

# 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



January 2007

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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](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).

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## 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](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.

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## 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

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

2007 Holiday Schedule	
Monday, January 1	New Year's Day
Monday, January 15	Dr. Martin Luther King, Jr.'s Birthday
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

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The Cahaba GBA E-mail Notification Service is available. Currently, we have 5,310 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.

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## 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/](http://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>.

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## Schedule of Upcoming Events Provider Outreach and Education

Date	Course/Event	Location
01/17/07	Ask Cahaba B Teleconference Dial-In: 1-877-239-9402 Conf. ID: 1321334	AL, GA & MS Part B Providers

For additional details and registration regarding any event above, please visit our website at [www.cahabagba.com/apps/course\\_registration/al/calendar.jsp](http://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](http://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](http://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

## Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)

**Note:** This article was changed on December 8, 2006 to add emphasize that this coverage is for a one-time only service and it must also be as a result of a referral from an initial preventive physical exam and is also subject to other limitations as discussed in this article and in CR5235.

### Provider Types Affected

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

### Background

This article and related CR5235 highlight the fact that section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysms (AAA) under Medicare Part B, effective for services furnished on or after January 1, 2007, as a result of a referral from an Initial Preventive Physical Examination (IPPE) and subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test.

### Key Points

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

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

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*Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), continued from the previous page*

**Payment**

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

**Fls will pay for the AAA screening only** when the services are performed in a hospital, including a **CAH, IHS facility, an SNF, RHC, or FQHC** and submitted on one of the following Types Of Bills (TOBs): **12X, 13X, 22X, 23X, 71X, 73X, 85X**.

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

<b>Facility</b>	<b>Type of Bill</b>	<b>Payment</b>
Hospitals subject to OPPS	12X, 13X	OPPS
Method I and Method II Critical Access Hospitals (CAHs)	12X and 85X	101% of reasonable cost
IHS providers	13X, revenue code 051X	OMB-approved outpatient per visit All Inclusive Rate (AIR)
IHS providers	12X, revenue code 024X	All-inclusive inpatient ancillary per diem rate
IHS CAHs	85X, revenue code 051X	101% of the all-inclusive facility specific per visit rate
IHS CAHs	12X, revenue code 024X	101% of the all-inclusive facility specific per diem rate
SNFs **	22X, 23X	Non-facility rate on the MPFS
RHCs*	71X, revenue code 052X	All-inclusive encounter rate

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*Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), continued from the previous page*

Facility	Type of Bill	Payment
FQHCs*	73X, revenue code 052X	All-inclusive encounter rate
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12X, 13X	94% of provider submitted charges or according to the terms of the Maryland Waiver

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

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

### **Implementation**

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

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

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

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

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*Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), continued from the previous page*

**Additional Information**

The official instructions for CR 5235, issued to your Medicare carrier, FI, MAC, FQHC, RHC, SNF, or CAH regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1113CP.pdf> on the CMS website. The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 18, has been updated to include the requirements to implement section 5112 of the DRA of 2005. The new sections of this chapter address the payment and allowable settings for AAA and the sections are attached to CR5235.

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

**MLN Matters MM5235**

## Laboratory Competitive Bidding Demonstration

### Provider Types Affected

Physicians and all providers who bill Medicare carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the Competitive Bidding Demonstration area (CBA) sites

### Background

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

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

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

### Key Points

This article and Change Request (CR) 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this article and CR5359 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

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

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*Laboratory Competitive Bidding Demonstration, continued from the previous page*

### **Required Bidders**

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

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

### **Passive Laboratories**

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

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

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

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.
- **Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considered “passive-ESRD” laboratories.** Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration tests provided to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007 through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

### **Winners**

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

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*Laboratory Competitive Bidding Demonstration, continued from the previous page*

**Non-Winners**

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

Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

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

**Demonstration-Covered Laboratory Tests**

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

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

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

**Demonstration Sites**

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

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

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

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*Laboratory Competitive Bidding Demonstration, continued from the previous page*

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

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

***Implementation***

CR5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

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

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

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

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

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

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

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*Laboratory Competitive Bidding Demonstration, continued from the previous page*

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

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

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

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

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

**Implementation**

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

**Additional Information**

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

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

**MLN Matters MM5359**

## 2007 Clinical Laboratory Fee Schedule - Annual Update

### Provider Types Affected

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

### Provider Action Needed

This article and related CR5362 contain important information regarding:

- The 2007 annual updates to the clinical laboratory fee schedule
- Mapping for new codes for clinical laboratory tests, and
- Laboratory costs related to services subject to reasonable charge payments.

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

### Key Points

#### **Update to Fees**

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

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

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

#### **National Minimum Payment Amounts**

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

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

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

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*2007 Clinical Laboratory Fee Schedule - Annual Update, continued from the previous page*

**National Limitation Amounts (Maximum)**

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

**Access to 2007 Clinical Laboratory Fee Schedule**

Internet access to the 2007 clinical laboratory fee schedule data file should be available after November 20, 2006, at <http://www.cms.hhs.gov/ClinicalLabFeeSched> on the Centers for Medicare & Medicaid Services (CMS) website.

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

**Public Comments**

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

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

**Additional Pricing Information**

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

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

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

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

**Organ or Disease Oriented Panel Codes**

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

**Mapping Information**

CMS advises the following:

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

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### Laboratory Costs Subject to Reasonable Charge Payment in 2006

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

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

When these services are performed for independent dialysis facility patients, *Medicare Claims Processing Manual*, Chapter 8, §60.3 instructs the reasonable charge basis applies. However, when these services are performed for hospital based renal dialysis facility patients, payment is made on a reasonable cost basis. Also, when these services are performed for hospital outpatients, payment is made under the hospital Outpatient Prospective Payment System (OPPS).

### Blood Products

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

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

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

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

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**Transfusion Medicine**

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

**Reproductive Medicine Procedures**

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

**Additional Information**

For complete details regarding CR5362, please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1122CP.pdf> on the CMS website.

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

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

**MLN Matters MM5362**

## **Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

### **Provider Types Affected**

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

### **Provider Action Needed**

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

### **Background**

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

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

Payment on a fee schedule basis is required for:

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

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

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*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), continued from the previous page*

### Deleted HCPCS Codes

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

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

### Added HCPCS

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

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

### Payment Rates for Oxygen and Oxygen Equipment

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

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*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), continued from the previous page*

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

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

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

**Gap-Fill Items**

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

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

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*Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), continued from the previous page*

**Additional Information**

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

For complete details regarding this Change Request (CR) please see the official instruction (CR5417) issued to your Medicare A/B MAC, DMERC, DME MAC, FI, RHHI, or carrier. That instruction may be viewed by going to

<http://www.cms.hhs.gov/Transmittals/downloads/R1125CP.pdf> on the CMS website.

**MLN Matters MM5417**

## Outpatient Therapy Cap Exceptions Clarifications

**Note: This article was revised on December 4, 2006, to reflect the correct effective and implementation dates as described in CR5271, which CMS recently revised. While CR5271 also reflects effective and implementation dates in January 2007 for Medicare system changes, the information in this article clarifies existing processes.**

### Provider Types Affected

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

### Provider Action Needed

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

### Background

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

### Review of this exception process

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

Exception Processes fall into two categories:

#### 1) Automatic Process Exceptions

Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if they meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Publication 100-04, Chapter 5, (as revised by CR5271) for exception from the therapy cap for 2006.

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*Outpatient Therapy Cap Exceptions Clarifications, continued from the previous page*

## **2) Manual Process Exceptions**

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

### **The clarifications to questions generated from CR 4364**

Your FI, RHHI, or carrier:

1. Will grant exceptions for any number of medically necessary services for 2006 that meet the automatic process exception criteria, if the beneficiary meets the conditions described in *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR5271).
2. Will grant an exception to the therapy cap, by approving any number of additional therapy treatment days, when these additional treatment days are deemed medically necessary based on documentation that you have submitted for services provided in 2006.
3. Will utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance in which you do not submit all required documentation with the exception request for services provided in 2006.
4. Must reply as soon as practicable to a request for exception for services provided in 2006. They will grant an exception to the therapy cap, approving the number of treatment days that you or the beneficiary request (not to exceed 15 future treatment days), if they do not make a decision within 10 business days of receipt of any request and appropriate documentation.
5. Will allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.
6. Will follow the manual description for allowing exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process for services provided in 2006.
7. Will allow automatic process exceptions when complexities occur in combination with other conditions that **may or may not be on the list** in the *Medicare Claims Processing Manual* in 2006.
8. Will, when a patient is being treated under the care of two physicians for separate conditions, accept as appropriate documentation either 1) A combined plan of care certified by one of the physicians/NPPs, or 2) Two separate plans of care certified by separate physicians/NPPs.

