN.JOHN. Report the name on the claims as "Obrien," not O'Brien.

Example #2: The name appears as JOHN.OBRIEN. The name would need to be submitted with the first name as Obrien and the last name as John.

Example #3: The name displays as OBRIEN.M.JOHN. Submit the claim with the last name OBRIEN and the first name with the initial M.

- The patient's name should appear exactly the same on Claim Pages 01 and 05.

```
MAP1711        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 01
SC                       UB92 CLAIM INQUIRY                       SV:
HIC 111222333B    TOB XXX  S/LOC P B9997     OSCAR XXXXXX         UB-FORM
NPI            TRANS HOSP PROV                  PROCESS NEW HIC
PAT.CNTL#: 12345678             TAX#/SUB:                 TAXO.CD:
STMT DATES FROM 011807  TO 011807  DAYS COV       N-C       CO      LTR
LAST PATIENT                        FIRST JOSEPHINE      MI J  DOB 12251910
```

```
MAP1715        M E D I C A R E  A  O N L I N E  S Y S T E M    CLAIM PAGE 05
SC                       UB92 CLAIM INQUIRY
HIC 111222333B    TOB XXX  S/LOC P B9997  PROVIDER XXXXXX
INSURED NAME REL CERT-SSN-HIC  SEX GROUP NAME   DOB   INS GROUP NUMBER
A PATIENT          JOSEPHINE    F              12251910
                 111222333B
B

C
```

Please note: If you have a claim that is returned to you for correction for this reason code, make sure that you correct the beneficiary's name on both Claim Page 01 and 05. If you are unable to correct the beneficiary's name, contact a Customer Service Representative (CSR) at the phone number listed on the "Contact Us" page of this *Medicare A Newsline*, so that the FISS eligibility record can be updated.

Claims that go to the RTP file, or reject cause delays in the processing of Medicare claims, as well as delays in obtaining timely payments for services provided. In addition, they also create unnecessary costs to the Medicare program.

You can find more information on using ELGH and ELGA by accessing the "Checking Beneficiary Eligibility" section of the *FISS Reference Guide* at https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_elig.pdf

Please make sure that this information is shared with the appropriate staff in your facility. If you have questions about this information, please contact a Customer Service Representative (CSR) at the phone number listed on the "Contact Us" page of this *Medicare A Newsline*.

Incorrect Billing of Multiple Units/Multiple Claim Lines per Date of Service of CPT Code 94664

During a recent review of claims, the Comprehensive Error Rate Testing (CERT) program identified the inappropriate billing of Current Procedural Terminology (CPT) code 94664 (demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device). Cahaba GBA, LLC conducted further data analysis of the claims submitted for CPT code 94664 by all bill types for dates of service from October 2005 through October 2006. Review of this data revealed the incorrect billing of greater than one unit of CPT code 94664 on a single claim line per date of service **and/or** the incorrect billing of multiple claim lines of CPT code 94664 per date of service.

The "2006 CPT Expert" specifically instructs providers to "report 94664 only once per date of service;" therefore, multiple units and/or multiple procedures of CPT code 94664 per day are not covered.

Cahaba GBA, LLC asks that all providers review their billing of CPT code 94664 since October 1, 2005, to ensure appropriate claims submission. Providers are encouraged to correct all claims inappropriately billed with multiple units and/or multiple claim lines per date of service of CPT code 94664. For assistance, please see the "Claims Corrections Menu" section of the *Fiscal Intermediary Standard System Reference Guide*, which can be found at:
https://www.cahabagba.com/part_a/education_and_outreach/educational_materials/fiss_correct.pdf

Please remember the importance of accurate coding and billing of services in adherence with the Centers for Medicare & Medicaid Services (CMS) coverage criteria. We appreciate your response to this educational effort to assure appropriate payment of claims for medically necessary, covered, and correctly billed services.

Billing Errors Identified by Comprehensive Error Rate Testing (CERT) Program

The CERT program is how the Centers for Medicare & Medicaid Services (CMS) evaluates the accuracy by which Medicare contractors, like Cahaba GBA, LLC, process Medicare claims. When CERT determines that we have processed a claim incorrectly, we are notified of the error, and steps are taken to adjust the

payment of the claim. Review the list of errors that have been recently identified by CERT, and ensure that education is done to prevent this error from occurring within your facility. These errors have also been added to the Summary of Common Errors Identified by the Comprehensive Error Rate Testing (CERT) Program page of our Web site at:
https://www.cahabagba.com/part_a/education_and_outreach/cert/cert_errors.htm

Provider Type	TOB	Error Identified by CERT
Hospital Outpatient/ Critical Access Hospital (CAH)	13X and 85X	HCPCS J0885 is for Epoetin Alfa injection (non-ESRD use) 1000 units. Documentation did not support the correct amount of units billed. Two units were denied for incorrect coding.
Hospital Outpatient/CAH	13X and 85X	HCPCS 88305 is for Level IV – Surgical pathology, gross and microscopic exam. No laboratory report for surgical pathology report billed. Unable to determine if service was rendered. Units for this code were denied due to insufficient documentation.
Hospital Outpatient/CAH	13X and 85X	HCPCS 97110 (therapeutic procedure, one or more areas, each 15 minutes) and 97535 (self-care management training). Response to Tech Stop did not include requested documentation. No documentation of total treatment time to support all therapy units billed. Reduced from 4 units to 1 unit for each HCPCS for incorrect coding.
CAH	11X	Revenue code 250: General Pharmacy. Response to Tech Stop with requested itemized billing. Claim billed with 42 units. Documentation shows 32 units were for self-administered drugs. Reduced to 10 units due to non-covered self-administered drugs.

Historically, CERT data has shown that the top error among Medicare Part A providers is related to incorrect coding. In most cases, these errors are associated with using the incorrect HCPCS code, or billing incorrect units based on the HCPCS code description. For example, Cahaba GBA, LLC was assessed an error by CERT when the provider billed a claim using HCPCS 84155, total protein except by refractory; serum. However, the documentation submitted to CERT supported HCPCS 84156, physician orders and lab results for a total protein except by refractory; urine. **Providers should have a quality assurance or quality improvement process in place to verify that the service billed is consistent with the services that were ordered and provided.** These processes will help ensure that the appropriate service is billed, CERT errors are reduced, and subsequently, the provider's claim is processed and paid correctly.

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.

As a result of the LCD consolidation process, the LCDs listed on the following page will retire effective March 1, 2007.

Iowa	Alabama
Blepharoplasty/Brow Ptosis Repair/Blepharoptosis Repair for Visual Impairment	Blepharoplasty / Brow Ptosis Repair
Echocardiography and Doppler Color Flow Velocity Mapping	Echocardiography
Noninvasive Vascular Studies	Non-Invasive Cerebrovascular Arterial Studies
Paravertebral Facet Joint Block	
Paravertebral Nerve Block	

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

Provider Enrollment

The following are frequently asked questions concerning the provider enrollment process and completion of the CMS-855A Medicare Enrollment Application.

