

# Medicare A Newsline

Important Information from Cahaba Government Benefit Administrators®, LLC



August 1, 2007

Vol. 14, No. 11

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](http://www.cahabagba.com)



## The Inside Story

### News from CMS

- Ⓜ News FLASH Messages from CMS ..... 1
- Ⓜ Important Information for Providers/Suppliers Regarding National Plan and Provider Enumeration System (NPPES) Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes ..... 3
- Ⓜ National Provider Identifier (NPI) Required to Enroll in Electronic Data Interchange (EDI), and Update of Telecommunication and Transmission Protocols for EDI..... 10
- Ⓜ Medicare Contractor Annual Update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) ..... 11
- Ⓜ Appeals Transition—BIPA Section 521 Appeals..... 13
- Ⓜ July 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective July 1, 2007, and Revisions to January 2007, April 2007, and October 2006 Quarterly ASP Medicare Part B Drug Pricing Files..... 15
- Ⓜ Update of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) and Enhancement of Medicare Remit Easy Print (MREP) ..... 18
- Ⓜ Revision to Medicare Publication 100-09, Chapter 3 – Provider Inquiries and Chapter 6 – Provider Customer Service Program Updates ..... 21

- Ⓜ Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program—**Revised** ..... 24
- Ⓜ Update to the 2007 Medicare Physician Fee Schedule Database (MPFSDB) ..... 26
- Ⓜ October Quarterly Update to 2007 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement ..... 28
- Ⓜ Charges for Missed Appointments ..... 30
- Ⓜ Medicare Payment for Preadministration-Related Services Associated with IVIG Administration—Payment Extended through CY 2007—**Revised** ..... 31
- Ⓜ Update—Long Term Care Hospital Prospective Payment system (LTCH PPS) Rate Year (RY) 2008 .. 33
- Ⓜ Percutaneous Transluminal Angioplasty (PTA)..... 37

### News from Cahaba GBA, LLC

- Ⓜ **Urgent Request:** Security to Access FISS or ELGA/ELGH Will be Affected by the Transition of Data Processing Activities ..... 41
- Ⓜ ELGA/ELGH Modifications to Medicare Advantage Plan Information ..... 42






The Inside Story Continued on the Next Page

#### Key for Icons:

- |  |  |   |
|--|--|---|
| Ⓜ All Providers  | Ⓜ Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Providers | Ⓜ Community Mental Health Center (CMHC) Providers   |
| Ⓜ Hospital/Critical Access Hospital (CAH) Providers    | Ⓜ Renal Dialysis Facility (RDF)  | Ⓜ Comprehensive Outpatient Rehabilitation Facility (CORF) Providers and Outpatient Physical Therapy (OPT) Providers |
| Ⓜ Skilled Nursing Facility (SNF) / Swing Bed 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.

## News from Cahaba GBA, LLC - continued

 Updated Top Inquiries Frequently Asked Questions (FAQs) .....43	 Critical Access Hospital Questions and Answers About Infusion .....45
 Avoid Claim Processing Delays When Using Not Otherwise Classified (NOC) HCPCS Codes ....44	 How to Report Modifier 50 Appropriately .....46
 Availability of the Provider Contact Center .....44	<b>Cahaba GBA, LLC Learning Corner</b> .....47

### Disclaimer

This educational material was prepared as a tool to assist Medicare providers and other interested parties and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within this module, the ultimate responsibility for the correct submission of claims lies with the provider of services. Cahaba GBA, LLC employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of these materials. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

We encourage users to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. Although this material is not copyrighted, CMS prohibits reproduction for profit making purposes.

### American Medical Association Notice and Disclaimer

CPT codes, descriptors and other data only are copyright 2006 American Medical Association. All rights reserved.

### ICD-9 Notice

The ICD-9-CM codes and descriptors used in this material are copyright 2006 under uniform copyright convention. All rights reserved.

## News FLASH Messages from CMS For All Providers



### Medicare Fee-For-Service (FFS) Contingency Plan Announced!

Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007. For more information on this contingency plan, please visit the NPI dedicated website at: <http://www.cms.hhs.gov/NationalProvIdentStand/>



### **National Provider Identifier (NPI) News**

Medicare is now asking that submitters send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume. Additional information can be found at the CMS NPI Web site at: <http://www.cms.hhs.gov/NationalProvIdentStand/>

---



**An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals** educational video program, provides information on Medicare-covered preventive services, risk factors associated with various preventable diseases, and highlights the importance of prevention, detection, and early treatment of disease. The program is an excellent resource to help physicians, providers, suppliers, and other health care professionals learn more about preventive benefits covered by Medicare. Running approximately 75 minutes in length, the program is suitable for individual viewing or for use in conjunction with a conference or training session. To order your copy today, go to the Medicare Learning Network Product Ordering page at [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) on the CMS Web site. Available in DVD or VHS format.

---



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

Want to know when the latest Medicare Learning Network (MLN) products are available? By subscribing to the MLN\_EDUCATION\_PRODUCTS-L listserv you will receive e-mail notifications of new and updated MLN products. To subscribe to the MLN\_EDUCATION\_PRODUCTS-L listserv or to any of the many other CMS listservs, go to the CMS Mailing Lists web page at <http://www.cms.hhs.gov/apps/maillinglists/> and sign up today.



## Important Information for Providers/Suppliers Regarding National Plan and Provider Enumeration System (NPPES) Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes

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

**National Provider Identifier (NPI) News** – Medicare is now asking that submitters send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume. Additional information can be found at the CMS NPI Web site at: <http://www.cms.hhs.gov/NationalProvIdentStand/>

**MLN Matters Number:** SE0725

**Related CR Release Date:** N/A

**Related CR Transmittal #:** N/A

**Related Change Request (CR) #:** N/A

**Effective Date:** N/A

**Implementation Date:** N/A

### Provider Types Affected

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

### Provider Action Needed

#### STOP – Impact to You

Certain information you enter into the National Plan and Provider Enumeration System (NPPES) in order to obtain and maintain your National Provider Identifier (NPI) is used by Medicare in processing claims.

#### CAUTION – What You Need to Know

If the information you entered in NPPES is not correct, your claims may reject. It is important to verify that information was entered correctly. Other guidance in this article will also help assure your claims are processed timely and correctly.

#### GO – What You Need to Do

CMS recommends that physicians, providers, and suppliers validate their NPPES data and be sure their staff are aware of the key elements that need to be correct as explained in this article. Also, you may want to be sure your staff are aware of the important billing tips in this article.

### Background

As Medicare begins to implement the NPI into its systems, several enumeration and billing errors have been identified that may result in claim rejections.

### ***Common Enumeration Errors in NPES***

Below are some of the more frequent errors providers have been making when applying for NPIs:

- **Errors in Employer Identification Number (EIN):** As a reminder, providers that are organizations are required to report the EIN when they apply for an NPI (on-line, paper, and electronic file interchange (EFI)). That EIN may also be the Taxpayer Identification Number (TIN). With the revised NPI Application/Update Form (CMS-10114) (to be used beginning July 10, 2007, for on-line, paper, and EFI), organizations that are subparts will be required to report the legal business name (LBN) of their “parent” and the “parent’s” TIN. The applicant will continue to be required to report its EIN. **If the EIN error is on the Medicare provider enrollment record, the provider should submit a CMS-855 to the Medicare contractor to correct it.**
- **Invalid or incomplete data within the ‘Other Provider Identifiers’ section of the NPES online application, such as:**
  - The absence of the Medicare legacy number,
  - Not having the ‘Type’ listed as Medicare for a Medicare provider number, and/or
  - Reporting Medicare provider numbers that do not belong to the provider applying for the NPI and, therefore, should not be linked to the assigned NPI.
- **Reporting an Incomplete Identifier:** Medicare providers/suppliers need to ensure that, if reporting their Medicare legacy identifiers to NPES, they report the full identifier. This means that suffixes to the OSCAR/Certification Numbers are to be reported. If the full identifier is not reported, it will be impossible for Medicare to establish the linkage from the NPI to that particular Medicare legacy identifier when using NPES data and the NPI crosswalk.
- **Having More than the Allowable Number of Legacy Numbers:** At the present time, the NPES can capture a grand total of 20 “Other Provider Identification Numbers.” While this adequately accommodates the majority of providers/suppliers, it does not accommodate all of them. NPES will be expanded to capture more than 20 “Other Provider Identification Numbers” at a future date. Medicare providers/suppliers who have more than 20 Medicare legacy identifiers that need to be linked directly to the NPI to be assigned should contact their Medicare fee-for-service contractors to determine how best to inform those contractors of all of the Medicare legacy identifiers.
- **Listing Legacy Numbers that Do Not Belong to the Applicant:** The provider/supplier should make sure that any Medicare legacy identifier(s) (OSCAR/Certification Number, Provider Identification Number (PIN), Unique Physician Identification Number (UPIN), and National Supplier Clearinghouse (NSC) Number) entered in that field in NPES are those that will need to be linked directly to the NPI to be assigned. That is, do not list in the “Other Provider Identification Numbers” section identifiers that belong to providers other than the one that is applying for the NPI. Specific examples follow in the “Do’s and Don’ts” section below.

### ***Do’s and Don’ts When Reporting “Other Provider Identification Numbers” in NPES***

- **For a Medicare physician or other practitioner applying for an NPI:** DO include your UPIN (if one was assigned) and your PIN when applying for an NPI. DO NOT include the PIN of your group practice or clinic if you are affiliated with a group practice or clinic.
- **For a Medicare group practice or clinic applying for an NPI:** DO include your PIN. DO NOT include the PINs or UPINs of any of the members of the group practice or clinic.
- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy/DME supplier:** DO include both NSC Numbers (pharmacy and DME supplier).

- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy:** DO include the NSC number assigned to the pharmacy, but DO NOT include the NSC number assigned to the DME supplier.
- **For a Medicare pharmacy that is applying for an NPI as a DME supplier:** DO include the NSC Number assigned to the DME supplier. DO NOT include the NSC Number assigned to the pharmacy.
- **For a Medicare hospital swing bed unit that is applying for an NPI as a swing bed unit:** DO include the OSCAR/Certification Number assigned to the swing bed unit. DO NOT include the OSCAR/Certification Number assigned to the hospital.
- **For a Medicare hospital that is applying for an NPI but does not want swing bed units or rehabilitation units (if they have these units) to have their own NPIs:** DO include the OSCAR/Certification number assigned to the hospital and the OSCAR/Certification Numbers assigned to both the swing bed unit and the rehabilitation unit.