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*Outpatient Therapy Cap Exceptions Clarifications, continued from the previous page*

9. Will update the list of exceptions in 2006 according to the changes provided in this transmittal. You should be aware that they may expand (but not contract) this list if their manual process exception decisions lead them to believe further exceptions should be allowed.
10. Will not require the additional documentation that is encouraged but not required in the manuals.
11. Will interpret a referral or an order or a plan of care dated after an evaluation, as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.
12. Will not deny payment for re-evaluation **only** because an evaluation or re-evaluation was recently done, as long as documentation supports the need for re-evaluation. A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.
13. Will require clinicians to write Progress Reports at least during each Progress Report Period. Note that required elements of the Progress Report that are written into the Treatment Notes or in a Plan of Care may acceptably fulfill the requirement for a Progress Report. In these instances, a separate Progress Report is not required.
14. Will require, on pre or postpay medical review of documentation, that when the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each Progress Report Period and sign the Progress Report.
15. Will continue to use Medicare Summary Notice (MSN) message 38.18 on all Medicare MSN forms, both in English and in Spanish. This message reads: "ALERT: Coverage by Medicare will be limited for outpatient Physical Therapy (PT), Speech-Language Pathology (SLP), and Occupational Therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are \$1,740 for PT and SLP combined and \$1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE."
16. Will continue to enforce Local Coverage Determinations (LCDs).

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*Outpatient Therapy Cap Exceptions Clarifications, continued from the previous page*

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

**Additional Information**

You can find more information about outpatient therapy cap exceptions by going to CR5271, issued in 3 transmittals. As attachments to those transmittals, you will find updated manual sections for:

The *Medicare Claims Processing Manual*, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation). (This will be at <http://www.cms.hhs.gov/Transmittals/downloads/R1106Cp.pdf>.)

The *Medicare Program Integrity Manual*, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.1.1 (Exception from the Uniform Dollar Limitation ("Therapy Cap")). (This will be at <http://www.cms.hhs.gov/Transmittals/downloads/R171PI.pdf>); and,

The *Medicare Benefit Policy Manual*, Chapter 15, Section 220.3 (Documentation Requirements for Therapy Services.) This is available at <http://www.cms.hhs.gov/Transmittals/downloads/R60BP.pdf> on the CMS site.

These manual revisions include numerous additional changes and clarifications.

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

**MLN Matters MM5271**

## **Competitive Acquisition Program (CAP) – Claim Processing for Not Otherwise Classified (“NOC”) Drugs**

### **Provider Types Affected**

Physicians participating in the Medicare Part B Drug CAP

### **Impact on Providers**

This article is based on Change Request (CR) 5259, which describes the process for adding Not Otherwise Classified (NOC) Drugs to the CAP beginning in 2007. It provides additional details, information and instructions for the implementation of the CAP as outlined previously in CRs 4064, 4306, 4309 and 5079 and the *MLN Matters* articles related to those CRs.

### **Background**

As discussed in the November 21, 2005 CAP final rule ([http://www.access.gpo.gov/su\\_docs/fedreg/a051121c.html](http://www.access.gpo.gov/su_docs/fedreg/a051121c.html)) and in response to public comments about beneficiary access to new medications, CMS provided for the addition of NOC drugs to the CAP beginning in 2007. CMS believes that the addition of NOC drugs to the CAP will improve beneficiaries' access to newly marketed drugs that have a national sales price, will decrease the reliance on buy and bill acquisition and will further simplify the drug acquisition process for physicians who have elected to participate in the CAP.

### **Process To Add NOC Drugs to a CAP Vendor's Drug List**

The process for adding NOC drugs to the CAP will basically follow the process for adding other drugs to the CAP as described in CR5079. An approved CAP vendor will be required to submit a written request to add specific NOC drugs to the CAP designated carrier. The request must include:

- A rationale for the proposed change,
- A discussion of the impact on the CAP (including safety, waste, etc.), and
- The potential for cost savings.

CMS will define a list of CAP NOC drugs that the approved CAP vendor must use when requesting the addition of NOC drugs to the CAP. The CAP NOC drug list will be based on the ASP NOC list, but will include only drugs that are both likely to fit the existing CAP drug category (or categories) and drugs that have a single national ASP-based payment amount. The CAP NOC drug list will be posted on the CMS CAP website and updated quarterly.

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*Competitive Acquisition Program (CAP) – Claim Processing for Not Otherwise Classified (“NOC”) Drugs, continued from the previous page*

If approved, changes will become effective at the beginning of the following quarter. CMS will post the changes on the CMS website (<http://www.cms.hhs.gov/CompetitiveAcquisforBios/>) and notify the carriers and participating CAP physicians of any changes on a quarterly basis. Participating CAP physicians will be notified of changes to their approved CAP vendor’s CAP drug list on a quarterly basis and at least 30 days before the approved changes are due to take effect. CAP drug list approvals apply only to the CAP vendor who submitted the request and to the category identified on the request. Therefore, each vendor’s drug list may contain different drugs after changes to the initial drug list are approved. The CAP NOC drug payment amount will be at the same rate as published on the ASP NOC file consistent with the next quarterly update, and the payment amount will be updated annually as for other CAP drugs.

**CAP NOC Claims Submission Requirements**

CMS requires the use of a CAP-specific Q code (Q4082 Drug/bio NOC part B drug CAP) for CAP NOC drug claims in order to distinguish CAP NOC drug claims from ASP NOC claims and to prevent the CAP claims from being paid outside the Medicare Part B drug CAP. Physician drug administration claims for CAP NOC drugs are required to use the CAP-specific NOC Q-code: Q4082 Drug/bio NOC part B drug CAP and identify the specific NOC drug that had been administered in Item 19 on paper claims or Loop 2300 Segment NTE on electronic claims. Physician claims must also contain the appropriate CAP modifiers (J1, J2, J3) All other CAP claim parameters will remain the same

**Note:** Physicians who have elected to participate in the CAP should continue to use ASP NOC codes when billing for NOC drugs that are outside the CAP. Also remember that physicians who participate in the CAP are required to obtain all CAP drugs on the updates from the approved CAP vendor unless medical necessity requires the use of a formulation not supplied by the vendor.

**Returned CAP NOC Claims**

For the following three situations, if:

- The claim is submitted with a CAP NOC code, but the description does not match a CAP NOC drug on the approved list; or
- The claim is submitted with a CAP NOC code by a non-CAP physician; or
- The claim is submitted with a J NOC code with a description of a CAP approved NOC drug.

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*Competitive Acquisition Program (CAP) – Claim Processing for Not Otherwise Classified (“NOC”) Drugs, continued from the previous page*

Then:

- Claims will be returned to physicians with a reason code of 16 (Claim/service lacks information needed for adjudication) and remark code MA 130 (Your claims contain incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable).
- Remark code N350 (Missing/incomplete/invalid description of a service for a NOC code or unlisted procedure) will also appear in the first situation.
- Remark code N56 (Procedure code billed is not correct/valid for the services billed or the date of service billed) will appear in the second and third situations.

**Implementation**

The implementation date for CR5259 is January 2, 2007.

**Additional Information**

Section 303 (d) of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, requires the implementation of a Competitive Acquisition Program (CAP) for Medicare Part B drugs and biologicals (“drugs”) not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians will be given a choice between buying and billing these drugs under the Average Sales Price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. A participating CAP physician will submit a claim for drug administration to the Medicare local carrier. An approved CAP vendor will submit a claim for the drug product to the CAP Medicare designated carrier.

Change Request (CR) 5259 is not a stand-alone CR. It provides additional details, information, and instructions for the implementation of the Competitive Acquisition Program (CAP) as outlined in:

C 4064 (<http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf>;  
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>),

CR4306 (<http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf>),

CR4309 (<http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf>;  
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf>) and

CR 5079 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>;  
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf>).

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*Competitive Acquisition Program (CAP) – Claim Processing for Not Otherwise Classified (“NOC”) Drugs, continued from the previous page*

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1034CP.pdf> on the CMS website.

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

**MLN Matters MM5259**

## **Cavernous Nerves Electrical Stimulation with Penile Plethysmograph**

### **Provider Types Affected**

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

### **Provider Action Needed**

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

CR5294, from which this article is taken, announces` the results of a National Coverage Determination (NCD) addressing Cavernous Nerves Electrical Stimulation with Penile Plethysmography performed for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

It states that CMS, after reviewing the evidence, has determined that this test is not reasonable and necessary for Medicare beneficiaries undergoing these procedures. Make sure that your billing staffs are aware of this NCD.

