



April 15, 2006 Newsletter

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KEY

- A** All Providers
- H** Hospital Providers
- S** Skilled Nursing Facility (SNF) Providers
- O** Comprehensive Outpatient Rehabilitation Facility (CORF) And Outpatient Physical Therapy (OPT) Providers
- C** Community Mental Health Center (CMHC) Providers
- R** Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Providers
- E** End-Stage Renal Disease (ESRD) Providers
- P** Hospice Providers
- M** Home Health Providers

If you have any questions regarding this newsletter, please contact your Customer Service Representative. However, some articles may contain a specific telephone number to contact for assistance.

Mutual of Omaha Insurance Company
Medicare Area

To stay informed of Medicare issues as they arise, please register for our Electronic Mail List at: www.mutualmedicare.com/signup

Fiscal Intermediary (FI) Notice to Providers, Intern and Resident Information System (IRIS) Programs

The Office of Financial Management will post two IRIS programs (Version 3.1 of IRISV3 and Version 1.1 of IRISEDV3) with updated files (medical school codes, residency type codes, and IRISV3 Operating Instructions) on the redesigned Centers for Medicare & Medicaid Services' (CMS) web site during March 2006 for downloading by Medicare providers. The web page address for downloading these programs is: <http://www.cms.hhs.gov/IRIS>.

If you have any questions, please contact Jennifer Lange (866) 734.9444 x5375 or John Schulte 866.734.9444 x2928.

2006 Standard Medicare Prescription Drug Coverage: Understanding Costs to Beneficiaries- The Twelfth in the Medlearn Matters Series on Drug Plans

Medlearn Matters Number: SE0618
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

Physicians, providers, and suppliers, and their staff who provide service to people with Medicare

Important Points to Remember

Key points to remember about the new Medicare prescription drug coverage include the following:

- Beneficiaries can join a Medicare Prescription Drug Plan that covers prescription drugs only and keep their Original Medicare coverage. Or, they can join a Medicare Advantage Plan or other Medicare Health Plan that covers doctor and hospital care as well as prescriptions.
- Medicare prescription drug coverage is NOT automatic - people must join a plan to get coverage
- Your patients have an initial opportunity to join a Medicare drug plan now through May 15, 2006.
- Most people will have to pay a higher premium that includes a penalty if they wait to join a Medicare drug plan until after May 15, 2006, unless they have other coverage that, on average, is at least as good as Medicare prescription drug coverage.

<p>This penalty consists of an additional 1% of the base premium for every month the person went without coverage, and is levied as long as the person is enrolled in a Medicare drug plan.</p>

- People who do not join a Medicare drug plan by May 15, 2006, may also have to wait until November 15, 2006 for their next opportunity to join.

If your Medicare patients ask you questions about the new coverage, you can refer them to <http://www.medicare.gov> and 1-800-MEDICARE for additional information and assistance.

General Information

One of the issues that may be most important for your patients involves what Medicare prescription drug coverage means to them in terms of cost. This article focuses on the out-of-pocket expenses that your patients will incur under this new program and highlights the costs covered by a standard plan.

Actual costs of the specific Medicare Prescription Drug Plans and the Medicare Advantage Plans or other Medicare Health Plans in each area are available in the "Medicare & You 2006" handbook and at <http://www.medicare.gov> on the web.

Costs Covered by a Standard Plan

Costs for your patients who join a Medicare drug plan will vary depending on their financial situation and which Medicare drug plan they join. All Medicare drug plans will offer at least the standard level of coverage described below.

Medicare drug plans may design their plans differently as long as what their plan offers is, on average, at least as good as the standard coverage. Some plans may offer more coverage for higher premiums.

Patient costs under standard Medicare drug coverage as defined by the MMA for 2006 will include the following:

- A monthly premium (average of \$32 in 2006);
- A \$250 deductible;
- Person pays, on average, 25% of allowable drug expenses up to a coverage limit of \$2,250 (plan pays the other 75%);
- After \$2,250 in covered drug costs, person pays 100% of covered drug costs until \$3,600 limit in true out-of-pocket spending is reached;
- About 5% coinsurance for covered drug costs after \$3,600 out-of-pocket limit is reached.