If Medicare providers/suppliers determine that they should make changes to their NPPES records, they may do so by going to NPPES at <https://nppes.cms.hhs.gov/> at any time and updating their information. Or, if they prefer, they may send updates on the paper NPI Application/Update Form (CMS-10114). Forms may be requested by calling the NPI Enumerator at their toll-free number, which is 1-800-465-3203, TTY 1-800-692-2326. The revised CMS-10114 is to be used beginning July 10, 2007. These forms can be obtained from the Enumerator, as outlined above, or you may download the form from the CMS Forms page at <http://www.cms.hhs.gov/cmsforms> on the Web.

CMS recommends that Medicare providers/suppliers make a copy of their NPPES information by doing a “print screen” of their NPPES record or make a photocopy of the completed paper NPI Application/Update form and keep it on hand for reference if they encounter problems.

***Common Error in Reporting Change of Ownership to Medicare***

**Delays in reporting Change of Ownership:** Whenever there is a change of ownership, the provider is responsible for reporting that change to the appropriate Medicare contractor within 30 days. Providers are supposed to report that change on the CMS-855.

***How to Use Your NPI When Billing Medicare Part A (Institutional) Claims to a Fiscal Intermediary (FI) or A/B MAC***

For providers who submit electronic Part A institutional claims to Medicare FIs or A/B MACs, a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Failure to properly submit the NPI in the correct loops may cause the claim to reject. Organization providers should utilize their NPI in the 2010AA or 2010AB loop. The attending, operating or other physicians should be identified in the 2310A, B and C loops respectively. If 2420A loop is used, the Attending Physician NPI must be submitted.

**Below is a guide to use when submitting primary NPIs:**

<b>Name/Loop</b>	<b>Legacy Information</b>	<b>NPI Information</b>
Billing Provider 2010AA Loop	OSCAR	Provider NPI
Pay to Provider 2010AB Loop	OSCAR	Provider NPI
Attending Physician 2310A Loop	PIN, UPIN	Physician NPI

Name/Loop	Legacy Information	NPI Information
Operating Physician 2310B Loop	PIN, UPIN	Physician NPI
Other Physician 2310C	PIN, UPIN	Physician NPI
Attending Physician 2420A	PIN, UPIN	Physician NPI

Some Medicare FIs and A/B MACs have developed front-end reason codes that will return claims to the providers when the NPI and Legacy combination submitted does not match the NPI crosswalk.

If a reject or RTP (Return to Provider) is received, providers are encouraged to verify that their NPI/Legacy combination is valid in NPPES first at: <https://nppes.cms.hhs.gov/>

**The following is a listing of Fiscal Intermediary Standard System (FISS) Front-end Processing Reason Codes:**

Code	Description
<b>32000</b>	This claim has been rejected because the intermediary has no record of the Medicare provider number submitted. <b>Note from Cahaba:</b> This reason code is set to RTP.
<b>32102</b>	The claim contains an NPI but the first digit of the NPI is not equal to “1”, “2”, “3”, “4” or the 10th digit of the NPI does not follow the check digit validation routine. Please verify billing and, if appropriate, correct. **Online providers – press PF9 to store the claim. **Other providers – return to the intermediary. <b>Note from Cahaba:</b> This reason code is set to RTP.
<b>32103</b>	NPI/OSCAR pair on the claim is not present in the Medicare NPI Crosswalk File. This edit applies to the NPI associated with the OSCAR number. Please verify provider billing number and, if appropriate, please correct either NPPES or your CMS-855 information.  Please verify all of your information in NPPES. You should validate that the NPI/OSCAR pair you are using on the claim reflects the OSCAR number that you reported to NPPES. You may view/correct your NPPES information by going to <a href="https://nppes.cms.hhs.gov">https://nppes.cms.hhs.gov</a>  If your NPPES information is correct, and you have included all Medicare legacy identifiers (OSCARs) in NPPES, but you are still experiencing problems with your claims that contain a valid NPI, you may need to submit a Medicare enrollment application (i.e. – the CMS 855). Please contact your contractor prior to submitting a CMS-855 form. <b>Note from Cahaba:</b> This reason code is set to RTP.
<b>32104</b>	The NPI and the legacy (OSCAR) number are present on the claim and the NPI is present in the Crosswalk File, but the associated legacy (OSCAR) number in the Crosswalk file does not match the legacy (OSCAR) number on the claim. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other Providers – Return to the intermediary. <b>Note from Cahaba:</b> This reason code is set to RTP.

<b>Code</b>	<b>Description</b>
<b>32105</b>	The NPI is present in the Crosswalk File but the NPI corresponds to more than one legacy (OSCAR) number. Enter the OSCAR number associated with the NPI submitted. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
<b>32107</b>	The NPI for the attending physician on the claim is not present in the Crosswalk File. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
<b>32108</b>	The attending physician's NPI and UPIN are present on the claim and the attending physician's NPI is present in the Crosswalk File, but the attending physician's UPIN in the Crosswalk File does not match the attending physician's UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
<b>32109</b>	The operating physician's NPI on the claim is not present in the Crosswalk File. Please verify billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
<b>32110</b>	The operating physician's NPI and UPIN are present on the claim and the operating physician's NPI is present in the Crosswalk File, but the operating physician's UPIN in the Crosswalk File does not match the operating physician's UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
<b>32111</b>	The other physician NPI on the claim is not present in the Crosswalk File. Please verify the billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
<b>32112</b>	The other physician's NPI and UPIN are present on the claim and the other physician's NPI is present in the Crosswalk File, but the other physician's UPIN in the Crosswalk File does not match the other physician's UPIN on the claim. Please verify the UPIN and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.
<b>32113</b>	The taxonomy code entered is invalid. Or, a taxonomy code is required when the NPI is present in the Crosswalk File and the NPI corresponds to more than one legacy (OSCAR) number. Please verify the billing number and, if appropriate, correct. ***Online providers – Press PF9 to store the claim. ***Other providers – Return to the intermediary.

**If your FI or A/B MAC is using the MEDATRAN claims translator, below is a list of EDI Inbound Reject codes you may receive:**

<b>Edit Number</b>	<b>Loop</b>	<b>Edit Description</b>
99	2010AA	The NPI/Legacy combination does not match the NPI crosswalk.

<b>Edit Number</b>	<b>Loop</b>	<b>Edit Description</b>
99	2010AB	The NPI/Legacy combination does not match the NPI crosswalk.
99	2310A,B,C	The NPI/Legacy combination does not match the NPI crosswalk.
99	2420A	The NPI/Legacy combination does not match the NPI crosswalk.

***How to Use Your NPI When Billing Medicare Part B (Professional) Claims to Carriers and A/B MACs***  
For providers who submit electronic professional claims to Medicare Part B carriers and A/B MACs, CMS test data indicates that a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Even if you have validated your NPPES data, failure to properly submit the NPI in the correct loops may cause the claim to reject. Group providers should utilize the materials for a full and accurate statement of their contents.

GROUP NPI in the 2010AA or 2010AB loop. The INDIVIDUAL or MEMBER OF GROUP NPI should only be submitted in the 2310B or 2420A loops.

Below is a guide to use when submitting primary NPIs:

<b>Name/Loop</b>	<b>Legacy Information</b>	<b>NPI Information</b>
Billing Provider 2010AA Loop	Group PIN Individual PIN	Group NPI Individual NPI
Pay to Provider 2010AB Loop (this should only be submitted if different from Billing Provider)	Group PIN Individual PIN	Group NPI Individual NPI
Rendering Provider 2310B Loop (this should only be submitted if a group practice)	Individual / Member of Group PIN	Individual / Member of Group NPI
Rendering Provider 2420A Loop (this should only be submitted if a group practice)	Individual / Member of Group PIN	Individual / Member of Group NPI

Some carriers and A/B MACs will return the informational messages or edits below when the NPI and legacy identifier combination submitted does not match the NPI crosswalk. As of the date of this article, claims with NPI/legacy identifiers are not rejecting because Part B contractors (except CIGNA Tennessee and Idaho), have “crosswalk bypass” logic in their system that will allow invalid pairs to process on the legacy number. The informational edits you are receiving are a warning that your claims will reject when the logic is removed. Providers are encouraged to verify that the NPI/legacy identifier combination is valid on NPPES at <https://nppes.cms.hhs.gov> prior to submission of Medicare claims.

**Following is a listing of the edits you may receive when billing Professional Part B claims:**

<b>Edit Number</b>	<b>Loop</b>	<b>Edit Description</b>
M340	2010AA	The NPI/Legacy combination does not match the NPI crosswalk.
M341	2010AB	The NPI/Legacy combination does not match the NPI crosswalk.
M343	2310B	The NPI/Legacy combination does not match the NPI crosswalk.
M347	2420A	The NPI/Legacy combination does not match the NPI crosswalk.

***Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007, for DME Suppliers Submitting Claims to DME MACS Only.***

DME suppliers are reminded that important changes will occur on your electronic remittance advice and your standard paper remittance actions, effective July 2, 2007. As of that date when you have submitted an NPI on your claim, your DME MAC will report on the 835 (or via the Medicare Remit Easy Print (MREP) Software) as follows:

- The billing/pay-to NPI will be reported at the Payee level (Loop 1000B in N104 with the XX qualifier in N103 of the 835),
- The TIN (EIN/SSN) will be reported in the REF segment (Loop 1000B, data field REF 02 with qualifier TJ in REF 01 of the 835) as Payee Additional ID,
- Any relevant Rendering Provider NPI will be reported at the claim level (Loop 2100, data field NM 109 with qualifier XX in NM 108 on the 835) if different from the Payee NPI, and
- Any relevant Rendering NPI(s) will be reported at the service line level (Loop 2110, data field REF 02 with qualifier HPI in REF 01 on the 835) when different from the claim level Rendering NPI.

When you do not report your NPI, but report your legacy National Supplier Clearinghouse (NSC) number on a claim, Medicare will continue to report legacy numbers in generating your remittance advice. Further information regarding the remittance changes may be found in CR5452, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf> or in the related MLN Matters article, MM5452, <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf> on the CMS Web site.

**Important NOTE: The 835 Remittance Advice changes listed above will be effective for other providers submitting Part A Institutional claims and Part B Professional claims, at a later date. Medicare will notify submitters when a date is determined.**

**Additional Information**

You may also want to review MLN Matters article SE0679, which has additional information on the overall NPI activity. This article is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf> on the CMS Web site. Important information regarding current NPI implementation contingency plan is in article MM5595, which is available at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

**Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



## **National Provider Identifier (NPI) Required to Enroll in Electronic Data Interchange (EDI), and Update of Telecommunication and Transmission Protocols for EDI**

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:** MM5637

**Related Change Request (CR) #:** 5637

**Related CR Release Date:** July 6, 2007

**Effective Date:** October 1, 2007

**Related CR Transmittal #:** R1283CP

**Implementation Date:** October 1, 2007

### **Provider Types Affected**

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), Medicare administrative contractors (A/B MACs), or durable medical equipment Medicare administrative contractors (DME MACs)) for services provided to Medicare beneficiaries.

