

Medicare B Newsline



Important Information from Cahaba Government Benefit Administrators® LLC
 Cahaba GBA is the Medicare Part B Contractor for the states of Alabama, Georgia,
 and Mississippi



February 2007

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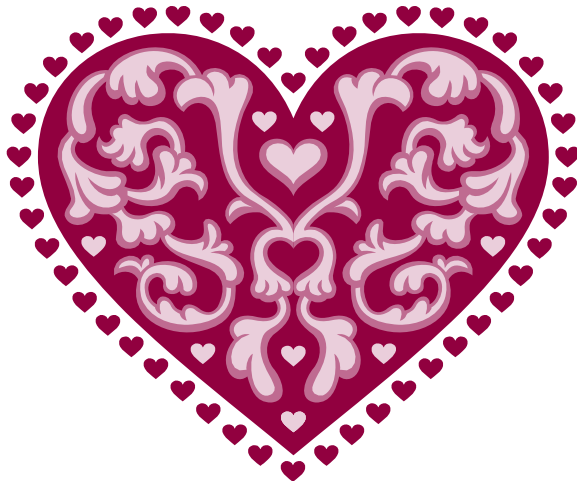
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Electronic Data Interchange (EDI) Media Changes

Some contractors allowed providers to submit Electronic Data Interchange (EDI) claims via fax-imaging, diskette, tape, or other similar storage media. Effective January 16, 2007, Carriers, DMERCs, DME MACs, A/B MACs, and FIs are no longer permitted to accept claims via fax-imaging, tape, or other similar storage media.

CMS Change Request 5225

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Please Route

Remember that this newsletter, and all other Medicare publications, serves as your official notice of Medicare coverage and billing information. If you have any questions about the information included in this newsletter, please call your Provider Contact Center.

This bulletin shall be shared with all health care practitioners and managerial members of your provider staff. Bulletins are available at no cost from our website https://www.cahabagba.com/part_b/education_and_outreach/newsletters/index.htm.

Routing List

- Provider/Supplier
 - Administrator
 - Office/Clinic Manager
 - Medical Personnel
 - Billing/Insurance Staff
 - Other Additional Staff
-
-

Disclaimer

The following disclaimer is applicable to all telephone inquiries to Medicare:

The information provided in no way represents a guarantee of payment. The benefits quoted are based upon information present in our computer records and may not reflect information recently received. Benefits for any claim will be provided according to the patient's eligibility, the provision of the law, regulations and instructions from the Centers for Medicare and Medicaid Services (CMS).

Advanced Beneficiary Notices (ABNs)

The Advanced Beneficiary Notice (ABN) form, CMS-R-131, is available on the Beneficiary Notices Initiative (BNI) website. For replicable ABN forms and information see http://www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopOfPage.

General Medicare Questions for Medicare Recipients

Do some of your patients have questions regarding their Medicare benefits and you are not sure how to answer? Medicare recipients should call **1-800-MEDICARE (1-800-633-4227)** for all questions related to Medicare claims and services, instead of calling a specific contractor telephone number for each type of claim. Questions regarding specific claims will be automatically routed to the appropriate Medicare contractor's call center for response.

Medicare Part B Provider Call Center Hours and Telephone Numbers

The Medicare Part B Provider Call Centers may be reached Monday through Friday between the hours of:

- Alabama 8:00 a.m. – 4:30 p.m. CST
- Georgia 8:00 a.m. – 4:00 p.m. EST
- Mississippi 8:00 a.m. – 4:00 p.m. CST

The Interactive Voice Response (IVR) System is available from 6:00 a.m. - 11:00 p.m. Monday through Friday and can be accessed Saturdays from 6:00 a.m. - 6:00 p.m.

The following is a list of toll-free numbers for the Cahaba GBA Provider Call Centers:

- Alabama: 866 539-5598
- Georgia: 877 567-7271
- Mississippi: 866 419-9454

The Medicare Part B offices will be closed for the following holidays in 2007:

2007 Holiday Schedule	
Friday, April 6	Good Friday
Monday, May 28	Memorial Day
Wednesday, July 4	Independence Day
Monday, September 3	Labor Day
Thursday, November 22 Friday, November 23	Thanksgiving
Monday, December 24 Tuesday, December 25	Christmas

Cahaba Government Benefit Administrators (GBA) Email Notification Service—Subscribe NOW

The Cahaba GBA E-mail Notification Service is available. Currently, we have 5,477 members subscribed.

We encourage everyone to enroll. You will receive timely CMS and Medicare contractor news detailing policy, benefits, claims submission, claims processing and education event updates. Having the most current information will help you avoid costly and time-consuming claim processing interruptions in your practice.

This service is FREE. You will need a valid e-mail address to subscribe. The e-mail address can be your own personal e-mail address or a general e-mail address used by your organization. There is no limit on the number of people or individual e-mail addresses that can subscribe from your organization.

How to Subscribe

To subscribe for e-mail notification, use the following steps:

- Subscribe to the new Cahaba GBA E-mail Notification Service at: <http://www.cahabagba.com/forms/subscribeForm.htm>.
- Complete the Subscription Form. The required fields are marked with an asterisk (*). The form also requests general information about you and your organization. Next, select from a list of general topics, Medicare A topics or Medicare B topics that interest you. Select none, or as many as you like. If you choose not to make a selection, you will receive electronic e-mail notifications related to all topics.
- Click on the “Sign Up for News” button.
- You will receive an e-mail confirmation message from “cahaba_news” to confirm your subscription. Simply reply to the message to confirm.
- You will receive another e-mail message announcing that you have successfully subscribed to the Cahaba GBA E-mail Notification Service.

Your e-mail address will not be shared with other subscribers or given to advertisers, and once subscribed, you can unsubscribe from the list at any time. Please review our Privacy Policy at http://www.cahabagba.com/part_b/privacy.htm for more information.

NPI Countdown

Countdown has begun; do you have your NPI? Don't risk disruption to your cash flow – Get your NPI now! National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every healthcare provider needs to get an NPI! Learn more about NPI and how to apply by visiting www.cms.hhs.gov/NationalProvIdentStand/ on the CMS website.

This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A Countdown Clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at <http://www.wedi.org/npioi/index.shtml>.

Schedule of Upcoming Events Medicare Part B

Date	Course/Event	Location
02/22/07	Open LCD Development Meeting Medicare Part B - Georgia	Savannah, GA
03/01/07	Open LCD Development Meeting Medicare Part B – Alabama and Mississippi	Birmingham, AL
04/18/07	Ask Cahaba B Teleconference Part B Providers – AL, GA & MS	NA - Teleconference
06/28/07	Open LCD Development Meeting Medicare Part B - Georgia	Savannah, GA
06/28/07	Open LCD Development Meeting Medicare Part B – Alabama and Mississippi	Birmingham, AL
07/18/07	Ask Cahaba B Teleconference Part B Providers – AL, GA & MS	NA - Teleconference
10/17/07	Ask Cahaba B Teleconference Part B Providers – AL, GA & MS	NA - Teleconference
10/25/07	Open LCD Development Meeting Medicare Part B - Georgia	Savannah, GA
10/30/07	Open LCD Development Meeting Medicare Part B – Alabama and Mississippi	Birmingham, AL

For additional details and/or registration regarding any event above, please visit our website at www.cahabagba.com/apps/course_registration/al/calendar.jsp.

NPI Billing Alert

Do you need a Group National Provider Identifier (NPI)?

Group providers must report their group NPI on all claims for payment process by May 23, 2007. Claims could be denied or rejected, seriously impacting your cash flow.

During the Stage 2 NPI transition period of October 1, 2006 through May 22, 2007, Medicare is recommending that providers submit claims with both NPIs and legacy provider numbers. Since October 1st, Cahaba GBA, LLC has seen a high error rate with group claims being received without a group payee NPI. If you are a provider who is part of a group, you must identify your claims with not only your own individual NPI, but with a group payee NPI.

The most common definition of a group is an established practice with more than one provider working for that practice under the same tax ID. Incorporated sole practitioners are also considered a group practice. If your practice has not applied for a group payee NPI, you must do so. The Group NPI stays with the group. If your practice currently has a legacy group number, you will need to obtain and bill with a group payee NPI. (The group PIN is located in the upper right corner of the electronic and paper remittance notices in the "Provider #" field. You will need this number when applying for your NPI.)

Electronic claim submitters should contact your vendor, billing service or clearing house, or refer to **Change Request (CR) 5229** for additional billing information. This CR can be located at www.cms.hhs.gov/transmittals/downloads/R234OTN.pdf.

Hardcopy claim submitters should continue to submit the original (12-90 version) CMS-1500 form using your legacy numbers through January 1, 2007. From January 2, 2007, through March 30, 2007, either the original Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version can be used. After April 1, 2007, the revised (08-05) CMS-1500 form must be submitted. **Please refer to the [NPI 1500 Claim Form \(pdf\)](#) link for a claim form and NPI references.** You may also refer to Change Request (CR) 5060 for NPI billing instructions. This CR can be located at www.cms.hhs.gov/transmittals/downloads/R1058CP.pdf.

For additional information, all providers should refer to the CMS website at <http://www.cms.hhs.gov/NationalProvIdentStand/>. NPI applications may be submitted online at <https://nppes.cms.hhs.gov> or you can call the NPI enumerator to request a paper application at **1-800-465-3203**.

If you have any questions, please contact the Provider Contact Center servicing your state at:

- Alabama Providers: 1-866-539-5598
- Georgia Providers: 1-877-567-7271
- Mississippi Providers: 1-866-419-9454

Outpatient Therapy Cap Exception Process for 2007

Provider Types Affected

Providers, physicians, and Non-Physician Practitioners (NPPs) who bill Medicare contractors (Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs), carriers, and Part A/B Medicare Administrative Contractors (A/B MACs) under the Part B benefit for therapy services.

Provider Action Needed

Be sure you are aware of the requirements for the therapy cap exceptions for calendar year 2007, especially the use of the KX modifier and the rules governing the exceptions.

Background

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

On January 1, 2006, Medicare implemented financial limitations on covered therapy services (therapy caps); however, the 2006 Deficit Reduction Act provided for exceptions to this dollar limitation when the provision of additional therapy services is determined to be medically necessary. This exceptions process has been extended by recent legislation (the Tax Relief and Health Care Act of 2006) for one year (calendar year 2007).

Remember that a therapy cap exception may be made when a beneficiary requires continued skilled therapy (in other words, therapy beyond the amount payable under the therapy cap) to achieve their prior functional status or maximum expected functional status within a reasonable amount of time. Documentation supporting the medical necessity of those therapy services must be kept on file by the provider.

Additionally, you should note that, in 2006, Exception Processes fell into two categories, Automatic, and Manual. Beginning January 1, 2007, there is no manual process for exceptions, and all services that require exceptions to caps will be processed using the automatic process.

Key Points

CR 5478, from which this article is taken, provides instructions to contractors regarding the short-term implementation of this legislation.

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Outpatient Therapy Cap Exception Process for 2007, continued from the previous page

Details about these instructions follow:

- Contractors will grant exceptions for any number of medically necessary services if the beneficiary meets the conditions described in the *Medicare Claims Processing Manual* (100-04), Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation) for 2007, (displayed in Table 1, below). **The following ICD-9 codes describe the most typical conditions (etiology or underlying medical diagnoses) that may result in exceptions (marked X) and complexities that MIGHT cause medically necessary therapy services to qualify for the automatic process exception (marked *) for each discipline separately. When the cell in the table is marked with a dash (-), the diagnosis code in the corresponding row is not appropriate for services by the discipline in the corresponding column. Therefore, services provided by that discipline for that diagnosis do not qualify for exception to caps. Services may be appropriate when provided by that discipline for another diagnosis appropriate to the discipline, which may or may not be on this table, and that diagnosis should be documented on the claim, if possible, or in the medical record.**

Table 1

ICD-9 codes describing diagnoses that may result in excepted conditions (marked X) and complexities (marked *) that MIGHT cause medically necessary therapy services to qualify for the automatic process exception.