Individuals with standard coverage will pay the full cost of their prescriptions for drug spending between \$2,250 and up to their true out-of-pocket limit of \$3,600. However, plan enrollees will still be able to obtain their plan's discounted price for prescription drugs in this coverage gap.

Alternate Coverage

Plans are able to offer alternative coverage structures. For example, a plan can offer a deductible lower than \$250, or use tiered copayments rather than coinsurance – provided that the alternative coverage structure meets certain tests of actuarial equivalence.

Also, plans may offer additional drug coverage that supplements the standard coverage. Medicare payments to plans do not subsidize such supplemental coverage.

Costs for Patients With Medicare and Full Medicaid Benefits

Under Part D, starting in 2006, Medicare will provide primary drug coverage for individuals who are dually eligible for Medicare and Medicaid. Dually eligible individuals who earn incomes up to 100% of the federal poverty level will have Medicare prescription drug coverage with no deductibles, no premiums, nominal copays, and no coverage gap.

Beneficiaries who do not qualify for Medicaid, but whose incomes are below 150 percent of poverty and who meet an asset test, will qualify for extra help paying for Medicare prescription

drug coverage. Beneficiaries who qualify for extra help can join a Medicare drug plan with full or partial coverage for premiums and cost-sharing and no coverage gap.

Specific Information on Out-of-Pocket Expenses

Medicare Drug Plan Premiums

Medicare drug plan monthly premiums vary, depending on the plan; however:

- All regions of the country have multiple plan options with premiums significantly below \$30.
- There will be at least one prescription drug plan with a premium below \$20 per month in every region of the country except Alaska.
- The average monthly beneficiary premium is \$32.20, about \$384 per year.

True Out-Of-Pocket Costs

The cost to beneficiaries with Medicare for Medicare prescription drug coverage over and above the monthly premium is often referred to as “true out-of-pocket expenses” or TrOOP.

The TrOOP represents the amount a beneficiary must spend on Part D covered drugs until catastrophic coverage begins. That catastrophic coverage begins when the beneficiary’s out-of-pocket expenses reach \$3,600 in a year.

In addition to paying the base premium for their plan, Medicare beneficiaries will also pay TrOOP costs including the following:

- A deductible amount (\$250) and coinsurance (25% of covered drug costs during the plan payment + coinsurance stage);
- All costs during the coverage gap stage; and
- Five percent of covered drug costs during the catastrophic coverage stage.

These additional TrOOP expenses are explained as follows:

Deductible (From \$0 to \$250: A net value of \$250)

Under standard coverage, plan enrollees pay a \$250 deductible each calendar year out of their own pockets for Part D covered drugs.

Plan Payments + Coinsurance (From \$251 to \$2250)

Once the annual (\$250) deductible is met, standard coverage pays for 75% of the next \$2,000 (or up to \$1,500) for covered (allowable) drugs and biologicals. The remaining 25% (a maximum of \$500) of the cost is covered by the beneficiary via coinsurance/copayments.

Coverage Gap (From \$2,251 to \$3,600 TROOP limit)

Once covered drug costs have reached the plan payment + coinsurance + deductible limit of \$2,250, the plan does not pay again until the plan enrollee has reached the \$3,600 limit in out-of-pocket spending. The beneficiary pays all covered drug costs incurred in this “gap.” The total out of pocket cost (not including premiums) to this point (deductible + plan payments + coinsurance + coverage gap) is \$3,600 for coverage through the full “gap” (see TrOOP discussion below.)

Catastrophic Coverage (Costs over \$3,600 TROOP limit)

Once the individual’s true out-of-pocket spending reaches \$3,600, costs for necessary covered drugs are covered as follows:

- Reinsurance – 80% of covered drug-related costs are covered by Medicare;
- Plan payments – 15% of covered drug-related costs are covered by the drug plan;

- Coinsurance – 5% of covered drug-related costs are covered by the individual.

What Counts Toward True Out-of-Pocket (TrOOP) Costs?

Beneficiaries must adhere to their plan’s formulary, prior authorization, and formulary exceptions processes in order for their out-of-pocket spending to count toward the \$3,600 limit.

