

Medicare B Newsline



CAHABA
GOVERNMENT
BENEFIT
ADMINISTRATORS LLC



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 2009

Topics Include:

Clinical Laboratory

Laboratory National Coverage Determination (NCD) Edit
Software for January 2009..... 38

Disclaimer..... 2

Durable Medical Equipment (DME)

2008 Jurisdiction Code List for Durable Medical Equipment,
Prosthetics, Orthotics, and Supply (DMEPOS)- **Revised**..... 45

Education From Electronic Data Interchange (EDI)

AL- Top Five Reasons For Claim Rejections for November 2008.. 5

GA- Top Five Reasons For Claim Rejections for November 2008 6

MS- Top Five Reasons For Claim Rejections for November 2008. 7

Education From Medical Review

Bevacizumab (Avastin®)- Expanded Coverage..... 13

Chemotherapeutics Agents- Gemcitabine Hydrochloride
(Gemzar®) and Rituximab (Rituxan®)-Expanded Coverage..... 16

Local Coverage Determination (LCD) Updates- 2009

CPT/HCPCS Codes..... 15

Medicare Articles Database..... 12

Paclitaxel Protein-Bound Particles (Abraxane®)- Expanded
Coverage..... 14

Education From Provider Contact Center

Provider Contact Center Hours and Training Day Schedule..... 3

Education From Provider Outreach and Education (POE)

Cahaba GBA E-mail Notification Service..... 4

Change to Duplicate Remittance Requests Policy..... 17

Claim Filing Time Limit..... 17

General Medicare Questions for Medicare Recipients..... 2

Healthcare Common Procedure Coding System (HCPCS) Codes

Used for Home Health Consolidated Billing Enforcement- Update 28

Health Insurance Claim (HIC) Number..... 8

Health Insurance Claim (HIC) Number Suffixes..... 9

Health Professional Shortage Area (HPSA) Bonus Payment
Policy Changes..... 36

Independent Diagnostic Testing Facility- Update..... 18

News Flash Messages From CMS..... 25

Remittance Advice Remark Code (RARC) and Claim Adjustment
Reason Code (CARC) Update..... 30

Thermal Intradiscal Procedures (TIPs)..... 41

Upcoming Educational Events..... 24

Holiday Schedule..... 3

Medicare B Newsline Quality Survey..... 46

Please Route..... 2

Provider Contact Center Hours

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

- Alabama: 8:00 a.m. – 5.00 p.m. CST
- Georgia: 8:00 a.m. – 4:00 p.m. EST
- Mississippi: 8:00 a.m. – 4:00 p.m. CST

Except on Training Days and Federal Holidays. See our [Training Schedule](#) for specific information.

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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Please Route

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

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

Routing List

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

Disclaimer

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

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

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 services. Questions regarding specific claims will be automatically routed to the appropriate Medicare contractor's call center for response. **Please do not ask your patients to contact Medicare on a claim that you accepted assignment on.**

Medicare Part B Provider Contact 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. – 5:00 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

Note: Please do not ask your patients to contact Medicare on a claim that you accepted assignment on. The provider's office should contact Medicare NOT the patient on a questionable claim.

January Training Day Schedule

Day and Date	Time
Friday, January 9, 2009	10:00 a.m.- 12:00 EST / 9:00 a.m.- 11:00 a.m. CST
Friday, January 30, 2009	10:00 a.m.- 12:00 EST / 9:00 a.m.- 11:00 a.m. CST

Holiday Schedule

The Medicare Part B offices will be closed for the following holidays in 2009:

2009 Holiday Schedule	
Thursday, January 1, 2009	New Year's Day
Monday, January 19, 2009	Martin Luther King Jr. Day
Friday, April 10, 2009	Good Friday
Monday, May 25, 2009	Memorial Day
Friday, July 3, 2009	Independence Day
Monday, September 7, 2009	Labor Day
Thursday, November 26, 2009 Friday, November 27, 2009	Thanksgiving
Thursday, December 24, 2009 Friday, December 25, 2009	Christmas

Note: Provider Contact Centers also close on federal holidays, such as President's Day, Columbus Day, Veteran's Day, etc. for continuing education training.

Cahaba Government Benefit Administrators (GBA) Email Notification Service

The Cahaba GBA E-mail Notification Service is available. Currently, we have **7,525** Medicare Part B members subscribed (Alabama: 2,350, Georgia: 3,928 and Mississippi: 1,247). There is a combined Medicare provider count in the states of Alabama, Georgia and Mississippi of **43,528**. CAN YOU AFFORD NOT TO BE SIGNED UP?

We are encouraging everyone to enroll, including ALL office associates. 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.

We try very hard not to send out multiple messages in a given day; however, some urgent topics require us to email you which means you may receive several different messages in a day. We also consolidate messages when possible.

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

Your e-mail address will not be shared with other subscribers or given to advertisers, and once subscribed, you can unsubscribe from the list at any time. Please review our [Privacy Policy](#) for more information.

Alabama

Top Five Reasons for Claim Rejections for November 2008

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.

See [Audit Trail Explanations](#) for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

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 2008**, these are:

1. 421- DIAG CODE (XXXXX) INVALID FOR DATE SVC- 7,610 claims

The date of service was outside of the effective date range of the diagnosis code used. The invalid diagnosis code will appear inside the parenthesis.

2. 385- CLAIM CONTAINS A MEDICARE LEGACY ID IN LOOP : XXXX- 7,068 claims

Claim contained a legacy provider number, such as a PTAN or UPIN, in the indicated loop.

3. 434- PROC CODE REQUIRES REFERRING NPI- 6,823 claims

Procedure code billed was for a diagnostic procedure such as an x-ray or lab work which requires the NPI of the ordering physician, or a consultation, which requires the NPI of the referring physician, and this was not submitted on the claim.

4. 888- INSTREAM REJECTION- 2,656 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:

http://www.cahabagba.com/part_b/edi/hipaa_identifying_your_errors.htm

5. 377- PAID & ADJUSTMENT AMOUNTS DO NOT EQUAL CLAIM CHARG- 2,397 claims

The submitted claim was a Medicare Secondary Payer claim, and the paid plus the adjustment amounts do not total the total claim charged amount. For help submitting these claims see this article on our website:

https://www.cahabagba.com/part_b/msp/Providers_Electronic_Billing_Instructions.htm.

Georgia

Top Five Reasons for Claim Rejections for November 2008

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.

See [Audit Trail Explanations](#) for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

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 2008**, these are:

1. 434- PROC CODE REQUIRES REFERRING NPI- 10,320 claims

Procedure code billed was for a diagnostic procedure such as an x-ray or lab work which requires the NPI of the ordering physician, or a consultation, which requires the NPI of the referring physician, and this was not submitted on the claim.

2. 421- DIAG CODE (XXXXX) INVALID FOR DATE SVC- 8,167 claims

The diagnosis code indicated was not valid on the date-of-service billed.

3. 888- INSTREAM REJECTION- 7,110 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:

http://www.cahabagba.com/part_b/edi/hipaa_identifying_your_errors.htm

4. 385- CLAIM CONTAINS A MEDICARE LEGACY ID IN LOOP : XXXX- 5,685 claims

The indicated loop contained a legacy identifier, such as a PTAN or UPIN.

5. 377- PAID & ADJUSTMENT AMOUNTS DO NOT EQUAL CLAIM CHARG- 4,297 claims

The claim was submitted as a Medicare Secondary Payer claim and the paid plus the adjustment amounts did not total up to the total claim charged amount. For help submitting this type of claim see this article on our website:

https://www.cahabagba.com/part_b/msp/Providers_Electronic_Billing_Instructions.htm.

Mississippi

Top Five Reasons for Claim Rejections for November 2008

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.

See [Audit Trail Explanations](#) for a more complete list of edits, along with descriptions of loops that might be referenced in an edit.