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
V43.61-V43.69	Joint Replacement	X	X	--
V45.4	Arthrodesis Status	*	*	--
V45.81-V45.82 and V45.89	Other Postprocedural Status	*	*	--
V49.61-V49.67	Upper Limb Amputation Status	X	X	--
V49.71-V49.77	Lower Limb Amputation Status	X	X	--
V54.10-V54.29	Aftercare for Healing Traumatic or Pathologic Fracture	X	X	--
V58.71-V58.78	Aftercare Following Surgery to Specified Body Systems, Not Elsewhere Classified	*	*	*
244.0-244.9	Acquired Hypothyroidism	*	*	*
250.00-251.9	Diabetes Mellitus and Other Disorders of Pancreatic Internal Secretion	*	*	*
278.00-278.01	Obesity and Morbid Obesity	*	*	*
280.0-289.9	Diseases of the blood and blood-forming organs	*	*	*
290.0-290.43	Dementias	*	*	*
294.0-294.9	Persistent Mental Disorders due to Conditions Classified Elsewhere	*	*	*
295.00-299.91	Other Psychoses	*	*	*
300.00-300.9	Anxiety, Disassociative and Somatoform Disorders	*	*	*
310.0-310.9	Specific Nonpsychotic Mental Disorders due to Brain Damage	*	*	*
311	Depressive Disorder, Not Elsewhere Classified	*	*	*
315.00-315.9	Specific delays in Development	*	*	*
317	Mild Mental Retardation	*	*	*

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Outpatient Therapy Cap Exception Process for 2007, continued from the previous page

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
320.0-326	Inflammatory Diseases of the Central Nervous System	*	*	*
330.0-337.9	Hereditary and Degenerative Diseases of the Central Nervous System	X	X	X
340-345.91 and 348.0-349.9	Other Disorders of the Central Nervous System	X	X	X
353.0-359.9	Disorders of the Peripheral Nervous system	X	X	--
365.00-365.9	Glaucoma	*	*	*
369.00-369.9	Blindness and Low Vision	*	*	*
386.00-386.9	Vertiginous Syndromes and Other Disorders of Vestibular System	*	*	*
389.00-389.9	Hearing Loss	*	*	*
401.0-405.99	Hypertensive Disease	*	*	*
410.00-414.9	Ischemic Heart Disease	*	*	*
415.0-417.9	Diseases of Pulmonary Circulation	*	*	*
420.0-429.9	Other Forms of Heart Disease	*	*	*
430-438.9	Cerebrovascular Disease	X	X	X
440.0-448.9	Diseases of Arteries, Arterioles, and Capillaries	*	*	*
451.0-453.9 and 456.0-459.9	Diseases of Veins and Lymphatics, and Other Diseases of Circulatory System	*	*	*
465.0-466.19	Acute Respiratory Infections	*	*	*
478.30-478.5	Paralysis, Polyps, or Other Diseases of Vocal Cords	*	*	*
480.0-486	Pneumonia	*	*	*
490-496	Chronic Obstructive Pulmonary Disease and Allied Conditions	*	*	*
507.0-507.8	Pneumonitis due to solids and liquids	*	*	*
510.0-519.9	Other Diseases of Respiratory System	*	*	*
560.0-560.9	Intestinal Obstruction Without Mention of Hernia	*	*	*
578.0-578.9	Gastrointestinal Hemorrhage	*	*	*
584.5-586	Renal Failure and Chronic Kidney Disease	*	*	*
590.00-599.9	Other Diseases of Urinary System	*	*	*
682.0-682.8	Other Cellulitis and Abscess	*	*	--
707.00-707.9	Chronic Ulcer of Skin	*	*	--
710.0-710.9	Diffuse Diseases of Connective Tissue	*	*	*
711.00-711.99	Arthropathy Associated with Infections	*	*	--
712.10-713.8	Crystal Arthropathies and Arthropathy Associated with Other Disorders Classified Elsewhere	*	*	--
714.0-714.9	Rheumatoid Arthritis and Other Inflammatory Polyarthropathies	*	*	--
715.00-715.98	Osteoarthritis and Allied Disorders (Complexity except as listed below)	*	*	--
715.09	Osteoarthritis and allied disorders, multiple sites	X	X	--
715.11	Osteoarthritis, localized, primary, shoulder region	X	X	--
715.15	Osteoarthritis, localized, primary, pelvic region and thigh	X	X	--
715.16	Osteoarthritis, localized, primary, lower leg	X	X	--
715.91	Osteoarthritis, unspecified id gen. or local, shoulder	X	X	--
715.96	Osteoarthritis, unspecified if gen. or local, lower leg	X	X	--
716.00-716.99	Other and Unspecified Arthropathies	*	*	--
717.0-717.9	Internal Derangement of Knee	*	*	--
718.00-718.99	Other Derangement of Joint (Complexity except as listed below)	*	*	--
718.49	Contracture of Joint, Multiple Sites	X	X	--
719.00-719.99	Other and Unspecified Disorders of Joint (Complexity except as listed below)	*	*	--

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Outpatient Therapy Cap Exception Process for 2007, continued from the previous page

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
719.7	Difficulty Walking	X	X	--
720.0-724.9	Dorsopathies	*	*	--
725-729.9	Rheumatism, Excluding Back (Complexity except as listed below)	*	*	--
726.10-726.19	Rotator Cuff Disorder and Allied Syndromes	X	X	--
727.61-727.62	Rupture of Tendon, Nontraumatic	X	X	--
730.00-739.9	Osteopathies, Chondropathies, and Acquired Musculoskeletal Deformities (Complexity except as listed below)	*	*	--
733.00	Osteoporosis	X	X	--
741.00-742.9 and 745.0-748.9 and 754.0-756.9	Congenital Anomalies	*	*	*
780.31-780.39	Convulsions	*	*	*
780.71-780.79	Malaise and Fatigue	*	*	*
780.93	Memory Loss	*	*	*
781.0-781.99	Symptoms Involving Nervous and Musculoskeletal System (Complexity except as listed below)	*	*	*
781.2	Abnormality of Gait	X	X	--
781.3	Lack of Coordination	X	X	--
783.0-783.9	Symptoms Concerning Nutrition, Metabolism, and Development	*	*	*
784.3-784.69	Aphasia, Voice and Other Speech Disturbance, Other Symbolic Dysfunction	*	*	X
785.4	Gangrene	*	*	--
786.00-786.9	Symptoms involving Respiratory System and Other Chest Symptoms	*	*	*
787.2	Dysphagia	*	*	X
800.00-828.1	Fractures (Complexity except as listed below)	*	*	--
806.00-806.9	Fracture of Vertebral Column With Spinal Cord Injury	X	X	--
810.11-810.13	Fracture of Clavicle	X	X	--
811.00-811.19	Fracture of Scapula	X	X	--
812.00-812.59	Fracture of Humerus	X	X	--
813.00-813.93	Fracture of Radius and Ulna	X	X	--
820.00-820.9	Fracture of Neck of Femur	X	X	--
821.00-821.39	Fracture of Other and Unspecified Parts of Femur	X	X	--
828.0-828.1	Multiple Fractures Involving Both Lower Limbs, Lower with Upper Limb, and Lower Limb(s) with Rib(s) and Sternum	X	X	--
830.0-839.9	Dislocations	X	X	--
840.0-848.8	Sprains and Strains of Joints and Adjacent Muscles	*	*	--
851.00-854.19	Intracranial Injury, excluding those With Skull Fracture	X	X	X
880.00-884.2	Open Wound of Upper Limb	*	*	--
885.0-887.7	Traumatic Amputation, Thumb(s), Finger(s), Arm and Hand (complete)(partial)	X	X	--
890.0-894.2	Open Wound Lower Limb	*	*	--
895.0-897.7	Traumatic Amputation, Toe(s), Foot/Feet, Leg(s) (complete)(partial)	X	X	--
905.0-905.9	Late Effects of Musculoskeletal and Connective Tissue Injuries	*	*	*
907.0-907.9	Late Effects of Injuries to the Nervous System	*	*	*

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Outpatient Therapy Cap Exception Process for 2007, continued from the previous page

ICD-9 Cluster	ICD-9 (Cluster) Description	PT	OT	SLP
941.00-949.5	Burns	*	*	*
952.00-952.9	Spinal Cord Injury Without Evidence of Spinal Bone Injury	X	X	X
953.0-953.8	Injury to Nerve Roots and Spinal Plexus	X	X	*
959.01	Head Injury, Unspecified	X	X	X

- Medicare contractors will allow automatic process exceptions for diagnoses in the table above or any other diagnosis for which therapy services are appropriate when the beneficiary needs therapy services above the therapy cap (due to the occurrence of any condition or complexity that is appropriately documented).
 - For the therapy HCPCS codes subject to the cap limits in your claims to be excepted, you must include the KX modifier to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record. In CY 2007, when claims contain a KX modifier, contractors will override edits that indicate that a therapy service has exceeded the financial limitation, and will pay for the service if it is otherwise covered and payable.
 - Contractors will not use the KX modifier as the sole indicator of services that do exceed caps in 2007, because, there will be services with appropriately used KX modifiers that do not represent services that exceed the cap.
 - Contractors will require that the documentation for outpatient therapy services include objective, measurable patient function information, either by using one of the four recommended (but not required) measurement tools:
 - *(National Outcomes Measurement System (NOMS) by the American Speech Language Hearing Association,*
 - *Patient Inquiry by Focus On Therapeutic Outcomes, Inc. (FOTO),*
 - *Activity Measure – Post Acute Care (AM-PAC), or*
 - *OPTIMAL by Cedaron through the American Physical Therapy Association),*
- or** by including other information as described in the *Medicare Benefit Policy Manual* (Publication 100-02), chapter 15 (Covered Medical and Other Health Services), section 220.3C (Documentation Requirements for Therapy Services -- Evaluation/Re-Evaluation and Plan of Care).

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- If one of these instruments is not in the patient's medical record, the record must contain documentation to indicate objective, measurable beneficiary physical function including, for example: 1) Functional assessment individual item and summary scores (and comparisons to prior assessment scores) from commercially available therapy outcomes instruments other than those listed above; or 2) Functional assessment scores (and comparisons to prior assessment scores) from tests and measurements validated in the professional literature that are appropriate for the condition/function being measured; or 3) Other measurable progress towards identified goals for functioning in the home environment at the conclusion of this therapy episode of care.

The automatic exceptions process for therapy claims reporting the KX modifier does not preclude these claims from being subject to review. The contractor may review claims when they are potentially fraudulent, where there is evidence of misrepresentation of facts, or where there is a pattern of aberrant billing.

Note: Claims for services above the cap, which are denied, are considered benefit category denials, and the beneficiary is liable. Further, providers do not need to issue an ABN for these benefit category denials.

Be aware that contractors do not have to search their files to either retract payment for claims already paid or to retroactively pay claims, but will reopen and/or adjust claims brought to their attention.

Final note: The CR5478 also relocates some information. Comprehensive Outpatient Rehabilitation Facilities (CORF) policies for 1) Group therapy services and 2) Therapy students, are the same as other Part B outpatient services policies for group therapy services and therapy students; and can now be found in the *Medicare Benefit Policy Manual*, chapter 15, section 230.