### **Provider Action Needed**

#### **STOP – Impact to You**

If not already enrolled for use of electronic billing and other electronic data interchange (EDI) transactions, you will not be able to enroll to begin use if you have not yet obtained a National Provider Identifier (NPI).

#### **CAUTION – What You Need to Know**

CR 5637, from which this article is taken, announces that providers must obtain an NPI, as a condition for initial enrollment, for the use of EDI. Your Medicare contractor will not issue you an EDI access number and password until you obtain an NPI.

#### **GO – What You Need to Do**

If you have not already obtained your NPI, you should apply now. You can apply on line by going to: <https://nppes.cms.hhs.gov/>

### **Background**

Since May 2006, providers have been required to obtain an NPI prior to initial Medicare enrollment, or before updating their enrollment records, but were not required to have an NPI, as a condition for enrollment, in order to begin using electronic data interchange (EDI) transactions.

CR 5637, from which this article is taken, announces that effective October 1, 2007, providers will need to obtain an NPI, as a condition for initial enrollment, for the use of EDI.

This is being implemented to further support efforts by CMS to have all providers obtain NPIs as soon as possible. Moreover, as indicated in MLN Matters article MM5595 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>), Medicare is monitoring claims to determine the level of NPI reporting. This is being done to determine when it will be reasonable for Medicare to begin rejecting claims that lack an NPI for billing, pay-to or rendering providers.

CR 5637 also updates EDI connectivity information in the *Medicare Claims Processing Manual*, §24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), §20 (EDI Enrollment) and §30.3 (Telecommunications and Transmission Protocols) because some of the information in the manual is obsolete due to technology changes.

In summary, these changes are:

- Medicare contractors will use V.90 56K modems for EDI transactions submitted via dial-in connections;
- Medicare contractors will offer data compression in a means that an EDI transaction sender/receiver requests, using the V.90 56 K modem, PK ZIP version 2.04x or higher, WinZIP or V.42 bis data compression;
- DME MACs will reject standard National Council for Prescription Drug Programs (NCPDP) transactions that do not use the standard NCPDP electronic envelope;
- Medicare contractors may, but are not required to, accommodate other types of data compression that an EDI submitter/receiver requests.

### **Additional Information**

You can find more information about the requirement for an NPI in order to be able to use EDI transactions, by going to CR 5637, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1283CP.pdf> on the CMS Web site. As an attachment to CR 5637, you will find updated *Medicare Claims Processing Manual*, §24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), §20 (EDI Enrollment) and §30.3 (Telecommunications and Transmission Protocols). You can find more information about EDI on the CMS Web site at <http://www.cms.hhs.gov/ElectronicBillingEDITrans/>, and more information about the NPI at <http://www.cms.hhs.gov/NationalProvidentstand/> the on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



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

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:** MM5643

**Related CR Release Date:** June 15, 2007

**Related CR Transmittal #:** R1269CP

**Related Change Request (CR) #:** 5643

**Effective Date:** October 1, 2007

**Implementation Date:** October 1, 2007

## Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Medicare administrative contractors (A/B MACs), durable medical equipment administrative contractors (DMACs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs)).

## What Providers Need to Know

CR 5643, from which this article is taken, reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2007, (for institutional providers, effective for discharges on or after October 1, 2007).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS Web site at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage), or at the National Center for Health Statistics (NCHS) Web site at <http://www.cdc.gov/nchs/icd9.htm> in June of each year.

## Background

ICD-9- CM codes, became mandatory as follows:

- In 1979 for use in reporting provider services on Form CMS-1450;
- On April 1, 1989, for use by all physician services submitted on Form CMS-1500; and
- On October 1, 2003, for all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59);

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

CMS issued CR 5643 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2007, (for institutional providers, effective for discharges on or after October 1, 2007).

You should remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs)), and for all institutional claims; but is not required for ambulance supplier claims.

## Additional Information

You can find the official instruction, CR 5643, issued to your Medicare contractor by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1269CP.pdf> on the CMS Web site. As mentioned, you can find the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS Web site at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage), or at the National Center for Health Statistics (NCHS) Web site at <http://www.cdc.gov/nchs/icd9.htm> in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for \$25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing Manual* (CMS Pub. 100-04), Chapter 23 (Fee Schedule Administration and Coding Requirements), §10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01\\_overview.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage) on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

#### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



### **Appeals Transition - BIPA Section 521 Appeals**

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:** MM5460

**Related CR Release Date:** June 29, 2007

**Related CR Transmittal #:** R1274CP

**Related Change Request (CR) #:** 5460

**Effective Date:** July 1, 2007

**Implementation Date:** October 1, 2007

#### **Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

#### **Provider Action Needed**

This article is based on CR 5460, which notifies Medicare contractors about their need to comply with changes to provisions in Chapter 29 of the *Medicare Claims Processing Manual* (Publication 100-04) that address the appointment of representatives, fraud and abuse, guidelines for writing appeals correspondence, and the disclosure of information.

#### **Background**

The Medicare claims appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) and the Medicare Prescription Drug Improvement and Modernization Act (MMA). The Social Security Act (Section 1869(c)), as amended by BIPA and MMA, requires changes to the Code of Federal Regulations (CFR; Title 42) regarding:

- Appointment of representatives,
- Fraud and abuse,
- Guidelines for writing appeals correspondence, and
- The disclosure of information.

Therefore, CMS is revising provisions in Chapter 29 of the *Medicare Claims Processing Manual* that address these changes.

The purpose of CR 5460 is to notify Medicare contractors about their need to comply with these revised *Medicare Claims Processing Manual* provisions, which are included as an attachment to CR 5460. Some of the key changes to the manual direct Medicare contractors to:

- Follow the procedures that define who may be a representative and how a representative is appointed (via the CMS-1696 Appointment of Representative (AOR) form);
  - Do not accept an appointment if the contractor has evidence that the appointment should not be honored;
  - Send notice only to the representative when the contractor takes action or issues a redetermination [if there is an appointed representative];
  - Provide assistance in completing the CMS-1696 form, as needed; and
  - Do not release beneficiary-specific information to a representative before the beneficiary or appellant and the prospective representative have completed and signed the CMS-1696 or other conforming written instrument.

Please note that the AOR applies to all services, claims and appeals submitted on behalf of the beneficiary for the duration of the AOR.

- Follow the procedures that describe the process a beneficiary must use to assign their appeal rights to a provider (via the CMS-20031) Transfer of Appeal Rights form):
  - For each new appeal request, a form needs to be submitted. This form is valid for all levels of the appeal process including judicial review, even in the event of the death of the beneficiary;
  - If a provider furnishes the service, he/she would be a party to the initial determinations, only providers or suppliers who are not a party may accept assignment of appeal rights from a beneficiary. That is assignment of appeal rights applies only to providers and suppliers who are never a party to an appeal because they do not participate in Medicare and have not taken the claim on assignment; and
  - The provider or supplier who accepts the appeal rights to collect payment from the beneficiary for the item or service that is the subject of the appeal. The provider or supplier may collect any applicable deductible or coinsurance. The provider or supplier agrees to this waiver by completing and signing Section II of the Transfer of Appeal Rights form.
- Provide redetermination letters that are understandable to beneficiaries.

Please note that an **Assignment of Appeal Rights** is valid for the duration of an appeal unless it is revoked by the beneficiary.

### **Additional Information**

The official instruction, CR 5460, issued to your Medicare contractor regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1274CP.pdf> on the CMS Web site. The revised portions of the *Medicare Claims Processing Manual* are attached to that CR.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



## **July 2007 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective July 1, 2007, and Revisions to January 2007, April 2007, and October 2006 Quarterly ASP Medicare Part B Drug Pricing Files**

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:** MM5646

**Related CR Release Date:** June 15, 2007

**Related CR Transmittal #:** R1270CP

**Related Change Request (CR) #:** 5646

**Effective Date:** July 1, 2007

**Implementation Date:** July 2, 2007

### **Provider Types Affected**

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

### **Provider Action Needed**

This article is based on CR 5646, which informs Medicare providers of the availability of the July 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007, April 2007, and October 2006 ASP files. Providers should make certain that your billing staffs are aware of these changes.

### **Background**

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPTS, will be paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers, and CMS supplies Medicare contractors (carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. CMS also posts these files to its Web site at: <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/>

As announced in late 2006, after carefully examining Section 1847A of the Social Security Act, as added by the Medicare Modernization Act of 2003, CMS has been working further to ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A. As part of this effort, CMS reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” are operationalized in the context of payment under section 1847A. For the purposes

of identifying “single source drugs” and “biological products” subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. CMS will consider:

- The FDA approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003, the payment limit under Section 1847A for that biological product or single source drug will be based on the pricing information for products produced or distributed under the applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may also be operationalized through use of existing specific HCPCS codes or “not otherwise classified” HCPCS codes.

**For 2007, a separate fee of \$0.152 per International Unit (I.U.) of blood clotting factor furnished is payable when a separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.**

### ***ASP Methodology***

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent (106%) of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPTS.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPTS at the amount specified for the APC to which the product is assigned.
- Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. **The payment allowance limits will not be updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded.
- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department and, then, is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPTS where the payment allowance limit is 95 percent of the published AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006,

the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPSS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after June 19, 2007, revised January 2007, April 2007, and October 2006 ASP payment files, and the July 2007 ASP file will be available for retrieval from the CMS ASP Web page. The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP Web page is located at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/> on the CMS Web site. The revised files are applicable to claims based on dates of service as shown in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
July 2007	July 1, 2007, through September 30, 2007
January 2007	January 1, 2007, through March 31, 2007
April 2007	April 1, 2007, through June 30, 2007

**NOTE: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.**

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

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); [http://www.ssa.gov/OP\\_Home/ssact/title18/1842.htm](http://www.ssa.gov/OP_Home/ssact/title18/1842.htm)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

## Additional Information

The official instruction (CR 5646) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1270CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

## Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



## Update of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) and Enhancement of Medicare Remit Easy Print (MREP)

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:** MM5634

**Related CR Release Date:** June 15, 2007

**Related CR Transmittal #:** R1267CP

**Related Change Request (CR) #:** 5634

**Effective Date:** July 1, 2007

**Implementation Date:** July 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

This article is based on CR 5634, which instructs Medicare contractors that a Remittance Advice Remark Code (RARC) must be used with Claim Adjustment Reason Codes (CARCs) 16, 17, 96, 125, and A1. CR 5634 also instructs that updated Medicare Remit Easy Print (MREP) software will be provided which incorporates enhancements approved CMS and the currently valid Claim Adjustment Reason and Remittance Advice Remark Codes.

## Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions (submission of claims, claims inquiries, electronic remittance advice, etc.) adopted under HIPAA using valid standard codes. The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 transactions are part of the Transactions and Code Sets Rule selected by HIPAA, and the ANSI X12 subcommittee ‘N’ covers standards in the insurance

industry, including health insurance (hence these are X12N standards). The ANSI ASC X12N transaction number 835 (ANSI ASC X12N-835) is the ANSI standard electronic remittance advice (ERA) transaction that provides payment information on a submitted claim.

***Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) Update***

As a reminder, Medicare policy states that:

- Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions, and
- Remittance Advice Remark Codes (RARCs) **are required in the remittance advice for both paper and electronic formats.**

When the payment differs from the amount being billed, Payers communicate the reason for any adjustment using:

- **Group Codes** (which identify who is financially responsible for the amount that the payer is not reimbursing),
- **CARCs** (which provide an explanation why an amount is being adjusted), and
- **RARCs** (which provide a supplemental explanation about the adjustment). Any RARC that has the word “Alert” is an informational remark code that does not provide any supplemental explanation for a specific adjustment but provides general information related to adjudication.

The following table includes Group Codes currently being used by CMS:

<b>Group Code</b>	<b>Definition</b>
<b>CO</b>	Contractual Obligation (Provider is financially responsible)
<b>PR</b>	Patient responsibility (Provider can collect the amount from patient)
<b>OA</b>	Other Adjustment (Generally used to report bundling/unbundling situation, predetermination of benefits, and secondary payments)
<b>CR</b>	Correction (Used with reversal and correction)

The ANSI ASC X12N-835 Implementation Guide (version 004010A1) requires CARCs (if needed) but does not require use of RARCs. A HIPAA compliant version of the Implementation Guide for transaction 835 (Health Care Claim Payment & Remittance Advice) is available at: <http://www.wpc-edi.com/HIPAA>

The code committee that maintains the CARC code set recently modified five CARCs (16, 17, 96, 125, and A1). These CARCs were selected for modification because they were very generic, and they were used most frequently. Of these five CARCs, the following four now require the use of at least one appropriate RARC, and they are effective April 1, 2007:

<b>CARC</b>	<b>Definition</b>
<b>16</b>	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
<b>17</b>	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

<b>CARC</b>	<b>Definition</b>
<b>96</b>	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
<b>125</b>	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

The remaining 1 CARC (which follows) also requires at least one RARC, but it is **effective June 1, 2007**.

<b>CARC</b>	<b>Definition</b>
<b>A1</b>	Claim denied charges

CMS instructed your Medicare contractor(s) to analyze their current use of RARCs with CARCs 16, 17, 96, and 125, and determine if any existing RARCs (that are not currently being used) may be appropriate to explain an adjustment. Your Medicare contractor(s) may start using any of the currently existing RARCs with CARCs 16, 17, 96, 125, and A1.

Note: The most current list of RARCs can be found at: <http://www.wpc-edi.com/codes>

In addition, the committee that maintains reason codes approved the following CARC effective February 28, 2007:

<b>CARC</b>	<b>Definition</b>
<b>204</b>	<b>This service/equipment/drug is not covered under the patient's current benefit plan</b>

Your Medicare contractor(s) may use CARC 204 instead of CARC 96 and an appropriate remark code, e.g., N130.

<b>CARC</b>	<b>Definition</b>
<b>N130</b>	<b>Consult plan benefit documents for information about restrictions for this service</b>

RARC N130 will be used with CARC 96 as a default combination to be reported on all DME claims if:

- No code has been assigned by your Medicare contractor, and
- The service is not covered by Medicare.

### ***Medicare Remit Easy Print (MREP) Enhancement***

CMS developed Medicare Remit Easy Print (MREP) software that gives providers a tool to read and print an electronic remittance advice (RA) in a human readable format. Providers who use the MREP software have the ability to print paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that can be included with claims submissions to secondary/tertiary payers for Coordination of Benefits. Information regarding MREP and instructions on obtaining MREP are available through your Medicare contractor.

In a continuing effort to improve MREP, CMS established a process to receive suggestions to enhance the functionality and effectiveness of MREP from providers, contractors, and CMS staff. The next updated

version of MREP that incorporates improvements approved by CMS will be available in July 2007. Note that the timeline for the annual MREP enhancement update has changed from October to July.

### **Additional Information**

The official instruction, CR 5634, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1267CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



## **Revision to Medicare Publication 100-09, Chapter 3 – Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates**

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:** MM5597

**Related CR Release Date:** June 29, 2007

**Related CR Transmittal #:** R19COM

**Related Change Request (CR) #:** 5597

**Effective Date:** May 23, 2007

**Implementation Date:** July 30, 2007

### **Provider Types Affected**

All physicians, suppliers, and providers who submit written inquiries to, or contact the toll-free lines at, their Medicare contractors [fiscal intermediaries (FIs), carriers, Part A/B Medicare administrative contractors (A/B MACs), DME Medicare administrative contractors (DME MACs), and/or regional home health intermediaries (RHHIs).]

### **Provider Action Needed**

CR 5597 contains a number of revisions to the *Medicare Contractor Beneficiary and Provider Communications Manual*, including changes for authenticating providers who make inquiries of Medicare contractors. Due to the Medicare fee-for-service contingency plan for the National Provider Identifier (NPI), the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that CMS requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare fee-for-service provider contact centers (PCCs), will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and written inquiry units.

While the authentication rules are part of CR 5597, for complete details about these rules under the Medicare NPI contingency plan, see MLN Matters article SE0721, which you will find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf> on the CMS Web site.

The remainder of this article provides information on the highlights of changes announced in CR 5597.

## Background

CR 5597 modifies *Medicare Contractor Beneficiary and Provider Communications Manual*, Publication 100-09. These changes are summarized as follows:

### *Overlapping Claims—New Rules*

- Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.
- When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/ legacy number or NPI, beneficiary name, Health Insurance Claim Number (HICN), and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.
- Contractors shall release overlapping claim information whether a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.
- For specific information regarding the resolution of claims rejected by Medicare's Common Working File (CWF) system, refer to the *Medicare Claims Processing Manual*, Chapter 27, §50 at <http://www.cms.hhs.gov/manuals/downloads/clm104c27.pdf> on the CMS Web site.

### *Information Available on the IVR*

- **USE THE IVR whenever possible.** Providers should be aware that if a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information is available on the IVR, the CSR/correspondent will probably encourage you to use the self-service options that are available.
- If at any time during a telephone inquiry, you request information that can be found on the IVR the CSR will most likely refer you back to the IVR.

### *Information Available on the Remittance Advice (RA)*

- **USE THE RA whenever possible.** If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.
- To make your job easier you may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available at: [http://www.cms.hhs.gov/AccessstoDataApplication/02\\_MedicareRemitEasyPrint.asp](http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp) on the CMS Web site.

- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, “Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers,” which is available at [http://www.cms.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf) on the CMS Web site.
- Also available is a Web site that serves as a resource allowing providers to check the definitions of Claim Adjustment Reason Codes and Remittance Advice Remark Codes. This information is available at <http://www.wpc-edi.com/products/codelists/alertservice> on the Washington Publishing Company Web site.
- There is a web-based training course, “Understanding the Remittance Advice for Professional Providers,” which is available at: [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) on the CMS Web site. The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

#### ***Authentication of Beneficiary Elements—additions to current rules***

CR 5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR 5597 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R19COM.pdf> on the CMS Web site.

#### ***Additional Key Points of CR 5597***

- Medicare’s CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the Report of Contact made during a telephone response to a written inquiry, Medicare contractors will send you a letter detailing the discussion. This letter may be sent to you by e-mail or fax, if you request, unless the details include specific beneficiary or claim related information.
- When your Medicare contractor schedules a training event for which there is a charge for attendance and you register and pay, but are unable to attend, you may be entitled to a refund of some or all of your payment. But, to receive such a refund, **you must notify the contractor before the event.**

#### **Additional Information**

For complete details regarding this CR please see the official instruction (CR 5597) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R19COM.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

#### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



## **Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program—Revised**

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network* (MLN) *Special Edition* article entitled “Pre-Bidding Activities for the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program,” which was published in the June 1, 2007, *Medicare A Newslines*. This Special Edition 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:** SE0714 Revised

**Related Change Request (CR) #:** N/A

**Related CR Release Date:** N/A

**Effective Date:** N/A

**Related CR Transmittal #:** N/A

**Implementation Date:** N/A

**Note:** This article was changed on July 9, 2007, to add a link to a related DMEPOS Competitive Bidding article SE0717 under the “Basic Instructions” section of this article. All other information remains the same.

### **Provider Types Affected**

All suppliers of durable medical equipment (DME) that wish to participate in the Medicare DMEPOS competitive bidding program.

### **Provider Action Needed**

This Special Edition (SE) article, SE0714, outlines the pre-bidding activities that DME suppliers need to follow in order to participate in the Medicare DMEPOS Competitive Bidding Program.

### **Background**

Providers and suppliers that furnish certain DMEPOS to Medicare beneficiaries under Medicare Part B will have an opportunity to participate in a competitive acquisition program (the “Medicare DMEPOS Competitive Bidding Program”). This program will improve the accuracy of Medicare’s payments for certain DMEPOS, reduce beneficiary out-of-pocket expenses, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services.

To assist with the DMEPOS Competitive Bidding Program, CMS awarded a contract to Palmetto GBA to serve as the Competitive Bidding Implementation Contractor (CBIC) for program implementation and monitoring.

As the DMEPOS Competitive Bidding Program progresses, suppliers may want to view the final rule governing the program, which is available at <http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1270f.pdf> on the CMS Web site. In addition, you may want to visit <http://www.cms.hhs.gov/competitiveacqfordmepos> for more complete information on the program and the process whereby suppliers can bid and participate.

There are other MLN Matters articles on the program. These articles are discussed briefly in the “Additional Information” section of this article.