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 2008**, these are:

1. 434- PROC CODE REQUIRES REFERRING NPI- 12,990 claims

Procedure code billed was for a diagnostic procedure such as an x-ray or lab work which requires the NPI of the ordering physician, or a consultation, which requires the NPI of the referring physician, and this was not submitted on the claim.

2. 436- INVALID LINE LEVEL CLIA NUMBER- 8,071 claims

The CLIA submitted for a specific charge on the claim was not valid.

3. 385- CLAIM CONTAINS A MEDICARE LEGACY ID IN LOOP : XXXX- 4,474 claims

A legacy provider number, such as a PTAN or UPIN, was billed in the indicated loop.

4. 421- DIAG CODE (XXXXX) INVALID FOR DATE SVC- 3,751 claims

The diagnosis code submitted was not valid on the date-of-service billed.

5. 888- INSTREAM REJECTION- 2,927 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:

http://www.cahabagba.com/part_b/edi/hipaa_identifying_your_errors.htm

Medicare Health Insurance Claim (HIC) Number

A Medicare card is issued to every person who is entitled to Medicare benefits and may be identified by its red, white and blue coloring. This card identifies the Medicare beneficiary and includes the following information:

- Name (exactly as it appears on the Social Security records);
- Medicare Health Insurance Claim (HIC) number;
- Beginning date of Medicare entitlement for hospital and/or medical insurance;
- Sex; and, Beneficiary's signature

MEDICARE		HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)			
NAME OF BENEFICIARY			
JANE DOE			
MEDICARE CLAIM NUMBER		SEX	
000-00-0000-A		FEMALE	
IS ENTITLED TO		EFFECTIVE DATE	
HOSPITAL (PART A)		07-01-1986	
MEDICAL (PART B)		07-01-1986	
SIGN HERE →		<i>Jane Doe</i>	

Three of the top five reasons for claim rejection in any given month are for:

- The last name submitted for the beneficiary does not match the last name we have on record for the HIC number on the claim. The beneficiary's last name must include apostrophes, spaces, hyphens, etc., if they appear in the beneficiary's last name on his or her Medicare card.
- The first name submitted for the beneficiary does not match the first name we have on record for the HIC number on the claim. The beneficiary's first name must appear as it does on the beneficiary's Medicare card. This includes spaces, hyphens, apostrophes, etc.
- The HIC number not matching the name we have on record. The Medicare Claim Number must appear on the claim exactly as it does on the beneficiary's card.

It is extremely important that you submit the patient's complete name and HIC number to Medicare or any other health care provider you use (i.e. clinical laboratories, radiology imaging groups, or outpatient therapy providers, etc.). This will ensure that those providers have the correct patient information to file their claims as well.

Health Insurance Claim (HIC) Number Suffixes

The following is a list of different types of suffixes that may appear on a beneficiary's Medicare Health Insurance Claim number (HIC).

Suffix	Sex	Explanation
A	M or F	Primary wage earner
B	F	Aged wife, first claimant
B1	M	Husband, first claimant
B2	F	Young wife, first claimant
B3	F	Aged wife, second claimant
B4	M	Aged husband, second claimant
B5	F	Young wife, second claimant
B6	F	Divorced wife, first claimant
B7	F	Young wife, third claimant
B8	F	Aged wife, third claimant
B9	F	Divorced wife, second claimant
BA	F	Wife age 62 or older, fourth claimant
BD	F	Wife age 62 or older, fifth claimant
BG	M	Husband age 62 or older, third claimant
BH	M	Husband age 62 or older, fourth claimant
BJ	M	Husband age 62 or older, fifth claimant
BK	F	Wife under age 62, fourth claimant
BL	F	Wife under age 62, fifth claimant
BN	F	Divorced wife, third claimant
BP	F	Divorced wife, fourth claimant
BQ	F	Divorced wife, fifth claimant
BT	M	Divorced husband, second claimant
BW	M	Young husband, second claimant
C1-C9	M or F	Child (includes minor, student, or disabled child)
CA-CK	M or F	Child (includes minor, student, or disabled child)
CB	M or F	Child or grandchild, disabled or student
D	F	Aged widow, first claimant
D1	M	Widower, first claimant
D2	F	Aged widow, second claimant
D3	M	Widower, second claimant
D4	F	Widow, remarried after age 60
D5	M	Widower, remarried after age 60
D6	F	Surviving divorced wife, first claimant
D7	F	Surviving divorced wife, second claimant
D8	F	Aged widow, third claimant
D9	F	Widow, remarried after age 60, second claimant
DA	F	Widow, remarried after age 60, third claimant
DC	M	Surviving divorced husband, first claimant
DD	F	Widow age 60 or older, fourth claimant
DG	F	Widow age 60 or older, fifth claimant
DH	M	Widower age 60 or older, third claimant

DJ	M	Widower age 60 or older, fourth claimant
DK	M	Widower age 60 or older, fifth claimant
DL	F	Widow remarried after 60, fourth claimant
DM	M	Surviving divorced husband, second claimant
DN	F	Widow remarried after 60, fifth claimant
DP	M	Widower remarried, second claimant
DQ	M	Widower remarried, third claimant
DR	M	Widower remarried, fourth claimant
DT	M	Widower remarried, fifth claimant
DV	F	Surviving divorced wife, third claimant
DW	F	Surviving divorced wife, Fourth claimant
DX	M	Surviving divorced husband, fourth claimant
DY	F	Surviving divorced wife, fifth claimant
DZ	F	Surviving divorced wife, fifth claimant
E	F	Widowed mother, first claimant
E1	F	Surviving divorced mother, first claimant
E2	F	Widowed mother, second claimant
E3	F	Surviving divorced mother, second claimant
E4	M	Widower
E5	M	Surviving divorced father, first claimant
E6	M	Widower father, second claimant
E7	F	Widowed mother, third claimant
E8	F	Mother, fourth claimant
E9	M	Surviving divorced father, second claimant
EA	F	Mother, fifth claimant
EB	F	Surviving divorced mother, third claimant
EC	F	Surviving divorced mother, fourth claimant
ED	F	Surviving divorced mother, fifth claimant
EF	M	Father, third claimant
EG	M	Father, fourth claimant
EH	M	Father, fifth claimant
EJ	M	Surviving divorced father, third claimant
EK	M	Surviving divorced father, fourth claimant
EM	M	Surviving divorced father, fifth claimant
F1	M	Father
F2	F	Mother
F3	M	Stepfather
F4	F	Stepmother
F5	M	Adopting father
F6	F	Adopting mother
F7	M	Second alleged father
F8	F	Second alleged mother
J1	M or F	Primary prouty* entitled to deemed HIB, less than three quarters of coverage
J2	M or F	Primary prouty* entitled to deemed HIB, over two quarters of coverage
J3	M or F	Primary prouty* not entitled to deemed HIB, less than three quarters of coverage