### **Background**

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

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

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

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*Cavernous Nerves Electrical Stimulation with Penile Plethysmograph, continued from the previous page*

CR5294, from which this article is taken, announces the results of this NCD. It provides that CMS has reviewed the evidence and determined that: 1) Cavernous Nerves Electrical Stimulation with Penile Plethysmography is not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures, and 2) this test is **noncovered** under Medicare (as specified the *Medicare National Coverage Manual* (100-03, Section 160.26 (Cavernous Nerves Electrical Stimulation with Penile Plethysmography)).

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

Physicians should use HCPCS code 58899 to bill this for test. Your FIs and carriers will suspend claims containing this code to determine whether this test is the service being billed, and will deny the line item associated with it, using Medicare Summary Notice 21.11 (This test was not covered by Medicare at the time you received it).

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

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

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

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*Cavernous Nerves Electrical Stimulation with Penile Plethysmograph, continued from the previous page*

**Additional Information**

You can find more information about payment for Cavernous Nerves Electrical Stimulation with Penile Plethysmography by going to CR5294, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R61NCD.pdf> on the CMS site. You will find revised section 160.26 (Cavernous Nerves Electrical Stimulation with Penile Plethysmography) of the *Medicare National Coverage Manual* (Publication 100-03) as an attachment to this CR.

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

**MLN Matters MM5294**

## New 2007 Current Procedural Terminology (CPT) Mammography Codes

### Provider Types Affected

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

### Provider Action Needed

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

Failure to submit the correct codes will cause your claims to be returned and not processed. Make sure that your billing staffs are aware of the CPT code changes.

### Background

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

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

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

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

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*New 2007 Current Procedural Terminology (CPT) Mammography Codes, continued from the previous page*

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

**Additional Information**

You can find more information about the new 2007 mammography CPT codes by going to CR5327, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1070CP.pdf> on the CMS website.

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

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

**MLN Matters MM5327**

## Duplicate Claim Edit for the Technical Component (TC) of Radiology and Pathology Laboratory Services

### Provider Types Affected

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

### Provider Action Needed

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

### Background

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

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

### Key Points

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

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*Duplicate Claim Edit for the Technical Component (TC) of Radiology and Pathology Laboratory Services, continued from the previous page*

- Effective for claims received on or after April 1, 2007, Medicare will reject/deny reject a Part B TC or globally billed pathology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay when billed by a physician/supplier. Such services will also be rejected/denied when they match with a date of service of a hospital outpatient bill (bill types 13X and 85X0 previously processed by Medicare).
- If providers submit a TC of a radiology or pathology service with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay the carrier will use Remittance Advice Reason Code 109 "Claim not covered by this payer/contractor." when denying a service line item.
- Where Medicare systems detect that a Part B TC or globally billed radiology or physician pathology service has been paid and Medicare subsequently receives a hospital inpatient bill for the same date of service, the Medicare carrier will adjust a TC of a radiology or physician pathology service line item and recoup the payment made for that service from the physician/supplier. The Medicare carrier will also adjust a TC of a pathology service for an outpatient claim. The same Remittance Advice Reason Code of 109 will be used in such cases.
- Effective for claims received on or after April 1, 2007, the carrier will deny an incoming Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a posted hospital inpatient bill. Again, the carrier will use Remittance Advice Reason Code 109. In addition, the Medicare carrier will recoup payment made to the physician/supplier if a subsequent hospital inpatient bill is received for those same services.
- Carriers will not search their files to either retract payment or retroactively pay claims prior to the implementation of CR5347. However, they will adjust claims if they are brought to their attention.

**Implementation**

This change will be implemented on April 2, 2007.

**Additional Information**

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

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

**MLN Matters MM5347**

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

### **Provider Types Affected**

Physicians, suppliers and providers billing Medicare carriers, Durable Medical Equipment Regional Carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), or Part A/B Medicare Administrative Contractors (A/B MACs) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

### **Provider Action Needed**

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

### **Background**

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

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

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

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

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

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*Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses, continued from the previous page*

These tables are:

**Dialysis Supplies Billed With AX Modifier**

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

**Dialysis Supplies Billed Without AX Modifier**

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

**Dialysis Equipment Billed With AX Modifier**

E0210NU	E1632	E1637	E1639
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**Dialysis Equipment Billed Without AX Modifier**

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

Carriers and A/B MACs will make payment for splints and casts furnished in 2007 based on the lower of the actual charge or the payment limits established for these codes.

**Carriers, DMERCs and DME Medicare Administrative Contractors (MACs)** to will use the 2007 reasonable charges or the same payment limits to pay claims for items furnished from January 1, 2007 through December 31, 2007. **Those 2007 payment limits are in the table at the end of this article.**

**Additional Information**

Instructions for calculating:

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

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*Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses, continued from the previous page*

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

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

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

**2007 Payment Limits for Splints and Casts**

Code	Payment Limit	Code	Payment Limit
A4565	\$7.19	Q4025	\$31.60
Q4001	\$40.91	Q4026	\$98.64
Q4002	\$154.63	Q4027	\$15.80
Q4003	\$29.39	Q4028	\$49.33
Q4004	\$101.74	Q4029	\$24.16
Q4005	\$10.83	Q4030	\$63.59
Q4006	\$24.42	Q4031	\$12.08
Q4007	\$5.43	Q4032	\$31.79
Q4008	\$12.21	Q4033	\$22.53
Q4009	\$7.23	Q4034	\$56.05
Q4010	\$16.28	Q4035	\$11.27
Q4011	\$3.61	Q4036	\$28.03
Q4012	\$8.14	Q4037	\$13.75
Q4013	\$13.16	Q4038	\$34.44
Q4014	\$22.21	Q4039	\$6.89
Q4015	\$6.58	Q4040	\$17.22
Q4016	\$11.10	Q4041	\$16.71
Q4017	\$7.61	Q4042	\$28.53
Q4018	\$12.14	Q4043	\$8.36
Q4019	\$3.81	Q4044	\$14.27
Q4020	\$6.08	Q4045	\$9.70
Q4021	\$5.63	Q4046	\$15.61
Q4022	\$10.17	Q4047	\$4.84
Q4023	\$2.83	Q4048	\$7.81
Q4024	\$5.08	Q4049	\$1.77

**MLN Matters MM5382**

## **Clinical Laboratory Improvement Amendment Act (CLIA) - Tests Granted Waived Status under CLIA**

The Clinical Laboratory Improvement Amendment Act (CLIA) of 1998, Public Law 100-578, amended §353 of the Public Health Services Act to extend to the Department of Health and Human Services authority to regulate all laboratories that examine human specimens to provide information to assess, diagnose, prevent or treat any disease or impairment. CLIA mandates that virtually all laboratories including Physician Office Laboratories (POLs) meet applicable Federal requirements and have a CLIA certificate in order to receive reimbursement from Federal programs. CLIA also lists requirements for laboratories performing only certain tests to be eligible for a Certificate of Waiver or a Certificate for Physician-Performed Microscopy (PPMP) procedures.

**The latest tests approved and/or changed by the Food and Drug Administration, as waived tests, have been shaded for your convenience.**

When you submit claims for diagnostic laboratory services to Medicare, you must enter your CLIA certification number in Item 23 of the CMS-1500 claim form or in the equivalent field position for electronic submitters. A claim that is received without this number will be a Returned Unprocessable Claim (RUC). RUC rejections have no appeal rights, and must be resubmitted with correct information for payment.

If the same physician has performed tests in more than one laboratory on the same CMS-1500 claim form, the appropriate CLIA number should be associated with the tests. This will require the provider to submit a separate claim for each location (CLIA number) where a test was performed.

For more information about CLIA, visit CMS's website at [www.cms.hhs.gov/clia/](http://www.cms.hhs.gov/clia/). If you are uncertain of your CLIA certification, contact:

Betty Logan  
Georgia Department of Human Resources  
Office of Regulatory Services  
Diagnostic Services Unit  
2 Peachtree Street 33-391  
Atlanta, GA 30303-3142  
404 657-5447

### **Types of CLIA Certificates**

**Certificate of Waiver** - This certificate is issued to a laboratory to perform only waived tests.

**Certificate for Provider-Performed Microscopy Procedures (PPMP)** - This certificate is issued to a laboratory in which a physician, midlevel practitioner, or dentist performs tests listed in the PPMP chart. This certificate also permits providers to perform laboratory services listed in the CLIA Waived Tests chart.