Additional Information

You can find more information about the outpatient therapy cap exception process for 2007 by going to CR 5478. CR5478 is actually issued in 3 separate transmittals, one for each manual being revised. The attachments to each of the transmittals include the updates to the *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation) for 2007; the *Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.1.1 (Exception From the Uniform Dollar Limitation ("Therapy Cap")), and the *Medicare Benefit Policy Manual*, chapter 15 (Covered Medical and Other Health Services), Section 220.3C (Documentation Requirements for Therapy Services -- Evaluation/Re-Evaluation and Plan of Care). You are encouraged to be familiar with these important manual sections. You can find these transmittals on the CMS website at:

- The *Medicare Claims Processing Manual* transmittal - <http://www.cms.hhs.gov/transmittals/downloads/R1145CP.pdf>;

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Outpatient Therapy Cap Exception Process for 2007, continued from the previous page

- The *Medicare Benefit Policy Manual* transmittal - <http://www.cms.hhs.gov/transmittals/downloads/R63BP.pdf> and
- The *Medicare Program Integrity Manual* transmittal - <http://www.cms.hhs.gov/transmittals/downloads/R181PI.pdf>.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5478

2007 Physician Fee Schedule Payment Policies

Provider Types Affected

Physicians and other providers who bill Medicare carriers, Fiscal Intermediaries (FI) and A/B MACs for services, including ambulance and telehealth services.

What you Need to Know

CR 5443, from which this article was taken: 1) Summarizes significant issues contained in the Medicare Physician Fee Schedule Regulation for 2007 (including publishing the Ambulance Inflation Factor (AIF) for CY 2007); and 2) Announces the telehealth originating site facility fee for 2007. CR5443 also discusses several provisions of the recently enacted Tax Relief and Health Care Act of 2006. You should refer to the *Background* and *Additional Information* sections, below, for more details and information on how to find the background/reference documents.

Background

Tax Relief and Health Care Act of 2006

The Tax Relief and Health Care Act of 2006 set the 2007 conversion factor for physician payment at the same level as in 2006 (\$37.8975), reversing the statutorily mandated 5.0 percent negative update. However, it does not maintain 2007 physician payments at 2006 levels. There are a number of other factors that affect payment rates for 2007 and this article discusses several of those factors. The legislation also extends the 1.0 floor on work Geographic Practice Cost Indices (GPCIs) through December 31, 2007. Practice expense GPCIs and malpractice GPCIs are not affected by this provision.

Section 202 of this act mandates that Medicare Part B will cover, for 2007 only, the administration of vaccines that are covered under Part D of Medicare. A new G code (G0377) has been created for the administration of Part D vaccines and payment for G0377 will be crosswalked to CPT code 90471 for one year. When a physician administers a Part D vaccine, the physician should use G0377 to bill the local carrier for the administration of the vaccine. Payment to the physician will be on an assigned basis only. Normal beneficiary deductible and coinsurance requirements apply to the administration. Payment for Part D covered vaccines is made solely by the participating Prescription Drug Plan. Medicare Part B will not pay for the vaccine itself.

Medicare Physician Fee Schedule Regulation for 2007

Section 1848(b)(1) of the Social Security Act requires the Centers for Medicare and Medicaid Services (CMS) to establish (by regulation, before November 1 of each year) fee schedules that establish payment amounts for physicians' services for the subsequent year.

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2007 Physician Fee Schedule Payment Policies, continued from the previous page

Accordingly, on November 1, 2006, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) final rule for calendar year 2007. In this rule (effective January 1, 2007) Medicare:

- Will increase physician payment for the time spent talking with Medicare beneficiaries about their health care. The 2007 final rule significantly increases the Relative Value Units' (RVU) work component for the face-to-face visits (evaluation and management or "E&M services"), during which the physician and patient discuss the patient's health status and the steps that can be taken to maintain or improve the patient's health.
- Adopts work values for CPT codes 97802, 97803, 97804, G0270, and G0271.
- Expands its preventive services benefits to include:
 - Adding a one-time preventive ultrasound screening for abdominal Aortic Aneurysms (AAA), for at risk beneficiaries, only available as part of the Initial Preventive Physical Examination (also referred to as the Welcome to Medicare physical);
 - Adding Insuring more accurate and reliable bone mass measurements are performed for Medicare beneficiaries; and
 - Adding Exempting the colorectal cancer screening benefit from the Part B deductible.
- Adjusts the methodology for determining practice expense (such as office overhead) RVUs. As part of the methodology, CMS will use a bottom-up methodology for direct costs, use supplementary survey data for indirect costs, and eliminate the non-physician work-pool. This methodology (to be phased over a four-year period) will be more transparent than the existing methodology, allowing specialties and other stakeholders to predict the effects of proposals to improve accuracy of practice expense payments.
- Adds diabetes outpatient self-management training and medical nutrition therapy services to the list of covered and separately payable services included in the Federally Qualified Health Center benefit, making these services more available to beneficiaries in both rural and urban underserved areas.
- Caps payment rates for imaging services under the physician fee schedule at the amount paid for the same services when performed in hospital outpatient departments; includes a list of codes to which the Outpatient Prospective Payment System (OPPS) cap would apply; and reduces the payment for certain multiple imaging procedures on contiguous body parts by 25% after full payment for the first procedure.

Note: CMS will apply the multiple imaging reductions first, followed by the OPSS imaging cap, if applicable.

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2007 Physician Fee Schedule Payment Policies, continued from the previous page

The final rule also:

- Finalizes drug manufacturer reporting requirements and addresses a number of technical Average Sales Price (ASP) issues such as the treatment of bona fide service fees in the context of the ASP calculation and the definition of nominal sales;
- Codifies the public consultation process for developing payment amounts for new clinical laboratory tests;
- Adopts supplier standards for Independent Diagnostic Testing Facilities (IDTFs);
- Continues the temporary intravenous immune globulin pre-administration-related services fee into 2007;
- Addresses the final regulations affecting ambulance payment policy under the ambulance fee schedule, which will improve the accuracy of payments for ambulance services and incorporate changes in geographic adjustments based on the most recent census data.
- Announces an Ambulance Inflation Factor (AIF) for CY 2007 of 4.3%, and further
 - 1) Clarifies the designation of areas as urban or rural to incorporate changes made by the Office of Management and Budget to the Metropolitan Statistical Areas (MSAs);
 - 2) Replaces the Goldsmith Modification (identifying rural census tracts within MSAs) with the most recent version based on Rural Urban Commuting Areas; and
 - 3) Discontinues formal annual reviews of “low billers” and air ambulances to determine whether adjustments are needed in the ambulance fee schedule conversion factors.
- Includes a discussion of exceptions to the therapy cap for CY2006 and 2007 and announces that the 2007 therapy cap is \$1,780. (Note that Section 201 of the Tax Relief and Health Care Act of 2006 extended the exceptions process until December 31, 2007.)
- Amends the reassignment of payment regulations to state that an individual supplier furnishing a service has unrestricted access to the billings submitted by the entity receiving Medicare payment for services furnished by that supplier, irrespective of whether the supplier is an employee or independent contractor.
- Announces that the drug add-on adjustment to the End Stage Renal Disease (ESRD) composite payment rate for 2007 will increase from 14.5 percent to 15.1 percent.

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2007 Physician Fee Schedule Payment Policies, continued from the previous page

Lastly, the final rule addresses comments received on the separate notice published June 29, 2006 (Five Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology (CMS-1521-PN)), which is contained in an attachment to CR 5443. Further discussion of the above-summarized items is in that same attachment to CR5443.

Telehealth originating site facility fee for 2007

Section 1834(m) of the Social Security Act established the Medicare telehealth originating site facility fee payment amount for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI).

The MEI increase for 2007 is 2.1%. Thus for calendar year 2007, the payment amount for HCPCS code "Q3014, telehealth originating site facility fee" is 80% of the lesser of the actual charge, or \$22.94.

Note that the beneficiary is responsible for any unmet deductible amount or coinsurance.

The Medicare telehealth originating site facility fee and MEI increase by applicable time period is shown in Table 1, below.

Table 1

Medicare Telehealth Originating site Facility Fee and MEI by Time Period		
Facility Fee	MEI	Time Period
\$20.00	N/A	10/01/2001 – 12/31/2002
\$20.60	3.0%	01/01/2003 – 12/31/2003
\$21.20	2.9%	01/01/2004 – 12/31/2004
\$21.86	3.1%	01/01/2005 – 12/31/2005
\$22.47	2.8%	01/01/2006 – 12/31/2006
\$22.94	2.1%	01/01/2007 – 12/31/2007

Additional Information

You can find more information about the 2007 Physician Fee Schedule Payment Policies by going to CR 5443, located at <http://www.cms.hhs.gov/Transmittals/downloads/R258OTN.pdf> on the CMS website.

Please see, as an attachment to that CR, a document entitled *Revisions to Payment Policies and Five-Year Review of Work Relative Value Units Under the Physician Fee Schedules for CY 2007, and Other Changes to Payment Under Part B; Revisions to the Payment Policies of Ambulance Services Under the Fee Schedule for Ambulance Services; Ambulance Inflation Factor Update for CY 2007*, for more details on the significant issues discussed in the final rule.

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2007 Physician Fee Schedule Payment Policies, continued from the previous page

You can find the November 1, 2006 CMS press release entitled *MEDICARE ANNOUNCES FINAL RULE SETTING PHYSICIAN PAYMENT RATES AND POLICIES FOR 2007*, by going to <http://cms.hhs.gov/apps/media/press/release.asp?Counter=2044>; and other information about the physician fee schedule by going to the CMS Physician Center Website at <http://cms.hhs.gov/center/physician.asp>.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5443

Clinical Laboratory Improvement Amendments (CLIA) Edits

Provider Types Affected

Providers and clinical laboratories that submit claims to Medicare carriers for CLIA-related services

Key Points

The HCPCS codes that are considered laboratory tests under CLIA are subject to change each year. Effective January 1, 2006, there are new HCPCS codes, including modifiers, for 2006 that are either subject to CLIA edits or excluded from CLIA edits.

HCPCS codes subject to or excluded from CLIA edits are described in Change Request (CR) 4321 and in the attachments to that CR which revise the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 16, Laboratory Services.

The new 2006 HCPCS codes are listed in Table 1 of this article. Please note that this list does not include new HCPCS codes for waived tests or provider-performed procedures.

These HCPCS codes are subject to CLIA edits, therefore a CLIA number must be submitted on claims by facilities for these HCPCS codes. The HCPCS codes listed in the Table 1 **require a facility to have** either:

- A CLIA certificate of registration (certificate type code 9);
- A CLIA certificate of compliance (certificate type code 1); or
- A CLIA certificate of accreditation (certificate type code 3).

Facilities will not be permitted to bill for the tests listed in Table 1 of this article:

- If they **do not have** a valid, current, CLIA certificate;
- If they **have** a current CLIA certificate of waiver (certificate type code 2); or
- If they **have** a current CLIA certificate for provider-performed microscopy procedures (certificate type code 4).

Effective January 19, 1993, a laboratory that holds a certificate for provider-performed microscopy procedures may perform only those tests specified as provider-performed microscopy procedures and waived tests and no others. The provider-performed microscopy procedures are described in Table 2 of this article.

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Clinical Laboratory Improvement Amendments (CLIA) Edits, continued from the previous page

The following new HCPCS codes for 2006 in the 80000 series are excluded from CLIA edits and **do not require** a facility to have any CLIA certificate:

- 86923 - Compatibility test each unit; electronic;
- 86960 - Volume reduction of blood or blood products (e.g., red blood cells or platelets), each unit; and
- 87900 - Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics.

Relevant Links

For a complete list of the specific HCPCS codes subject to CLIA edits please refer to <http://www.cms.hhs.gov/CLIA/downloads/Subject.to.CLIA.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

For a complete list of the specific HCPCS codes in the 80000 series that are excluded from CLIA edits please refer to <http://www.cms.hhs.gov/CLIA/downloads/cpt4exc.pdf> on the CMS website.

CR4321 is the official instruction issued to your carrier regarding changes mentioned in this article, MM4321. CR4321 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R865CP.pdf> on the CMS website.

If you have any questions, please contact your state's Provider Contact Center.

Table 1

The HCPCS codes listed in the chart on the next page are new for 2006 and are subject to CLIA edits. The list does not include new HCPCS codes for waived tests or provider-performed procedures. Effective January 1, 2006, the HCPCS codes listed below require a facility to have either a CLIA certificate of registration (certificate type code 9), a CLIA certificate of compliance (certificate type code 1), or a CLIA certificate of accreditation (certificate type code 3).