J4	M or F	Primary prouty* not entitled to deemed HIB, over two quarters of coverage
K1	F	Prouty* wife entitled, less than three quarters
K2	F	Prouty* wife entitled, over two quarters
K3	F	Prouty* wife not entitled, less than three quarters
K4	F	Prouty* wife entitled, less than three quarters
K5	F	Second prouty* wife entitled, less than three quarters
K6	F	Second prouty* wife entitled, over two quarters
K7	F	Second prouty* wife not entitled, less than three quarters
K8	F	Second prouty* wife not entitled, over two quarters
K9	F	Entitled to HIB less than three quarters, third claimant
KA	F	Entitled to HIB three quarters or more, third claimant
KB	F	Not entitled to HIB less than three quarters, third claimant
KC	F	Not entitled to HIB three quarters or more, third claimant
KD	F	Entitled to HIB less than three quarters, fourth claimant
KE	F	Not entitled to HIB three quarters or more, fourth claimant
KF	F	Not entitled to HIB less than three quarters, fourth claimant
KG	F	Not entitled to HIB three quarters or more, fourth claimant
KH	F	Entitled to HIB less than three quarters, fifth claimant
KJ	F	Entitled to HIB three quarters or more, fifth claimant
KL	F	Not entitled to HIB three quarters or more, fifth claimant
KM	F	Not entitled to HIB three quarters or more, fifth claimant
M	M or F	Uninsured, not qualified for deemed HIB
M1	M or F	Uninsured, qualified for but refused HIB
T	M or F	Uninsured, entitled to HIB under deemed or renal provisions
TA	M or F	MQGE**, primary claimant
TB	M or F	MQGE** aged spouse, first claimant
TC	M or F	MQGE** disabled adult child , first claimant
TD	M or F	MQGE** aged widow(er), first claimant
TE	M or F	MQGE** young widow(er), first claimant
TF	M	MQGE** parent, male
TH	M or F	MQGE** aged spouse, third claimant
TJ	M or F	MQGE** aged spouse, fourth claimant
TK	M or F	MQGE** aged spouse, fifth claimant
TL	M or F	MQGE** aged widow(er), second claimant
TM	M or F	MQGE** aged widow(er), third claimant
TN	M or F	MQGE** aged widow(er), fourth claimant
TP	M or F	MQGE** aged widow(er), fifth claimant
TQ	F	MQGE** parent, female
TR	M or F	MQGE** young widow(er), second claimant
TS	M or F	MQGE** young widow(er), third claimant
TT	M or F	MQGE** young widow(er), fourth claimant
TU	M or F	MQGE** young widow(er), fifth claimant
TV	M or F	MQGE** disabled widow(er), fifth claimant
TW	M or F	MQGE** disabled widow(er), first claimant
TX	M or F	MQGE** disabled widow(er), second claimant
TY	M or F	MQGE** disabled widow(er), third claimant
TZ	M or F	MQGE** disabled widow(er), fourth claimant

T2-T9	M or F	Disabled child , second to ninth claimant
W	F	Disabled widow, first claimant
W1	M	Disabled widower, first claimant
W2	F	Disabled widow, second claimant
W3	M	Disabled widower, second claimant
W4	F	Disabled widow, third claimant
W5	M	Disabled widower, third claimant
W6	F	Disabled surviving divorced wife, first claimant
W7	F	Disabled surviving divorced wife, second claimant
W8	F	Disabled surviving divorced wife, third claimant
W9	F	Disabled widow, fourth claimant
WB	M	Disabled widower, fourth claimant
WC	F	Disabled surviving divorced wife, fourth claimant
WF	F	Disabled widow, fifth claimant
WG	M	Disabled widower, fifth claimant
WJ	F	Disabled surviving divorced wife, fifth claimant
WR	M	Disabled surviving divorced husband, first claimant
WT	M	Disabled surviving divorced husband, second claimant

*Prouty- A person who turned 72 prior to 1968. Social Security Administration term established to distinguish certain eligible people.

** MQGE= Medicare Qualified Government Employee

Medicare Articles Database

The Medical Review Department is in the process of updating articles in the Centers for Medicare & Medicaid Services (CMS) Medicare Articles Database. Please check the Cahaba GBA Web site regularly under Part B ['News'](#) for articles that are being added to the database.

Articles currently on the Medicare Articles Database can be searched from <http://www.cms.hhs.gov/mcd/search.asp?from2=search1.asp&>.

Bevacizumab (Avastin®) – Expanded Coverage

Effective for claims with dates of service on and after **December 1, 2008**, coverage for Bevacizumab (Avastin®) has been expanded to reflect off-label coverage for Central Nervous System Cancers. The following ICD-9 codes have been added for coverage:

- 191.0 - 191.9 (malignant neoplasm of brain)

In accordance with the NCCN Drugs and Biologicals Compendium, and to align with the Cahaba Part A Local Coverage Determination (LCD) for this drug, the following ICD-9 codes have been added for coverage:

- 183.2 – 183.5
- 183.8
- 183.9
- 189.1
- V10.00
- V10.05
- V10.06
- V10.3

A complete list of payable ICD-9 codes for Bevacizumab (Avastin®), as well as the other chemotherapeutic agents for which Cahaba GBA Part B has automated payment edits, can be viewed in the article titled 'Chemotherapeutic Agents' (A46312). This article can be accessed from the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/search.asp?from2=search1.asp&> and keying in the Article document ID (A46312).

Providers are encouraged to review this information to ensure compliance.

This notification was posted in the '[News](#)' section of the Web site on November 21, 2008.

Paclitaxel Protein-Bound Particles (Abraxane®) – Expanded Coverage

Effective for claims with dates of service on and after **December 1, 2008**, coverage of Paclitaxel Protein-Bound Particles (Abraxane®) (J9264) is expanded to include the off-label indication of Non-small cell lung cancer (NSCLC). The following ICD-9 codes have been added to the list of payable diagnosis codes:

- 162.0
- 162.2 – 162.5
- 162.8 – 162.9

A complete list of payable ICD-9 codes for Paclitaxel Protein-Bound Particles (Abraxane®), as well as the other chemotherapeutic agents for which Cahaba GBA Part B has automated payment edits, can be viewed in the article titled 'Chemotherapeutic Agents' (A46312). This article can be accessed from the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/search.asp?from2=search1.asp&> and keying in the Article document ID (A46312).

Providers are encouraged to review this information to ensure compliance.

This notification was posted in the '[News](#)' section of the website on November 21, 2008.

Local Coverage Determination (LCD) Updates – 2009 CPT/HCPCS Codes

The table below describes the revisions made to Local Coverage Determinations (LCDs) as a result of the Annual CPT/HCPCS Update for 2009. Please make note of these revisions, which will become effective **January 1, 2009**.

Drugs and Biologicals: Immune Globulin Intravenous (IVIg) (L24985)

Q4097 (Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg) is invalid December 31, 2008 and is being replaced by **J1459** (Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g. liquid 500 mg)).

Medicine: Transthoracic Echocardiography (TTE) (L26086)

The description of **93307** was revised with the creation of **93306**. The following CPT code descriptions are effective January 1, 2009:

93307: Echocardiography, transthoracic, real-time with image documentation (2D), includes m-mode recording, when performed, complete, without spectral or color doppler echocardiography

93306: Echocardiography, transthoracic, real-time with image documentation (2D), includes m-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography

As a result, **93306** will be added to the list of CPT codes for this LCD. This code is currently addressed in the LCD and does not establish any new indications within, nor restrict, the current coverage.

Effective **January 1, 2009**, these revised LCDs can be accessed on the [Active Local Coverage Determinations](#) web page, where you can click on your state for the information you need.

This notification was posted in the '[News](#)' section of the website on December 2, 2008.

Expanded Coverage for Chemotherapeutics Agents: Gemcitabine Hydrochloride (Gemzar®) and Rituximab (Rituxan®)

In accordance with the NCCN Drugs and Biologicals Compendium, and to align with the Cahaba Part A Local Coverage Determinations (LCDs) for Gemcitabine Hydrochloride (Gemzar®) and Rituximab (Rituxan®), the following ICD-9 codes have been added to the Cahaba Part B automated payment edits for these chemotherapeutic agents effective for claims with dates of service on and after **January 1, 2009**:

Gemcitabine Hydrochloride (Gemzar®) (J9201):

- 196.0 – 198.82

Rituximab (Rituxan®) (J9310):

- 273.4
- 287.30
- 287.33
- 714.1 – 714.33
- 795.79

A complete list of payable ICD-9 codes for these chemotherapeutics agents, as well as the other chemotherapeutic agents for which Cahaba GBA Part B has automated payment edits, can be viewed in the article titled 'Chemotherapeutic Agents' (A46312). This article can be accessed from the CMS Medicare Coverage Database at <http://www.cms.hhs.gov/mcd/search.asp?from2=search1.asp&> and keying in the Article document ID (A46312).