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*Clinical Laboratory Improvement Amendment Act (CLIA) - Tests Granted Waived Status under CLIA, continued from the previous page*

- Certificate of Registration - This certificate is issued to a laboratory that enables the entity to conduct moderate or high complexity laboratory testing or both until the entity is determined by survey to be in compliance with the CLIA regulations.

**Due to the size of the list of tests granted waived status under CLIA, it is being made available in Adobe's Portable Document Format (PDF). Adobe's Acrobat Reader is required and is available, free of charge, from Adobe's website.**

**[Download the list](#) here.**

**MLN Matters MM5404**

## **Medicare Part B Drug Competitive Acquisition Program (CAP): Do Not Bill a Prescription Order Number More Than Once**

### **Provider Types Affected**

Physicians participating in the CAP for Part B Drugs and Biologicals

### **Provider Action Needed**

A CAP prescription order number must only be used on one claim line. It should not be reused on another claim line on the same claim, and it should not be reused on any other claim.

The Centers for Medicare & Medicaid Services (CMS) has found some CAP claims are being processed incorrectly when CAP prescription order numbers are reused when billing for CAP drugs. The prescription order number is intended to be a unique identifier, and it should not be reused.

### **Background**

This special edition article is being released by the CMS to provide a clarification on billing for drugs under the CAP for Part B Drugs and Biologicals.

### **CAP Claims Processing**

In order for the CAP vendor's drug claim to be processed and paid, physicians must submit:

- A corresponding drug administration claim; and
- A no-pay claim line for the drug.

The vendor's drug claim and the physician's claim are then matched in the claims processing system by the prescription order number, and the vendor is paid for the drug that was administered.

A physician's no-pay claim line consists of:

- The CAP drug's Health Care Procedure Coding System (HCPCS) code,
- A billed amount (which must not equal zero), and
- The number of HCPCS billing units that were administered.

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*Medicare Part B Drug Competitive Acquisition Program (CAP): Do Not Bill a Prescription Order Number More Than Once, continued from the previous page*

The CAP prescription order number is:

- A **unique** number generated by the approved CAP vendor;
- Used to match CAP claims in the payment system; and
- Associated with a line on an electronic claim.

CMS has found that some CAP claims are being processed incorrectly due the following:

- Drugs ordered under one, unique prescription order number are being billed on multiple claim lines; and
- The prescription order number is being reused with the modifier 76. (See the Additional Information Section of this article for a definition of modifier 76.)

**Note:** A CAP prescription order number must **only be used on ONE claim line**. It should not be reused on another claim line on the same claim, and it should not be reused on any other claim.

**CAP Billing Example**

If a CAP vendor has shipped a drug using one prescription order number but the drug is administered in several doses, the total amount administered should be identified in the number of billing units.

**Example:**

The approved CAP vendor has shipped 20 Heparin Units of J1642 Heparin Sodium (Heparin Lock Flush) under the prescription order number QXXXJ1642YYYYY. (**Note:** HCPCS Code J1642 has the descriptor: Inj heparin sodium per 10 u.)

- The patient's IV lines required two 10 Unit heparin flushes during the course of the office visit.
- Since the HCPCS code defines J1642 as 10 Units of heparin and a total of 20 units of heparin were administered, this situation would be:
  - Billed as 2 billing units of J1642 on a line containing a J1 no-pay CAP modifier, and
  - Associated with prescription order number QXXXJ1642YYYYY.

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*Medicare Part B Drug Competitive Acquisition Program (CAP): Do Not Bill a Prescription Order Number More Than Once, continued from the previous page*

**Additional Information**

If you have any questions, please contact your carrier at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

For additional information about CAP billing refer to the billing tip sheet at [www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/cap\\_billtips.pdf](http://www.cms.hhs.gov/CompetitiveAcquisforBios/Downloads/cap_billtips.pdf) on the CMS website.

Physician billing information on the Competitive Acquisition Program (CAP) may be found at [http://www.cms.hhs.gov/CompetitiveAcquisforBios/02\\_infophys.asp](http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp) on the CMS website.

In addition, you can find MM4064 (MMA- Competitive Acquisition Program (CAP) for Part B Drugs – Coding, Testing, and Implementation) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm4064.pdf> on the CMS website.

You can also find SE0672 (Clarification of Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0672.pdf> on the CMS website.

**Modifier 76-** Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier 76 to the repeated service.

**Note:** When it is medically necessary to repeat a service, the first service should be reported in the usual manner. The repeat service should be reported on the next line with modifier 76 appended to the procedure code. In the event it is medically necessary to repeat a procedure more than twice, report the second line with the 76 modifier and the appropriate number of units in the units field. If a service is repeated more than once, additional documentation should be provided in the narrative field of the claim to support the medical necessity of the repeat services. The patient's medical records must always document the medical necessity of performing repeat procedures and be available to the carrier upon request.

***CMS Special Edition Article SE0677***

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

### **Provider Types Affected**

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

### **What You Need to Know**

CR 5407, from which this article is taken, notes that for Calendar Year (CY) 2007, there are no significant changes to the End Stage Renal Disease (ESRD) composite rate payment methodology; but announces that the Centers for Medicare & Medicaid Services (CMS) made two updates: 1) To the drug add-on adjustment to the composite rate; and 2) To the wage index and transition.

### **Background**

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

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

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

### **Drug add-on adjustment**

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

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

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

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*Implementation of Changes in End Stage Renal Disease (ESRD) Payment for Calendar Year (CY) 2007, continued from the previous page*

**Wage index and transition**

CR 5407 also announces an update to the wage index adjustment to reflect the latest hospital wage data, including a budget neutrality adjustment to the wage index for CY 2007 (the second year of the 4-year transition period). Consistent with the transition blends, CMS is implementing a 50/50 blend between an ESRD facility's Metropolitan Statistical Area (MSA) based composite rate, and its CY 2007 Core Based Statistical Area (CBSA) based rate reflecting its revised wage index values.

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

**Additional Information**

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

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

**MLN Matters MM5407**

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

### **Provider Types Affected**

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

### **What You Need to Know**

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

### **Background**

The following provides instructions for the CY2007 Payment Rate Increases for RHC and FQHC services.

### **RHCs:**

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

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

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

### **FQHCs:**

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

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

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

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

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

*continued on the next page*

*Announcement of Medicare Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Payment Rate Increases, continued from the previous page*

**Additional Information**

The official instruction, CR5435, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1126Cp.pdf> on the CMS website.

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

**MLN Matters 5435**

## **Processing All Diagnosis Codes Reported on Claims Submitted to Carriers**

### **Provider Types Affected**

All physicians and providers submitting claims to carriers

### **Provider Action Needed**

Effective, at the earliest, July 1, 2007, the carrier standard system for Medicare will automatically process all diagnosis codes that you submit on your claims.

CR4276, the second phase in the implementation of the Negotiated Rulemaking agreement to automatically consider all diagnosis codes reported on claims, includes finalization of the requirements and coding development for the standard system used by Medicare carriers.

Make sure that your billing staffs are aware of these changes that allow eight diagnosis codes on Medicare claims effective, at the earliest, July 1, 2007.

### **Background**

While the American National Standards Institute (ANSI) 837P 4010A allows the reporting of up to eight diagnosis codes in the 2300 loop, the Medicare carrier standard system uses only the first four diagnosis codes when processing HIPAA format claims. Carriers have used a manual process to consider the remaining diagnosis codes in the Medicare payment determination.

In CR4276, from which this article is taken, CMS is requiring that (effective no earlier than July 1, 2007) the Medicare carrier standard system capture and process all diagnosis codes that are reported, up to the maximum of eight, on any claim (both electronic and paper) processed.

### **Additional Information**

You can find more information about the application of all diagnosis codes reported in processing carrier claims by viewing CR4276 at <http://www.cms.hhs.gov/Transmittals/downloads/R1095CP.pdf> on the CMS website.

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

### **MLN Matters MM4276**

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

### Provider Types Affected

Ambulatory surgical centers (ASCs) submitting claims to Medicare carriers or Fiscal Intermediaries (FIs) for ASC services provided to Medicare beneficiaries.

### Impact on Providers

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

### Background

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

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

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

CR5211, from which this article is taken, implements the required biennial ASC update, which includes changes made by the American Medical Association for the CY 2007 Common Procedural Terminology (CPT). These changes include replacing the ASC 2-digit payment group code designation next to the ASC-approved Healthcare Common Procedure Coding System (HCPCS) codes with an “yy” designation for these codes, which will be defined as “the procedure is approved to be performed in an ambulatory surgical center.”