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Clinical Laboratory Improvement Amendments (CLIA) Edits, continued from the previous page

Table 1: 2006 HCPCS Codes Subject to CLIA Edits

HCPCS	Modifier	Description
0103T		Holotranscobalamin, quantitative
0111T		Long-chain (C20 – 22) omega-3 fatty acids in red blood cell (RBC) membranes
80195		Sirolimus
82271		Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; other sources
83631		Lactoferrin, fecal; quantitative
83695		Lipoprotein (a)
83700		Lipoprotein, blood; electrophoretic separation and quantitation
83701		Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (e.g., electrophoresis, ultracentrifugation)
83704		Lipoprotein, blood; quantitation of lipoprotein particle numbers and lipoprotein particle subclasses (e.g., by nuclear magnetic resonance spectroscopy)
83900		Molecular diagnostics; amplification of patient nucleic acid, multiplex, first two nucleic acid sequences
83907		Molecular diagnostics; lysis of cells prior to nucleic acid extraction (e.g., stool specimens, paraffin embedded tissue)
83908		Molecular diagnostics; signal amplification of patient nucleic acid, each nucleic acid sequence
83909		Molecular diagnostics; separation and identification by high resolution technique (e.g., capillary electrophoresis)
83914		Mutation identification by enzymatic ligation or primer extension, single segment, each segment (e.g., Oligonucleotide Ligation Assay (OLA), Single Base Chain Extension (SBCE), or Allele-Specific Primer Extension (ASPE))
86200		Cyclic Citrullinated Peptide (CCP), antibody
86355		B cells, total count
86357		Natural Killer (NK) cells, total count
86367		Stem cells (i.e., CD34), total count
86480		Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response
87209		Smear, primary source with interpretation; complex special stain (e.g., trichrome, iron hemotoxylin) for ova and parasites
88333		Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), initial site
88333	TC	Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), initial site
88333	26	Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), initial site
88334		Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), each additional site
88334	TC	Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), each additional site
88334	26	Pathology consultation during surgery; cytologic examination (e.g., touch prep, squash prep), each additional site

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Clinical Laboratory Improvement Amendments (CLIA) Edits, continued from the previous page

HCPCS	Modifier	Description
88384		Array-based evaluation of multiple molecular probes; 11 through 50 probes
88384	TC	Array-based evaluation of multiple molecular probes; 11 through 50 probes
88384	26	Array-based evaluation of multiple molecular probes; 11 through 50 probes
88385		Array-based evaluation of multiple molecular probes; 51 through 250 probes
88385	TC	Array-based evaluation of multiple molecular probes; 51 through 250 probes
88385	26	Array-based evaluation of multiple molecular probes; 51 through 250 probes
88386		Array-based evaluation of multiple molecular probes; 251 through 500 probes
88386	TC	Array-based evaluation of multiple molecular probes; 251 through 500
88386	26	Array-based evaluation of multiple molecular probes; 251 through 500 probes
89049		Caffeine Halothane Contracture Test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report

Effective January 19, 1993, a laboratory that holds a certificate for provider performed microscopy procedures may perform only waived tests and those tests specified as provider-performed microscopy procedures in the following table, and no others.

Table 2: Provider-Performed Microscopy Procedures

HCPCS Code	Test
0103T	Holotranscobalamin, quantitative
Q0111	Wet mounts, including preparations of vaginal, cervical, or skin specimens
Q0112	All potassium hydroxide (KOH) preparations
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital direct, qualitative examinations of vaginal or cervical mucous
81015	Urinalysis; microscopic only
81000	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy (NOTE: May only be used when the lab is using an automated dipstick urinalysis instrument approved as waived.)
81020	Urinalysis; two or three glass test
89055	Fecal leukocyte examination
89190	Nasal smears for eosinophils
G0027	Semen analysis; presence and/or motility of sperm excluding Huhner

MLN Matters MM4321

Average Sales Price (ASP) January 2007 Quarterly Update

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 Change Request (CR) 5413 which informs Medicare contractors to download the January 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2006, April 2006, July 2006, and October 2006 files.

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 OPPS, will be paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (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.

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 OPPS.

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Average Sales Price (ASP) January 2007 Quarterly Update, continued from the previous page

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 determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products 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 OPSS 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.
- Payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent (95%) of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for **drugs 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 approved by the Food and Drug Administration, are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 17, Drugs and Biologicals) for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent (100%) 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.

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Average Sales Price (ASP) January 2007 Quarterly Update, continued from the previous page

- The payment allowance limits for **new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration (FDA)** and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent (106%) of the WAC or invoice pricing, if the WAC is not published. 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. 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 December 19, 2006, the revised April, July and October 2006 and January 2007 ASP file and ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP webpage, and 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 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
April 2006	April 1, 2006 through June 30, 2006.
July 2006	July 1, 2006 through September 30, 2006.
October 2006	October 1, 2006 through December 31, 2006.
January 2007	January 1, 2007 through March 31, 2007.

Note: The absence or presence of a Healthcare Common Procedure Coding System (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) 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. 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.

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Average Sales Price (ASP) January 2007 Quarterly Update, continued from the previous page

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.

Additional Information

For complete details, please see the official instruction issued to your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHs regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1129CP.pdf> on the CMS website.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5413

Coordination of Medicare Secondary Payer (MSP) Claims for the Competitive Acquisition Program (CAP)

Provider Types Affected

Physicians who bill Medicare Carriers and Part A/B Medicare Administrative Contractors (A/B MACs) for drugs paid under the CAP program.

Background

This article and related change request (CR) 5332 provides additional details, information and instructions for CAP MSP claims and instances in which a beneficiary's MSP status is incorrectly determined. Section 303 (d) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established section 1847B of the Social Security Act requiring the implementation of a Competitive Acquisition Program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians are given a choice between buying and billing these drugs for beneficiaries with Medicare as their primary insurer under the Average Sales Price (ASP) system or obtaining these drugs from vendors selected through a competitive bidding process.

Participating CAP physicians agree to obtain all drugs included in the CAP drug category for Medicare beneficiaries who do not have another primary insurer from the approved CAP vendor. However, Medicare statutes allow for limited exceptions to this requirement.

One such exception includes Medicare Secondary Payer (MSP) situations. Section 1862(b) establishes provisions for Medicare as a secondary payer that are codified in 42 CFR Part 411. Section 1862(b) (6) specifically instructs physicians and other suppliers to identify, from information obtained from the beneficiary, payers primary to Medicare and to bill such payers prior to billing Medicare.

This CR instructs carriers to continue allowing CAP physicians to obtain physician administered drugs from entities approved by the primary plan and bill the primary payer outside the CAP vendor when Medicare beneficiaries have other insurance primary to Medicare.

Note: the term "carrier" also refers to A/B MACS as those entities replace carriers as part of Medicare's contracting reform implementation.

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Coordination of Medicare Secondary Payer (MSP) Claims, continued from the previous page

Key Points

When drugs are obtained through the CAP for beneficiaries with insurance primary to Medicare:

- Where a CAP provider renders drugs covered under the CAP to a Medicare beneficiary, who has other coverage primary to Medicare, the provider and the CAP vendor must first bill the appropriate primary insurer for the drug and the administration service.
- In situations where the participating CAP provider and the approved CAP vendor determined that Medicare was the primary payer and ordered and administered the drugs through the CAP, but before Medicare paid the claim, learned that another payer was primary to Medicare, the approved CAP vendor and the participating CAP physician should first bill the primary payer.
- In both of the preceding situations, CAP providers should submit all MSP claims for drug administration services (even if they believe no balance is due).
- Upon receipt of the primary insurer's payment, MSP claims should then be submitted by the physician to the local carrier for the administration service and by the CAP vendor to the CAP designated carrier for the drug.
- Remember that your Medicare carrier will return all CAP MSP claims from CAP providers as unprocessable if the claim does not contain a prescription number and an applicable CAP no pay modifier with the following message: RA Remark Code MA130 – Your claim contains incomplete or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

When drugs are obtained outside of the CAP for beneficiaries with Medicare:

- CAP providers should report the CAP MSP modifier on each MSP claim drug line when the participating CAP provider obtained a CAP drug outside of the CAP program because the provider determined that another insurer was primary to Medicare but when the claim processed it was determined that Medicare was primary.
- CAP providers should use the "J3" modifier temporarily until a specific CAP MSP modifier is created.
- Participating CAP physicians are required to maintain documentation in the beneficiary's medical record to provide further information on why they determined that Medicare was secondary to another payer. The local carrier may request the physician provide this documentation for their review purposes.
- Be aware that local carriers will deny claims when a primary Medicare claim is received and MSP is indicated in Medicare's records unless the CAP MSP modifier is used.

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Coordination of Medicare Secondary Payer (MSP) Claims, continued from the previous page

- If Medicare paid as primary and the CAP provider later learns that there is another primary payer to Medicare, the physician is obligated to notify Medicare by contacting the Coordination of Benefits Contractor and provide them with the MSP information.

Implementation

The implementation date for this instruction is January 2, 2007

Additional Information

For complete details including the revised sections of Chapters 3 and 5 of the *Medicare Secondary Payer (MSP) Manual* and the revised sections of Chapter 17 of the *Medicare Claims Processing Manual*, please see the official instruction, CR5332, issued to your Medicare Carrier or A/B MAC regarding this change. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R57MSP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R1088CP.pdf> on the CMS website.

For additional information about the implementation of the CAP program you may want to review the following *MLN Matters* articles on the CMS website:

MM4404 (MMA Competitive Acquisition Program (CAP) for Part B Drugs Physician Election) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4404.pdf> on the CMS website.

MM4309 (MMA - Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf> on the CMS website.

MM5079 (Competitive Acquisition Program (CAP) - Creation of Automated Tables for Provider Information, Expansion of CAP Fee Schedule File Layout, and Additional Instructions for Claims Received from Railroad Retirement Board Beneficiaries) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf> on the CMS website.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5332

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Regional Carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed

CR 5346, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective January 2, 2007. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits transactions.

The remittance advice remark code list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at <http://wpc-edi.com/codes>. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5346, effective on and after January 1, 2007.

CMS has also developed a new tool to help you search for a specific category of code and that tool is at <http://www.cmsremarkcodes.info>. Note that this website does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You can see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest remittance advice remark code and claim adjustment reason code updates by going to CR 5346, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1087CP.pdf> on the CMS website.