Q1. The contact person for our organization is changing. How should this be reported to Cahaba?

A1. The provider should complete the CMS-855A application to request a change in the contact person. Detailed instructions for completing the CMS-855A application are included at https://www.cahabagba.com/part_a/enroll_update_your_records/enroll_packet.htm on the Cahaba GBA, LLC Web site. The enrollment application is on the Centers for Medicare & Medicaid Services (CMS) Web site. A link to this is available from the above referenced page. Please ensure that if your provider is not in the Provider Enrollment Chain and Ownership System (PECOS), that the application is completed in its entirety similar to an initial enrollment. If your provider has not submitted an application since July 29, 2002, the provider will not be in PECOS.

Q2. Our provider will be terminating its Medicare number. How should this be reported to Cahaba?

A2. The provider should complete the CMS-855A application to request to voluntarily terminate participation in the Medicare program. Instructions for completing the CMS-855A along with a link to the application are available at the Web address in "A1" above. For terminations, the application is not required to be completed in full.

Q3. We submitted a CMS-855A to request a change in a managing employee. We received an information request letter from Cahaba stating that we must complete the entire application. Why does the full application need to be completed when the administrator is the only change that took place?

A3. CMS requires that all enrollment information from the CMS-855 application be input into the Provider Enrollment Chain and Ownership System (PECOS). In order to create a record in PECOS, certain required information must be populated (e.g., correspondence, practice location, and pay-to address). This information cannot be entered into PECOS unless it is verified to be current and correct. To make this determination, the provider must submit the most current information via the 855 application.

Refer to the July 1, 2006, through December 31, 2006, *Medicare A Newsline* issues for additional questions/answers regarding the National Provider Identifier (NPI), Electronic Funds Transfer (EFT), and submission of the varying types of CMS-855A applications.

Provider Enrollment Contact Information
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 GBA, LLC.

Medicare Part A
Attention: Provider Reimbursement
P.O. Box 361930
Birmingham, AL 35236-1930

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

Contact our Iowa office if your provider is located in the state of Iowa or is a component provider or a national chain organization that has single intermediary status with Cahaba GBA, 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

Provider Enrollment Web site Information
CMS Web site: http://www.cms.hhs.gov/MedicareProviderSupEnroll/
Cahaba GBA Web site: http://www.cahabagba.com/part_a/enroll_update_your_records/index.htm

Change in Information Required to Access Eligibility IVR

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

Effective January 19, 2007, the information required to access a Medicare beneficiary's eligibility information via the Interactive Voice Response (IVR) (866-539-5598) changed. You are now required to enter the first six letters of the patient's last name, and the first initial of the patient's first name. This

information is in addition to the patient's Medicare number and date of birth, which were previously required. In addition, the IVR will no longer voice back the spelling of the patient's last name, first initial or gender. This change will ensure that our providers have the information necessary to appropriately identify the beneficiary, as required by the Health Insurance Portability and Accountability Act (HIPAA), while protecting the privacy of our Medicare beneficiaries.

To enter the beneficiary's last name, use the keypad on your telephone and press the keys that correspond with the first 6 letters of the beneficiary's last name. For example, the last name "Anderson" would be entered as 263377. If the beneficiary's last name is less than six letters, you must press 0 (zero) to complete the six characters. For example, if the beneficiary's name is Cox, press 269000.

Updates have been made to the detailed IVR script available at:
https://www.cahabagba.com/part_a/contact_IVR_alab.htm

To access the eligibility IVR, follow the steps below:

- Call the IVR - 866-539-5598
- Press **option 1** if you are a HealthSouth provider. Press **option 2** if you are a Medicare Part A provider
- Press **option 3** for other options
- Press **option 1** if your provider number contains only numbers. Press **option 2** if your provider number contains a letter in the third position
- Key your Medicare provider number.
- Verify your provider name (Press 1 if correct, press 2 to try again if incorrect)
- Press **option 1** for Eligibility
- Press **option 1** if a letter(s) follows the Medicare number
- Press **option 2** if a letter(s) precedes the Medicare number
- Key nine digit Medicare number
- Verify Medicare number (If correct press **1**/ if not correct press **2** until correct suffix/prefix is given then press **1**)
- Key Beneficiary's date of birth (MMDDCCYY)
- Using your telephone keypad, press the keys that correspond with the first 6 letters of the beneficiary's last name. For example, the last name Anderson would be entered as 263377. If the beneficiary's last name is less than 6 letters, press 0 (zero) to complete the 6 characters. For example, if the beneficiary's name is Cox, press 269000.
- Using your telephone keypad, press the key that corresponds with the first initial of the beneficiary's first name.
- Press **option 1** for Inpatient Eligibility
- Press **option 2** for Outpatient Eligibility

After completing these steps, the following eligibility information will be given

Inpatient Eligibility

- Medicare effective dates for Part A and Part B
- Last billing date on record and days available as of that last billing date (Regular hospital full/coinsurance days, SNF full/coinsurance days, lifetime reserve days, and life psychiatric days)
- Medicare (primary or secondary)

- HMO (is or is not on file)
- Home Health record (is or is not on file)

Outpatient Eligibility

- Medicare effective dates for Part A and Part B
- Deductible status
- Home Health record (is or is not on file)
- Medicare (primary or secondary)
- HMO (is or is not on file)

Currently, hospice information is not available on the IVR; however, this is a feature that will be available in the future.

For assistance in using the IVR, please contact a Customer Service Representative at the appropriate phone number listed on the "Contact Us" page of this *Medicare A Newsline*.

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
March 1, 2007	10:30 a.m.–12:30 p.m. CT
March 8, 2007	10:30 a.m.–12:30 p.m. CT
March 15, 2007	10:30 a.m.–12:30 p.m. CT
March 22, 2007	10:30 a.m.–12:30 p.m. CT

Medicare Forum

Do you have a Medicare question or topic that you would like addressed in the *Home Health & Hospice Medicare A Newsline*? If so, fax it to the Provider Outreach and Education (POE) department at 515-471-7584, or e-mail it to ianewsline@cahabagba.com. Please include your facility's name, provider number, your name, and your telephone number. Responses to the inquiries received in this e-mail box will be provided only through the *Medicare Forum* article, if appropriate. If you need an immediate response to a question, please contact a Customer Service Representative (CSR) for assistance. The CSR telephone numbers are listed under the "Contact Us" page of this newsletter. We also welcome your comments or suggestions on this publication and other Cahaba GBA, LLC customer service activities.

The following answers are in response to questions from the January 11, 2007, CERT Ask-The-Contractor Teleconference (ACT).