CR5211 also revises the manner in which ASC payment groups are defined. The number of ASC payment groups that carriers and Fiscal Intermediaries (FI) currently use to identify ASC payment amounts for individual HCPCS codes is being expanded in order to accommodate the new payment amounts that will be assigned to certain ASC services in Calendar Year (CY) 2007 under the DRA requirement. The ASC payment groups will now be called ASC PRICER groups. The additional ASC PRICER groups reflect the DRA-driven payment amounts, which will be included in the ASC PRICER files that carriers, and certain FIs, use to process ASC facility claims.

And lastly, CR5211 includes payment file retrieval instructions that your carriers and FIs will use to access the final payment files on, or after, the specified retrieval date provided in CMS’s notification.

*continued on the next page*

*2007 Update of HCPCS Codes and Payments for Ambulatory Surgical Centers (ASCs), continued from the previous page*

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

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

**Additional Information**

For complete details, please see CR 5211, the official instruction issued to your carrier/intermediary regarding this change, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1013CP.pdf> on the CMS website. Attached to CR5211 is the ASC List of Approved Procedures HCPCS Code Changes (deletions/additions) for January 1, 2007.

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

**MLN Matters MM5211**

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

### **Provider Types Affected**

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

### **Provider Action Needed**

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

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

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

### **Background**

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

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

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

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

*continued on the next page*

*Claims Submitted With Only a National Provider Identifier (NPI) During the Stage 2 NPI Transition Period, continued from the previous page*

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

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

**Additional Information**

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

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

**MLN Matters MM5378**

## Correct Coding Initiative (CCI) Edits; Version 13.0

### Provider Types Affected

Physicians who submit claims to Medicare carriers and A/B Medicare Administrative Contractors (A/B MACs)

### Background

This article and related Change Request (CR) 5422 provide a reminder for physicians to take note of the quarterly updates to the coding initiatives. The latest package of Correct Coding Initiative (CCI) edits, Version 13.0, effective January 1, 2007, will be available via the CMS Data Center (CDC).

Physicians may view the current CCI edits and the current Mutually Exclusive Code (MEC) edits at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> on the Centers for Medicare & Medicaid Services (CMS) website.

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice. The latest package of CCI edits, Version 13.0, is effective on January 1, 2007. This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables:

- Column 1/Column 2 Correct Coding Edits table; and
- MEC Edits table.

### Additional Information

The CCI and MEC file formats will be maintained in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 20.9, which can be found at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS website. You may see the official instruction (CR5422) issued to your Medicare carrier or A/B MAC by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1124CP.pdf> on the CMS website.

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

### **MLN Matters MM5422**

## Alabama

### Top Five Reasons for Claim Rejections for November 2006

Audit trails show which of your claims were accepted by the Cahaba GBA Part B processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 3:30 p.m. Central Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA Part B EDI Services is providing you with the top five reasons for claim rejections. For the month of **November 2006**, these are:

#### 1. **421- DIAG CODE (XXXXX) INVALID FOR DATE SVC- 8,314 claims**

The invalid diagnosis code will appear inside the parenthesis. Be sure that you are using the latest ICD-9 diagnosis codes, and that the code you are using is the most specific one. Also be sure that you are not using a date of service that is **before** the effective date of the diagnosis code.

#### 2. **209- INVALID LAST NAME FOR HIC NUMBER- 8,637 claims**

The last name submitted for the beneficiary does not match the last name we have on record for the HIC number on the claim.

#### 3. **210- INVALID FIRST NAME/INIT FOR HIC- 8,201 claims**

The first name submitted for the beneficiary does not match the first name we have on record for the HIC number on the claim.

#### 4. **434- PROC CODE REQUIRES REFERRING UPIN- 5,740 claims**

There is a procedure code on the claim that requires a Unique Physician's Identification Number (UPIN). This is required for diagnostic procedures such as x-rays, lab work, EKGs, etc. The UPIN of the physician who ordered the test should be used. A UPIN begins with a letter and is followed by five digits (e.g. Z12345).

#### 5. **888- INSTREAM REJECTION- 4,139 claims**

There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred. If you need help locating specific positions in your 4010A1 file here is an article explaining one way you may do this:

[https://www.cahabagba.com/part\\_b/edi/hipaa\\_identifying\\_your\\_errors.htm](https://www.cahabagba.com/part_b/edi/hipaa_identifying_your_errors.htm)

For further assistance with Instream Rejection edits contact your software vendor, clearing house, or billing service.

## Georgia

### Top Five Reasons for Claim Rejections for November 2006

Audit trails show which of your claims were accepted by the Cahaba GBA Part B processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 4:30 p.m. Eastern Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA Part B EDI Services is providing you with the top five reasons for claim rejections. For the month of **November 2006**, these are:

#### 1. 209- INVALID LAST NAME FOR HIC NUMBER -16,696 claims

The last name submitted for the beneficiary does not match the last name we have on record for the HIC number on the claim.

#### 2. 210- INVALID FIRST NAME/INIT FOR HIC - 15,764 claims

The first name submitted for the beneficiary does not match the first name we have on record for the HIC number on the claim.

#### 3. 434- PROC CODE REQUIRES REFERRING UPIN - 10,680 claims

There is a procedure code on the claim that requires a Unique Physician's Identification Number (UPIN). This is required for diagnostic procedures such as x-rays, lab work, EKGs, etc. The UPIN of the physician who ordered the test should be used. A UPIN begins with a letter and is followed by five digits (eg. Z12345).

#### 4. 421- DIAG CODE (XXXXX) INVALID FOR DATE SVC - 9,186 claims

The invalid diagnosis code will appear inside the parenthesis. Be sure that you are using the latest ICD-9 diagnosis codes, and that the code you are using is the most specific one. Also be sure that you are not using a date of service that is **before** the effective date of the diagnosis code.

#### 5. 380- OTAF AMOUNT REQUIRED WITH CAS/CO (CONTRACTUAL OBLI -5,215 claims

The claim was a Medicare Secondary Payer (MSP) claim with a group code 'CO' given for an adjustment from the primary payer. This indicates the provider has a contract with the primary payer to accept the primary payer's approved amount as payment in full (OTAF). The OTAF amount must be submitted on the claim in this circumstance and was missing.

For an explanation of how to submit MSP claims electronically, and for definitions of OTAF and other terms, please see these articles on our website:

[https://www.cahabagba.com/part\\_b/msp/Providers\\_Electronic\\_Billing\\_Instructions.htm](https://www.cahabagba.com/part_b/msp/Providers_Electronic_Billing_Instructions.htm)

[https://www.cahabagba.com/part\\_b/whats\\_new/news\\_msp\\_billing\\_clarification.htm](https://www.cahabagba.com/part_b/whats_new/news_msp_billing_clarification.htm)

## Mississippi

### Top Five Reasons for Claim Rejections for November 2006

Audit trails show which of your claims were accepted by the Cahaba GBA Part B processing system, along with claims that were rejected and the reason for the rejection. Referring to this report will allow you to correct and resubmit claims quickly, resulting in a dramatically reduced turnaround time. You will also become aware of any major problems with your claims so they can be corrected before they create an interruption in your cash flow. Audit trail reports are available the next business day for files that are received before 3:30 p.m. Central Time. If you are not receiving your audit trails contact your software vendor, billing service, or clearing house.

In order to increase the number of claims that successfully pass through audit trails and into processing Cahaba GBA Part B EDI Services is providing you with the top five reasons for claim rejections. For the month of **November 2006**, these are:

#### 1. 209- INVALID LAST NAME FOR HIC NUMBER- 5,701 claims

The last name submitted for the beneficiary does not match the last name we have on record for the HIC number on the claim.

#### 2. 421- DIAG CODE (XXXXX) INVALID FOR DATE SVC- 4,726 claims

The invalid diagnosis code will appear inside the parenthesis. Be sure that you are using the latest ICD-9 diagnosis codes, and that the code you are using is the most specific one. Also be sure that you are not using a date of service that is **before** the effective date of the diagnosis code.

#### 3. 210- INVALID FIRST NAME/INIT FOR HIC- 4,714 claims

The first name submitted for the beneficiary does not match the first name we have on record for the HIC number on the claim.

#### 4. 362- BILLING & RENDERING PROVIDER MUST BE IN SAME GROUP- 2,778 claims

The rendering provider number on the claim is not affiliated with the billing or pay-to provider number.