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

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Remittance Advice Remark Code and Claim Adjustment Reason Code Update, continued from the previous page

Remittance Advice Remark Code Changes

Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
N370	New	Billing exceeds the rental months covered/approved by the payer.	Medicare initiated
N371	New	Alert: title of this equipment must be transferred to the patient. *	Medicare initiated
N372	New	Only reasonable and necessary maintenance/service charges are covered.	Medicare initiated
MA02	Modified	If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.	Modified effective 8/1/06
M114	Modified	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, contact your local contractor.	Modified effective 8/1/06
N199	Modified	Additional payment/recoupment approved based on payer-initiated review/audit.	Modified effective 8/1/06
There are no deactivated remittance advice remark code changes			

***NOTE: Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, in some cases another/other remark code(s), for an adjustment. Newly created informational codes will have "Alert" in the text to identify them as informational rather than explanatory codes. For example, this informational code is sent per state regulation, but does not explain any adjustment:**

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

These informational codes will be used only if specific information needs to be communicated but not as default codes

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*Remittance Advice Remark Code and Claim Adjustment Reason Code Update,
continued from the previous page*

Reason Code Changes

Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
196	New	Claim/service denied based on prior payer's coverage determination	New as of June, 2006
16	Modified	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.)	Modified as of February, 2002 and June, 2006
17	Modified	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.)	Modified as of February, 2002 and June, 2006
96	Modified	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.)	Modified as of February, 2002 and June, 2006
125	Modified	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.)	Modified as of February, 2002 and June, 2006
43	Retired	Gramm-Rudman reduction.	Modified as of June, 06, and deactivated on July 1, 2006

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5346

Infrared Therapy Devices

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Regional Carriers (DMERCs), DME Medicare Administrative Contractors (DME/MACs), Fiscal Intermediaries (FIs), and/or Regional Home Health Intermediaries (RHHIs), for the use of infrared therapy devices for treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5421. Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services (CMS) has made a National Coverage Determination (NCD) stating the use of infrared and/or near-infrared light and/or heat, including Monochromatic Infrared Energy (MIRE), **is non-covered for the treatment**, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Background

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

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

- **Effective for services performed on or after October 24, 2006**, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) are non-covered as DME or PT/OT services when used for the treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.
- Claims will be denied with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9 codes:
 - 250.60-250.63,
 - 354.4, 354.5, 354.9,
 - 355.1-355.4,
 - 355.6-355.9

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Infrared Therapy Devices, continued from the previous page

- 356.0, 356.2-356.4, 356.8-356.9,
 - 357.0-357.7,
 - 674.10, 674.12, 674.14, 674.20, 674.22, 674.24,
 - 707.00-707.07, 707.09-707.15, 707.19,
 - 870.0-879.9,
 - 880.00-887.79,
 - 890.0-897.7, or
 - 998.31-998.32.
- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects Types Of Bills (TOBs) 12X, 13X, 22X, 23X, 34X, 74X, 75X and 85X.
 - If you submit a claim for one of the non-covered services, your patient will receive the Medicare Summary Notice (MSN) message stating “This service was not covered by Medicare at the time you received it”. The Spanish translation is: “Este servicio no estaba cubierto por Medicare cuando usted lo recibió.”
 - If you submit a claim for one of the non-covered services you will receive a remittance advice notice that reads: Claim Adjustment Reason Code 50, “These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.”
 - Physicians, physical therapists, occupational therapists, Outpatient Rehabilitation Facilities (ORFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Home Health Agencies (HHAs), and hospital outpatient departments should note that you are liable if the service is performed, unless the beneficiary signs an Advanced Beneficiary Notice (ABN).
 - DME suppliers and HHA be aware that you are liable for the devices when they are supplied, unless the beneficiary signs an ABN.

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Infrared Therapy Devices, continued from the previous page

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5421) issued to your Medicare A/B MAC, FI, DME MAC, RHHI, or carrier. There are actually two transmittals associated with CR5421. The first is the national coverage determination transmittal, located at <http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf> on the CMS website. In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1127CP.pdf> on the CMS site.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters 5421

2007 Medicare Physician Fee Schedule Database (MPFSDB) – Emergency Update

Note: This article was revised on January 12, 2007 to reflect that CR5459 was revised by CMS. The article was revised to reflect the new CR release date, transmittal number, and the Web address for accessing CR5459. All other information remains the same.

Provider Types Affected

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

Background

This article and related Change Request (CR) 5459 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS Final Rule. CR5459 amends those payment files.

Key Points

You may wish to review **Attachment 1** of the CR5459, which is located at <http://www.cms.hhs.gov/Transmittals/downloads/R1143CP.pdf> on the CMS website. The following key points summarize the specifics that are identified in the attachment to CR5459.

- The physician fee schedule status indicators for oncology demonstration codes G9050 to G9062 for 2007 are “I”; these **codes are invalid** for Medicare use in 2007, thus, payment will not be made for these codes in 2007. (For more details on the Oncology Demonstration, see the MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4219.pdf> on the CMS site.)
- Oncology **demonstration codes** G9076, G9081, G9082, G9118, G9119, G9120, G9121, G9122, and G9127 are **deleted and will not be paid for services provided after December 31, 2006 in 2007.**
- Active Oncology demonstration codes in the range G9063 to G9139 have status indicators of “M” on the Medicare physician fee schedule database. (Note: See requirement above for discontinued oncology demonstration codes within this range). Those filing claims may report these codes for oncology disease status in 2007, but payment will not be made for these codes for services provided after December 31, 2006.
- Category II codes 3047F and 3076F and Category III code 0152T have been deleted for 2007.
- G codes G0377 and G8348 through G8368 will be added to the 2007 HCPCS file.

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2007 Medicare Physician Fee Schedule Database (MPFSDB) – Emergency Update, continued from the previous page

- Q codes Q4083, Q 4084, Q4085, and Q4086 will be added, even though they are not on the 2007 HCPCS file. Note that corresponding ASP amounts will be reflected in updated 2007 ASP pricing files to be posted to the CMS website.
- Incorrect Diagnostic Supervision Indicators were assigned to some codes and these codes and correct indicators are listed in the attachment to CR5459.
- Corrected Multiple Procedure Codes of 0 and Diagnostic Family Imaging Indicators of 99 have been assigned to codes G0389, G0389-TC, 70554, 70554-TC, 70555, 70555-TC, 76776, and 76776-TC.
- As identified in the attachment to CR5459, correct work, practice expense, and/or malpractice relative value units (RVUs) have been assigned for codes 44180, 44186, 73223, 73223-26, 76775, 76775-TC, 76775-26, 93503, 93539, 93540, 93541, 93542, 93543, 93544, 93545, 95060, 95065, G0389, G0389-TC, and G0389-26.
- As a result of the Tax Relief and Health Care Act of 2006, effective January 1, 2007, G0377 (Administration of vaccine for Part D drug) is added to the MPFS with a status indicator of X. Payment for HCPCS code G0377 is linked to CPT code 90471 (just as payment is made for G0008, G0009, and G0010). For 2007 only, the legislation provides for Part B to pay for the administration of a covered Part D vaccine. When a physician administers a Part D vaccine, the physician should use G0377 to bill the local carrier for the administration of the vaccine. Payment to the physician will be on an assigned basis only. Normal beneficiary deductible and coinsurance requirements apply to this administration. Payment for Part D covered vaccines is made solely by the participating Prescription Drug Plan. Medicare will not pay for the vaccine itself.
- Effective January 1, 2007, the following G codes are added to the MPFSDB with a status indicator of M: G8348, G8349, G8350, G8351, G8352, G8353, G8354, G8355, G8356, G8357, G8358, G8359, G8360, G8361, G8362, G8363, G8364, G8365, G8366, G8367, and G8368.
- CMS has established separate payment for sodium hyaluronate products that have come on the market since October 2003. Four interim Q codes are in effect for these products as of January 1, 2007, i.e., Q4083 (Hyalgan/supartz inj per dose), Q4084 (Synvisc inj per dose), Q4085 (Euflexxa inj per doses), and Q4086 (Orthovisc inj per dose).
- Procedure status I is assigned to J7319, effective January 1, 2007.
- Effective January 1, 2007, the HCPCS codes Q9958, Q9959, Q9960, Q9961, Q9962, Q9963, and Q9964 will be assigned to procedure status indicator E.

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2007 Medicare Physician Fee Schedule Database (MPFSDB) – Emergency Update, continued from the previous page

- As a courtesy to the public, CMS has established RVUs for a number of codes, even though the codes are either bundled or not valid for Medicare purposes. These codes are 38204, 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214, and 38215. The RVUs are listed for these codes in the attachment to CR5459.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5459) 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/R1152CP.pdf> on the CMS website.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5459

Revisions to Procedures to Establish Good Cause and Qualified Independent Contractor (QIC) Jurisdictions

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (A/B Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs), carriers, Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Regional Carriers (DMERCs) or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

Background

The purpose of CR 5386 is to notify providers and suppliers of the restructured Part B/DME QIC jurisdictions. Under the new jurisdictions, three QICs will process reconsiderations as follows:

- Two QICs will process reconsiderations of carrier and A/B MAC re-determinations effective November 15, 2006 for contractors that process claims in the North jurisdiction and January 1, 2007 for contractors that process claims in the South jurisdiction. Your contractor will reference the appropriate QIC in the Medicare Redetermination Notice (MRN). In order to expedite your request for appeal, please make sure you follow the instructions on your MRN regarding where to submit your request for reconsideration. If you have already submitted a reconsideration request with the incumbent QIC, please do not submit a duplicate request; and
- The third QIC will process all reconsiderations of DMERC and DME MAC re-determinations effective December 1, 2006.

Key Points

- Your contractor will reference the appropriate QIC with jurisdiction in the redetermination letter.
- One QIC will process all reconsiderations of DME claims.
- There are two QIC jurisdictions for Part B claims: a North jurisdiction and a South jurisdiction.
 - **The North** QIC jurisdiction includes the following states: Alaska, Arizona, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, District of Columbia, New York, Pennsylvania, New Jersey, Delaware, Maryland, Ohio, Kentucky, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Missouri, Iowa, Washington, Oregon, Nevada, Idaho, Wyoming, Montana, California, Utah, Kansas, Nebraska, North Dakota, South Dakota, Hawaii, American Samoa, Guam, and the Northern Marianas Islands.
 - **The South** QIC jurisdiction is comprised of the following states: Colorado, Connecticut, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, Florida, North Carolina, South Carolina, Virginia, West Virginia, Puerto Rico, and Virgin Islands.

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Revisions to Procedures to Establish Good Cause and Qualified Independent Contractor (QIC) Jurisdictions, continued from the previous page

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5386) issued to your Medicare A/B MAC, FI, carrier, RHHI, DMERC or DME MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1136CP.pdf> on the CMS website.

For additional supporting information that details the general appeals process in initial determinations please see MLN Matters article MM4019 at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4019.pdf> on the CMS website.

MLN Matters article MM3530, which can be found at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3530.pdf> on the CMS website, provides a detailed explanation of the term 'vacate a dismissal' as well as more background information about the second level of appeals process for Medicare Part A and Part B claims called 'reconsiderations.'

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5386

Medically Unlikely Edits (MUEs)

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare Fiscal Intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Regional Carriers (DMERCs), DME Medicare Administrative contractors (DME/MACs), and/or Regional Home Health Intermediaries (RHHIs).

Background

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as MUEs. The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs.

- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- The MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria or Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

Key Points

- CR5402 states that Medicare contractors will deny the claim line or RTP claims with units of service that exceed MUE criteria and pay the other services on the claim as part of initial claims processing activities.
- The MUEs that will be implemented by this notice are based on anatomic considerations. CMS believes that most MUEs based on anatomic considerations are not controversial, but CMS will allow and require an appeals process for those claim line items that are denied as a result of an MUE edit.
- An appeals process will not be allowed or required for claims that are RTP'ed as a result of an MUE edit. Instead, providers should resubmit corrected claims.
- This set of MUEs that is based on anatomical considerations addresses approximately 2,800 codes.
- Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"), and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

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Medically Unlikely Edits (MUEs), continued from the previous page

Additional Information

For complete details regarding CR 5402 please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R178PI.pdf> on the CMS website.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5402

IVIG Administration—Medicare Payment for Pre-administration-Related Services

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

You may bill for pre-administration-related services associated with Intravenous Immune Globulin (IVIG) administration (HCPCS code G0332) during calendar year 2007. The pre-administration-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.

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

Make sure that your billing staff is aware that they must include your claim for the IVIG pre-administration-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 pre-administration-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 pre-administration-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 pre-administration-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.

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IVIG Administration—Medicare Payment for Pre-administration-Related Services, continued from the previous page

- 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: 12x, 13x, 85x).
- You need to use HCPCS code G0332 –Pre-administration-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 pre-administration 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.
- Your claims for pre-administration-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 website

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5428

2007 Medicare Physician Fee Schedule (MPFS) and Extension of the Participating Enrollment Period

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries, which are paid based on the MPFS.

What You Need to Know

This article is based on Change Request (CR) 5448. The Tax Relief and Health Care Act of 2006 changes the update to the 2007 conversion factor for services paid under the MPFS, and this change is effective for services provided on or after January 1, 2007.

The Tax Relief and Health Care Act of 2006 set the 2007 conversion factor for physician payment at the same level as in 2006 (\$37.8975), reversing the statutorily mandated 5.0 percent negative update. However, it does not maintain 2007 physician payments at 2006 levels. There are a number of other factors that affect payment rates for 2007.