Providers are encouraged to review this information to ensure compliance.

This notification was posted in the ['News'](#) section of the website on December 2, 2008.

Changes to Duplicate Remittance Requests Policy

According to the *Medicare Claims Processing Manual* (Pub. 100-04, Ch. 22, §10) the Centers for Medicare & Medicaid Services (CMS) allows contractors to charge for generating and mailing duplicate remittance advice (both electronic and paper) to recoup costs when generated at the request of a provider or any entity working on behalf of the provider.

Effective **February 1, 2009**, when a provider requests a copy of a remittance advice (electronic or paper), Cahaba GBA will charge \$5.00 for each copy. Requests will be completed within 45 business days of receipt. Requests must be submitted using the "[Request for Duplicate Remittance Advice](#)" form. Return this form and your check payable to "Cahaba GBA" to the address provided on the form.

Note: Remember that an electronic remittance advice (ERA) file is available to download for 45 days. If necessary, you may request the ERA to be made available in your mailbox for another 45 days; however, after the second 45 days, the ERA file is no longer available.

Claim Filing Time Limit

Medicare law prescribes specific time limits within which claims for benefits may be submitted. The terms of the law require that the claim be filed no later than the end of the calendar year following the year in which the service was furnished.

For Dates of Service:

October 1, 2005-September 30, 2006:
 October 1, 2006-September 30, 2007:
 October 1, 2007-September 30, 2008:
 October 1, 2008-September 30, 2009:

Claim Must Be Filed By:

Claims filed by: Time Limit Expired**
 Claims filed by: December 31, 2008
 Claims filed by: December 31, 2009
 Claims filed by: December 31, 2010

Claims for dates of service in October, November or December (the last three months of a year) are an exception to this rule. These dates are called "drop dead dates". The filing limit for these claims is the end of the second calendar year after the date of service (the second year following the year in which the services were rendered).

***Any claim in which the claim filing time limit has expired will result in a denial with MRN remark message "MA 29 - The time limit for filing has expired."*

Claim Filing Penalties

The Omnibus Budget Reconciliation Act of 1989 requires a Medicare supplier to submit a completed claim within one year when providing covered items to a Medicare beneficiary. If an assigned claim is not filed within one year, Medicare will reduce the allowed amount by 10% for payable claims.

- Up to 1 Year – No Penalty
- After 1 Year – 10% Penalty Reduction

Independent Diagnostic Testing Facilities- Update

The Independent Diagnostic Testing Facilities (IDTF) Coding List has been updated. The “**Supervising Physician Qualification Requirement**” for the following list of codes will be changed effective **January 1, 2009** to reflect “Radiologist or Vascular Surgeon”.

A complete list of procedure codes commonly performed in an IDTF can be accessed at http://www.cahabagba.com/part_b/enroll_update_your_records/enroll_idtf_list.pdf.

Note: The publication of these codes and requirements does not indicate that all the codes listed are allowed in an Independent Diagnostic Testing Facility.

CPT	Description	Supervising Physician Qualification Requirement	Technician Qualification
70496	CT angiography, head	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-CT)
70498	CT angiography, neck	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-CT)
70544	MR angiography, head w/o dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-MR)
70545	MR angiography, head w/dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-MR)
70546	MR angiography, head w/o & w/dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-MR)
70547	MR angiography, neck w/o dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-MR)
70548	MR angiography, neck w/ dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-MR)
70549	MR angiography, neck w/o & w/dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-MR)
71275	CT angiography, chest	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-CT)
71555	MR angiography, chest w or w/o dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-MR)
72191	CT angiography, pelvis w/o & w/dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-CT)
72198	MR angiography, pelvis w/o & w/dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-MR)

73206	CT angiography, upper extremity w/o & w/dye	Radiologist or Orthopedic Surgeon or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-CT)
73706	CT angiography, lower extremity w/o & w/dye	Radiologist or Orthopedic Surgeon or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-CT)
73725	MR angiography, lower extremity w or w/o dye	Radiologist or Orthopedic Surgeon or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-MR)
74175	CT angiography, abdomen w/o & w/dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-CT)
74185	MR angiogram, adb w or w/o dye	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-MR)
75600	Contrast x-ray exam of aorta	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75605	Contrast x-ray exam of aorta	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75635	CT angiogram abdominal arteries	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-CT)
75650	Artery x-rays, head & neck	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75658	Artery x-rays, arm	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75660	Artery x-rays, head and neck	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75662	Artery x-rays, head and neck	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75665	Artery x-rays, head and neck	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75671	Artery x-rays, head and neck	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75676	Artery x-rays, neck	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75680	Artery x-rays, neck	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75685	Artery x-rays, spine	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-

			R)
75705	Artery x-rays, spine	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75710	Artery x-rays, arm/leg	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75716	Artery x-rays, arm/legs	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75722	Artery x-rays, kidney	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75724	Artery x-rays, kidneys	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75726	Artery x-rays, abdomen	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75731	Artery x-rays, adrenal gland	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75733	Artery x-rays, adrenals	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75736	Artery x-rays, pelvis	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R).
75741	Artery x-rays, lung	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75743	Artery x-rays, lungs	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75746	Artery x-rays, chest	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75756	Artery x-rays, chest	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75790	Visualize A-V shunt	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75810	Vein x-ray, spleen/liver	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75820	Vein x-ray, arm/leg	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75822	Vein x-ray, arm/legs	Radiologist or Vascular	Certified Radiologic

		Surgeon	Technologist (ARRT:R.T.-R)
75825	Vein x-ray, trunk	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75827	Vein x-ray, chest	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75831	Vein x-ray, kidney	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75833	Vein x-ray, kidneys	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75840	Vein x-ray, adrenal gland	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75842	Vein x-ray, adrenal glands	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75860	Vein x-ray, neck	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75870	Vein x-ray, skull	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75872	Vein x-ray, skull	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75880	Vein x-ray, eye socket	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75885	Vein x-ray, liver	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75887	Vein x-ray, liver	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75889	Vein x-ray, liver	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75891	Vein x-ray, liver	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75893	Venous sampling by catheter	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75898	Follow-up angiography	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)

75900	Arterial catheter exchange	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75945	Intravascular ultrasound	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
75946	Intravascular us add-on	Radiologist or Vascular Surgeon	Certified Radiologic Technologist (ARRT:R.T.-R)
76937	US guide, vascular access	Radiologist or Vascular Surgeon	Credentialed by ARDMS or ARRT:R.T-S
93875	Extracranial study	Radiologist, Neurologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93880	Extracranial study	Radiologist, Neurologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93882	Extracranial study	Radiologist, Neurologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93886	Intracranial study	Radiologist, Neurologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93888	Intracranial study	Radiologist, Neurologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93890	TCD, vasoreactivity study	Radiologist, Neurologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93892	TCD, emboli detect w/o injection	Radiologist, Neurologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93893	TCD, emboli detect w injection	Radiologist, Neurologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93922	Extremity study	Radiologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93923	Extremity study	Radiologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93924	Extremity study	Radiologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93925	Extremity study	Radiologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93926	Extremity study	Radiologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT

93930	Upper extremity study	Radiologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS-RDMS, RDCS, ARRT-RS, or RVT
93931	Upper extremity study	Radiologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS
93965	Extremity study	Radiologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS
93970	Extremity study	Radiologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS
93971	Extremity study	Radiologist, Cardiologist, or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS
93975	Vascular study	Radiologist or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS
93976	Vascular study	Radiologist or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS
93978	Vascular study	Radiologist or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS
93979	Vascular study	Radiologist or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS
93980	Penile vascular study	Radiologist, Urologist, or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS
93981	Penile vascular study	Radiologist, Urologist, or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS
93990	Doppler flow testing	Radiologist or Vascular Surgeon	Credentialed by ARDMS RVT or ARRT: VS, RVS

Upcoming Educational Events....