#### 5. 888- INSTREAM REJECTION- 2,620 claims

There was a problem involving HIPAA required loops, segments, or values. The specific loop will be identified, for example, 'ELEMENT N401 (D.E. 19) AT COL. 4 IS MISSING, THOUGH MARKED "MUST BE USED" (LOOP:2010BA POS:3140)'. The number after 'POS' indicates the position in the file where the error occurred. If you need help locating specific positions in your 4010A1 file here is an article explaining one way you may do this:

[https://www.cahabagba.com/part\\_b/edi/hipaa\\_identifying\\_your\\_errors.htm](https://www.cahabagba.com/part_b/edi/hipaa_identifying_your_errors.htm)

For further assistance with Instream Rejection edits contact your software vendor, clearing house, or billing service.

## Education from Medical Review

The table below provides notification of the changes made to previously published articles as a result of the **Annual CPT/HCPCS Update for 2007**. Please make note of these changes, which will become effective January 1, 2007.

These articles can be obtained from the CMS Medicare Coverage Database located at: <http://www.cms.hhs.gov/mcd/> - key in the document ID (Article ID number).

Article Title	CPT / HCPCS Code	Description
Bone Mass Density Article #A41549	76070	Deleted 12/31/2006; replaced by 77078
	76071	Deleted 12/31/2006; replaced by 77079
	76075	Deleted 12/31/2006; replaced by 77080
	76076	Deleted 12/31/2006; replaced by 77081
	76078	Deleted 12/31/2006; replaced by 77083
	77078	Added 1/1/2007- Computed tomography, bone mineral density study, 1 or more sites; axial skeleton
	77079	Added 1/1/2007- Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral)
	77080	Added 1/1/2007- Dual-energy X-ray Absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton
	77081	Added 1/1/2007- Dual-energy X-ray Absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral)
	77083	Added 1/1/2007-Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry), 1 or more sites
Vertebral Fracture Assessment Article #A42489	76077	Deleted 12/31/2006; replaced by 77082
	76075	Deleted 12/31/2006; replaced by 77080
	76076	Deleted 12/31/2006; replaced by 77081
	77082	Added 1/1/2007- Dual-energy X-ray Absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment
	77080	Added 1/1/2007- Dual-energy X-ray Absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton
77081	Added 1/1/2007- Dual-energy X-ray Absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral)	

## Local Coverage Determination (LCD) Updates

The table below provides notification of the changes made to previously published Local Coverage Determinations (LCDs) and related Articles as a result of the **Annual CPT/HCPCS Update for 2007**. Please make note of these changes, which will become effective January 1, 2007.

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

LCD Title	CPT / HCPCS Code	Description
Epidural and Intrathecal Injections (Article)	76005	Deleted 12/31/2006; replaced by 77003
	77003	Added 1/1/2007 - Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction
Hyaluronate Joint Injections	J7317	Deleted 12/31/2006
	J7320	Deleted 12/31/2006
	J7319	Added 1/1/2007 - Hyaluronan (Sodium Hyaluronate) or derivative, Intra-Articular injection, per injection
	J3590	Removed from LCD effective 1/1/2007. Used for High Molecular Weight Hyaluronan (Orthovisc®)
Kyphoplasty and Vertebroplasty	76012	Deleted 12/31/2006; replaced by 72291
	76013	Deleted 12/31/2006; replaced by 72292
	72291	Added 1/1/2007 - Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under fluoroscopic guidance
	72292	Added 1/1/2007 - Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body, under CT guidance

Mohs' Micrographic Surgery (MMS)	17304	Deleted 12/31/2006
	17305	Deleted 12/31/2006
	17306	Deleted 12/31/2006
	17307	Deleted 12/31/2006
	17310	Deleted 12/31/2006
	17311	Added 1/1/2007 - MOHS Micrographic Technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stains(s) (e.g., hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves or vessels; first stage, up to 5 tissue blocks
	17312	Added 1/1/2007 - MOHS Micrographic Technique...; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)
	17313	Added 1/1/2007 - MOHS Micrographic Technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stains(s) (e.g., hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks
	17314	Added 1/1/2007 - MOHS Micrographic Technique...; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)
17315	Added 1/1/2007 - MOHS Micrographic Technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stains(s) (e.g., hematoxylin and eosin, toluidine blue); each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure)	

Nerve Blocks/Paravertebral Nerve Blocks (Article)	76005	Deleted 12/31/2006; replaced by 77003
	76360	Deleted 12/31/2006; replaced by 77012
	77003	Added 1/1/2007 - Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction
	77012	Added 1/1/2007 - Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation
Paravertebral Facet Joint Block (Article)	76005	Deleted 12/31/2006; replaced by 77003
	76360	Deleted 12/31/2006; replaced by 77012
	77003	Added 1/1/2007 - Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction
	77012	Added 1/1/2007 - Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation
Paravertebral Facet Joint Denervation (Article)	76005	Deleted 12/31/2006; replaced by 77003
	76360	Deleted 12/31/2006; replaced by 77012
	77003	Added 1/1/2007 - Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction
	77012	Added 1/1/2007 - Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation

Removal of Benign or Premalignant Skin Lesions	17000 17003 17004	<p>Removed from LCD effective 1/1/2007 due to code description change.</p> <p>17000 - Destruction (e.g., laser surgery, electro-surgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); first lesion</p> <p>17003 - Destruction (e.g., laser surgery, electro-surgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses); second through 14 lesions, each</p> <p>17004 - Destruction (e.g., laser surgery, electro-surgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (e.g., actinic keratoses), 15 or more lesions</p>
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## Update to Local Coverage Determination for Amifostine (Ethyol®)

- **Alabama – L5710**
- **Georgia – L6858**
- **Mississippi – L20898**

Notification of the final Local Coverage Determination for Amifostine (Ethyol®) was published in the March 2006 issue of the Medicare newsletter. The LCD lists ICD-9 codes that support medical necessity. Effective immediately, the following revision is being made under the subtitle “Primary Diagnosis Codes” for ICD-9 code V58.11:

“Use this ICD-9 code when Amifostine is used to reduce the toxicity of cisplatin” is being changed to:

“Use this ICD-9 code when Amifostine is used to reduce the toxicity of platinum-based chemotherapy”.

A copy of the updated Local Coverage Determination can be found at <http://www.cahabaqba.com>. Click on your state for the information you need.

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## Dacogen™ (Decitabine) For Injection –Updated ICD-9 Code

In the July 2006 newsletter, we provided notice of the FDA approval of Dacogen™ (Decitabine) for injection for the treatment of MyeloDysplastic Syndrome (mds). Effective October 1, 2006, ICD-9 code 238.7 is invalid and is being replaced with ICD-9 codes 238.72-238.75. These new ICD-9 codes should be used for services rendered October 1, 2006 and after. Claims submitted with ICD-9 code 238.7 after October 1, 2006 will be rejected.

Effective **January 1, 2007**, HCPCS code J0894 has been assigned to use when billing for Dacogen™ (injection, Decitabine, 1 mg). HCPCS code J9999 will not be appropriate to use as of January 1, 2007.

## **Bevacizumab (AVASTIN™) - Treatment of Neovascular (Wet) Macular Degeneration**

This article was initially published in the July 2006 Newsline and was revised in the December 2006 Newsline. The entire article is being republished with an additional statement regarding drug compounding. This new requirement becomes effective immediately.

Cahaba GBA, LLC will consider claims for Bevacizumab (AVASTIN™) for neovascular ("wet") macular degeneration on an individual basis.

Neovascular Age-related Macular Degeneration (AMD), when untreated or refractory to usual therapies, almost always leads to permanent blindness. As such, additional therapeutic interventions have been pursued in order to try and salvage the vision of AMD patients who have failed to respond to the usual therapies.

One of these options is the use of bevacizumab. Bevacizumab is not FDA approved for the treatment of AMD. Bevacizumab works by blocking vascular endothelial growth factor, a potent angiogenic and permeability factor, and as such it is attracting much attention as a potential treatment option for neovascular age-related macular degeneration as well as for macular edema. The physician's decision to use bevacizumab is based on favorable, though not definitive, studies.

The USP DI includes the following "off-label" indication for Bevacizumab: *Treatment of neovascular (wet) age-related macular degeneration in patients failing standard therapy.*

The ophthalmology community is increasingly using intravitreal bevacizumab in the treatment of wet AMD that has not responded to other accepted therapies.

The use of bevacizumab is not to be taken lightly. The agent has many potential medical complications. Bevacizumab comes from the manufacturer in a concentration unsuitable for ocular use and, therefore, must be diluted before such use.

To use this agent, the ophthalmologist must have extensive experience in the treatment of wet AMD and be well versed with the latest guidelines on care before, during and after the administration of bevacizumab.

### **Required Medical Record Documentation**

All of the following criteria should be clearly documented in the patient's medical record prior to the use of bevacizumab for the treatment of wet AMD.