Q1 What is a Tech Stop when group therapy is used? What is the purpose of this particular tech stop for group? Is there some issue when coding group therapy?

A1. Tech stops are a way for the CERT Review Contractor (CRC) to communicate that there is missing or incomplete documentation, such as a lab result or physician's order. The question specifically addresses Tech Stops for group therapy, which can occur for missing documentation or missing minutes. The local coverage determinations (LCDs) (L13314-OT and L13267-PT) for Current Procedural Terminology (CPT) code 97150 (Group Therapy), specifically mentions additional documentation should include:

1. Documentation of the specific skilled treatments used in the group and how they related to the plan of care.
2. Documentation of the number of persons in the group.

> *Resources*:
> **LCDs L13314 and L13267**
> https://www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm or
> http://www.cms.hhs.gov/mcd/search.asp
> Enter the LCD # in the "Have the document ID? Use the ID Search" box in the upper right hand corner of the screen. Enter the LCD # and press Enter. Click on the "Search Now" box and select appropriate LCD for IA or AL.

Q2. Where and how do we check the status of our CERT chart? How do we know when CERT has received our documentation? How are we notified of a CERT decision?

A2. Providers are unable to check the status of a CERT request or their response to CERT. Nor can CERT notify providers when their documentation has been received by CERT. However, if CERT does not receive the provider's documentation, the CERT contractor, and perhaps Cahaba GBA, LLC, will contact the provider to request or check the status of the requested documentation. After the CERT Review Contractor (CRC) has made a decision and the decision is to adjust the payment, that information is communicated to the contractor (Cahaba GBA, LLC). Cahaba then adjusts the claim according to CERT's decision. After the adjustment has finished processing, the adjustment will

appear on the provider's remittance advice (RA) or electronic remittance advice (ERA). The RA/ERA is the only notification providers receive indicating CERT's decision. Providers can identify claims adjusted for CERT on the RA/ERA by looking for a TOB ending in an H, for example 32H or 13H. This type of bill will also appear in FISS. There is no communication regarding claims in which CERT agrees with the original payment decision. In addition, comments are added to FISS page 04, which indicate the adjusted claim is due to a CERT adjustment. As a reminder, if you have a claim adjusted by CERT, you can appeal the decision by using your traditional Medicare appeals rights. Or if you have additional documentation that was not submitted with your original documentation, you can submit late documentation at any time.

Resources:
March and August 2006, *Medicare A Newslines*
https://www.cahabagba.com/part_a/education_and_outreach/newsletter/index.htm

Hospital, Critical Access Hospital (CAH), Skilled Nursing Facility (SNF) and Swing Bed (SB) Providers

The following questions and answers are in response to the January 25, 2007, Ask–The–Contactor Teleconference (ACT) entitled "Benefits Exhaust and No–Payment Billing."

Q1. When we have had a no-payment or benefits exhaust claim process through Medicare, do we want a denial or rejection from Medicare and what reason code?

A1. These are the following reason codes added to the Fiscal Intermediary Standard System (FISS) for full benefits exhaust, partial benefits exhaust and no-payment claims:

- **7C028** – Reject for Full Benefits Exhaust
  "Benefits are exhausted on an SNF claim for services subject to benefit period determinations."
- **7C029** – Reject Partial Benefits Exhaust
  "Benefits are partially exhausted on an SNF claim for services subject to benefit period determinations."
- **7SNSC** – Reject for No-Payment Claims
  "Service provided was not skilled."
- **7CS04** – Denial for No-Payment Claims
  "Denial for condition code 21 claims."

Q2. We are receiving reject reason code 31992 for no-payment claims. Can you explain this?

A2: Reason code 31992 is an FISS auto reject due to condition code 21 being used on inpatient claims. During the Ask–The–Contractor Teleconference (ACT), we reported that this reason code would eventually stop. However, following this teleconference it was determined that this reason code will remain effective and will not be replaced by 7SNSC.

Q3. How do you bill for a resident that you have been submitting no-payment claims on for several months, and in the middle of the current month the resident goes to the hospital for a two day inpatient admission and then returns to your facility. Do you bill one or two claims? If you bill two claims, what admission date do you use on the second claim?

A3. In your scenario, there is not a new three-day hospital qualifying stay for a new benefit period. When a SNF resident is readmitted to your facility within thirty-days, you must continue to submit your no-payment 210 type of bills (TOBs). In your scenario, you will submit 2 claims. Your first

claim will be a 210 TOB with a patient status code 02 (discharged to hospital). The hospital will submit their claim for the two days the resident was an inpatient at their facility because the resident cannot be an inpatient in more than one facility at one time. The hospital will discharge the resident back to your facility. Your second claim will be a 210 TOB and you will report the date of the original admission on your claim, with the patient status code of 30 (still a patient). You have the option to submit your 210 TOB monthly or at the time of discharge. On FISS claim page 04, include remarks for both of your claims.

Medicare General Information, Eligibility, and Entitlement Manual (CMS Pub. 100-01, Ch. 3, §10.4.2)
http://www.cms.hhs.gov/manuals/downloads/ge101c03.pdf

Medicare Claims Processing Manual (CMS Pub. 100-04, Ch. 6, §40.3.2)
http://www.cms.hhs.gov/manuals/downloads/clm104c06.pdf

Q4. What occurrence span code and date will be used for the scenario in question #3?

A4. You will enter the occurrence span code 70 to signify the original three-day hospital qualifying stay and the from/through dates of that original hospital qualifying stay for the span code dates.

Q5. Is there a limit on the length of the stay for patients at a critical access hospital (CAH)?

A5. CAHs must maintain an annual average length of stay of 96 hours or less for their acute care patients. There is no length of stay limit for swing bed patients.

News from Cahaba GBA, LLC for Hospital/CAH, SNF/SB, RHC/FQHC, and RDF Providers

Educational Article—Appropriate Billing of Drug Wastage–Correction

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

We first published the article "Educational Article—Appropriate Billing of Drug Wastage" in the December 1, 2006, Medicare A Newsline. Please note the correction in **bold** text.

The Centers for Medicare & Medicaid Services (CMS) outlines coverage of drug wastage in *The Medicare Claims Processing Manual*, (CMS Pub 100-4), Chapter 17, §40, by encouraging the most efficient use of medications to avoid drug wastage. In determining the appropriateness of billing for drug wastage, providers must consider the following:

- Drug Packaging—Dose Options:
    - Are there multiple vial sizes and dose options or is the drug *only* packaged in an amount that exceeds the patient's need?

- What is the shelf-life of the drug?
- Patient Considerations:
  - What is the volume of patients receiving the medication?
  - What is the frequency of administration?
  - Is it practical to coordinate the schedules of patients receiving **the drug** to reduce the potential for drug wastage?