Other changes adopted in the physician fee schedule final rule that affect 2007 payment rates include changes in the practice expense RVU-setting methodology, refinements to the practice expense RVUs, re-weighting of geographic adjustment factors, limits on payments for imaging services required by the Deficit Reduction Act, and other annual refinements including coding changes.

Both the Centers for Medicare & Medicaid Services (CMS) and your local Medicare contractor will display the resulting new fees on its Website no later than December 31, 2006. (Carriers' Websites will display the new fees including the PAR/NONPAR, and limiting charge rates.) The revised fees under the 2007 MPFS will be effective for services provided on or after January 1, 2007.

The change to the 2007 MPFS will also result in an extension of the participation enrollment period to February 14, 2007. Therefore, the participation enrollment period runs from November 15, 2006, through February 14, 2007. The effective date for any participation change is January 1, 2007.

Physicians who wish to sign an agreement and become Participating (Par) physicians can access the Par Agreement (CMS-460 form) from the CD which was mailed to all physicians last November. Physicians can also request the CMS-460 form from their local Medicare contractor. Existing Par physicians who no longer wish to be Par must notify their Medicare contractor in writing of their decision to terminate their Par agreement. Physicians who change their Par status during the extension period should begin to submit claims based on their new Par status.

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2007 Medicare Physician Fee Schedule (MPFS) and Extension of the Participating Enrollment Period, continued from the previous page

Background

Based on the new Tax Relief and Health Care Act of 2006, Change Request 5448 emphasizes the following:

- 1) Change to the 2007 MPFS rates;
- 2) Capability of Medicare contractors to begin processing claims for services paid under the MPFS with the new fees beginning January 2, 2007; and
- 3) Extension of the participation enrollment period to February 14, 2007.

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

Note: Services not paid under the MPFS (e.g., Durable Medical Equipment (DME), clinical lab, etc) **are not impacted by this instruction**, and claims containing those services will also be processed beginning January 2, 2007.

In addition, Medicare contractors will:

- Have hard copies of the new 2007 MPFS to mail to those physicians/practitioners that do not have ready Internet access and request a copy;
- Not charge providers requesting hard copy 2007 MPFS who do NOT have ready Internet access;
- Charge a reasonable fee for mailing hard copies of the 2007 MPFS to providers who do have ready Internet access but want a hard copy for convenience;
- Accept any participation changes made during the extended enrollment period that are received or post-marked by February 14, 2007. All participation changes are effective January 1, 2007; and
- Load their updated local Medicare Participating Physician/Supplier Directories (MEDPARDs) to their Websites within 30 days following the close of the extended enrollment period.

Additional Information

For complete details, please see the official instruction, CR5448, issued to your carrier, FI, RHHI, or A/B MAC regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1131CP.pdf> on the CMS website.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5448

Influenza Virus and the Pneumococcal Vaccines Payment Allowances

Provider Types Affected

Physicians, non-physician practitioners, providers and suppliers billing Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs) and carriers for the influenza and pneumococcal vaccines.

Background

This article and related change request (CR) 5365 provide the payment allowances for the following influenza virus vaccines: CPT codes 90655, 90656, 90657, and 90658 as well as the pneumococcal vaccine (CPT 90732) when payment is based on 95 percent of the Average Wholesale Price (AWP).

Key Points

- Effective September 1, 2006, the Medicare Part B payment allowance for CPT 90655 is \$15.377.
- Effective September 1, 2006, the Medicare Part B payment allowance for CPT 90656 is \$16.574.
- Effective September 1, 2006, the Medicare Part B payment allowance for CPT 90657 is \$6.312.
- Effective September 1, 2006, the Medicare Part B payment allowance for CPT 90658 is \$12.624.
- Effective September 1, 2006, the Medicare Part B payment allowance for CPT 90732 is \$27.028.
- Annual Part B deductible and coinsurance amounts do not apply to these services.
- All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- Note that your carrier or FI may also cover CPT 90660 (FluMist, a nasal influenza vaccine) if they determine its use is medically reasonable and necessary for the beneficiary.
- Please take note of this pricing information to ensure accurate claims processing. Your carrier or FI will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, they will adjust claims brought to their attention.

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Influenza Virus and the Pneumococcal Vaccines Payment Allowances, continued from the previous page

Implementation

While the implementation of these rates will occur on January 22, 2007, the rates apply to dates of service on or after September 1, 2006.

Additional Information

To view CR 5365, the official instruction issued to your Medicare FI, Carrier or A/B MAC on this issue, visit <http://www.cms.hhs.gov/Transmittals/downloads/R256OTN.pdf> on the CMS website.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5365

Cardiac Output Monitoring by Thoracic Electrical Bioimpedance (TEB)

Provider Types Affected

Physicians who bill Part A/B Medicare Administrative Contractors (A/B MACs), or Medicare carriers for services to Medicare beneficiaries

Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered the Medicare coverage policy for TEB for drug-resistant hypertension and decided to retain current coverage as written in section 20.16 of the *National Coverage Determinations (NCD) Manual*.

Effective for dates of service on and after November 24, 2006, the current policies for cardiac output monitoring by TEB listed at section 20.16 of the *NCD Manual* will remain the same. Medicare A/B MACs and carriers will continue to make reasonable and necessary determinations for the use of TEB related to drug-resistant hypertension only. All other coverage and non-coverage policies at section 20.16 remain in effect.

Additional Information

For complete details regarding this Change Request (CR) including the revised section of 20.16 of the NCD manual, please see the official instruction (CR5414) issued to your Medicare A/B MAC or carrier. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/R63NCD.pdf> on the CMS website.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5414

Private Contracting- Definition of Physician/Practitioner

Provider Types Affected

Registered dietitians or nutrition professionals providing services to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 5426 which updates the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 15, Section 40.4) to include registered dietitians and nutrition professionals in the list of practitioners who can opt out of Medicare if certain conditions are met, and to provide services through private contracts that would otherwise be covered by Medicare.

Background

Prior to enactment of the Medicare Benefits Improvement and Protection Act of 2000 (BIPA), the Social Security Act (Section 1802(b)(5)(C)) did not include registered dietitians or nutrition professionals among the list of practitioners who may choose to opt out of Medicare.

BIPA (Section 105(d)) amended the definition of practitioner included in the Social Security Act (Section 1842(b)(18)(c)) to include registered dietitians or nutrition professionals in the list of practitioners who can opt out of Medicare if certain conditions are met.

CR5426 amends the *Medicare Benefit Policy Manual* (Publication 100-02, Chapter 15, Section 40.4 (Definition of Physician/Practitioner)) to include registered dietitians and nutrition professionals to be consistent with the Social Security Act (Section 1802(b)(5)(C)). The revised section 40.4 (Pub. 100-02, Chapter 15) is attached to CR5426.

Additional Information

The official instruction, CR5426, issued to your carrier or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R62BP.pdf> on the CMS website.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5426

Correction to CR4136: New Waived Tests

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

Only this sentence has been revised. All other information remains as it is written in CR4136.

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

Provider Types Affected

All providers and suppliers billing Medicare carriers for laboratory tests

Background

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

Key Points

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

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

Implementation

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

Additional Information

The official instruction, CR5131, issued to your Medicare carrier regarding this change can be found at <http://www.cms.hhs.gov/transmittals/downloads/R988CP.pdf> on the CMS website.

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters MM5131

Outpatient Therapy - Additional DRA Mandated Service Edits

Note: CMS has rescinded transmittal 1016 and replaced it with transmittal 1019 to correct typographical errors in the business requirement section addressed to contractors. This replacement does not affect the instructions provided in the CMS Internet-only-manual Pub 100-04, Medicare Claim Processing, and the information in section 20.2 – Reporting of Service Unit with HCPCS remains the same. Transmittal 1016 was posted to the provided educational website <http://www.floridamedicare.com> on August 3, 2006.

The Centers for Medicare & Medicaid Services (CMS) has issued instructions that provide additional limitations on outpatient therapy services, consistent with the provisions of the Deficit Reduction Act of 2005 Section 5107 requires limitations on outpatient therapy services, for the purpose of identifying and eliminating improper payments.

Certain services are limited to certain numbers of units per day for physical therapy, occupational therapy and speech-language pathology, separately to control inappropriate billing. CMS Internet-only-manual Pub 100-04, Medicare Claim Processing, Chapter 5, Part B Outpatient Rehabilitation and CORF/OPT Services, Section 20.2, Reporting of Service Units with HCPCS has been revised to incorporate these instructions and proper billing examples.

Reporting of Service Units with HCPCS

General

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

Timed and Untimed Codes

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

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Outpatient Therapy - Additional DRA Mandated Service Edit, continued from the previous page

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

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

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

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

Counting Minutes for Timed Codes in 15 Minute Units

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

Units Number of Minutes

- 1 unit: ≥ 8 minutes through 22 minutes
- 2 units: ≥ 23 minutes through 37 minutes
- 3 units: ≥ 38 minutes through 52 minutes
- 4 units: ≥ 53 minutes through 67 minutes
- 5 units: ≥ 68 minutes through 82 minutes
- 6 units: ≥ 83 minutes through 97 minutes
- 7 units: ≥ 98 minutes through 112 minutes
- 8 units: ≥ 113 minutes through 127 minutes

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

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Outpatient Therapy - Additional DRA Mandated Service Edit, continued from the previous page

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

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

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

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

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

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

Example 1

24 minutes of neuromuscular reeducation, CPT code 97112
23 minutes of therapeutic exercise, CPT code 97110
Total timed code treatment time was 47 minutes.

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

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

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Outpatient Therapy - Additional DRA Mandated Service Edit, continued from the previous page

Example 2

20 minutes of neuromuscular reeducation (97112)
20 minutes therapeutic exercise (97110)
40 Total timed code minutes.

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

Example 3

33 minutes of therapeutic exercise (97110)
7 minutes of manual therapy (97140)
40 Total timed minutes.

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

Example 4

18 minutes of therapeutic exercise (97110)
13 minutes of manual therapy (97140)
10 minutes of gait training (97116)
8 minutes of ultrasound (97035)
49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Example 5

7 minutes of neuromuscular reeducation (97112)
7 minutes therapeutic exercise (97110)
7 minutes manual therapy (97140)
21 Total timed minutes

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Outpatient Therapy - Additional DRA Mandated Service Edit, continued from the previous page

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

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

Specific Limits for HCPCS

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

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

Use the chart in the following manner:

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

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Outpatient Therapy - Additional DRA Mandated Service Edit, continued from the previous page

- When a “sometimes therapy” code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart below per patient, per provider/supplier, per day.

HCPCS	Code Description and Claim Line Outlier/Edit Details	Timed or Untimed	PT Allowed units	OT Allowed units	SLP Allowed units	Physician/NPP NOT under Therapy POC
92506	Speech/hearing evaluation	Untimed	0	0	1	N/A
92597	<i>Oral speech device eval</i>	Untimed	1	1	1	N/A
92607	<i>Ex for speech device rx, 1hr</i>	Timed	0	1	1	N/A
92611	<i>Motion fluoroscopy/swallow</i>	Untimed	0	1	1	1
92612	<i>Endoscope swallow test (fees)</i>	Untimed	0	1	1	1
92614	<i>Laryngoscopic sensory test</i>	Untimed	0	1	1	1
92616	<i>Fees w/laryngeal sense test</i>	Untimed	0	1	1	1
95833	<i>Limb muscle testing, manual</i>	Untimed	1	1	0	1
95834	<i>Limb muscle testing, manual</i>	Untimed	1	1	0	1
96110	<i>Developmental test, lim</i>	Untimed	1	1	1	1
96111	<i>Developmental test, extend</i>	Untimed	1	1	1	1
97001	<i>PT evaluation</i>	Untimed	1	0	0	N/A
97002	<i>PT re-evaluation</i>	Untimed	1	0	0	N/A
97003	<i>OT evaluation</i>	Untimed	0	1	0	N/A
97004	<i>OT re-evaluation</i>	Untimed	0	1	0	N/A

CR 5253, Transmittal 1019

Medicare Fee for Service (FFS) Implementation of the National Provider Identifier (NPI)

Provider Types Affected

ALL FFS providers who bill Medicare

Background

The Centers for Medicare & Medicaid Services (CMS) is publishing this Special Edition (SE) article to remind providers that on May 23, 2007, the NPI will replace health care provider identifiers that are in use today in HIPAA standard transactions. Health care providers should remember that getting an NPI is free and easy. Time is running out! It is estimated that, once a provider obtains an NPI, it may take up to 120 days to implement the NPI in current business practices. The following key points will assist Medicare providers as they transition from the application stage to the implementation stage to ensure NPI readiness.