The following types of spending count toward the \$3,600 threshold:

- The beneficiary’s own out-of-pocket spending;
- Spending by a family member or official charity, on behalf of the beneficiary;
- Supplemental drug coverage provided through qualifying state pharmacy assistance programs (SPAP) or Medicare’s extra help; and
- Under the Centers for Medicare & Medicaid Services’ (CMS’) demonstration authority, supplemental drug coverage paid for with MA rebate dollars.

In summary, the amount that a beneficiary must spend on part D-covered drugs until catastrophic coverage is reached, based on the 2006 standard coverage, is as follows:

<p>\$250 deductible + \$500 plan enrollee coinsurance during initial coverage + \$2,850 coverage gap = \$3,600 (plus the monthly premium, which averages \$384/year)</p>

Once this cost has been reached for covered drugs, catastrophic coverage begins.

Related Links

HHS Secretary Mike Leavitt recently released a two-month progress report on Medicare Prescription Drug Coverage that takes a hard look at what is working and what needs to improve. To view the report, visit: <http://www.hhs.gov/medicare2final.pdf> on the web.

For more information about *Medicare Prescription Drug Coverage for Providers*, visit http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage on the CMS web site.

Denial of Claims Not Timely Filed

Related Change Request (CR) #: 4041

Medlearn Matters Number: MM4041

Related CR Release Date: February 2, 2006

Related CR Transmittal #: R830CP

Effective Date: July 1, 2006

Implementation Date: July 3, 2006

Provider Types Affected

Providers billing fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) for services provided to Medicare beneficiaries

Provider Action Needed

Impact to You

This article is based on information contained in CR4041, which clarifies that a determination relating to the untimely submission of a Medicare claim by a provider or supplier is not an initial determination and cannot be appealed.

What You Need to Know

Claims that are filed after the “timely filing period” will be denied as specified in the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 1, Section 70.1. When a claim is denied because it was filed after the timely filing period, the denial will not constitute an “initial determination.” As such, the determination that a claim was not filed timely cannot be appealed.

What You Need to Do

Be aware of the time limits for filing Medicare claims and the consequences of untimely filing.

Background

The Centers For Medicare & Medicaid Services (CMS) issued a technical correction to the June 30, 2005 Federal Register, Interim Final Rule, “Medicare Program: Changes to the Medicare Claims Appeal Procedures (42 CFR Parts 401 and 405),” that clarified that a determination regarding the untimely submission of a Medicare claim is not an initial determination and cannot be appealed.

Specifically, 42 CFR Section 405.926(n) indicates that a determination that a provider or supplier failed to submit a claim timely or failed to submit a timely claim, despite being requested to do so by the beneficiary or the beneficiary’s subrogee, is not an initial determination and cannot be appealed.

CR4041 informs all Medicare providers of the above technical correction to the June 30, 2005 interim final rule, “Medicare Program: Changes to the Medicare Claims Appeal Procedures” and revises the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 1 (General Billing Requirements), Sections 70.4 and 70.8.6 to incorporate these changes.

Additional Information

For complete details, including the revised sections of the *Medicare Claims Processing Manual* and a table that illustrates the timely filing limit for dates of service in each calendar month, please see the official instruction issued to your carriers, FIs, DMERCS, or RHHIs regarding this change. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R830CP.pdf> on the CMS web site.

If you have any questions, please contact your Medicare contractor (carrier, FI, etc.) at their toll-free number, which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.

Repeat Tests for Automated Multi-Channel Chemistries for End Stage Renal Disease (ESRD) Beneficiaries

Related Change Request (CR) #: 4101
Related CR Release Date: October 28, 2005
Related CR Transmittal #: R733CP
Effective Date: January 1, 2006
Implementation Date: April 3, 2006

Medlearn Matters Number: MM4101

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers and/or fiscal intermediaries (FIs) for services provided to Medicare ESRD beneficiaries

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4101 provides details regarding the payment policy for End Stage Renal Disease (ESRD)-related Automated Multi-Channel Chemistry (AMCC) Tests (i.e., the ESRD 50/50 rule), and clarifies a coding issue concerning repeat tests using the Current Procedure Terminology (CPT) modifier 91.

What You Need to Know

Clinical diagnostic laboratory tests ordered by an ESRD facility must follow accepted CPT guidelines. Specifically, **Modifier 91 must be used on any subsequent service** being billed if 1) any single service (same CPT code) is ordered (for the same beneficiary), and 2) the specimen is collected more than once in a single day, and the service is medically necessary. Also, any line item on a claim with a modifier 91 will be included into the calculation of the 50/50 rule, and after the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.