If after review of the above criteria, it is determined that the remainder of a vial or other package must be discarded after administering the drug to a Medicare patient, coverage is available for the drug discarded along with the amount administered. Documentation of drug wastage in the medical record is expected. The coverage of discarded drugs applies only to single–dose vials. Multi-dose vials are not subject to payment for discarded amounts of a drug.

Example: According to the product information found in the latest addition of the United States Pharmacopoeia-Drug Information (USP-DI), epoetin alpha (EPO) is available in 1mL single-dose vials in multiple strengths, including 2000 units/mL, 3000 units/mL, 4000 units/mL, 10,000 units/mL and 40,000 units/mL. Multi-dose vials are also available in 10,000 units/mL – in 2 mL vials and 20,000 units/mL – in 1 mL vials. The shelf life of the multi–dose vial is 21 days. Because of the multiple dose options available for exact dose administration, the duration of stability of the multi-dose vial and the volume of patients receiving EPO, it was determined that claims should **not** be submitted with billing for wastage of EPO.

For additional information regarding the appropriate billing of drug wastage, please review the *Medicare Claims Processing Manual,* (CMS Pub 100-4), Chapter 17, §40, located at: http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf

News from Cahaba GBA, LLC for Hospital/CAH and CMHC Providers

Widespread Probe Review Results—Review of CPT Code 90801 (Psychiatric Diagnostic Interview Examination)

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

Medical Review recently completed a widespread probe review of claims submitted by outpatient hospitals and community mental health centers (CMHCs) for Current Procedural Terminology (CPT) code 90801 greater than one revenue unit per date of service. These claims were randomly selected from dates of service between June 2006 and December 2006. Please note that the error rate is based on the percent of charges denied divided by the charges reviewed. The review results are as follows:

- Providers included in review—9
- Claims Reviewed—47
- Claims Denied—45
- Charges Reviewed—$ 11,997.00

- Charges Denied—$ 9,549.90
- Error Rate—80 percent

The medical review decisions were based on the "CPT Expert 2006" description of CPT code 90801 as the psychiatric diagnostic interview examination that includes a history, mental status exam, and a disposition, as well as ordering and medical interpretation of laboratory or other medical diagnostic studies. "The CPT Assistant" (Volume 11, Issue 3, March 2001), states that CPT code 90801 is most often performed during the initial phase of treatment, as the goal of the examination is to establish a diagnosis and treatment protocol for the patient. The "CPT Assistant" further describes CPT code 90801 as including the following elements:

- Pre-service work—discussion with person making referral, review of records
- Intra-service work—complete psychiatric history, complete mental status exam, physical exam, laboratory tests, establishing definitive diagnosis and treatment plan
- Post-service work—arranging further studies and further care, report or discussion with referral source, dictating results of exam, any additional discussions after review of results of studies conducted

For coverage consideration, the above elements of CPT code 90801 should be evident in the documentation. Per definition, CPT code 90801 is a single **untimed** service; therefore, multiple units per date of service are not covered, regardless of the number of professionals involved in the examination process.

Ongoing data analysis will monitor the utilization of CPT code 90801 to ensure compliance with these educational instructions.

News from Cahaba GBA, LLC for Hospital/CAH Providers

Widespread Probe Results and Review Notification for Inpatient Rehabilitation Facility Prospective Payment System Claims for Type of Bill 11X with a Case Mix Group of A0801–A0806

This article applies to inpatient rehabilitation facility (IRF) providers who submit claims to the Cahaba GBA, LLC office in Iowa.

As a result of the analysis of errors related to the widespread probe review for topic 5TR03 for claims reviewed between June 15, 2006, through September 27, 2006, Cahaba GBA, LLC will be initiating a continuing widespread review for inpatient rehabilitation facility prospective payment system (IRF PPS) providers. The topic code for this review will be 5TR04, and will select claims for type of bill (TOB) 11X with a Case Mix Group (CMG) of A0801-A0806. Claims will be selected across the provider community billing these services that meet the parameters of the edit. Once selected, the claims will be reviewed for medical necessity (e.g., compliance with the Centers for Medicare & Medicaid Services (CMS) guidelines, contractor local coverage determinations (LCDs), correct billing and coding). Results of the widespread probe review are summarized below.

- **Error rate:** 99.27 percent
- **Number of provider reviewed:** 18

Patients needing rehabilitative services require a hospital level of care, if they need a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade their ability to function. There are two basic requirements that must be met for inpatient hospital stays for rehabilitation care to be covered:

- The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and
- It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility such as a SNF, or on an outpatient basis.

In order to meet the above requirements the following basic components must be met:

- Close medical supervision by a physician with specialized training or experience in rehabilitation
- Twenty-four hour rehabilitation nursing
- Intense level of services
- Multidisciplinary team approach

Although all admissions must meet medical necessity, routine admissions for single joint replacements' postoperative rehabilitation, debility, cardiac rehabilitation, and pulmonary rehabilitation would not be expected. However when such an admission meets the coverage criteria, careful attention to documentation as to why the patient requires intensive inpatient rehabilitation should be present.

The majority of denials of IRF claims reviewed resulted from the information submitted did not provide the medical justification for the IRF services. The medical review of inpatient rehabilitative treatment of lower extremity joint replacement decisions were based on the LCD L15198—Inpatient Rehabilitation, which outlines specific documentation requirements to support the medical necessity for all inpatient rehabilitation admissions.

The LCD may be found at https://www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm on our Web site.

One claim was denied due to a lack of record submission in a timely manner, resulting in a 56900 denial. According to *Medicare Program Integrity Manual*, (CMS Pub 100-8), 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 thirty-day time period to respond. If the ADR requested information is not received within forty-five days after the date of the request, then the claim must be denied.

In addition to the previously mentioned references, IRFs billing for inpatient rehabilitation services should review the *Medicare Benefit Policy Manual* (CMS Pub 100-2), Chapter 1, §110, and the *Medicare Claims Processing Manual* (CMS Pub 100-4), Chapter 3, §140 to ensure adherence to all coverage criteria. These references can be found at http://www.cms.hhs.gov/manuals on the CMS Web site. Additional information regarding inpatient rehabilitation services may be found in the *Federal Register*, Volume 69, Number 89/ Friday, May 7, 2004, pages 25762-25763 and the United States Government Accountability Office (GAO) Report, April 2005 at: http://www.gao.gov/new.items/d05366.pdf

In addition, watch the "Calendar of Educational Events" page on our Web site at https://www.cahabagba.com/apps/course_registration/ia/calendar.jsp for an upcoming IRF teleconference.

Availability of National Quality Initiative Programs

Quality health care for people with Medicare is a high priority for the Centers for Medicare & Medicaid Services (CMS). In recent years, programs have been launched to assure quality health care. Through our partnership with the Quality Improvement Organizations (QIOs), we are promoting these national quality improvement initiatives.