Medicare Part B, Provider Outreach and Education are planning the following educational events. You should watch for future listserv notifications and continue to visit our website at www.cahabagba.com/apps/course_registration/al/calendar.jsp for additional details and/or registration for these events. Please join us!

Ask Cahaba B (Teleconference)

Topic: Physician Quality Reporting Initiative and E-Prescribing Program

Date: January 14, 2009

Time: 10:00 a.m. – 11:00 Central, 11:00 a.m. – 12:00 Eastern

Open to the first 100 callers. Registration is required.

New Provider Workshop (Face to Face)

Date: February 12, 2009

Time: To Be Decided

Place: Hyatt Place

4686 Highway 280 East

Birmingham, AL 35242

Registration is required.

Medicare 101 Series– Part 1 of 3 (Webinar)

CPT and Modifier Coding

Date: March 19, 2009

Time: 10:00 a.m. – 11:00 Central, 11:00 a.m. – 12:00 Eastern

Registration is required for this event.

Medicare 101 Series – Part 2 of 3 (Webinar)

Billing Basics & CMS 1500 Claim Form

Date: March 24, 2009

Time: 10:00 a.m. – 11:00 Central, 11:00 a.m. – 12:00 Eastern

Registration is required for this event.

Medicare 101 Series – Part 3 of 3 (Webinar)

Appeals

Date: March 26, 2009

Time: 10:00 a.m. – 11:00 Central, 11:00 a.m. – 12:00 Eastern

Registration is required for this event.

News Flash Messages From CMS

Flu Season

Flu Season Is Upon Us! Begin now to take advantage of each office visit as an opportunity to encourage your patients to get a flu shot. It's still their best defense against combating the flu this season. (Medicare provides coverage of the flu vaccine without any out-of-pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) And don't forget, health care personnel can spread the highly contagious flu virus to patients. Protect yourself. Don't Get the Flu. Don't Give the Flu. Get Your Flu Shot. Remember - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professionals, please go to http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS Web site.

Physician Quality Reporting Initiative (PQRI)

The Centers for Medicare & Medicaid Services (CMS) will begin testing eleven new quality measures for possible adoption in the PQRI program in future years. To learn more about how you can help CMS test these measures, visit <http://www.cms.hhs.gov/pqri> on the CMS Web site and select the "Measures/Codes" link on the left side of the page. And as a reminder, all educational resources about the 2008 PQRI are available on the dedicated PQRI webpage on the CMS Web site. To access this web page, visit <http://www.cms.hhs.gov/pqri> on the CMS Web site.

E-Prescribing Incentive Program

The Centers for Medicare & Medicaid Services (CMS) has posted "Medicare's Practical Guide to the E-Prescribing Incentive Program", which explains the e-prescribing incentive program, how eligible professionals can participate, and how to choose a qualified e-prescribing system. To read or print the guide, visit <http://www.cms.hhs.gov/partnerships/downloads/11399.pdf> on the CMS Web site. By adopting e-prescribing through Medicare's program, eligible professionals can save time, enhance office and pharmacy productivity, and improve patient safety and quality of care while earning incentives from Medicare. For additional information about e-prescribing, you can also visit: <http://www.cms.hhs.gov/PQRI> and select "E-prescribing Incentive Program"; or visit <http://www.cms.hhs.gov/eprescribing> (for information on Part D e-prescribing standards that will be effective April 1, 2009); and <http://www.ehealthinitiative.org/> to download "A Clinician's Guide to Electronic Prescribing".

continued on the next page

News Flash Messages From CMS, continued from the previous page

ICD-10-Clinical Modification/Procedure Coding System Fact Sheet

The ICD-10-Clinical Modification/Procedure Coding System Fact Sheet, which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in downloadable format from the Centers for Medicare & Medicaid Services Medicare Learning Network at <http://www.cms.hhs.gov/MLNProducts/downloads/ICD-10factsheet2008.pdf> on the CMS Web site.

Medicare Learning Network (MLN)

Would you like to stay informed of the educational products from the? If so, you can join the Medicare Learning Network (MLN) Education Products mailing list, which will deliver the latest information about new and revised MLN products, right to your inbox. To join, visit https://list.nih.gov/cgi-bin/wa?SUBED1=mln_education_products-l&A=1; then enter your email address and full name. Click "Join the List". Follow the instructions in the confirmation email you will receive to confirm your subscription to the list. (Note: the sender of this email will appear as "NIH LISTSERV SERVER".)

Competitive Acquisition Program (CAP) for Drugs and Biologicals

The Medicare Part B Competitive Acquisition Program (CAP) for Drugs and Biologicals has been postponed for 2009. Information about upcoming CAP deadlines is available at http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp on the CMS Web site.

Physician Quality Reporting Initiative (PQRI)

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a new self-service look-up tool is now available on the Physician Quality Reporting Initiative (PQRI) Portal at <http://www.qualitynet.org/pqri>, which allows an eligible professional at the Tax Identification Number (TIN) level to see if their 2007 PQRI Feedback Report is available. Once on the site, go to the "Verify TIN Report Portlet" which is located at the bottom left of the page. Enter the TIN and a message appears that indicates if a 2007 PQRI Feedback Report is or is not available. This self-service look-up tool does not allow the eligible professional to view their 2007 PQRI Feedback Report. The availability of the 2007 PQRI Feedback Report is helpful for the eligible professional to know because it enables them to decide if they need to register for an IACS account so that they can log into and view their 2007 PQRI Feedback Report. Additional information is in MLN Matters Special Edition articles SE0830-- (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0830.pdf>) and SE0831-- (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0831.pdf>) on the CMS Web site.

continued on the next page

News Flash Messages From CMS, continued from the previous page

Medicare Payments Reductions

Your Medicare payments could be reduced if the Internal Revenue Service (IRS) needs to collect overdue taxes that you owe. The Taxpayer Relief Act of 1997, Section 1024, authorizes the IRS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Should you owe such taxes and your payments are reduced, your remittance advice will reflect a provider level adjustment code (PLB) of "WU" in the PLB03-1 data field. For more information, please see MLN Matters Article #MM6125 available at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf> on the CMS Web site.

Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

What You Need to Know

This article is based on Change Request (CR) 6262 which provides the annual HH consolidated billing update effective January 1, 2009.

What You Need to Do

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

Background

The Social Security Act (Section 1842(b)(6); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see http://edocket.access.gpo.gov/cfr_2005/octqtr/42cfr409.100.htm on the Internet and in the *Medicare Claims Processing Manual* (Chapter 10, Section 20.1), available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Web site.

The home health consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (i.e., 'K' codes) throughout the calendar year.

The **following HCPCS code is added** to the home health consolidated billing supply code list, and it is a new code that does not replace any prior HCPCS code on the list:

Added HCPCS Code	Descriptor
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each.

continued on the next page

Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes Used for Home Health Consolidated Billing Enforcement, continued from the previous page

The following HCPCS code is deleted from the home health consolidated billing supply code list, and this code is being removed because it is non-covered by Medicare statute.

Deleted HCPCS Code	Descriptor
A6413	Adhesive Bandage, First-Aid Type, any size, each

Additional Information

The official instruction, CR 6262, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1633CP.pdf> on the CMS Web site.

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

MLN Matters MM6262

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6229 which updates Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs). If you use the Medicare Remit Easy Print software, note that Medicare will update that software as a result of implementing CR 6229. Be sure billing staff are aware of these updates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions adopted under HIPAA using valid standard codes. Medicare policy states that Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions. Medicare policy further states that appropriate Remittance Advice Remark Codes (RARCs) that provide either supplemental explanation for a monetary adjustment or policy information are required in the remittance advice transaction.