## Basic Instructions

### *All suppliers submitting a bid must:*

- Be in good standing and have an active National Supplier Clearinghouse number (NSC#);
- Meet any local or state licensure requirements, if any, for the item being bid;
- Be accredited or be pending accreditation. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. (For a listing of CMS-approved accrediting organizations, please visit [http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS\\_Accreditation\\_Organizations.pdf](http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf) on the CMS Web site.) MLN Matters article SE0713 provides additional information on accreditation and is located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf>; and
- Complete initial registration in the internet application (Individuals Authorized Access CMS Computer Services, (IACS)) to get a USER ID and password. Suppliers need to complete this initial registration process early to avoid delays in being able to submit bids. The initial registration process requires the **authorized official**, as identified in Section 15 of the CMS 855S, to complete the information required in the internet application. The authorized official's information must match the information on file at the National Supplier Clearinghouse. To complete this initial registration and obtain a USER ID and password, please go to: <https://applications.cms.hhs.gov>

### *All suppliers submitting a bid should:*

- Review MLN Matters article SE0717, "Initial Supplier Registration for Competitive Bidding Program is Now Open," which provides important information about the registration process. SE0717 can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0717.pdf> on the CMS Web site;
- Review the information in the Bid Application Tool Kit to facilitate a better understanding of the bidding process and rules. This information is located on the CBIC Web site at [http://www.dmecompetitivebid.com/cbic/cbic.nsf/\(subpages\)/CBICSuppliersBid%20Application%20Tool%20Kit](http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersBid%20Application%20Tool%20Kit);
- View the educational webcast to learn more about the Medicare DMEPOS Competitive Bidding Program and detailed information on the bid application process. This information is located on the CBIC Web site at [http://www.dmecompetitivebid.com/cbic/cbic.nsf/\(subpages\)/CBICSuppliersEducational%20Tools](http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersEducational%20Tools); and
- CMS encourages you to register to receive updates on the Competitive Bidding Program. You may do so by going to <http://www.cms.hhs.gov/apps/maillinglists/> on the CMS Web site.

## Additional Information

The CMS complete listing of all DME resources is available at <http://www.cms.hhs.gov/center/dme.asp> on the CMS Web site. A background review of the rationale for this program is at [http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DME\\_sum.pdf](http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DME_sum.pdf) on the CMS Web site.

MLN Matters article SE0713, "Accreditation Information for Suppliers of Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS)," relates to this article and provides an overview of the Medicare Modernization Act legislation and how it impacts this competitive bidding program. It also outlines the quality standards for suppliers, describes the status of accreditation, and provides the web addresses of the ten accrediting organizations. SE0713 can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf> on the CMS Web site.

Another article, MM5574, provides more overview information regarding the DMEPOS Competitive Bidding Program and that article is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf> on the CMS site.

#### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



### **Update 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:** MM5614

**Related CR Release Date:** May 29, 2007

**Related CR Transmittal #:** R1258CP

**Related Change Request (CR) #:** 5614

**Effective Date:** January 1, 2007

**Implementation Date:** July 2, 2007

#### **Provider Types Affected**

Physicians and providers who submit claims to Medicare contractors (Fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), carriers) for services rendered to Medicare beneficiaries that are paid based on the MPFSDB.

#### **Provider Action Needed**

##### **STOP – Impact to You**

Payment files for the MPFS were issued based on the December 1, 2006 Medicare Physician Fee Schedule Final Rule. CR 5614, amends those files and includes new/revised codes for the Physician Quality Reporting Initiative (PQRI)

#### **CAUTION – What You Need to Know**

Physicians and providers may want to pay particular attention to Attachment 1 of CR 5614 that identifies the changes included in the July Update to the 2007 MPFSDB—the highlights of attachment 1 are:

- Effective for dates of service on or after July 1, 2007, Category II modifier 8P will be recognized in addition to Category II modifiers 1P, 2P and 3P. (NOTE: Modifier 8P is intended to be used as a “reporting modifier” to allow the reporting of circumstances when an action described in a measure’s numerator is not performed and the reason is not otherwise specified.)
- Effective for dates of service on or after January 1, 2007, Medicare contractors will update their systems to reflect 11 base units for CPT code 00797.
- This CR 5614 lists the new Category II HCPCS codes that will be added to the MPFSDB with a status indicator of “M” for the PQRI.

## GO – What You Need to Do

Make certain that your billing staffs are aware of these changes.

### Background

Section 1848 (c)(4) of the Social Security Act provides for the establishment of the policies needed in order to implement relative values for physicians' services. CR 5614 is the official document that announces these changes in the Medicare schedule. Rather than duplicate all the additions, deletions and changes in this article, CMS directs you to CR 5614, which contains lengthy lists of these items. CR 5614 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1258CP.pdf> on the CMS Web site.

As mentioned above, the key portion of CR 5614 is Attachment 1, which includes the following information:

- Several changes retroactive to January 1, 2007. The changes are for the following CPT/HCPCS codes:
  - 00797 (base units set to 11);
  - 0115T, 0116T, and 0117T (procedure status is now N);
  - 19301 (short descriptor is Partial mastectomy);
  - 33208 (work RVUs set to 8.72);
  - 75365-TC (diagnostic indicator set to 02); and
  - 77422, 77423, G9041, G9042, G9043, G9044 (PE RVU changes).
- Codes 0024T and 0133T are assigned a procedure status of I effective for dates of service on or after July 1, 2007.
- As previously mentioned, modifier 8P is added for the PQRI program.
- The list of G codes that are no longer used for the PQRI program as of July 1, 2007.
- The list of new CPT Category II codes, new G codes and the new/revised descriptors for the codes that will be used for the PQRI, effective for dates of service on or after July 1, 2007.
- Information on Category III codes (0178T through 0180T (all of which deal with electrocardiograms), 0181T (corneal hysteresis determination, by air impulse stimulation, bilateral, with interpretation and report), and 0182T (High dose rate-electronic brachytherapy, per fraction), which are effective for dates of service on or after July 1, 2007.
- Effective July 1, 2007, HCPCS codes J1567, J7611, J7612, J7613, and J7614 will be assigned a procedure status of I. **Note: MM5635 implemented HCPCS coding changes for Immune Globulin. On and after July 1, 2007, HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. Liquid), 500 mg) will no longer be payable by Medicare.** To view the new HCPCS codes for Immune Globulin, please go to <http://www.cms.hhs.gov/MLNMArticles/downloads/mm5635.pdf> on the CMS Web site.
- Information related to HCPCS codes Q4087 through Q4095, which are added to the MPFSDB as of July 1, 2007, with a status indicator of E.

Also, attachment 3 (which is informational only) states that the Performance Payment Indicator has been changed to '1' for the extensive list of carrier priced codes identified in attachment 3.

### Additional Information

For complete details regarding this CR, please see the official instruction (CR 5614) issued to your Medicare carrier, FI, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1258CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



## October 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:** MM5636

**Related CR Release Date:** June 15, 2007

**Related CR Transmittal #:** R1266CP

**Related Change Request (CR) #:** 5636

**Effective Date:** April 1, 2002

**Implementation Date:** October 1, 2007

### Provider Types Affected

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

### What Providers Need to Know

- The 2007 FI annual update Major Category IV A. Mammography Screening codes (77055 and 77056), that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS) are REMOVED with a retroactive effective date of January 1, 2007. CR 5636, on which this article is based, removes these two codes from the FI file.
- Healthcare Common Procedure Coding System (HCPCS) codes Q1001 and Q1002 are added to the File 1 Coding file and are effective for dates of service prior to June 30, 2005. Please refer to the “Background” and “Additional Information” sections for more information.

### Background

Periodically, CMS updates the lists of HCPCS codes (for FIs carriers and DME/MACs) that are subject to the consolidated billing provision of the SNF PPS. This particular update, however, applies to providers who bill for New Technology IntraOcular Lenses (NTIOLs) furnished in ASCs as well as providers billing Medicare FIs for Major Category IV. A. Mammography Screening. The mammography codes for screening and diagnostic mammography services that are **no longer valid as of January 1, 2007, are:**

- Diagnostic mammography, unilateral—CPT code **77055**
- Diagnostic mammography, bilateral—CPT code **77056**

NTIOLs that are now reimbursable separately by the carrier/MAC for dates of service prior to June 30, 2005 are:

- **Q1001** (Category 1, AMO Array Multifocal lens: Model # SA40N); and
- **Q1002** (Category 2, Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Lens).

In addition, Medicare edits allow the payment of the \$50 additional fee for Category 3 NTIOLs for dates of service prior to January 1, 2007, when billed with HCPCS code **Q1003**. (See MM4361 for additional information about NTIOLs and **Q1003** and the article may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4361.pdf> on the CMS Web site.)

Remember that:

- With the exception of SNFs, Medicare will not pay providers for services appearing on the list of services 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 non-therapy 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, carriers 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**

To see the official instruction (CR 5636) issued to your Medicare carrier, FI or A/B MAC, go to <http://www.cms.hhs.gov/Transmittals/downloads/R1266CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

Also, MM3901 is the article that announced the cessation of the additional \$50 payment for NTIOLs for codes Q1001 and Q1002 and that article may be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3901.pdf> on the CMS Web site.

You can find more information about the new 2007 mammography CPT codes by going to CR 5327, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1070CP.pdf> on the CMS Web site. There, as an attachment to that CR, you will find revised Chapter 18 (Preventive and Screening Services), §20 (Mammography Services) of the *Medicare Claims Processing Manual* (CMS Pub. 100-04).

### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



## Charges for Missed Appointments

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:** MM5613

**Related CR Release Date:** June 29, 2007

**Related CR Transmittal #:** R1279CP

**Related Change Request (CR) #:** 5613

**Effective Date:** October 1, 2007

**Implementation Date:** October 1, 2007

### Provider Types Affected

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

### Provider Action Needed

#### STOP – Impact to You

CMS policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments. However, Medicare itself does not pay for missed appointments, so such charges should not be billed to Medicare.

#### CAUTION – What You Need to Know

Providers may **not charge ONLY** Medicare beneficiaries for missed appointments; they must **also charge non-Medicare patients**. The amount the physician/supplier charges Medicare beneficiaries for missed appointments must be the same as the amount that they charge non-Medicare patients.

#### GO – What You Need to Do

Make certain that your billing staff is aware that you may bill the beneficiary directly, that Medicare itself does not make any payments for missed appointments, and that Medicare should not be billed for these charges.

### Background

According to Chapter 12, section 30.3.13 of the *Medicare Claims Processing Manual* (CMS Pub. 100-04), which is attached to CR 5613, CMS policy allows physicians, providers, and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments and the charges for Medicare and non-Medicare patient are the same. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

The other key points of CR 5613 are:

- The provider may bill the Medicare beneficiary directly.
- Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians, or other suppliers.