For more information about these national quality initiatives, please go to http://www.cms.hhs.gov/QualityInitiativesGenInfo/ at the CMS Web site. This site will also provide you with links to the various provider-specific quality initiative programs.

In addition, information is available at www.nhqualitycampaign.org from the nursing home national campaign Web site. Tools and resources to support quality initiatives for all provider types, and contact information for each state's QIO can be found at: www.medqic.org

Widespread Probe Results and Review Notification for Skilled Nursing Facility Non-Prospective Payment System Providers for Claims with Type of Bill 22X and 23X and Primary Diagnosis 331.0

This article applies to Fiscal Intermediary (FI) Providers who Submit Claims to the Cahaba GBA, LLC office in Iowa.

As a result of the analysis of errors related to the widespread probe review for topic 5TN07 for claims reviewed between April 28, 2006, through November 10, 2006, Cahaba GBA, LLC will be initiating a continuing widespread review for outpatient therapy providers. The topic code for this review will be 5TN15, and will select claims for type of bill (TOB) 22X and 23X with a primary diagnosis of 331.0 – Alzheimer's disease. Claims will be selected across the provider community billing these services that meet the parameters of the edit. Once selected, the claims will be reviewed for medical necessity (e.g. compliance with the Centers for Medicare & Medicaid Services (CMS) guidelines, contractor local coverage determinations (LCDs), correct billing and coding). Results of the widespread probe review are summarized below.

- **Error rate:** 65.12 percent
- **Number of providers reviewed:** 51

Out of 88 claims reviewed by Medical Review, 82 were either partially or fully denied. The following describes some of the denials and how to prevent them.

The majority of denials for skilled nursing facility (SNF) nonprospective payment system (non-PPS) claims reviewed were because the medical necessity of the service or treatment was not supported in the medical record. As stated in the LCD, therapy services are covered provided such services are of a level of complexity and sophistication, or the patient's condition is such that the services can be safely and effectively performed only by a licensed qualified therapist or licensed therapist assistant. Doing repetitive exercises that can be taught to another caregiver to increase strength and endurance are not covered. This does not require the skills of a therapist.

Fourteen claims were denied for insufficient documentation for the services provided. Daily treatment encounter notes need to document the skilled interventions provided by the therapist. A grid with a Current Procedural Terminology (CPT) code and times does not show what skilled intervention was provided.

Nine claims were denied for no documentation for services provided. Daily treatment encounter notes are required. Weekly progress notes are not sufficient to show what services were provided at each visit.

Six claims were denied due to a lack of record submission in a timely manner, resulting in a 56900 denial. According to *Medicare Program Integrity Manual*, (CMS Pub 100-8), Chapter 3, § 3.4.1.2, if a coverage or coding determination cannot be made based upon the information on the claim, the FI may solicit additional documentation from the provider by issuing an additional documentation request (ADR) and must notify the provider of the thirty-day time period to respond. If the ADR requested information is not received within forty-five days after the date of the request, the claim must be denied.

Four claims were denied for missing or invalid certification for services. Covered therapy services must relate directly and specifically to an active written treatment plan and must be reasonable and necessary to the treatment of the individual's illness or injury. The plan of treatment should address specific therapeutic goals for which modalities and procedures are outlined in terms of type, frequency and duration. The plan of care must be certified/approved by the physician, optometrist, or qualified nonphysician practitioner. Without the signed and dated physician certification of the plan of care, therapy services cannot be covered.

Other reasons for which claims were denied related to documentation did not support the CPT/HCPCS code billed, guidelines for coverage were not met, and no evidence of need for evaluation or re-evaluation. The daily treatment encounter notes need to support each CPT/HCPCS billed each day. Refer to the LCD applicable to the type of therapy for further information.

LCDs have been established to assist with providing Medicare covered therapy services. The LCDs can be found at https://www.cahabagba.com/part_a/policies_medical_review/lcd_active.htm on our Web site. The LCD for physical therapy is L13267; the LCD for occupational therapy is L13314; and the LCD for speech-language pathology is L1078. Coverage and billing information is also available at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS Web site. Refer to the *Medicare Benefit Policy Manual* (CMS Pub. 100-02), Chapter 15 §§220-230 and the *Medicare Claims Processing Manual* (CMS Pub. 100-04), Chapter 5, §20.

In addition, the teleconference "2007 Outpatient Therapy Services Coverage and Documentation Requirements – Part A Medical Review Update" will be offered March 1 and March 2, 2007. You may register for this teleconference at https://www.cahabagba.com/apps/course_registration/ia/calendar.jsp on our Web site.

Widespread Probe Results and Review Notification—Skilled Nursing Facility Prospective Payment System and Swing Bed Claims with a RUG-III Code CAXX2, CAXX3, and CAXX4

This article applies to Fiscal Intermediary (FI) Providers who Submit Claims to the Cahaba GBA, LLC office in Iowa.

As a result of the analysis of errors related to the widespread probe review for topic 5TS99 for claims reviewed between January 4, 2006, through September 30, 2006, Cahaba GBA, LLC will be initiating a widespread review for Skilled Nursing Facility Prospective Payment System (SNF PPS) and swing bed (SB) providers. The topic code for this review will be 5TSAL, and will select claims with a Resource Utilization Groups (RUG-III) code of CAXX2, CAXX3, and CAXX4. Claims will be selected across the provider community billing these services that meet the parameters of the edit. Once selected, the claims will be reviewed for medical necessity (e.g., compliance with the Centers for Medicare & Medicaid Services (CMS) guidelines, contractor local coverage determinations (LCDs), correct billing and coding). Results of the widespread probe review are summarized below.

- **Error rate:** 35.51 percent

Denials occurred on claims billed with RUG III codes CAXXX, or clinically complex services because the documentation did not support a skilled nursing service was provided or required on a daily basis in the SNF setting. In addition, denials were made because information was missing in the medical record that was requested in the additional development request (ADR) message.

To pay a RUG III code for nursing, the documentation should clearly indicate that the beneficiary is medically unstable or there is the reasonable potential for decline that requires the daily skills of a nurse within the SNF setting.

Nursing observation and assessment may be considered a skilled nursing service when it is likely or apparent the patient's change in condition requires a nurse to identify and evaluate their needs for possible modification in their plan of care until the treatment regimen is essentially stabilized. Indications such as, but not limited to, abnormal/fluctuating vital signs, significant changes in edema, signs and symptoms of infection, and/or significant respiratory changes may justify further observation and assessment within the SNF setting. Documentation should include treatments, nursing assessments and concerns, physician contacts, and abnormal conditions. Nursing observation and assessment is not reasonable and necessary where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

Additional information on observation and assessment can be found in the CMS *Medicare Benefit Policy Manual* (CMS Pub 100-2), Chapter 7, § 40.1.2.1, which can be found on the CMS Web site at: http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage

Widespread Edit for Skilled Nursing Facility and Swing Bed Prospective Payment System Claims with Length of Stay of at Least Thirty Days

This article applies to Fiscal Intermediary (FI) Providers who Submit Claims to the Cahaba GBA, LLC office in Iowa.