X12N 835 Health Care Remittance Advice Remark Codes

The Centers for Medicare & Medicaid Services (CMS) is the national maintainer of the remittance advice remark code list. This code list is used by reference in the ASC X12 N transaction 835 (Health Care Claim Payment/Advice) version 004010A1 Implementation Guide (IG). Under HIPAA, all payers, including Medicare, are required to use reason and remark codes approved by X12 recognized code set maintainers instead of proprietary codes to explain any adjustment in the claim payment. CMS, as the X12 recognized maintainer of RARCs, receives requests from Medicare and non-Medicare payers for new codes and modification/deactivation of existing codes. Additions, deletions, and modifications to the code list resulting from non-Medicare requests may or may not impact Medicare.

Note: The complete list of remark codes is available at <http://www.wpc-edi.com/codes> on the Internet.

Medicare contractors will use the latest approved and valid codes in the 835, corresponding Standard Paper Remittance (SPR) advice, and coordination of benefits transactions.

CMS has developed a new Web site to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of codes. At this site you can find some other information that is also available from the WPC Web site. The Web site address is <http://www.cmsremarkcodes.info/> on the Internet.

continued on the next page

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update, continued from the previous page

Note I: This Web site is not replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

Note II: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for a monetary adjustment. Codes that are “Informational” will have “Alert” in the text to identify them as informational rather than explanatory codes. These “Informational” codes may be used without any CARC explaining a specific adjustment.

An example of an informational code:

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

The above information is sent per state regulation, but does not explain any adjustment.

These informational codes are used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes when a RARC is required with a CARC -16, 17, 96, 125, and A1.

Remittance Advice Remark Code Changes

New Codes:

Code	Current Narrative	Medicare Initiated
N434	Missing/Incomplete/Invalid Present on Admission indicator. Start: 7/1/2008	
N435	Exceeds number/frequency approved /allowed within time period without support documentation. Start: 7/1/2008	
N436	The injury claim has not been accepted and a mandatory medical reimbursement has been made. Start: 7/1/2008	
N437	Alert: If the injury claim is accepted, these charges will be reconsidered. Start: 7/1/2008	
N438	This jurisdiction only accepts paper claims. Start: 7/1/2008	
N439	Missing anesthesia physical status report/indicators. Start: 7/1/2008	
N440	Incomplete/invalid anesthesia physical status report/indicators. Start: 7/1/2008	
N441	This missed appointment is not covered. Start: 7/1/2008	
N442	Payment based on an alternate fee schedule. Start: 7/1/2008	
N443	Missing/incomplete/invalid total time or begin/end time. Start: 7/1/2008	
N444	Alert: This facility has not filed the Election for High Cost	

	Outlier form with the Division of Workers' Compensation. Start: 7/1/2008	
N445	Missing document for actual cost or paid amount. Start: 7/1/2008	
N446	Incomplete/invalid document for actual cost or paid amount. Start: 7/1/2008	
N447	Payment is based on a generic equivalent as required documentation was not provided. Start: 7/1/2008	
N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement. Start: 7/1/2008	
N449	Payment based on a comparable drug/service/supply. Start: 7/1/2008	
N450	Covered only when performed by the primary treating physician or the designee. Start: 7/1/2008	
N451	Missing Admission Summary Report. Start: 7/1/2008	
N452	Incomplete/invalid Admission Summary Report. Start: 7/1/2008	
N453	Missing Consultation Report. Start: 7/1/2008	
N454	Incomplete/invalid Consultation Report. Start: 7/1/2008	
N455	Missing Physician Order. Start: 7/1/2008	
N456	Incomplete/invalid Physician Order. Start: 7/1/2008	
N457	Missing Diagnostic Report. Start: 7/1/2008	
N458	Incomplete/invalid Diagnostic Report. Start: 7/1/2008	
N459	Missing Discharge Summary. Start: 7/1/2008	
N460	Incomplete/invalid Discharge Summary. Start: 7/1/2008	
N461	Missing Nursing Notes. Start: 7/1/2008	
N462	Incomplete/invalid Nursing Notes. Start: 7/1/2008	
N463	Missing support data for claim. Start: 7/1/2008	
N464	Incomplete/invalid support data for claim. Start: 7/1/2008	
N465	Missing Physical Therapy Notes/Report. Start: 7/1/2008	
N466	Incomplete/invalid Physical Therapy Notes/Report. Start: 7/1/2008	
N467	Missing Report of Tests and Analysis Report. Start: 7/1/2008	
N468	Incomplete/invalid Report of Tests and Analysis Report. Start: 7/1/2008	
N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Start: 7/1/2008	Yes
N470	This payment will complete the mandatory medical reimbursement limit. Start: 7/1/2008	
N471	Missing/incomplete/invalid HIPPS Rate Code. Start: 7/1/2008	
N472	Payment for this service has been issued to another provider. Start: 7/1/2008	
N473	Missing certification. Start: 7/1/2008	
N474	Incomplete/invalid certification Start: 7/1/2008	
N475	Missing completed referral form. Start: 7/1/2008	
N476	Incomplete/invalid completed referral form Start: 7/1/2008	
N477	Missing Dental Models. Start: 7/1/2008	
N478	Incomplete/invalid Dental Models Start: 7/1/2008	

N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008	
N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer). Start: 7/1/2008	
N481	Missing Models. Start: 7/1/2008	
N482	Incomplete/invalid Models Start: 7/1/2008	
N483	Missing Periodontal Charts. Start: 7/1/2008	
N484	Incomplete/invalid Periodontal Charts Start: 7/1/2008	
N485	Missing Physical Therapy Certification. Start: 7/1/2008	
N486	Incomplete/invalid Physical Therapy Certification. Start: 7/1/2008	
N487	Missing Prosthetics or Orthotics Certification. Start: 7/1/2008	
N488	Incomplete/invalid Prosthetics or Orthotics Certification Start: 7/1/2008	
N489	Missing referral form. Start: 7/1/2008	
N490	Incomplete/invalid referral form Start: 7/1/2008	
N491	Missing/Incomplete/Invalid Exclusionary Rider Condition. Start: 7/1/2008	
N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge. Start: 7/1/2008	
N493	Missing Doctor First Report of Injury. Start: 7/1/2008	
N494	Incomplete/invalid Doctor First Report of Injury. Start: 7/1/2008	
N495	Missing Supplemental Medical Report. Start: 7/1/2008	
N496	Incomplete/invalid Supplemental Medical Report. Start: 7/1/2008	
N497	Missing Medical Permanent Impairment or Disability Report. Start: 7/1/2008	
N498	Incomplete/invalid Medical Permanent Impairment or Disability Report. Start: 7/1/2008	
N499	Missing Medical Legal Report. Start: 7/1/2008	
N500	Incomplete/invalid Medical Legal Report. Start: 7/1/2008	
N501	Missing Vocational Report. Start: 7/1/2008	
N502	Incomplete/invalid Vocational Report. Start: 7/1/2008	
N503	Missing Work Status Report. Start: 7/1/2008	
N504	Incomplete/invalid Work Status Report. Start: 7/1/2008	

Modified Codes

Code	Current Modified Narrative	Last Modified
M29	Missing operative note/report	7/1/08
N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	7/1/08
N26	Missing itemized bill/statement.	7/1/08
N40	Missing radiology film(s)/image(s).	7/1/08

N130	Alert: Consult plan benefit documents/guidelines for information about restrictions for this service.	7/1/08
N209	Missing/incomplete/invalid taxpayer identification number (TIN).	7/1/08
N232	Incomplete/invalid itemized bill/statement.	7/1/08
N233	Incomplete/invalid operative note/report.	7/1/08
N242	Incomplete/invalid radiology film(s)/image(s).	7/1/08
N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	7/1/08
N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.	7/1/08
N390	This service/report cannot be billed separately	7/1/08
N393	Missing progress notes/report	7/1/08
N394	Incomplete/invalid progress notes/report.	7/1/08

Deactivated Codes

There are no newly deactivated codes with CR 6229. Lists of all deactivated and scheduled to be deactivated RARCs are available at the WPC Web site at <http://www.wpc-edi.com/codes> on the Internet.