### **Patient Selection**

- Fluorescein angiograms and OCT's should be performed to evaluate the lesion type, location and size, and the presence of subretinal fluid.

*continued on the next page*

*Bevacizumab (AVASTIN™) - Treatment of Neovascular (Wet) Macular Degeneration, continued from the previous page*

- In accordance with the prescribing information for bevacizumab, screen all patients for medical conditions that would contraindicate the use of bevacizumab. This screening should include but is not limited to gastrointestinal hemorrhage or perforations, wound healing complications, other hemorrhage, arterial thromboembolic events, hypertension, proteinuria and heart failure. Currently published data excluded patients with a history of myocardial infarction or uncontrolled hypertension.
- Consider a medical screening and clearance for patients with medical comorbidities. Medical clearance should also be obtained when the patient is scheduled for any major surgery and should include when to stop the use of bevacizumab preoperatively and when bevacizumab may reasonably be restarted after surgery.

### **Patient Consent**

- The patient should be clearly aware of the real potential for complications associated with this drug. This includes not only ophthalmic complications (such as endophthalmitis, detached retina and complications of increased intraocular pressure) but also complications associated with the use of bevacizumab in the treatment of cancer.
- The use of bevacizumab for the treatment of wet AMD is "off-label" and not FDA approved.
- Entry in the medical record documenting that these items have been discussed and that the patient appears to understand the risks and benefits of the use of this drug in an off label setting. Formal consent and documentation should also follow specialty societies and risk management guidelines and may include added notes as recommended in these guidelines.

### **Drug Administration**

The medical record must contain the actual dosage, site, the lot number of the vial, date and time of administration and any unusual reactions.

### **CPT/HCPCS Codes**

J3590 should be used when bevacizumab injection is prepared in the physician's office or more often when a supplier or pharmacist compounds the drug and provides it to the physician to inject.

67028 Intravitreal injection of a pharmacologic agent (separate procedure)  
J3590 Unclassified biologics

### **ICD-9 Codes that are Covered**

362.52 exudative senile macular degeneration of retina

*continued on the next page*

*Bevacizumab (AVASTIN™) - Treatment of Neovascular (Wet) Macular Degeneration, continued from the previous page*

**Claim Information**

Providers should maintain required documentation in case this data is needed to properly adjudicate the claim.

For J3590, include the drug's name and the actual dose given in item 19 of the HCFA-1500 form or claim equivalent. If the drug is compounded, a copy of the compounding invoice will be needed to properly adjudicate the claim.

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## **Update to Local Coverage Determination for Oxaliplatin for Injection (Eloxatin™)**

- **Alabama – L13000**
- **Georgia – L11272**
- **Mississippi – L20096**

**Effective January 1, 2007:**

Notification of the Local Coverage Determination for Oxaliplatin for Injection (Eloxatin™) was published in the November 2005 issue of the *Medicare Focus*.

Effective for claims with dates of service January 1, 2007 and after, the LCD is updated to include coverage for the following USP DI off label indication:

Advanced/metastatic gastric carcinoma. Oxaliplatin in combination with irinotecan or fluorouracil with leucovorin or folinic acid has demonstrated activity in the treatment of advanced/metastatic gastric carcinoma.

ICD-9 codes 151.0-151.9 have been added for this indication.

A copy of the updated Local Coverage Determination can be found <http://www.cahabagba.com>. Click on your state for the information you need.

## **Update to Local Coverage Determination for Coronary CT Angiography and Electron Beam Computed Tomography of the Coronary Vessels**

- **Alabama – L21041**
- **Georgia – L21526**
- **Mississippi – L21609**

**Effective: January 1, 2007**

Notification of the final Local Coverage Determination for Coronary CT Angiography and Electron Beam Computed Tomography of the Coronary Vessels was published in the March 2006 issue of the Medicare newsletter. Effective for claims with dates of service January 1, 2007 and after, the LCD is updated to include coverage for the following indication:

*When used in the assessment of coronary or pulmonary venous anatomy for the procedures described below:*

CTA of the coronary veins is indicated when imaging of the coronary venous anatomy is necessary for biventricular pacemaker lead insertion.

CTA of the pulmonary veins is indicated when imaging of the pulmonary vasculature is necessary for pulmonary vein catheter ablation procedures for atrial fibrillation.

ICD-9 code V72.81 (preoperative cardiovascular examination) and either ICD-9 code 427.31 (atrial fibrillation) or 427.32 (atrial flutter) are to be used for these indications and have been added to the LCD. No other pre-procedure indications are covered at this time.

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

## **Update to Local Coverage Determination for Luteinizing Hormone-Releasing Hormone Analogs in the Treatment of Prostate Cancer**

- **Alabama – L6475**
- **Georgia – L20069**
- **Mississippi – L18126**

**Effective: January 1, 2007**

Notification of the final Local Coverage Determination for Luteinizing Hormone-Releasing Hormone Analogs in the Treatment of Prostate Cancer was published in the November 2005 issue of the Medicare newsletter. Under the 'Limitations' section, the LCD states that payment of these drugs will be according to the allowed amount of the lower-priced medication. Due to our LCD requirements to use the injectable form of this drug in certain circumstances, the LCD is being revised to separate the LHRH drugs into two groups for pricing purposes based upon their duration, and to implement a 'Least Costly Alternative (LCA)' for each group.

Group 1 includes the short acting LHRH agents (less than 12 month duration):

- J3315 - Injection, triptorelin pamoate, 3.75 mg - (Trelstar Depot, Trelstar LA)
- J9202 - Goserelin acetate implant, per 3.6 mg - (Zoladex)
- J9217 - Leuprolide acetate (for depot suspension), 7.5 mg - (Lupron, Eligard).

Group 2 includes the agents with a 12-month duration (yearly implants):

- J9219 - Leuprolide acetate implant, 65 mg - (Viadur)
- J9225 - Histrelin implant, 50 mg - (Vantas)

LCA pricing for each group is based on the quarterly lowest ASP (average sales price) priced drug in each group. Consequently, the LCA is subject to change.

Paragraph #2 under the 'Limitations' section of the LCD has been revised accordingly.

This revision will be effective for claims with dates of service January 1, 2007 and after.

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

## **Update to Local Coverage Determination for Cetuximab (ERBITUX®)**

- **Alabama – L16379**
- **Georgia – L16876**
- **Mississippi – L17574**

**Effective January 1, 2007**

Notification of the final Local Coverage Determination for Cetuximab (Erbix® was published in the November 2004 issue of the Medicare newsletter). The 'Documentation Requirements' section of this LCD state: 'Documentation should include immunohistochemical evidence of positive EGFR expression (e.g., DakoCytomation EGFR pharmDx™ test kit)'. This statement is being removed from the LCD.

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

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## **Update to Local Coverage Determination for Optical Coherence Tomography (OCT)**

- **Alabama – L21544**
- **Georgia – L20967**
- **Mississippi – L20762**

**Effective: January 1, 2007**

Notification of the final Local Coverage Determination for Optical Coherence Tomography (OCT) was published in the March 2006 issue of the Medicare newsletter. The LCD lists ICD-9-CM codes that support medical necessity. Effective for claims with dates of service January 1, 2007 and after, the LCD is updated to include coverage for ICD-9 code 115.92 (Histoplasmosis retinitis).

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

## Update to Local Coverage Determination (LCD) for Paravertebral Facet Joint Denervation

- Alabama – L20701
- Georgia – L6745
- Mississippi – L20681

**Effective: December 18, 2006**

Notification of the final Local Coverage Determination for Paravertebral Facet Joint Denervation was published in the November 2006 issue of the Medicare newsletter. Effective December 18, 2006, this statement under “Documentation Requirements” is being removed from this LCD:

*“If more than two nerves are denervated (unilateral or bilateral) in a treatment session, documentation must be clear as to necessity and indications for denervating the additional nerves.”*

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

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## Update to Cahaba GBA Self-Administered Drug List

Effective January 1, 2007, the miscellaneous code assigned to Immune Globulin Subcutaneous (Human), Vivaglobin® will be replaced by HCPCS code J1562 (injection, immune globulin, subcutaneous, 100 mg) based on changes resulting from the **Annual CPT/HCPCS Update for 2007**. This drug was added to the Self-Administered Drug list and became effective for non-coverage on May 16, 2006. Please make note of this change, which will become effective January 1, 2007.

This update applies to Georgia Medicare Part B, Mississippi Medicare Part B and Alabama Medicare Part A and B.

## FDA Drug HCPCS Updates

Effective January 1, 2007 miscellaneous codes for newly FDA-approved drugs published in previous articles will be updated based on changes resulting from the **Annual CPT/HCPCS Update for 2007**. Please make note of these changes, which will become effective January 1, 2007.