Medical Review has an ongoing widespread edit, topic 5TSAB, for Skilled Nursing Facility (SNF) and Swing Bed (SB) Prospective Payment System (PPS) claims (type of bill 18X and 21X) for lengths of stay of at least thirty days. Analysis of errors for claims reviewed between October 1, 2006, through December 31, 2006, indicate an overall denial rate of 46.15 percent. Based on the analysis of errors, this edit will continue as a widespread edit, selecting claims with a length of stay of at least thirty days.

Initially, the patient may have been admitted into the SNF or SB to receive daily skilled nursing for an unstable or potentially unstable medical condition and/or rehabilitation for conditions related to their three-day qualifying acute hospitalization. The patient may have also required inpatient skilled services initially for a condition that *developed* while the patient was in the SNF or SB while they were receiving care for a condition related to their qualifying hospitalization. On an ongoing basis, the SNF/SB must determine whether the patient continues to require the skilled setting.

The top denial for 5TSAB was “Information does not support need for skilled nursing facility care.” Medical review denials occurred for skilled nursing services when the documentation in the medical record depicted a patient whose medical condition had stabilized. This documentation indicated nursing was monitoring the patient, performing assessments, obtaining vital signs, and/or administering medications, and reporting laboratory and test results to the physicians. However, the documentation did not support that observation and assessment were warranted in the skilled setting because the patient’s condition was stable.

A patient may require skilled observation and assessment, and or management and evaluation of the care plan when it is evident their condition is becoming unstable, or is unstable. In this situation, skilled nursing may be required to provide interventions and treatment until the patient’s condition resolves, stabilizes, or returns to their baseline.

To support the patient’s unstable condition, documentation must indicate signs and symptoms and abnormal assessment results that are different from the patient’s baseline. To require the skilled setting, these changes in medical status would most likely require physician notification, physician orders, and nursing intervention. Simply monitoring a patient day after day, when their condition does not require intervention, is often an indication that observation and assessment at the skilled level is not medically necessary.

Medical review denials also occurred for skilled rehabilitation services. These denials occurred for several reasons, including:

- The documentation indicated the patient had met their therapy goals,
- The documentation portrayed a picture of a patient whose functional status no longer required the skilled setting,

- Minimal information was provided by therapy to indicate the types of skilled interventions provided to the patient, or why the patient required the interventions by the therapist.

The goal of therapy is for a patient to return to their highest level of function that is realistically attainable and within the context of their disability. However, the skills of a therapist may not necessarily be required on a daily basis in the skilled setting to attain this goal. On an ongoing basis, therapy, nursing, and other staff must determine if the patient's functional impairments continue to be at a level of complexity that require the daily skills of a therapist. It must also be determined whether the patient could safely and effectively participate with the facility's trained staff in a maintenance and/or restorative nursing program, or receive therapy services in a less intensive setting, such as outpatient or home health.

When the skills of a therapist are required on a daily basis, the documentation in the medical record should include specific descriptions of the patient's ongoing functional impairments using objective tests and measurements to clearly identify their deficits. Goals should be specific, realistic, and individualized. Each day, the skilled therapy services should be documented. At a minimum, therapy should do a weekly progress note. The progress note should be more than just a status report, and should reflect how the therapy interventions impacted the patient. The progress note should also include problems or difficulties encountered by the patient that impacted progress, specialized techniques that were utilized, status in relation to goal achievement and discharge, education provided to the patient, family, and/or staff, and any modifications made to the plan of care.

News from Cahaba GBA, LLC for CORF/OPT Providers

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The Appropriate Use of Occurrence Codes and Value Codes for Outpatient Therapy Services

Cahaba GBA, LLC has identified the incorrect use of occurrence codes and values codes during the review of outpatient therapy claims. This educational instruction outlines the appropriate use of occurrence codes and value codes when billing the fiscal intermediary (FI) for outpatient therapy services.

On therapy claims, the *Medicare Claims Processing Manual*, (CMS Pub 100-4), Chapter 5, §20, instructs providers to report the date the therapy plan of care was either established or last reviewed (see §220.1.3B) with occurrence code 17, 29, or 30, **and** the first day of treatment with occurrence code 35, 44, or 45. Providers should also report value codes 50, 51, or 52 to indicate the total number of physical therapy (PT), occupational therapy (OT), or speech-language pathology (SLP) therapy **visits** provided from the onset of treatment through the billing period.

The following table instructs providers billing for outpatient therapy services in the appropriate use of occurrence codes and value codes on the CMS 1450 (UB-92) and UB-04 claims along with the corresponding fields if entering claims into the Fiscal Intermediary Standard System (FISS) via direct data entry (DDE).

Form Locator (FL) Name	FL# UB-92	FL # UB-04	FISS Field	How to complete
Occurrence Code / Date	FL32	FL31	Claim Page 01, OCC CDS/Date	Enter occurrence code 11 (onset of symptoms/illness) and the date of symptom onset.
Occurrence Code / Date	FL33	FL32	Claim Page 01, OCC CDS/Date	If appropriate, enter one of the following occurrence codes and corresponding date: 28 – date CORF plan established or last reviewed 29 – date outpatient PT plan established or last reviewed 30 – date outpatient SLP plan established or last reviewed 17 – date OT plan established or last reviewed
Occurrence Code / Date	FL 34	FL 33	Claim Page 01 OCC CDS/Date	Enter one of the appropriate occurrence codes and corresponding date: 35 – date treatment started for PT 44 – date treatment started for OT 45 – date treatment started for SLP 46 – date cardiac rehabilitation started
Value Codes / Amount	FL 39-41	FL 39-41	Claim Page 01 Value Codes / Amounts	Enter the number of therapy **visits** from onset (at your facility) through this billing period (see below for additional instructions); enter one of the following codes in the "code" box of this FL/FISS field to indicate the type of therapy provided: 50 – PT 51 – OT 52 – SLP 53 – cardiac rehab

When billing therapy services, be certain to use the appropriate value codes in FL 39-41 or the "Value Codes" field on FISS Claim Page 01. Enter the total number of therapy visits from onset (at your facility) through this billing period in the dollar portion of the FL (right-justified to the left of the dollar/cents delimiter) followed by two zeros for value codes 50, 51, and 52. FL 39-41 or the "Value Codes" field on FISS Claim Page 01 are for entering cumulative **visits** not service units. The number in FL 39-41 or the "Value Codes" field on FISS Claim Page 01 should increase with each claim in a sequence.