- Claims for missed appointments sent to Medicare will be denied with the reason code 204. (This service/equipment/drug is not covered under the patient's current benefit plan.).
- In most instances, a hospital outpatient department can charge a beneficiary a missed appointment charge.
- In the event, however, that a hospital inpatient misses an appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the beneficiary a missed appointment fee.

### Additional Information

For complete details regarding this CR please see the official instruction (CR 5613) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1279CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the "[Contact Us](#)" page of our Web site and select "Telephone Us" to call the Provider Contact Center.

### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



## Medicare Payment for Preadministration-Related Services Associated with IVIG Administration—Payment Extended through CY 2007—Revised

The Centers for Medicare & Medicaid Services (CMS) has issued a revision to the *Medicare Learning Network (MLN) Matters* article entitled "Medicare Payment for Preadministration-Related Services Associated with IVIG Administration—Payment Extended through CY 2007," which was published in the February 1, 2007, *Medicare A Newslines*. 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:** MM5428 Revised

**Related Change Request (CR) #:** 5428

**Related CR Release Date:** December 22, 2006

**Effective Date:** January 1, 2007

**Related CR Transmittal #:** R1140CP

**Implementation Date:** January 2, 2007

**Note:** This article was changed on July 9, 2007, to reference MM5635. MM5635 implemented HCPCS coding changes for Immune Globulin. **On and after July 1, 2007, HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg) will no longer be payable by Medicare.** To view the new HCPCS codes, please go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5635.pdf> on the CMS Web site.

### Provider Types Affected

Physicians and hospitals that bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for Intravenous Immune Globulin (IVIG) administration.

## **Provider Action Needed**

### **STOP – Impact to You**

You may bill for preadministration-related services associated with Intravenous Immune Globulin (IVIG) administration (HCPCS code G0332) during calendar year 2007. The preadministration-related service must be billed on the same claim and have the same date of service as the claim for the IVIG itself (codes J1566 and/or J1567) and the drug administration service. **(See note above regarding J1567.)**

### **CAUTION – What You Need to Know**

CR 5428, from which this article was taken, extends payment of the preadministration-related service for IVIG through CY 2007 **but only when submitted on the same claim as the IVIG and its administration.**

### **GO – What You Need to Do**

Make sure that your billing staff is aware that they must include your claim for the IVIG preadministration-related services on the same claim (and with the same date of service) as the IVIG and its administration.

## **Background**

Under Section 1861(s)(1) and 1861(s)(2), Medicare Part B covers intravenous immune globulin (IVIG) administered by physicians in physician offices and by hospital outpatient departments. More specifically, when you administer IVIG to a Medicare beneficiary in the physician office or hospital outpatient department, Medicare makes separate payments to the physician or hospital for both the IVIG product itself and for its administration via intravenous infusion.

In addition, for 2006, CMS established a temporary preadministration-related service payment, for physicians and hospital outpatient departments that administer IVIG to Medicare beneficiaries, to cover the effort required to locate and acquire adequate IVIG product and to prepare for an infusion of IVIG during this current period where there may be potential market issues. **CR 5428, from which this article was taken, announces the extension of this temporary payment for the IVIG preadministration-related service through CY 2007.**

As a reminder, here are some important details that you should know:

- The policy and billing requirements concerning the IVIG preadministration-related services payment are the same in 2007 as they were in 2006.
- This IVIG pre-administration service payment is in addition to Medicare's payments to the physician or hospital for the IVIG product itself and for its administration by intravenous infusion.
- Medicare Carriers, FIs, or A/B MACs will pay for these services, that are provided in a physician office, under the physician fee schedule; and FIs or A/B MACs will pay for them under the outpatient prospective payment system (OPPS), for hospitals subject to OPPS (bill types: 12X, 13X) or under current payment methodologies for all non-OPPS hospitals (bill types: 12 X, 13 X, 85 X).
- You need to use HCPCS code G0332–Preadministration-Related Services for Intravenous Infusion of Immunoglobulin, (this service is to be billed in conjunction with administration of immunoglobulin) to bill for this service.
- You can bill for this only one IVIG preadministration per patient per day of IVIG administration.
- The service must be billed on the same claim form as the IVIG product (HCPCS codes J1566 (Injection, immune globulin, intravenous, lyophilized (E.G. powder), 500 mg) and/or J1567 (Injection, immune globulin, intravenous, non-lyophilized (E.G. liquid), 500 mg), and have the same date of service as the IVIG product and a drug administration service. **(See note above regarding J1567.)**

- Your claims for preadministration-related services will be returned/rejected by your FI, carrier, or A/B MAC if more than 1 unit of service of G0332 is indicated on the same claim for the same date of service. They will use the appropriate reason/remark code such as:
  - M80–“Not covered when performed during the same session/date as a previously processed service for the patient;”
  - B5–“Payment adjusted because coverage/program guidelines were not met or were exceeded;”
  - M67–“Missing other procedure codes;” and/or
  - 16–“Claim/service lacks information which is needed for adjudication.”

### **Additional Information**

You can find the official instruction, CR 5428, issued to your FI, carrier, or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1140CP.pdf> on the CMS Web site

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

## *News from CMS for Hospital/CAH Providers*



### **Update—Long Term Care Hospital Prospective Payment System (LTCH PPS) Rate Year (RY) 2008**

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: MM5652

Related CR Release Date: June 15, 2007

Related CR Transmittal #: R1268CP

Related Change Request (CR) #: 5652

Effective Date: Discharges on or after July 1, 2007

Implementation Date: July 2, 2007

### **Provider Types Affected**

Long term care hospitals paid under the LTCH PPS by Medicare fiscal intermediaries (FIs) and Part A/B Medicare administrative contractors (A/B MACs).

### **Provider Action Needed**

This article is based on CR 5652 which updates the changes to LTCH PPS for Rate Year 2008 (July 1, 2007–June 30, 2008) including PRICER updates, Short Stay Outlier (SSO) Updates, and Cost of Living Adjustment (COLA) updates).

## **Background**

On October 1, 2002, CMS implemented, through the Federal Register (August 30, 2002; [http://www.access.gpo.gov/su\\_docs/fedreg/a020830c.html](http://www.access.gpo.gov/su_docs/fedreg/a020830c.html)), a prospective payment system (PPS) for Long Term Care Hospitals (LTCHs) under the Medicare program in accordance with provisions of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000.

Payments under this system are made on a per discharge basis, using long-term care diagnosis-related groups (LTC-DRGs) that take into account differences in resource use of long-term care patients and the most recently available hospital discharge data. CMS is required to update the payments made under this PPS annually. There are two significant updates for LTCH PPS:

- The Rate Year update (July of each year), and
- The DRGs update (October of each year).

### ***PRICER Updates:***

For LTCH PPS rate year (RY) 2008, (Applies to discharges on or after July 1, 2007, through June 30, 2008)

- The standard Federal rate is \$38,356.45;
- The fixed-loss amount is \$20,738;
- The budget neutrality adjustment is 0 percent. (The PRICER payment amount will include the adjustment factor as 1.00.);
- The wage index phase-in percentage for cost reporting periods beginning on or after October 1, 2006, is 5/5ths (100 percent). The wage index table within the PRICER will include two columns:
  - A 4/5ths column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2006; and
  - A 5/5ths column for discharges occurring in LTCH cost report periods beginning during Fiscal Year 2007;
- The labor-related share is 75.788 percent; and
- The non-labor related share is 24.212 percent.

### ***Short Stay Outlier (SSO) Updates:***

The existing payment adjustment formula for short-stay outlier cases was revised for those cases where the patient's LTCH covered length of stay (LOS) is less than, or equal to an "IPPS-comparable" threshold for the DRG to which the case is assigned. For cases falling within this "IPPS-comparable" threshold, Medicare payments under the SSO policy will be subject to an additional payment option that for these cases, will substitute for the blend of an amount calculated from a blend of 120 percent of the LTC-DRG specific per diem amount and an amount comparable to a per diem payment under the IPPS that was finalized for RY 2007.

The IPPS-comparable threshold is defined as a length of stay at the LTCH that is less than, or equal to, the geometric average length of stay for the same DRG under the IPPS plus one standard deviation (refer to Table 3 in the LTCH PPS RY 2008 final rule (72 FR 26870 at 27019- 27029); [http://www.access.gpo.gov/su\\_docs/fedreg/a070511c.html](http://www.access.gpo.gov/su_docs/fedreg/a070511c.html))

If the covered LOS at the LTCH is within the IPPS-comparable threshold, Medicare payment will be based on an IPPS comparable per diem amount, capped at the full IPPS comparable amount. This option would replace the "blend" option and become part of the adjusted LTCH PPS payment formula.

Effective for discharges occurring on or after July 1, 2007, therefore, the adjusted Medicare payment for a case where the covered LOS at the LTCH is within the IPPS-comparable threshold will equal the least of:

- 100 percent of estimated cost of the case,
- 120 percent of the LTC-DRG per diem amount,
- The full LTC-DRG payment, or
- The “IPPS comparable” per diem amount, capped at the full IPPS comparable amount.

For SSO cases with lengths of stay exceeding the “IPPS comparable” threshold, the fourth payment option will continue to be the blend, described above.

Some good examples of computations for SSOs are provided in tables in Chapter 3, §150.9.1.1 of the *Medicare Claims Processing Manual* (CMS Pub. 100-04). That section is among the sections attached to CR 5652, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1268CP.pdf> on the CMS Web site.

***Cost of Living Adjustment Updates (COLA):***

LTCH PPS incorporates a COLA as part of the operating and capital payments in LTCH PPS. New COLAs for Alaska were implemented as part of the LTCH Final Rule for RY 2008. Those COLAs, which are effective for LTCH discharges occurring on or after July 1, 2007, are as follows:

Area	Cost of Living Adjustment Factor
<b>Alaska:</b>	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25

***Other Medicare Claims Processing Manual Revisions of Note:***

Also, note that effective for cost reporting periods beginning on or after July 1, 2007, the payment adjustment that governs LTCH HwHs (hospitals within hospitals) and satellites of HwHs discharging patients from their host hospital was extended to govern the discharges from all LTCHs (not already addressed by the existing policy) that are admitted from any referring hospital. This policy adjustment includes:

- Discharges from “grandfathered” LTCH HwHs and LTCH satellites that were admitted from their host hospitals;
- LTCH and LTCH satellite discharges admitted from referring hospitals that are not co-located with the discharging facility; and
- Discharges from “free-standing” LTCHs that were admitted from any referring hospital.