X12 N 835 Health Care Claim Adjustment Reason Codes

A national code maintenance committee maintains the health care Claim Adjustment Reason Codes (CARCs). The Committee meets at the beginning of each X12 trimester meeting (January/February, June and September/October) and makes decisions about additions, modifications, and retirement of existing reason codes. The updated list is posted 3 times a year around early November, March, and July. The list is available at <http://www.wpc-edi.com/codes> on the Internet.

New Codes:

Code	Current Narrative	Implementation Date
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Start Date: 6/1/2008	01/05/2009
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created. Start Date: 6/1/2008	01/05/2009
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims. Start Date: 6/1/2008	01/05/2009
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)Start Date: 6/1/2008	01/05/2009

Note: Codes 223 and 224 are Medicare initiated

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Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update, continued from the previous page

Modified Code(s):

Code	Current Narrative	Implementation Date
60	Charges for outpatient services with this proximity to inpatient services are not covered. This change to be effective 1/1/2009: Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	01/05/2009
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Worker's Compensation only)- Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code. Start: 01/27/2008- Stop 01/01/2009.	01/01/2009

Note: The Code Committee also reactivated CARC 2007

Additional Information

The official instruction, CR 6229, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1634CP.pdf> on the CMS Web site.

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

MLN Matters MM6229

Health Professional Shortage Area (HPSA) Bonus Payment Policy Changes

Provider Types Affected

Physicians and providers submitting claims to Medicare Carriers, Medicare Administrative Contractors (A/B MACs), and/or Fiscal Intermediaries (FIs) for services provided to Medicare beneficiaries in areas designated as geographic HPSAs.

Provider Action Needed

This article is based on Change Request (CR) 6106 and informs providers who are serving Medicare beneficiaries in areas that were eligible on December 31 of the prior year for the HPSA bonus but **not on the automated ZIP code list to use the AQ modifier to receive the HPSA bonus payment**. Make sure billing staff are aware of the clarified criteria for proper use of the AQ modifier.

Background

The Section 1833(m) of the Social Security Act provides for an additional 10 percent bonus payment for physicians' services furnished to a covered individual in an area that is designated as a geographic HPSA prior to the beginning of the year in which the services were provided. Such HPSA areas are identified by the Secretary of the Department of Health and Human Services prior to the beginning of such year. The Centers for Medicare & Medicaid Services (CMS) posts a file annually of ZIP codes within which the HPSA bonus payment should be made automatically. Physicians furnishing services in areas that were eligible for the HPSA bonus prior to the beginning of the year but not on the automated list have been instructed to use the AQ modifier to receive the HPSA bonus payment.

Key Points

- Effective for claims with dates of service on or after January 1, 2009, only services furnished in areas that are designated as geographic HPSAs as of December 31 of the prior year are eligible for the HPSA bonus payment.
- Services furnished in areas that are designated at any time during the current year will not be eligible for the HPSA bonus payment until the following year, provided they are still designated on December 31.
- If you are providing services to Medicare beneficiaries in areas that are designated on December 31 of the prior year **but not included on the list of zip codes eligible** for automated HPSA bonus payments make certain you **use the AQ modifier to receive the HPSA bonus payment**.
- Remember, your Medicare Contractor will automatically make a HPSA bonus payment to physicians providing eligible services in a ZIP code included in the annual file.

continued on the next page

Health Professional Shortage Area (HPSA) Bonus Payment Policy Changes, continued from the previous page

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 6106) issued to your Medicare A/B MAC, carrier or FI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1639CP.pdf> on the CMS Web site.

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

MLN Matters MM6106

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2009

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 6304 which announces the changes that will be included in the January 2009 release of the edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in October 2008.

Background

The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the *Medicare Claims Processing Manual*, Chapter 16, Section 120.2 (see <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf> on the CMS Web site), the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 6304 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for January 2009 as described below. These changes become effective for services furnished on or after January 1, 2009 and are as follows:

For HIV Testing:

- Add ICD-9-CM code 482.42 to the list of ICD-9-CM codes covered by Medicare for the HIV Testing (Diagnosis) (190.14) NCD.

For Partial Thromboplastin Time (PTT):

- Add ICD-9-CM code range 249.40-249.41 to the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.

For Prothrombin Time (PT):

- Add ICD-9-CM code range 249.40-249.41 and the ICD-9-CM codes 197.7, V15.21, V15.22, and V15.29 to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.
- Delete ICD-9-CM code V15.2 from the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.

continued on the next page

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2009, continued from the previous page

For Serum Iron Studies:

- Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91, 285.22, 285.29, V15.21, V15.22, and V15.29 to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.

For Blood Glucose Testing:

- Add ICD-9-CM code 482.42 and the code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the Blood Glucose Testing (190.20) NCD.

For Glycated Hemoglobin/Glycated Protein:

- Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.

For Thyroid Testing:

- Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.

For Lipid Testing:

- Add ICD-9-CM code ranges 249.00-249.01, 249.10-249.11, 249.20-249.21, 249.30-249.31, 249.40-249.41, 249.50-249.51, 249.60-249.61, 249.70-249.71, 249.80-249.81, and 249.90-249.91 to the list of ICD-9-CM codes covered by Medicare for the Lipids Testing (190.23) NCD.

For Gamma Glutamyl Transferase:

- Add ICD-9-CM code 275.2 to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.

For Fecal Occult Blood Test (FOBT):

- Add ICD-9-CM codes 530.86 and 530.87 to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (FOBT) (190.34) NCD.

For All 23 NCDs (190.12-190.34):

- Add ICD-9-CM codes V16.52 and V73.81 to the list of denied ICD-9-CM codes for all 23 Lab NCDs.

continued on the next page

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2009, continued from the previous page

Additional Information

The official instruction, CR 6304, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1645CP.pdf> on the CMS Web site.

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

MLN Matters MM6304

Thermal Intradiscal Procedures (TIPs)

Provider Types Affected

Physicians and other providers who bill Medicare carriers, Fiscal Intermediaries (FI), or Medicare Administrative Contractors (MAC) for providing thermal intradiscal procedures (TIP) to Medicare beneficiaries.

What You Need to Know

CR 6291, from which this article is taken, communicates the findings of a new national coverage determination (NCD) regarding thermal intradiscal procedures (TIPs), including billing requirements.

Effective for services performed on or after September 29, 2008, the Centers for Medicare & Medicaid Services (CMS) has concluded that the evidence does not demonstrate that TIPs improve health outcomes; and has therefore determined that TIPs are not reasonable and necessary for the treatment of low back pain.

Effective September 29, 2008, TIPs are non-covered for Medicare beneficiaries.

Specifically, CR 6291:

- Announces the relevant Current Procedural Terminology (CPT) codes that (effective September 29, 2008) will be denied when submitted, and also the codes that will be denied when identified as a TIP;
- Instructs Medicare contractors to deny claims for radiologic or fluoroscopic guidance when performed in conjunction with a TIP; and
- Urges physicians, ambulatory surgical centers (ASC), and hospitals to provide appropriate liability notices to beneficiaries.

You should make sure that your billing staffs are aware of this NCD regarding TIPs, the details of which can be found in the Background section that follows.

Background

Percutaneous Thermal Intradiscal procedures (TIPs) involve the insertion a catheter(s)/probe(s) into the spinal disc under fluoroscopic guidance in order to produce, or apply, heat and/or disruption within the disc to relieve low back pain.

On January 15, 2008, the CMS initiated a national coverage analysis (NCA) on TIPs. CR 6291 communicates the findings of this NCA, and the resultant NCD. Please note that this is the first NCD to address thermal intradiscal procedures (TIPs).