Example:

Mr. Jones had a fall with a knee injury on 12/28/05 (FL 32, occurrence code 11) and went to ABC Therapy for physical therapy services. His PT plan of treatment was established on 1/1/2006 (FL 33, occurrence code 29). He began his PT treatments on 1/1/2006 (FL 34, occurrence code 35). In January he received 10 physical therapy visits. In February, he received 9 visits. The claim submitted was for dates of service 2/1/06-2/28/06. The total number of visits for Mr. Jones since the onset of physical therapy at ABC

Therapy is 19. For this scenario, if filing on the CMS-1450 (UB 92) Form, in FL 39, enter value code 50 (for PT) and the value code amount, 19 00 (right-justified to the left of the dollar/cents delimiter). Please refer to Attachment #2 for a sample of a completed CMS-1450 (UB 92) form showing how to bill for outpatient therapy.

Refer to the following screen example if entering the claim directly into FISS. On Claim Page 01, enter the following value codes and dates: 11 122805, 29 010106, and 35 010106 in the "OCC CDS / Dates" fields, and enter value code 50 in the "Value Codes – Amounts" field and the amount, 19.00.

```
ZIP           SEX    MS   ADMIT DATE       HR     TYPE   SRC   D HM      STAT
    COND CODES 01     02     03     04     05     06     07     08     09     10
  OCC CDS/DATE 01 11 122805 02 29 010106 03 35 010106 04           05
               06            07            08            09           10
    SPAN CODES/DATES 01                  02                    03
 04                  05                  06                    07
 08                  09                  10                    FAC.ZIP
   DCN
        V A L U E   C O D E S  -  A M O U N T S  -  A N S I   MSP APP IND
 01 50 19.00              02                       03
 04                       05                       06
 07                       08                       09
      PLEASE ENTER DATA
       PRESS PF3-EXIT  PF5-SCROLL BKWD  PF6-SCROLL FWD  PF7-PREV   PF8-NEXT
```

We encourage all providers submitting claims to the FI for outpatient therapy services to review in detail the special coding requirements located in the *Medicare Claims Processing Manual*, (CMS Pub 100-4), Chapter 5, §20 found at http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf on the CMS Web site. In the future, Medical Review may utilize this information for data analysis of outpatient therapy services.

Additionally, providers should review the CMS Transmittal 1104, published November 3, 2006, for instructions about the UB-04 claim implementation, effective March 1, 2007. This may be found at http://www.cms.hhs.gov/Transmittals/Downloads/R1104CP.pdf on the CMS Web site.

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. – 4:30 p.m. Central Time.

- If you submit your Medicare claims to the Cahaba GBA, LLC office in Des Moines, call: **1-877-567-3092**, M–F, 8am–4:30pm CT.
- If you submit your Medicare claims to the Cahaba GBA, LLC office in Birmingham, Alabama, call: **1-866-539-5598**, M–F, 8am–5pm CT.

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

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

Questions can also be faxed to **515-471-7584** or e-mailed to ianewsline@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

- ✓ **Webinar Information**
  - ➢ ***FISS 401: Did I Do That?***—This Webinar will discuss using the FISS system to correct claims that have gone to the Return to Provider (RTP) file, adjust claims and cancel claims.

    March 6, 2007 **1:00 p.m.–3:00 p.m. Central Time (CT)**

    The registration deadline for this educational event is **March 1, 2007**. Registration is limited; therefore, we encourage you to register early to ensure your participation in this event.

- ✓ **Teleconference Title/Information:**
  - ➢ ***National Provider Identifier (NPI) Ask-The-Contractor (ACT) Teleconference***—This teleconference will present the most current NPI updates. Questions received in advance from participants will also be addressed.

    March 8, 2007 **1:00 p.m.–2:00 p.m. CT**

    The registration deadline for this educational event is **March 5, 2007**. Registration is limited; therefore, we encourage you to register early to ensure your participation in this event. Registered participants are encouraged to submit questions for the ACT by replying to the email confirming your registration for the event.

- **Teleconference Title/Information:**

  - ***Avoiding CERTain Errors…What Part A Providers Should Know***—This teleconference will discuss the Comprehensive Error Rate Testing (CERT) program denials, including denial reasons, how to avoid denials, and how to appeal denials.

    March 22, 2007 **10:30 a.m.–11:30 a.m. CT**

    The registration deadline for this educational event is **March 19, 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.

- **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

- ✓ **Online Courses** (continued) 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
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 March 1, 2007, Medicare A Newsline

- A -

ABN	Advance Beneficiary Notice
A/B MAC	Part A/B Medicare Administrative Contractors
ACT	Ask-The-Contractor Teleconference
ADR	Additional Development Request
AIR	All Inclusive Rate
ASC	Ambulatory Surgical Centers

- C -

CAH	Critical Access Hospital
CARC	Claim Adjustment Reason Code
CAS	Claim Level Adjustment Segment
CB	Consolidated Billing
CERT	Comprehensive Error Rate Testing
CMG	Case Mix Group
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CNS	Clinical Nurse Specialists
COB	Coordination of Benefits
CORF	Comprehensive Outpatient Rehabilitation Facility
CPT	Current Procedural Terminology
CR	Change Request
CRC	CERT Review Contractor
CSE	Claim Submission Error
CSR	Customer Service Representative
CT	Central Time
CWF	Common Working File

- D -

DDE	Direct Data Entry
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DMERC	Durable Medical Equipment Regional Carrier
DRG	Diagnosis–Related Group
DSMT	Diabetes Self-Management Training

- E -

EFT	Electronic Funds Transfer
EPO	Epoetin Alpha
ERA	Electronic Remittance Advice
ESRD	End Stage Renal Disease

- F -

FI	Fiscal Intermediary
FISS	Fiscal Intermediary Standard System
FL	Form Locator
FQHC	Federally Qualified Health Center

- G -

GAO	Government Accountability Office

- H -

HCPCS	Healthcare Common Procedure Code System
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HPTC	Health Care Provider Taxonomy Codes
HSCRC	Health Services Cost Review Commission

- I -

ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
IHS	Indian Health Service
IPF PPS	Inpatient Psychiatric Facility Prospective Payment System
IRF PPS	Inpatient Rehabilitation Facility Prospective Payment System
IV	Intravenous
IVR	Interactive Voice Response