In addition, the basic payment formula under the 25 percent threshold payment adjustment for Medicare discharges from referring hospitals is amended, effective for rate year 2008, as follows:

- For those admitted to grandfathered LTCH HwHs and LTCH satellites from the host hospitals:
  - If a grandfathered LTCH HwH’s admission from its host hospital exceed 25 percent or the applicable percentage of its discharges for the HwHs cost reporting period, an adjusted payment will be made in the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise pay under the Inpatient PPS (IPPS) for cases in excess of the 25 percent threshold.

- In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)
- For those admitted to all LTCHs and LTCH satellites from referring hospitals other than those with which they are co-located
  - If a LTCH HwH's admissions from its host hospital exceed 25 percent or the applicable percentage of its discharges for the HwH's cost reporting period, an adjusted payment will be made of the lesser of the otherwise full payment under the LTCH PPS and an amount that would be equivalent to what Medicare would otherwise be paid under the IPPS for cases in excess of the 25 percent threshold.
  - In determining whether a hospital meets the 25 percent criterion, patients transferred from the host hospital that have already qualified for outlier payments at the acute host would not count as part of the host's allowable percentage and therefore the payment would not be subject to the adjustment. Those patients would be eligible for full payment under the LTCH PPS. (Cases admitted from the host before the LTCH crosses the 25 percent or applicable threshold would be paid under the LTCH PPS.)

As in the case of the policy for co-located LTCHs and LTCH satellites, an additional adjustment is provided for patients admitted a LTCH and satellite LTCH located in rural areas or where the referring hospital is an MSA dominant or sole urban hospital. In such situations, instead of the 25 percent threshold, Medicare provides for a threshold of up to 50 percent for patients from any referring hospital in these categories.

Complete details on these manual revisions, including a discussion of the transition period for all LTCHs affected by these provisions, are available in an attachment to CR 5652 at the Web site mentioned previously.

### **Additional Information**

The official instruction, CR 5652, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1268CP.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the "[Contact Us](#)" page of our Web site and select "Telephone Us" to call the Provider Contact Center.

### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



## Percutaneous Transluminal Angioplasty (PTA)

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:** MM5660

**Related CR Release Date:** June 29, 2007

**Related CR Transmittal #:** R71NCD

**Related Change Request (CR) #:** 5660

**Effective Date:** April 30, 2007

**Implementation Date:** July 30, 2007

### Provider Types Affected

Physicians and hospitals who submit claims to Medicare contractors (Part A/B Medicare administrative contractors (A/B MACs), fiscal intermediaries (FIs) or carriers) for PTA services provided to Medicare beneficiaries.

### Provider Action Needed

#### STOP – Impact to You

On August 2, 2006, a request to reconsider the national coverage determination (NCD) for PTA and stenting of the carotid arteries initiated a national coverage analysis. CR 5660 communicates the findings resulting from that analysis.

#### CAUTION – What You Need to Know

Effective for dates of service performed on and after April 30, 2007, be aware of

- Clarifications regarding the use of PTA and stenting of the carotid arteries for patients at high risk for carotid endarterectomy (CEA); and
- **Note the process that facilities must follow for certification and recertification** that is specified in §20.7 of Publication100-03, the *Medicare National Coverage Determinations Manual*.

#### GO – What You Need to Do

If you are a provider of PTA and stenting of the carotid arteries services, be aware that CMS has reviewed the evidence and determined **that coverage for this NCD is unchanged** and that **facilities should follow the certification/recertification guidelines in CR 5660**. See the “Background” and “Additional Information” sections of this Medicare Modernization Act (MMA) update.

#### Background

On April 22, 2005, the CMS issued CR 3811 providing Medicare coverage for PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent when beneficiaries are at high risk for carotid endarterectomy (CEA). This NCD is contained in §20.7 of the *Medicare National Coverage Determinations Manual* and the **changes in the NCD are listed below**. To read the entire section of the NCD click on the official instruction issued with this change request that may be found in the “Additional Information” section of this article.

#### PTA is covered when used under the following conditions:

- Treatment of Atherosclerotic Obstructive Lesions.
  - In the lower extremities, i.e. the iliac, femoral, and popliteal arteries.

- In the upper extremities, i.e. the innominate, subclavian, axillary, and brachial arteries, but not head or neck vessels.
- Of a single coronary artery.
- Concurrent with Carotid Stent Placement.
  - Food and Drug Administration (FDA)-Approved Category B Investigational Device Exemption (IDE) Clinical Trials Effective July 1, 2001.
  - FDA-Approved Post Approval Studies—Effective October 12, 2004.
  - Patients at High Risk for Carotid Endarterectomy (CEA)—Effective March 17, 2005.

**NOTES:** Coverage is limited to procedures performed using FDA approved carotid artery stents and embolic protection devices.

The use of a distal embolic protection device is required. If deployment of the distal embolic protection device is not technically possible, then the procedure should be aborted given the risks of carotid artery stenting (CAS) without distal embolic protection.

- Concurrent with Intracranial Stent Placement
  - FDA-Approved Category B IDE Clinical Trials--Effective November 6, 2006.

CAS for patients who are not at high risk for CEA remains covered only in FDA-approved Category B IDE clinical trials under 42 CFR 405.201.

CMS has determined that PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent is not reasonable and necessary for all other patients.

***Facilities Certification***

Facilities must be certified for Medicare to cover the CAS procedures and must recertify every two (2) years in order to maintain Medicare coverage of CAS procedures. Recertification will occur when the facility documents that and describes how it continues to meet the CMS standards. The new recertification guidelines are as follows:

**At 23 months after initial certification:**

- Submission of a letter to CMS stating how the facility continues to meet the minimum facility standards as listed in §20.7 of the *Medicare National Coverage Determinations Manual*. (See the “Additional Information” section of this article for the Web link to the NCD within CR 5660)

**At 27 months after initial certification:**

- Submission of required data elements for all CAS procedures performed on patients during the previous two (2) years of certification.
- Required data elements:
  - Patients’ Medicare identification number if a Medicare beneficiary;
  - Patients’ date of birth;
  - Date of procedure;
  - Does the patient meet high surgical risk criteria (defined below)?
    - Age ≥80;
    - Recent (< 30 days) Myocardial Infarction (MI);

- Left Ventricle Ejection Fraction (LVEF) < 30%;
- Contralateral carotid occlusion;
- New York Heart Association (NYHA) Class III or IV congestive heart failure;
- Unstable angina: Canadian Cardiovascular Society (CCS) Class III/IV;
- Renal failure: end stage renal disease on dialysis;
- Common Carotid Artery (CCA) lesion(s) below clavicle;
- Severe chronic lung disease;
- Previous neck radiation;
- High cervical Internal Carotid Artery (ICA) lesion(s);
- Restenosis of prior carotid endarterectomy (CEA);
- Tracheostomy;
- Contralateral laryngeal nerve palsy.

Is the patient symptomatic (defined below)?

- Carotid Transient Ischemic Attack (TIA) persisting less than 24 hours;
- Non-disabling stroke: Modified Rankin Scale <3 with symptoms for 24 hours or more;
- Transient monocular blindness: amaurosis fugax;

Modified Rankin Scale score if the patient experienced a stroke;

Percent stenosis of stented lesion(s) by angiography;

Was embolic protection used?

Were there any complications during hospitalization (defined below)?

- Stroke: an ischemic neurologic deficit that persisted more than 24 hours
- MI
- Death

Recertification is effective for two (2) additional years during which facilities will be required to submit the requested data every April 1 and October 1.

CMS will consider the approval of national carotid artery stenting registries that provide CMS with a comprehensive overview of the registry and its capabilities, and the manner in which the registry meets CMS data collection and evaluation requirements. Specific standards for CMS approval are listed below. Facilities enrolled in a CMS approved national CAS registry will automatically meet the data collection standards required for initial and continued facility certification. Hospitals' contracts with an approved registry may include authority for the registry to submit required data to CMS for the hospital. A list of approved registries will be made available on the CMS coverage Web site. In addition, CMS will publish a list of approved facilities in the Federal Register.

### ***National Registries***

As noted above, CMS will approve national registries developed by professional societies and other organizations and allow these entities to collect and submit data to CMS on behalf of participating facilities

to meet facility certification and recertification requirements. To be eligible to perform these functions and become a CMS approved registry, the national registry, at a minimum, must be able to:

1. Enroll facilities in every US state and territory;
2. Assure data confidentiality and compliance with HIPAA;
3. Collect the required CMS data elements as listed above;
4. Assure data quality and data completeness;
5. Address deficiencies in the facility data collection, quality, and submission;
6. Validate the data submitted by facilities, as needed;
7. Track long term outcomes such as stroke and death;
8. Conduct data analyses and produce facility specific data reports and summaries;
9. Submit data to CMS on behalf of the individual facilities; and
10. Provide quarterly reports to CMS on facilities that do not meet or no longer meet the CMS facility certification and recertification requirements pertaining to data collection and analysis.

Registries wishing to receive this designation from CMS must submit evidence that they meet or exceed these 10 requirements. Though the registry requirements pertain to CAS, CMS strongly encourages all national registries to establish a similar mechanism to collect comparable data on CEA. Having both CAS and CEA data will help answer questions about carotid revascularization, in general, in the Medicare population.

#### **Additional Information**

For complete details regarding this CR please see the official instruction (CR 5660) issued to your Medicare carrier, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R71NCD.pdf> on the CMS Web site.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.

CR 3811 that is referenced in the “Background” section of this article can be reviewed by accessing the following link <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf> on the CMS Web site.

#### **Disclaimer**

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.



## **Urgent Request: Security to Access FISS or ELGA/ELGH Will be Affected by the Transition of Data Processing Activities**

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

Your security access to the Fiscal Intermediary Standard System (FISS) is changing. You must take action to ensure continued access to ELGA, ELGH, and/or FISS.

On July 2, 2007, Cahaba sent a letter to all Medicare Part A providers that submit claims to our Alabama office. This letter provided important information about a change in your security to access FISS, ELGA, and/or ELGH. If you did not receive this letter, you may access it at [https://www.cahabagba.com/part\\_a/whats\\_new/20070703\\_edi.pdf](https://www.cahabagba.com/part_a/whats_new/20070703_edi.pdf) on our Web site. In addition, please take time now to carefully read and follow the instructions below.

The Centers for Medicare & Medicaid Services (CMS) is consolidating Medicare data center activities into three Enterprise Data Centers (EDCs). One of the EDC contracts was awarded to Companion Data Services (CDS). **Effective August 31, 2007, data processing activities for all Part A Medicare providers who submit claims to the Cahaba office in Birmingham, Alabama will be transitioned to CDS.**

One of the requirements for this transition is to **establish new security Logon-IDs for each person** accessing the FISS or the eligibility systems, ELGA/ELGH. This means that **each** employee, who currently has access to FISS and/or ELGA/ELGH, will need their own unique Logon-ID and password.