The NCA addressed the use of TIPs to: 1) treat symptomatic patients with annular disruption of a contained herniated disc, 2) to seal annular tears or fissures, or 3) to destroy nociceptors for the purpose of relieving pain. It included the use of percutaneous intradiscal techniques that utilize devices employing a radiofrequency energy source or electrothermal energy to apply or create heat and/or disruption within the disc for

continued on the next page

Thermal Intradiscal Procedures (TIPs), continued from the previous page

coagulation and/or decompression of disc material. Further, it included techniques that use single or multiple probes/catheters which: 1) utilize a resistance coil or other thermal intradiscal technology; 2) are flexible or rigid; and 3) are placed within the nucleus, the nuclear-annular junction, or the annulus.

Although not meant to be a complete list, TIPs are commonly identified as

- Intradiscal Electrothermal Therapy (IDET);
- Intradiscal Thermal Annuloplasty (IDTA);
- Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT);
- Radiofrequency Annuloplasty (RA);
- Intradiscal Biacuplasty (IDB);
- Percutaneous (or plasma) Disc Decompression (PDD) or ablation; or
- Targeted Disc Decompression (TDD).

At times, TIPs are identified, or labeled, based on the name of the catheter(s)/probe(s) that are used (e.g. SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes); and each technique or device has its own protocol for application of the therapy.

Note: Percutaneous disc decompression or nucleoplasty procedures that do not utilize a radiofrequency energy source or electrothermal energy (such as the disc decompressor procedure or laser procedure) are not within this NCD's scope.

TIPs NCD Requirements

CR 6291 announces that CMS has concluded that the evidence does not demonstrate that TIPs improve health outcomes; and has therefore determined that TIPs are not reasonable and necessary for the treatment of low back pain.

Therefore, effective September 29, 2008, TIPs are non-covered for Medicare beneficiaries; and for services on and after that date, your carriers, FIs, and MACs will deny any claims that you submit for TIPs.

The following table displays the CPT/HCPCS codes that are identified for TIPs procedures performed within the annulus of the intervertebral disc. **On, or after, September 29, 2008, your Medicare contractors will deny claims that you submit for TIPs procedures with any of these non-covered codes.**

CPT/HCPCS Code	Description
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; one or more additional levels
0062T	Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level

0063T	Percutaneous intradiscal annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; one or more additional levels
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CPT Codes Identified For TIPs Procedures Performed Within the Annulus of the Intervertebral Disc*

*The change to add the non-covered indicator for these codes will be part of the January 2009 Medicare Physician Fee Schedule Update and the change to the status indicator to non-covered for the above HCPCS is part of the integrated Outpatient Code Editor (IOCE) update for January 2009 .

Note that the following CPT codes, which can be used for TIPs procedures performed within the nucleus of the disc (e.g., PDD or TDD procedures), can also be used for procedures that are not within the scope of this NCD:

- 62287 (Aspiration procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumbar);
- 22899 (Unlisted procedure, spine); and
- 64999 (Unlisted procedure, nervous system)

Please note that since codes 22899 or 64999 do suspend for review, when you submit them for TIPs procedures performed within the nucleus, **you should submit a clear description of the procedure in the narrative section of the claim. Contractors may also be advising providers to submit intervertebral disc nucleus procedures that are considered TIPs under codes 22899 or 64999 in order to avoid improper payment for a TIP under code 62287. Providers are also advised to submit the biacuplasty procedure under code 0062T (currently some providers are submitting this procedure under code 64999).**

In addition, as all TIPs procedures are performed with radiologic or fluoroscopic guidance, this ancillary service would be directly related to a noncovered service and would itself, therefore, also be noncovered. CR 6291 instructs your carrier, FI, or A/B MAC to deny claims for the radiologic or fluoroscopic guidance when performed in conjunction with a TIP.

When denying your TIPs claims, Medicare contractors will use:

- Medicare Summary Notice (MSN) 21.11 - "This service was not covered by Medicare at the time you received it;"
- Claim Adjustment Reason Code (CARC) 96 - "Non-covered charge(s)", and
- Remittance Advise Remark Code N386, "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have access, you may contact the contractor to request a copy of the NCD."

continued on the next page

Thermal Intradiscal Procedures (TIPs), continued from the previous page

Note: Carriers, FIs, and A/B MACs do not need to search their files to recoup payment for claims already paid, however they will adjust claims that are brought to their attention.

CR 6291 further advises physicians and hospitals to give beneficiaries, who choose to have this procedure, an Advance Beneficiary Notice (ABN), consistent with the *Medicare Claims Processing Manual*, Chapter 30, (Financial Liability Protections). This ABN, which you must issue prior to the procedure, should indicate that, after an NCA, Medicare issued a national coverage determination (NCD) (*Medicare National Coverage Determinations (NCD) Manual*, section 150.11 (Thermal Intradiscal Procedures (TIPs) (Effective September 29, 2008)) which states that TIPs are not reasonable and necessary for Medicare beneficiaries. Therefore, Medicare never pays for this service and the beneficiary would be held financially responsible if they decide to have this procedure.

You should be aware that unless the beneficiary was informed via the ABN prior to performance of the procedure that he/she would be financially responsible, you are liable for charges for TIPs.

You should also be aware that beginning March 1, 2009, the ABN-G will no longer be valid and you must issue the revised ABN (CMS-R-131).

Additional Information

You can find the official instruction, CR 6291, was issued to your carrier, FI or MAC in two transmittals. You will find revised *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 2 (Sections 90 – 160.26) (Coverage Determinations), Section 150.11 (Thermal Intradiscal Procedures (TIPs) (Effective September 29, 2008) is a national coverage determination (NCD)) at

<http://www.cms.hhs.gov/Transmittals/downloads/R97NCD.pdf> on the CMS Web site.

The transmittal that revises the *Medicare Claims Processing Manual*, Chapter 32 (Billing Requirements for Special Services), Sections 220 (Billing Requirements for Thermal Intradiscal Procedures (TIPs) Claims), 220.1 (General), 220.2 (Contractor A/B MAC), 220.3 (Medicare Summary Notice (MSN), Claim Adjustment Reason Code (CARA), and Remittance Advise Remark Code (RARC)), and 220.4 (Advanced Beneficiary Notice (ABN)) is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1646CP.pdf> on the CMS Web site.

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

MLN Matters MM6291

2008 Jurisdiction List for Durable Medical Equipment Prosthetics, Orthotics, and Supply (DMEPOS) Healthcare Common Procedure Coding System (HCPCS) Codes-Revised****

Note: This article was revised on **December 8, 2008**, to reflect that CR 6062 was revised by the Centers for Medicare & Medicaid Services on December 5, 2008. CR 6062 was revised to reflect a revised 2008 jurisdiction list to clarify that HCPCS code A4559 (coupling gel) may only be billed to the local carrier. The CR release date, transmittal number (above), and Web address for accessing CR 6062 were also revised. All other information remains the same.

Provider Types Affected

Providers and suppliers submitting claims to Medicare Contractors (carriers, DME Medicare Administrative Contractors (DME MACs), and Part A/B Medicare Administrative Contractor (A/B MACs)) for DMEPOS services provided to Medicare beneficiaries.

Impact on Providers

This article is informational and is based on Change Request (CR) 6062 that notifies providers that the spreadsheet containing an updated list of the HCPCS codes for DME MAC and Part B local carrier or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2008 Jurisdiction List is attached to CR6062 at <http://www.cms.hhs.gov/Transmittals/downloads/R1644CP.pdf> on the CMS Web site.

Additional Information

To see the official instruction (CR 6062) issued to your Medicare DME MAC, carrier, or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R1644CP.pdf> on the CMS Web site.

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

MLN Matters MM6062Revised

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