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

- L -

LCD Local Coverage Determination

LTCH PPS Long-Term Care Hospitals Prospective Payment System

- M -

MCIUR Managed Care Informational Unsolicited Response

MIRE Monochromatic Infrared Energy

MLN Medicare Learning Network

MMA Medicare Prescription Drug Improvement and Modernization Act of 2003

MPFS Medicare Physician Fee Schedule

MPFSDB Medicare Physician Fee Schedule Database

MSN Medicare Summary Notice

- N -

NCD National Coverage Determination

NEMB Notice of Exclusion from Medicare Benefits

NP Nurse Practitioners

NPI National Provider Identifier

NPP Nonphysician Practitioner

NUBC National Uniform Billing Committee

NUCC National Uniform Claim Committee

- O -

OMB Office of Management and Budget

OPPS Outpatient Prospective Payment System

ORF Outpatient Rehabilitation Facility

OT Occupational Therapy

- Q -

QIO Quality Improvement Organization

- P -

PA Physician Assistant

PCC Provider Contact Center

PECOS Provider Enrollment Chain and Ownership System

POE Provider Outreach and Education

POS Place of Service

PFFS Private Fee-For-Service

PS&R Provider Statistical and Reimbursement's Report

PT Physical Therapy

- R -

RA Remittance Advice

RARC Remittance Advice Remark Code

RHC Rural Health Clinic

RHHI Regional Home Health Intermediary

RTP Return to Provider

RUG-III Resource Utilization Groups

- S -

SB Swing Bed

S/LOC Status/Location

SLP Speech-Language Pathology

SNF Skilled Nursing Facility

SNF PPS Skilled Nursing Facility Prospective Payment System

- T -

TOB Type of Bill

- V -

UPIN Universal Provider Identifier Number

USP-DI United States Pharmacopoeia-Drug Information

- W -

WPC Washington Publishing Company

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC

Attachment # 1

ELGA Overview of Key Fields

Page #	Important Fields	Reason
Page 1	CORRECT CN, NM, IT, DB, SX	Provides correct Medicare number, name, date of birth and/or sex code if entered incorrectly.
	A-ENT, A-TRM, B-ENT, B-TRM	Ensure beneficiary entitlement to Medicare Part A &/or Part B.
	DOD	Ensure services are not after date of death.
	FULL-HOSP, CO-HOSP, FULL-SNF, CO-SNF, IP-DED	Verify number of full/coinsurance hospital/SNF days, & inpatient deductible amount remaining in the current benefit period.
	DED-TBM	Verify dollar amount of Part B deductible remaining for current year.
	PHYS THER TBM, OCC THER TBM	Verify dollar amount of PT and SLP, & OT caps remaining for current year.
	HMO, CURR-ID, OPT, ENTITL, TERM	Verify Medicare HMO (Medicare Advantage Plan) status, the OPT code and the enrollment and termination dates.
Page 2	PAP, PAP DATE	Verify services and dates for beneficiary eligibility for services.
	IMMUNO/TRANS	Verify transplant coverage and type.
	START DATE, TERM DATE, REVOC IND	Verify start date, term date and revocation indicator for four most recent hospice benefit periods.
Page 4	EPISODE START, EPISODE END, DOEBA, DOLBA	Indicates start and end date, and first and last visit in two most recent home health episodes. For prior home health episodes, enter a prior date in the APP DATE field.
Page 5	HCPCS CODE, TECH/PRO, RISK, DATES OF SERVICE	Verify the type and dates of the Medicare covered screening services that the beneficiary received.
Page 6	PREVENTIVE SERVICE, TECH DTE, PROF DTE	Verify the next date beneficiary is eligible to receive Medicare-covered preventive service.
Page 7	TOTAL SESSIONS, HCPCS, FROM, THRU	Verify total number of smoking cessation sessions, HCPCS codes, and from and thru dates of service.
Page 8 and up	MSP CODE, EFF DATE, TERM DATE, INSURER INFORMATION	Verify if beneficiary has a primary insurance, the type, effective and termination dates, and the name and address of the insurer.

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC

ELGH Overview of Key Fields

Page #	Important Fields	Reason
Page 1	CORRECT CN, NM, IT, DB, SX	Provides correct Medicare number, name, date of birth and sex code if entered incorrectly.
	A-ENT, A-TRM, B-ENT, B-TRM, DOD	Ensure beneficiary entitlement to Medicare Part A &/or Part B. Ensure services are not after date of death.
	PT TBM, OT TBM	Verify dollar amount of PT and SLP, and OT caps remaining for current year.
Page 3	START DATE, END DATE, INTER NUM, PROV NUM, PAT STAT	Indicates start and end date, intermediary number, provider number, and patient status at end of two most recent home health episodes. For prior home health episodes, enter a prior date in the APP DATE field.
Page 4	MSP CODE, EFF DATE, TRM DATE	Verify if beneficiary has insurance primary to Medicare, the type and the effective and termination dates.
Page 5	PLAN ID, OPT, EFF DATE, TERM DATE	Verify whether the patient has a Medicare HMO, the OPT code and the enrollment and termination dates.
Page 6	PREVENTIVE SERVICE, TECH DTE, PROF DTE	Verify the next date beneficiary is eligible to receive Medicare-covered preventive service.
Page 7	TOTAL SESSIONS, HCPCS, FROM, THRU	Verify total number of smoking cessation sessions, HCPCS codes, and from and thru dates of service.
Page 8	START DATE, TERM DATE, INTER NO, PROVIDER NO, REVOC IND	Start and term date, intermediary number, provider number, and revocation indicator for four most recent hospice election periods.

Example of an Outpatient Therapy Billing

Your Hospital Name
Address
City, State, Zip

3 PATIENT CONTROL NO.	4 TYPE OF BILL
00002	132

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-CD.	9 C-I D.	10 L-R D.	11
	0408YY	0412YY					

12 PATIENT NAME	13 PATIENT ADDRESS
Doe Jane	123 Main Street Anywhere IA 50000

14 BIRTH DATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
08311923	F		0408YY					30									

	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
a	11	0327YY	17	0408YY	44	0408YY						A
b												B
												C

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a	51	2 00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0430	Occupational Therapy	97110 GO	0408YY	002	72 00		
2								
3	0430	Occupational Therapy	97110 GO	0412YY	001	36 00		
4								
5	0434	Occupational Therapy/Eval	97003 GO	0408YY	001	108 00		
6								
7	0001	Total				216 00		
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicare	16-0000	Y				
B							
C							

57 DUE FROM PATIENT ➜

	58 INSURED'S NAME	59 P. REL	60 CERT.-SSN-HIC.-ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, Jane	01	123456789A		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN DIAG CD	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
836.1											

(Codes 68–75: OTHER DIAG. CODES)

79 P.C.
80 PRINCIPAL PROCEDURE CODE / DATE
81 OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE
OTHER PROCEDURE CODE / DATE

82 ATTENDING PHYS. ID H77191 Smith, John

83 OTHER PHYS. ID

OTHER PHYS. ID

84 REMARKS
a
b
c
d

85 PROVIDER REPRESENTATIVE X *Ima Clerk*
86 DATE *4/4/YY*

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.