What You Need to Do

Please see the *Background* section of this article for further details.

Background

ESRD 50/50 Rule

The Centers for Medicare & Medicaid Services (CMS) previously issued instructions to Medicare carriers regarding procedures to enforce compliance with the payment policy for End Stage Renal Disease (ESRD)-related Automated Multi-Channel Chemistry (AMCC) Tests (i.e., the ESRD 50/50 rule). The ESRD 50/50 rule requires a count of AMCC tests ordered to capture:

- The number of tests included in the composite payment rate paid to the ESRD facility; or
- The monthly capitation payment made to the furnishing physician;

Versus

- The number of covered non-composite tests performed for the same beneficiary, on the same date of service.

The proportion of the composite payment rate tests **versus** the number of covered non-composite tests calculated by the billing laboratory is used to determine whether separate payment may be made for all tests performed on that day.

In CR2813, CMS directed Medicare carriers to make the necessary systems changes to implement front-end edits in preparation for the standard system implementation of CR2813 in the January 2005 release.

Note: The carrier standard system changes needed to implement the new ESRD 50/50 rule compliance guidelines were partially implemented in the October 2004 release. Intermediary billing guidelines for ESRD 50/50 rule compliance have been in effect since October 2003.

CR2813 also directed the carriers not to post any information concerning the business requirements associated with the implementation of CR2813 until receiving further guidance from CMS.

Business Requirements Relating to Modifier 91

In June 2005, CMS issued CR3890, which required the implementation of the ESRD 50/50 rule for Carriers, effective January 2006. During the preparation for implementation, the provider community commented that business requirements relating to the use of Modifier 91 (Repeat Clinical Diagnostic Laboratory Test) were **inconsistent** with Current Procedural Terminology (CPT) procedures. CMS is adjusting the business requirements for proper use of Modifier 91.



A Medlearn Matters article, MM3890, is available for CR3890 at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3890.pdf> on the CMS web site.

Therefore, CR4101 directs that clinical diagnostic laboratory tests ordered by an ESRD facility must follow accepted CPT guidelines. Specifically, **Modifier 91 must be used on any subsequent service** being billed if:

- Any single service (same CPT code) is ordered (for the same beneficiary); and
- The specimen is collected more than once in a single day; and
- The service is medically necessary.

In addition, when using CPT Modifier 91, it must be used without regard to whether it is a:

- Composite rate test (Healthcare Common Procedure Coding System (HCPCS) Modifier CD);
- Composite rate test beyond the normal frequency (HCPCS Modifier CE); or

- Non-composite rate test (HCPCS Modifier CF).

Note: Any claim with a modifier 91 will be included into the calculation of the 50/50 rule, and after the calculation of the 50/50 rule, services used to determine the payment amount may never exceed 22.

Implementation

The implementation date for the instruction is April 3, 2006.

Additional Information

For complete details regarding CR4101, please see the official instruction issued to your carrier or intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R733CP.pdf> on the CMS web site.

From that web page, look for CR4101 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier or intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.

Modification of Roster Billing for Mass Immunizers Billing for Inpatient Part B Services (Type of Bills 12X and 22X)

Related Change Request (CR) #: 4242

Medlearn Matters Number: MM4242

Related CR Release Date: February 2, 2006

Related CR Transmittal #: R829CP

Effective Date: October 1, 2005

Implementation Date: July 3, 2006

Note: CR4242 rescinds and replaces CR3735.

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) for mass immunization services

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4242, which replaces CR3735 (Transmittal 542, dated April 29, 2005).

What You Need to Know

CR3735 incorrectly instructed providers to include the discharge date on the roster billing for mass immunizers. CR4242 removes this requirement and adds instructions to report the following additional (HIPAA required) data elements on the roster when billing for inpatient Part B services (TOBs 12x and 22x) effective October 1, 2005: admission date, admission type, admission diagnosis, patient's status code, and admission source code.

What You Need to Do

See the *Background* section of this article for further details regarding this change.