**To set up the new security, you must complete and return the “[EDI Services Part A Enrollment Application](#)” and the “[EDI Services Part A System Access Update Request](#)” forms no later than August 15, 2007.** Please complete both forms via our Web site by typing your information directly into the form fields. Print the forms, sign and fax both forms to **205-402-5706**. Failure to return the completed forms timely will result in your inability to log into the FISS and ELGA/ELGH, which will impact your submission of Direct Data Entry (DDE) claims, checking the status of claims, correcting claims, and viewing eligibility information. Ultimately, failure to respond will cause an interruption of your claims payment.

Once we receive your completed forms, your new security information will be sent to the address provided on the “EDI Services Part A System Access Update Request” form between August 15 and August 31, 2007, (if your forms are received by August 15, 2007). You will also receive revised procedures for signing into FISS, and/or ELGA/ELGH.

To complete this transition, FISS, ELGA/ELGH will not be available Friday, August 31, 2007, and will not be accessible again until Tuesday, September 4, 2007. Beginning Tuesday, September 4, 2007, you must use your new EDC security to access FISS, and/or ELGA/ELGH.

Please remember that if we do not receive your [“EDI Services Part A Enrollment Application”](#) and the [“EDI Services Part A System Access Update Request”](#) forms by **August 15, 2007**, you will not be able to access FISS, and/or ELGA/ELGH beginning **August 31, 2007**. If you have questions, please call our EDI Department at 866-582-3253.



## ELGA/ELGH Modifications to Medicare Advantage Plan Information

Effective July 2, 2007, modifications were made to the Medicare beneficiary eligibility screens showing Medicare Advantage (MA) information. This information can assist in verifying an MA Plan enrollment prior to admission for services and billing services to the Medicare Fee-for-Service (FFS) contractor. Claims submitted to Medicare that overlap a beneficiary election of a Medicare Advantage (MA) plan continue to cause a significant number of claim rejection.

Please share the following modifications with your appropriate staff.

### ELGA—Page 01

ELGA	CWF	PART A	ELIGIBILITY SYSTEM				ELGACRO
07/09/2007	14:47:22		BENEFICIARY INFORMATION				PAGE 01 OF 10
IP-REC CN		NM	IT	DB	SX	INT	
PN	APP		REAS		REQ		
CORRECT CN		NM	IT	DB	SX		
A-ENT	A-TRM		B-ENT		B-TRM		
DOD	LRSV	LPSY					
DAYS LEFT	FULL-HOSP	CO-HOSP	FULL-SNF	CO-SNF	IP-DED	DOEBA	
CURRENT						DOLBA	
PARTB YR	DED-TBM	PSYC	PHYS THER	OCC THER			
			TBM	TBM			
<b>FULL-NAME</b>							
<b>PLAN-TYPE</b>			CURR-ID	OPT	<b>ENR</b>	TERM	
ESRD: CODE-1	EFF DATE		CODE-2		EFF DATE		

**PLAN-TYPE** This field name was changed from “HMO” to “PLAN-TYPE”. This field will now provide the type of the Medicare Advantage plan. Valid values are:

- HMO (Health Maintenance Organization)
- PPO (Preferred Provider Organization)
- FFS Demo (Fee-for-Service Demonstration)
- Indemnity
- POS (Point of Sale)

**ENR** This field name was changed from “ENTITL” to “ENR”. This field displays the date an individual became enrolled in the Medicare Advantage plan.

ELGH 07/09/2007	CWF PART A 15:18:12	ELIGIBILITY SYSTEM PLAN INFORMATION	ELGHCRO PAGE 05 OF 09
HMO-REC CN <b>PLAN-TYPE</b>	NM PLAN-ID	IT OPT	DB <b>ENR-DATE</b> TRM-DATE
PF1=INQ SCREEN	PF3/CLEAR=END	PF7=PREV	PF8=NEXT

**PLAN-TYPE** This field is new. This field will provide the type of the Medicare Advantage plan. Valid values are:

- HMO
- PPO
- POS
- Indemnity
- FFS Demo

**ENR-DATE** This field name was changed from “EFF DATE” to “ENR-DATE”. This field displays the date an individual became enrolled in the Medicare Advantage plan.

If you have questions regarding this issue, refer to the “[Contact Us](#)” page of our Web site and select “Telephone Us” to call the Provider Contact Center.



**Updated Top Inquiries Frequently Asked Questions (FAQs)**

The FAQs for the top inquiries received in Cahaba GBA, LLC Provider Call Centers have been updated. Please use these to assist your staff with their Medicare billing questions. The updated FAQs can be accessed on our Web site using the following link:

[http://www.cahabagba.com/part\\_a/education\\_and\\_outreach/faq.htm](http://www.cahabagba.com/part_a/education_and_outreach/faq.htm)

Providers without Internet access may request a copy of the FAQs by calling the Provider Outreach and Education department at 515-471-7335.





## Avoid Claim Processing Delays When Using Not Otherwise Classified (NOC) HCPCS Codes

Claims submitted with NOC HCPCS/CPT codes (e.g., J3490, J3590) require manual pricing. Frequently, claims with NOC HCPCS/CPT codes must be moved to the Return to Provider (RTP) file to obtain specific information about the drug/procedure before manual pricing can be completed.

To avoid claim processing delays, include the following information in the “Remarks” field on the initial claim. This will allow us to immediately begin the manual pricing process without sending the claim to the RTP file.

- Name of Drug / Procedure
- Strength (e.g., 20 mg/ml)
- Dose (e.g., number of units administered)
- National Drug Code (NDC) Number
- Invoice Number
- Diagnosis supporting the need for the drug/procedure.

Please note that you should always check the current list of HCPCS codes to determine if a more appropriate code exists.



## 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 dates 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 Date	Time
August 2, 2007	10:30 a.m.–12:30 p.m. CT
August 9, 2007	10:30 a.m.–12:30 p.m. CT
August 16, 2007	10:30 a.m.–12:30 p.m. CT
August 23, 2007	10:30 a.m.–12:30 p.m. CT



## **Critical Access Hospital Questions and Answers About Infusion**

The following includes answers to questions received from the “Critical Access Hospital (CAH) Billing Updates” teleconference that was held April 25, 2007.

**Q1. If a patient is in observation and is getting either hydration therapy or IV infusion and receives it for ten hours, five on day one of observation and five on day two of observation, do we charge all the hours on day one or split the hours between the days?**

A1. According to CPT, "When reporting codes for which infusion time is a factor, use the actual time over which the infusion is administered." Therefore, assign the number of hours to the appropriate day.

**Q2. If we give a prophylactic antibiotic to all outpatient surgery patients receiving a specific procedure, but not to patients receiving some other type of outpatient procedure, do we treat the antibiotic as inherent to the procedure and not charge an injection code?**

A2. A service (infusion) that is an "inherent" part of a procedure should not be billed separately. See examples below.

**Q3. If a patient receives either injections or infusions during the recovery process, is that considered as inherent to the procedure and therefore a separate injection or infusion code should not be charged?**

A3. "Recovery" is an inherent part of a procedure; therefore, any "routine" recovery services are considered an "inherent" part of the procedure and not separately billable. However if a "nonroutine" service is delivered, those services are then separately billable.

Examples:

1. A patient has a cholecystectomy and in the recovery room it is noted that their blood pressure is consistently elevated to the point the physician feels it warrants treatment. IV Hydralazine is given. This is not a "routine" part of the recovery; therefore, the associated delivery services (i.e. infusion) are billable.
2. A patient has carpal tunnel repair and in the recovery room requests pain medication. The physician has ordered Morphine prn IV for pain. Pain control is an inherent part of a procedure; therefore, the delivery of the medication (as well as the medication) are not separately billable.
3. A patient has a procedure that involved a large amount of contrast material and the physician has ordered saline boluses/infusions in the recovery room. These saline boluses/infusions are an inherent part of the procedure and therefore not separately billable.



## **How to Report Modifier 50 Appropriately**

During a recent review of claims, the Comprehensive Error Rate Testing (CERT) program identified an inappropriate billing error on claims containing Modifier 50 to report a bilateral procedure. Modifier 50 applies to any bilateral procedure performed on both sides at the same operative session. The claims identified reported Modifier 50 on one detail line and, in addition, the same Current Procedural Terminology (CPT) code was reported on a different detail line. Two line items should not be submitted to report a bilateral procedure using modifier 50.

For additional information, please refer to the Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual*, Publication 100-4, Ch 4, §20.6.2 and Ch 23, §90. This manual can be found at <http://www.cms.hhs.gov/PCPricer/Downloads/clm104c04.pdf> on the CMS Web site.

## August Education Events

To register go to the "[Calendar of Educational Events](#)" page on our Web site. Select the event title for registration instructions.

➤ "[Dial In & Win With Timely Medicare Payments](#)" Ask-The-Contractor Teleconference (ACT)

**Date:** August 2, 2007

**Time:** 1:00 p.m.– 2:00 p.m. Central Time (CT)

**Registration Deadline:** July 26, 2007

**Intended Audience:** This ACT is intended for all Medicare Part A providers and staff

**Description:** This ACT will include information about the most common reasons why Medicare Part A claims are rejected or sent for correction.

➤ "[Renal Dialysis Facility \(RDF\) Billing Updates](#)" Teleconference

**Date:** August 14, 2007

**Time:** 10:00 a.m. – 12:00 p.m. CT

**Registration Deadline:** August 9, 2007

**Intended Audience:** This teleconference is available to all Medicare Part A independent renal dialysis facility billing personnel.

**Description:** This teleconference will provide updates and information on current billing issues related to end stage renal disease (ESRD) claims.

## Cahaba GBA, LLC Learning Corner

- Didn't find what you were looking for? [Visit our Web site](#)—it provides a variety of valuable information and is continuously updated. You may want to bookmark the [Medicare Part A](#) page for the most current Medicare A headlines or to subscribe to the Cahaba GBA, LLC [E-mail Notification Service](#). In addition, our online courses are computer-based and can be launched from the convenience of your own desk. All courses are free and open to anyone.

Course Title	Description
Adjusting and Canceling Claims <i>Updated</i>	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.
<b>FISS 101: Introduction to FISS</b>	Learn how to access FISS and receive an overview of FISS functions.
Insight into Medicare Coding	Learn the basics about Medicare coding.
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: <a href="#">CMS NPI Training Package</a>
Overview of Medicare	Learn the basics about the Medicare program.
Provider Enrollment	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.

**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](#).