Applying for an NPI

Visit the official CMS source for NPI-related information, including how to apply for an NPI, as well as free educational products, at <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS website.

Key Points

The following are the critical content areas for the Medicare FFS Health plan implementation of the NPI.

Medicare Legacy Numbers

After the compliance date, Medicare providers must begin submitting their NPIs instead of their Medicare legacy identifiers on claims they send to Medicare. A provider's Taxpayer Identification Number (TIN), which is the provider's Social Security Number or Employer Identification Number, will continue to be used when a provider needs to be identified as a taxpayer in HIPAA standard transactions. The Implementation Guides for each of the standard transactions indicate when it is necessary to identify a provider as a taxpayer.

- A related MLN Matters article, MM4023, may be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf> on the CMS website.

Electronic File Interchange (EFI)

Health industry organizations that are approved by CMS as Electronic File Interchange Organizations (EFIOs) can submit NPI application data for health care providers, including Medicare providers, in electronic files to the National Plan and Provider Enumeration System (NPPES) after obtaining the permission of the health care providers to do so. This process is called Electronic File Interchange (EFI). For health care providers who are approached by EFIOs, EFI is an alternative to having to apply for their NPIs via the web-based or paper application process. Providers, who are enumerated via EFI, receive their NPI notifications from the EFIO that had them enumerated. These notifications are not generated from NPPES.

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Medicare Fee for Service (FFS) Implementation of the National Provider Identifier (NPI), continued from the previous page

Designation of Subparts

CMS reminds Medicare providers to visit Medicare's Subparts Expectation Paper (entitled, "Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA," and located at

<http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf>

on the CMS NPI web page) for suggestions on how to determine their subparts. Remember, no health plan, not even Medicare, can instruct a provider on how to enumerate subparts. This is a business decision that the organization provider must make considering its unique business operations.

Durable Medical Equipment (DME) Enumeration Requirement

As mentioned in the paper entitled, "Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA" (see link in preceding paragraph), Medicare DME suppliers are required to obtain an NPI for every location. The only exception to this requirement is the situation in which a Medicare DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI (the individual's NPI) regardless of the number of locations the DME supplier may have.

Submitting your NPI on Medicare Electronic Claims

Until further notice, CMS recommends that Medicare providers submit claims using both the NPI and legacy number. *Claims submitted with only an NPI may be rejected/returned as unprocessable if Medicare systems are unable to properly match the incoming NPI with a legacy number. The provider will then need to resubmit the claim with the appropriate legacy number.*

A related MLN Matters article, MM5378, may be viewed at

<http://www.cms.hhs.gov/mlnmattersarticles/downloads/mm5378.pdf> on the CMS website.

Required Use of the NPI on Medicare Paper Claims

Medicare, as a health plan, will require the use of the NPI on its paper claims. The paper claim forms used by Medicare have been revised to accommodate use of the NPI. There will be transition periods for each of the revised forms. While the NPI cannot be used on the current paper claim forms, providers may begin using the NPI on the revised forms once the transition period for each form begins.

- The *MLN Matters* article related the transition from UB-92 to UB 04 can be viewed at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf> on the CMS website.
- The *MLN Matters* article related to the transition from CMS 1500 (12/90) to CMS 1500 (08/05) can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf> on the CMS website.

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Medicare Fee for Service (FFS) Implementation of the National Provider Identifier (NPI), continued from the previous page

Required Use of Taxonomy Codes on Institutional Provider Claims

Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a **taxonomy code** on all claims submitted to their FI. Taxonomy codes shall be reported by these facilities whether or not the facility has applied for NPIs for each of their subparts. Institutional providers that do not currently bill Medicare for services performed by their subparts are not required to use taxonomy codes on their claims to Medicare.

A recent *MLN Matters* article, MM5243, discusses this requirement in more detail and may be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5243.pdf> on the CMS website.

National Council of Prescription Drug Plans (NCPDP) Claims

The NCPDP format was designed to permit a prescription drug claim to be submitted with either an NPI or a legacy identifier, but no more than one identifier may be reported for a provider (retail pharmacy or prescribing physician) per claim. From October 1, 2006, through May 22, 2007, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have this information). (Refer to *MLN Matters* article MM4023 at the link provided earlier in this article.)

Medicare Remittance Advice Print Software

The 835-PC-Print and Medicare Remit Easy Print software were modified to enable either the NPI or a Medicare legacy number, or both, if included in the 835. (Refer to *MLN Matters* article MM4023.)

Communicating Your NPI to Medicare

Medicare providers should know that there is no "special process" or any need to call to communicate NPIs to the Medicare program. NPIs can be shared with the Medicare program by using them on your claims along with your legacy identifier. Secondly, for providers applying for Medicare enrollment, an NPI must be reported on the CMS-855 enrollment application (along with a photocopy of the NPI notification received by the provider from the NPPES or from an EFIO). Existing Medicare providers must provide their NPIs when making any changes to their Medicare provider enrollment information.

Sharing NPIs

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business, and with health plans that request their NPIs. In fact, as outlined in current regulation, all providers, including Medicare providers, that are HIPAA covered providers **must** share their NPI with other providers, health plans, clearinghouses, and any entity that may need those NPIs for use in standard transactions, including the need to identify an ordering or a referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their NPIs for them.

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Medicare Fee for Service (FFS) Implementation of the National Provider Identifier (NPI), continued from the previous page

Additional Information

NPI Questions

CMS continues to update our Frequently Asked Questions (FAQs) to answer many of the NPI questions we receive on a daily basis. Visit the following link to view all NPI FAQs:

http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=Qjr3YRYh&p_lva=&p_li=&p_page=1&p_cv=&p_pv=&p_prods=0&p_cats=&p_hidden_prods=&prod_lv1=0&p_search_text=NPI&p_new_search=1&p_search_type=answers.search_nl

Providers should remember that the NPI Enumerator can only answer/address the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter (i.e., for those providers enumerated via paper or web-based applications)
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at CustomerService@NPIenumerator.com.

Please Note: The NPI Enumerator's operation is closed on federal holidays. The federal holidays observed are: New Year's Day, Independence Day, Veteran's Day, Christmas Day, Martin Luther King's Birthday, Washington's Birthday, Memorial Day, Labor Day, Columbus Day, and Thanksgiving.

MLN Matters Special Edition SE0679

The New HHS National Clearinghouse for Long-Term Care Information Website

Provider Types Affected

Physicians and providers and their staff who provide services to Medicare beneficiaries

Provider Action Needed

This special edition article is for informational purposes and may assist providers when counseling their patients regarding long-term care. The article announces that the U.S. Department of Health and Human Services (HHS) has developed a consumer website to help beneficiaries carefully prepare a safe and secure strategy for their future healthcare needs. Resources on the new website include a Long-Term Care Planning Kit and detailed information on what long term care needs are; step-by-step planning; and financial preparation. The free Long-Term Planning Kit and resources to start the planning process can be found at <http://www.longtermcare.gov>. The planning kit may also be ordered by phone by calling 1-866-PLAN-LTC (1-866-752-6582). TTY users should call 800-427-5605.

Background

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to inform you that the National Clearinghouse for Long-Term Care Information is a new user-friendly consumer website that provides in-depth objective information on understanding, planning, and paying for long-term care. This important website is a collaborative effort between the Administration on Aging (AoA), the Centers for Medicare & Medicaid Services (CMS), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE), and it was developed as part of the Deficit Reduction Act (DRA) of 2005 (Section 6021 (d)) which allocated funds to the U.S. Department of Health and Human Services (HHS) to help Americans take an active role in planning for their future.

Located at <http://www.longtermcare.gov>, the Clearinghouse website features information and tools to help people better understand the risks for and the costs of long-term care, and it is part of ongoing efforts to increase public awareness about the importance of advance planning for future long-term care needs. Given that one of the biggest barriers to planning is misinformation about long-term care, the Clearinghouse website is designed to provide people with the trusted information and resources they need to take an active role in planning for possible future health care needs.

With an emphasis on the importance of future planning, the website provides a number of resources and interactive tools to help people prepare for their future healthcare needs including:

- Objective information on **specific long-term care planning options**, including the pros and cons of private financing options such as personal savings, long-term care insurance, reverse mortgages, and other options;
- In-depth information on the **availability and limitations of Medicaid** in all states, including eligibility and estate recovery requirements;

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The New HHS National Clearinghouse for Long-Term Care Information Website, continued from the previous page

- **State-specific long-term care insurance Partnership Programs** under Medicaid;
- **Planning resources** that include an interactive savings calculator, information on the costs of care across the United States, and examples illustrating how individuals have planned successfully; and
- **State and national contact information** for a range of long-term care programs and planning services.

The website also includes the Long-Term Care Planning Kit, initially developed for the “Own Your Future” Campaign. Information regarding this campaign is in MLN Matters article SE0671, located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0671.pdf> on the CMS site.

A survey showed that consumers who received the Long-Term Care Planning Kit were twice as likely to take some type of planning action, including evaluating their existing coverage, talking to a financial planner, buying long-term care insurance, or considering a reverse mortgage, as those who did not receive the Planning Kit. The Planning Kit can be ordered or downloaded on the Clearinghouse website at <http://www.longtermcare.gov>, as well as calling 1-866-PLAN-LTC. It can also be ordered or downloaded at <http://www.aoa.gov/ownyourfuture>.

Additional Information

For more information about the “Own Your Future” campaign and the National Clearinghouse for Long-Term Care Information, please visit <http://www.longtermcare.gov>.

MLN Matters Special Edition SE0680

Medicare Fee-for-Service (FFS) and Medicare Advantage (MA) Eligibility System Issues

Provider Types Affected

Physicians and providers who bill Medicare carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs).

Provider Action Needed

Be aware that Medicare reverses FFS payments when MA enrollments with retroactive dates are processed by CMS systems. Also know what action to take when there are conflicts in CMS eligibility data.

Background

In some cases, MA enrollments with retroactive dates are processed by CMS systems. The result is that Medicare may pay for the services rendered twice; once under fee-for-service and second by the MA payment systems in the monthly capitation rate to the plan.

The FFS contractor reverses the fee-for-service payment, recovers from the provider, and the provider then bills the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the Medicare fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary.

FFS Claims Paid in Error

Due to CMS beneficiary eligibility system updates, beneficiaries enrolled in MA organizations may be identified as having been inappropriately paid on a fee-for-service basis. FIs, carriers, and A/B MACs will adjust these claims and seek overpayments. Where such an overpayment is recovered from a provider, the related remittance advice for the claim adjustment will indicate Reason Code 24, which states: 'Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan'.

Whenever CMS reverses fee-for-service payments as a result of confirmed retroactive enrollment in an MA plan, the provider must bill the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary.

Information on which plan to contact can be determined through an eligibility inquiry or by contacting the beneficiary directly. To associate plan identification numbers with the plan name, go to http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage on the CMS website.

The Medicare beneficiary call center representatives at 1-800-MEDICARE have been trained to answer beneficiary inquiries that may arise in these situations.