Background

Change Request (CR) 4242 replaces CR3735 (Transmittal 542, dated April 29, 2005) and removes the requirement for reporting the discharge date on roster billing for mass immunizers billing for inpatient Part B services.

Because the current roster billing process for mass immunizers billing inpatient Part B services utilizing TOBs 12X (hospitals) and 22X (Skilled Nursing Facilities) does not require the reporting of additional data elements that are mandated by the Health Insurance Portability and Accountability Act (HIPAA), CR 4242:

- Updates the roster billing to include these HIPAA mandated data elements; and
- Instructs your FI to inform providers that mass immunize to report the following additional data elements on the roster when billing for inpatient Part B services (TOBs 12x and 22x) effective October 1, 2005:
 - Admission date
 - Admission type
 - Admission diagnosis
 - Patient's status code
 - Admission source code.

Implementation

The implementation date for this instruction is July 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R829CP.pdf> on the CMS web site.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web

April 2006 Non-Outpatient Prospective Payment System Outpatient Code Editor (Non-OPPS OCE) Specifications Version 21.2

Related Change Request (CR) #: 4359
Related CR Release Date: March 10, 2006
Related CR Transmittal #: R886CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Medlearn Matters Number: MM4359

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for services not subject to the OPPS

Provider Action Needed

This article is based on Change Request (CR) 4359, which announces that the April 2006 Non-OPPS OCE has been updated with new additions, changes, and deletions to HCPCS codes and procedure codes.

Background

Change Request (CR) 4359 informs your FIs and RHHIs that the Non-OPPS Outpatient Code Editor (OCE) used to process claims from hospitals not paid under the Outpatient Prospective Payment System (OPPS) has been updated with new additions, changes, and deletions to Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes.

To view the specific code updates, please see CR4359 at <http://www.cms.hhs.gov/Transmittals/downloads/R886CP.pdf> on the CMS web site.

Note that the code and description changes are the same code and description changes specified for the Medicare Code Editor (MCE).

Implementation

The implementation date for CR4359 is April 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R886CP.pdf> on the CMS web site.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.

April 2006 Outpatient Prospective Payment System Code Editor (OPPS OCE) Specifications Version 7.1

Related Change Request (CR) #: 4360
Related CR Release Date: March 10, 2006
Related CR Transmittal #: R888CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Medlearn Matters Number: MM4360

Provider Types Affected

Providers billing Medicare fiscal intermediaries (FIs) and regional home health intermediaries (RHHIs) for services paid under the OPPS

Provider Action Needed

This article is based on Change Request (CR) 4360 which informs your fiscal intermediary (FI) that the April 2006 Outpatient Prospective Payment System Outpatient Code Editor (OPPS OCE) specifications have been updated with new additions, deletions, and changes.

Background

Change Request (CR) 4360 reflects specifications that were issued for the January revision of the OPPS OCE (Version 7.0). The following is the summary of data changes effective April 1, 2006 (Version 7.1), and all shaded material in Attachment A of CR 4360 reflects changes that were incorporated into the April version of the revised OPPS OCE (Version 7.1).

CR4360 provides the revised OPPS OCE instructions and specifications that will be utilized under the OPPS for hospital outpatient departments, community mental health centers (CMHCs), and for limited services when provided in a comprehensive outpatient rehabilitation facility (CORF), home health agency (HHS) not under the Home Health Prospective Payment System, or to a hospice patient for the treatment of a non-terminal illness.

The modifications of the OPPS OCE for the April 2006 release (V7.1) are detailed in the tables within CR4360 and that CR is available at <http://www.cms.hhs.gov/Transmittals/downloads/R888CP.pdf> on the CMS web site.

You should also read through the specifications attached to CR4360 and note the highlighted sections, which indicate changes from the prior release of the OPPS OCE software.

Note also that some of these modifications have an effective date earlier than April 1, 2006, and such dates are reflected at the beginning of each table in CR4360.

Other changes in this version of the OPPS OCE include:

- Implementation of version 12.0 of the National Correct Coding Initiative (NCCI) file;
- Addition of 90471 and 90472 to the list of codes designated as vaccines; and
- Removal of 90740, 90743, 90744, 90746, 90747, and G0010 from the list of codes designated as vaccines.

Implementation

The implementation date for CR4360 is April 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R888CP.pdf> on the CMS web site.