Article Title	HCPCS Code	Description
Boniva® (ibandronate sodium)	J1740	Effective 1/1/2007 (injection, ibandronate sodium, 1 mg)
Dacogen™ (decitabine) for Injection	J0894	Effective 1/1/2007 (injection, decitabine, 1 mg)
Orencia® (abatacept)	J0129	Effective 1/1/2007 (injection, abatacept, 10 mg)

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## Consolidation of Local Coverage Determination (LCD) Identification (ID) Numbers

Due to consolidation efforts and upgrades to the Medicare Coverage Database (MCD), Cahaba GBA, LLC will replace the LCD ID numbers that are currently in place for the Alabama, Georgia and Mississippi LCDs with a single ID number to be used for all 3 Carriers. This consolidation will not change the content or coverage of the LCDs.

For example: the ID numbers for the LCD Abdominal / Retroperitoneal Ultrasound (L5382 for Alabama, L5417 for Georgia, and L20665 for Mississippi) will be changed to a new ID number that will be used for all 3 Carriers. The previous version of the LCD will be retired and accessible for review.

The consolidation of the LCD ID numbers will begin in January 2007 and is expected to be completed by December 31, 2007.

## 2007 Healthcare Common Procedure Coding System (HCPCS) Update

The annual update of CPT/HCPCS codes will be effective for services rendered on and after January 1, 2007. Services provided on or after January 1, 2007 should be filed using the 2007 codes. Services rendered in 2006 should be filed using 2006 codes.

HCPCS is a five-digit coding system using numbers and letters. There are two divisions of codes assigned and maintained by different organizations:

Level 1 - The first division is the CPT codes established by the American Medical Association. These codes range from 00100-99999 and represent physician services such as examinations, radiology, pathology, and surgery.

Level 2 - The second division of codes are assigned and maintained by CMS. These codes are a combination of one letter and four numbers that range from A0000-V9999. These codes are common to all carriers.

- [2007 Medicare Part B HCPCS Adds](https://www.cahabagba.com/part_b/whats_new/2007HCPCSAdds.pdf)  
[https://www.cahabagba.com/part\\_b/whats\\_new/2007HCPCSAdds.pdf](https://www.cahabagba.com/part_b/whats_new/2007HCPCSAdds.pdf)
- [2007 Medicare Part B HCPCS Changes](https://www.cahabagba.com/part_b/whats_new/2007HCPCSChanges.pdf)  
[https://www.cahabagba.com/part\\_b/whats\\_new/2007HCPCSChanges.pdf](https://www.cahabagba.com/part_b/whats_new/2007HCPCSChanges.pdf)
- [2007 Medicare Part B HCPCS Deletes](https://www.cahabagba.com/part_b/whats_new/2007HCPCSDeletes.pdf)  
[https://www.cahabagba.com/part\\_b/whats\\_new/2007HCPCSDeletes.pdf](https://www.cahabagba.com/part_b/whats_new/2007HCPCSDeletes.pdf)

## Once In A Lifetime Procedures

Cahaba Government Benefit Administrators (GBA) has a list of procedures considered as "Once in a Lifetime" that was consolidated in November 2006 for all Cahaba GBA Part B Medicare sites. There are edits in the system for these procedures. Please see the following list of procedures that are considered to be "Once In A Lifetime".

<b>CPT Code</b>	<b>DESCRIPTION</b>
23900	Interthoracoscapular amputation (forequarter)
24900	Amputation arm through humerus
24920	Amputation arm through humerus
25900	Amputation forearm
25905	Amputation forearm
27290	Interpelviabdominal amputation
27295	Disarticulation of hip
27590	Amputation, thigh
27591	Amputation, thigh
27592	Amputation, thigh
27880	Amputation, leg
27881	Amputation, leg
27882	Amputation, leg
28800	Amputation, foot
28805	Amputation, transmetatarsal
30160	Rhinectomy, total
31360	Laryngectomy, total
31365	Laryngectomy, total
31390	Pharyngolaryngectomy
31395	Pharyngolaryngectomy
31400	Arytenoidectomy or artenoidopexy
32440, 32442, 32445	Removal of lung, Total pneumonectomy
38100	Splenectomy
38102	Splenectomy (with other procedure)
38120	Laparoscopy, surgical, splenectomy
41140, 41145	Complete or total glossectomy
41150	composite procedure w/ floor mouth/mandibular.resection
41153	composite procedure w/ floor mouth resection
41155	composite procedure w/ floor mouth resection
41821	Operculectomy
42140	Uvulectomy
42820, 42825	Tonsillectomy (<12)
42821, 42826	Tonsillectomy (>12)
42830, 42835	Adenoidectomy (<12)
42831, 42836	Adenoidectomy (>12)
42842, 42844, 42845	Radical resection, tonsils

43107, 43108	Esophagectomy, total (without thoracotomy)
43112, 43113	Esophagectomy, total (with thoracotomy)
43620, 43621, 43622	Total gastrectomy
44150-44156	Colectomy, total
44160	Colectomy, partial w/removal terminal ileum and ileocolostomy
44950, 44955, 44960	Appendectomy
44970	Lap surgical appendectomy
45110, 45112	Proctectomy
45119	Proctectomy with creation of colonic reservoir
45120, 45121	Procetectomy with pull through procedure/anastomosis
47122	Hepatectomy; trisegmentectomy
47125	Hepatectomy; total left lobectomy
47130	Hepatectomy; trisegmentectomy
47135	Liver allotransplantation, partial or whole
47562	Cholecystectomy, laparoscopic, surgical
47563	Cholecystectomy, laparoscopic, surgical
47564	Cholecystectomy, laparoscopic, surgical
47600	Cholecystectomy
47605	Cholecystectomy
47610	Cholecystectomy
47612	Cholecystectomy
47620	Cholecystectomy
48155	Pancreatectomy, total
48160	Pancreatectomy, total or subtotal
50220	Nephrectomy
50225	Nephrectomy
50230	Nephrectomy
50234	Nephrectomy
50236	Nephrectomy
51570, 51575, 51580, 51585, 51590, 51595	Cystectomy, complete
51596	Cystectomy, complete w/continent diversion
51597	Pelvic exenteration, complete
52601	Transurethral resection of prostate
53210	Urethrectomy, total, female
53215	Urethrectomy, total, male
54125	Amputation of penis, complete
54130	Amputation of penis, radical
54135	Amputation of penis, radical
54152	Circumcision, except newborn
54161	Circumcision, except newborn
54861	Epididymectomy, bilateral
55810, 55812, 55815, 55821,	Prostatectomy, perineal radical

55831	
55840, 55842, 55845	Prostatectomy, retropubic radical
57110	Vaginectomy
57111	Vaginectomy
57112	Vaginectomy
57530	Trachelectomy (cervicectomy)
57531	Radical trachelectomy
58150	Total abdominal hysterectomy (w or w/o tube removal)
58152	Total abdominal hysterectomy w/colpo-urethrocystopexy
58200	Total abdominal hysterectomy, including partial vaginectomy)
58210	Radical abdominal hysterectomy
58240	Pelvic exenteration w/total hysterectomy
58260	Vaginal hysterectomy (uterus 250 or <)
58262, 58263	Vaginal hysterectomy (uterus 250 or <, w/ tube removal)
58267, 58270	Vaginal hysterectomy w/colpo-urethrocystopexy
58275, 58280, 58285	Vaginal hysterectomy
58290 - 58294	Vaginal hysterectomy - uterus > 250 grams)
58550, 58552	Laparoscopy, surgical, with vaginal hysterectomy
58953, 58954	Bilateral salpingo-oophorectomy
60220	Total thyroid lobectomy, unilateral
60240	Thyroidectomy, total
60252	Thyroidectomy, total or subtotal
60254	Thyroidectomy, total or subtotal
60260	Thyroidectomy, removal of remaining tissue after previous removal of a portion of thyroid
60270, 60271	Thyroidectomy, including substernal thyroid
60520, 60521, 60522	Thymectomy, partial or total
60540, 60545	Adrenalectomy, partial or complete
60650	Laparoscopy, surgical with adrenalectomy
61490	Craniotomy for lobotomy
65101, 65103, 65105	Enucleation of eye

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Your Name (optional): \_\_\_\_\_

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Please rate the publication by circling the number of your choice.  
(10 = Excellent, 5 = Satisfactory, 1 = Unacceptable)

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Design and physical appearance of the publication.

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

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

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Thank you for your time.

Please fax or mail your response to:

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