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Medicare Fee-for-Service (FFS) and Medicare Advantage (MA) Eligibility System Issues, continued from the previous page

Eligibility Data Discrepancies: Provider Action

Despite system corrections, there remain a small number (under 1000) of beneficiary eligibility records that have not been updated. CMS is working to correct this. In the interim, if a provider has information from the MA plan that conflicts with information received from an FI, carrier, or A/B MAC in reply to an eligibility inquiry, the provider should call the FI/carrier/MAC provider call center. The call center representative will check Medicare's Common Working File System and if the conflict is confirmed the provider will be referred to the CMS Regional Office for resolution.

Additional Information

If you have any questions, please contact your state's Provider Contact Center.

MLN Matters Special Edition SE0681

Approval For X STOP® Interspinous Process Decompression (IDP) System

Based on FDA approval, Cahaba GBA, LLC will approve the use of the X STOP® IDP device. This device is indicated in the treatment of patients age 50 and over suffering from neurogenic intermittent claudication secondary to a confirmed diagnosis of lumbar stenosis.

X STOP® is indicated for those patients with moderately impaired physical function who experience relief in flexion from their symptoms of leg/buttock/groin pain, with or without back pain, and have undergone a regimen of at least six months of nonoperative treatment. It may be implanted at one or two lumbar levels in patients in whom operative treatment is indicated at no more than two levels.

This procedure is payable for claims billed with ICD-9 codes 724.02 (spinal stenosis, lumbar region) and 349.9 (use for neurogenic intermittent claudication) and dates of service February 1, 2007 and after. The following CPT codes have been designated for this procedure:

- 0171T:** Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single;
- 0172T:** Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; each additional level.

Update to Local Coverage Determination for Creation or Revision of Arteriovenous Fistula (L24646)

Effective: February 1, 2007

Notification of the final Local Coverage Determination for Creation or Revision of Arteriovenous Fistula was published in the November 2005 issue of the Medicare newsletter. The LCD lists ICD-9-CM codes that support medical necessity. Effective for claims with dates of service February 1, 2007 and after, the LCD is updated to include coverage for ICD-9 codes 729.81, 996.70, and 996.74.

As the result of the process for consolidation of LCD identification (ID) Numbers for Cahaba GBA. LLC, which began in January 2007, a new LCD ID number was assigned to this LCD for Alabama, Georgia and Mississippi effective for February 1, 2007. For dates of service prior to February 1, 2007, please refer to the following retired LCD ID Numbers:

- **Alabama – L6076**
- **Georgia – L20034**
- **Mississippi – L20098**
-

A copy of the updated Local Coverage Determination can be found at the following web address: <http://www.cahabagba.com> where you can click on your state for the information you need.

Update to Local Coverage Determination for Colony Stimulating Factors (L24482)

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Effective: February 1, 2007

Notification of the final Local Coverage Determination for Colony Stimulating Factors was published in the July 2005 issue of the Medicare newsletter. The LCD lists ICD-9-CM codes that support medical necessity. Effective for claims with dates of service February 1, 2007 and after, the LCD is updated to include the following ICD-9 codes for HCPCS codes **J1440, J1441, J2820**:

V42.81 (Organ or tissue replaced by transplant - bone marrow)

V42.82 (Organ or tissue replaced by transplant - peripheral stem cells)

The note for ICD-9 code V42.9 under 'ICD-9 Codes that Support Medical Necessity' is being changed from: "This diagnosis should be billed when colony stimulating factors are given to bone marrow or stem cell recipients" to "This diagnosis should be billed when V42.81 or V42.82 is not appropriate".

As the result of the process for consolidation of LCD Identification (ID) Numbers for Cahaba GBA, LLC, which began in January 2007, a new LCD ID Number was assigned to this LCD for Alabama, Georgia and Mississippi effective for February 1, 2007.

- **Alabama – L6037**
- **Georgia – L19298**
- **Mississippi – L18052**

A copy of the updated Local Coverage Determination can be found at the following web address: <http://www.cahabagba.com> where you can click on your state for the information you need.

Update to Local Coverage Determination for Hyaluronate Joint Injections

- Alabama – L6789
- Georgia – L20965
- Mississippi – L17610

Effective: January 1, 2007

In the January 2007 Newline, we published notification of a revision to this LCD to reflect the Annual CPT/HCPCS Update for 2007 which removed J7317, J7320 and J3590 and added J7319 (Hyaluronan (Sodium Hyaluronate) or derivative, intra-articular injection, per injection). CMS reversed the decision to fold all sodium hyaluronate reimbursement codes into one code, and published new Q codes for each sodium hyaluronate product. For 2007, Medicare will recognize the following Q codes for purposes of billing sodium hyaluronate injections.

Q4083 - Hyaluronan or derivative, Hyalgan or Supartz, for intra-articular injection, per dose

Q4084 - Hyaluronan or derivative, Synvisc, for intra-articular injection, per dose

Q4085 - Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose

Q4086 - Hyaluronan or derivative, Orthovisc, for intra-articular injection, per dose

The LCD has been updated to include these HCPCS codes. These codes replace the use of J7317, J7319, J7320 and J3590 (as applicable).

A copy of the updated Local Coverage Determination can be found at the following web address: <http://www.cahabagba.com> where you can click on your state for the information you need.

How to Complete the Revised CMS-1500 (08/05) Claim Form Using Your National Provider Identifier (NPI) Number

Cahaba Government Benefits Administrators, LLC (Cahaba GBA) has implemented the revision of the CMS-1500 claim form to accommodate the reporting of the National Provider Identifier (NPI). The revised CMS-1500 claim form was effective January 2, 2007.

January 2, 2007	Health plans, clearinghouses and other information support vendors should be ready to handle and accept the revised CMS-1500 (08/05) claim form.
January 2, 2007- March 30, 2007	Providers can use either the current CMS-1500 (12/90) claim form OR the revised form. Medicare encourages providers to use both NPI and legacy information.
April 2, 2007	The current CMS-1500 (12/90) claim form version is discontinued; only the revised CMS-1500 (08/05) claim form is to be used. Medicare encourages providers to use both NPI and legacy information.
May 23, 2007	Only the revised CMS-1500 (08/05) claim form will be accepted. Providers must report NPI information only.

Effective April 2, 2007, only the revised CMS-1500 (08/05) form will be accepted by Medicare Part B. When using the revised CMS1500 (08/05) claim form prior to May 23, 2007, Medicare encourages providers to report both legacy numbers (prefixed by a qualifier) and your new NPI.

Effective May 23, 2007, only the revised CMS-1500 (08/05) claim form will be accepted and only NPI information should be reported.

The instructions listed in this article are specific to the items on the revised CMS1500 (08/05) claim form that are affected by the addition of the National Provider Identifier (NPI). For complete Item by Item instructions refer to Change Request 4293 dated March 31, 2006 and Change Request (CR) 5060 dated July 28, 2006. www.cms.hhs.gov/transmittals/downloads/R1058CP.pdf.

The following items are changes and descriptions on the revised CMS-1500 (08/05) form and must be completed correctly to assure claim acceptance.

Item 17a - Enter the CMS assigned UPIN of the referring/ordering physician listed in Item 17. The UPIN may be reported on the revised CMS-1500 (08/05) claim form **until May 22, 2007**, and **MUST** be reported if an NPI is not available.

Item 17b - Enter the NPI of the referring/ordering physician listed in Item 17 as soon as it is available.

continued on the next page

How to Complete the Revised CMS-1500 (08/05) Claim Form, continued from the previous page

Prior to May 23, 2007: Enter the qualifier 1G in the first block of 17a followed by the Legacy UPIN.

Qualifier	Legacy		
↓	↓		
<table border="1"> <tr> <td style="background-color: #cccccc;">17a. 1G D99999</td> </tr> <tr> <td>17b. NPI 1234567890</td> </tr> </table>		17a. 1G D99999	17b. NPI 1234567890
17a. 1G D99999			
17b. NPI 1234567890			
	↑		
	NPI		

Effective May 23, 2007: (Leave the shaded area blank)

Legacy	
↓	
<table border="1"> <tr> <td style="background-color: #cccccc;">17a. </td> </tr> </table>	17a.
17a.	
NPI	
↓	
<table border="1"> <tr> <td>17b. NPI 1234567890</td> </tr> </table>	17b. NPI 1234567890
17b. NPI 1234567890	

NOTE: Item 17a and/or Item 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, Item 17a is not to be reported but Item 17b **MUST** be reported when a service was ordered or referred by a physician.

When a claim involves multiple referring and/or ordering physicians, a separate CMS-1500 claim form shall be used for each ordering/referring physician. All physicians who order or refer Medicare beneficiaries or services must report either an NPI or UPIN or both prior to May 23, 2007. After that date, an NPI (but not a UPIN) must be reported even though they may never bill Medicare directly. A physician who has not been assigned a UPIN shall contact the Medicare carrier. Refer to Publication 100-08, Chapter 14, Section 14.6 of the CMS Online manual systems for additional information regarding UPINs. Refer to: www.cms.hhs.gov/manuals > Internet-Only Manuals (IOMs).

Item 24 - The six service lines in Item 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. **It is not intended to allow the billing of 12 service lines.** Submitting more than 6 line items on one CMS-1500 claim form would cause the claim to be returned without processing.

continued on the next page

How to Complete the Revised CMS-1500 (08/05) Claim Form, continued from the previous page

Item 24I - Prior to May 23, 2007, enter the ID qualifier 1C in the shaded portion.

Item 24J - Prior to May 23, 2007, enter the rendering provider's PIN in the shaded portion.

24.

I. ID QUAL.	J. RENDERING PROVIDER ID. #
1C	9999999999
NPI	

Qualifier

Legacy Number

NPI

Effective May 23, 2007, do not use the shaded portion. Enter the rendering provider's NPI number in the lower portion.

Item 24K - There is no Item 24K on this version.

Item 32a -- Enter the NPI of the service facility.

Item 32b - Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility. **Effective May 23, 2007, Item 32b is not to be reported.**

32.

a. 123456789	b. 1C 123445566A
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NPI #

Qualifier

Legacy Provider #

Item 33a - Effective May 23, 2007, **you MUST** enter the NPI of the billing provider or group. This is a required field.

Effective May 23, 2007, do not use the shaded portion. Enter the rendering provider's NPI number in the lower portion.

Item 24K - There is no Item 24K on this version.

continued on the next page

How to Complete the Revised CMS-1500 (08/05) Claim Form, continued from the previous page

Item 33a - Effective May 23, 2007, **you MUST** enter the NPI of the billing provider or group. This is a required field.

Item 33b - Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group prior to May 23, 2007. **Effective May 23, 2007, Item 33b is not to be reported. Leave this field blank.**

33.

a. 123456789	b. 1C 123445566A
NPI #	Qualifier Legacy Provider #

Please refer to the pdf link at the bottom of this page for the revised claim form with NPI references.

For additional information, all providers should refer to the CMS website at www.cms.hhs.gov/NationalProvIdentStand. NPI applications may be submitted online at <https://nppes.cms.hhs.gov> or you can call the NPI enumerator to request a paper application at **1-800-465-3203**.

For more information about how to complete your revised CMS1500 (08/05) claim form, please refer to Change Request (CR) 5060 for NPI billing instructions. This CR can be located at www.cms.hhs.gov/transmittals/downloads/R1058CP.pdf.

If you have any questions, please contact the Provider Contact Center servicing your state at:

Alabama Providers: 1-866-539-5598

Georgia Providers: 1-877-567-7271

Mississippi Providers: 1-866-419-9454

[NPI Claim Form With References](#)

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Please rate the publication by circling the number of your choice.
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Usefulness of the information.

10 9 8 7 6 5 4 3 2 1

Organization and layout of the information.

10 9 8 7 6 5 4 3 2 1

Design and physical appearance of the publication.

10 9 8 7 6 5 4 3 2 1

Value of *Medicare B Newslines* as a reference item.

10 9 8 7 6 5 4 3 2 1

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Yes _____ No _____

What can we do to make *Medicare B Newslines* a more effective publication?

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