If you have any questions, please contact your FI or RHHI at their toll-free number, which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.

Payment for Power Mobility Device (PMD) Claims

Related Change Request (CR) #: 4372

Medlearn Matters Number: MM4372

Related CR Release Date: March 10, 2006

Related CR Transmittal #: R215OTN

Effective Date: January 1, 2006

Implementation Date: No later than March 24, 2006

Provider Types Affected

Physicians, providers, and non-physician practitioners billing Medicare carriers, durable medical equipment regional carriers (DMERCs), regional home health intermediaries (RHHIs), and/or fiscal intermediaries (FIs) for PMDs and services related to prescribing PMDs

Important Points to Remember

Options for Submitting G0372 and E/M Codes

Providers billing a Medicare carrier have the following options for submitting the G0372 code and the E/M code during January 1, 2006, through March 31, 2006:

- Submit the G0372 code and E/M now on the same claim. Payment for these claims will be held through March 31, 2006.
- Hold all claims containing the G0372 code until after March 31, 2006.
- Submit the E/M service now and bill the G0372 code after March 31, 2006. The E/M service will be paid now. Note that this is not intended to require that Medicare fiscal intermediaries or carriers split claims submitted with both the E/M and G0372 code. Rather, the physician/provider may choose to submit two separate claims for the individual services.

Critical Access Hospitals billing the fiscal intermediary (FI) under Method II have the following options from January 1, 2006, through July 2, 2006, for submitting the G0372 code and the E/M code:

- Submit the G0372 and E/M now on the same claim. Payment for these claims will be held by the FI through July 2, 2006.
- Hold all claims containing the G0372 code until after July 2, 2006.

- Submit the E/M service now and bill the G0372 code after July 2, 2006. The E/M service will be paid now. Note that this is not intended to require the FIs or carriers to split claims submitted with both the E/M and G0372 code. Rather, the physician or treating practitioner may choose to submit two separate claims for the individual services.

Method II Critical Access Hospitals submitting claims on or after July 2, 2006, must bill the E/M and the G0372 code on the same claim.

Background

The Centers for Medicare & Medicaid Services (CMS) published an interim final rule on PMDs to conform its regulations to section 302(a)(2)(E)(iv) of the Medicare Modernization Act (MMA), which is codified at section 1834(a)(1)(E)(iv) of the Social Security Act (SSA). The effective date of the rule was October 25, 2005.

For PMDs, the MMA mandated that:

- A face-to-face examination of the individual be conducted by a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist; and
- That payment may not be made for a motorized or power wheelchair unless the physician or treating practitioner has written a prescription for the item.

By defining the practitioners allowed to conduct the face-to-face examination, it also effectively removed the current requirement that a beneficiary must be seen by a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology in order to get a power-operated vehicle (POV).

Submission of Medical Record and Prescription

Apart from the MMA requirements, the other key change made by this regulation is a requirement that the physician or treating practitioner must submit pertinent parts of the medical record (in lieu of the Certificate of Medical Necessity (CMN)), along with the prescription, to the durable medical equipment (DME) supplier within 30 days of the face-to-face examination.

A separate add-on payment (an add-on payment to the office visit billed with the code of G0372) was established by the rule to recognize the additional physician work and resources required for submitting pertinent parts of the medical record.

Payment for the history and physical examination is made through the appropriate evaluation and management (E&M) code along with the add-on payment (G0372) which goes to the local Medicare fiscal intermediary or carrier. The PMD claim will go to the local durable medical equipment regional carrier (DMERC).

Appropriations Act

Title II, Section 222, of the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 2006 (H.R. 3010) (the Appropriations Act) was signed into law on December 30, 2005. It states, in part:

SEC. 222. None of the funds made available under this Act may be used to implement or enforce the interim final rule published in the Federal Register by the Centers for Medicare & Medicaid Services on August 26, 2005, (70 Fed. Reg. 50940) prior to April 1, 2006.

Although this section of the Appropriations Act does not allow federal funds to implement or enforce the rule, CMS believes that this section does not affect the validity of the rule. Therefore, CMS is instructing DMERCs and/or DME PSCs that, between January 1, 2006 to April 1, 2006, contractors will only pay PMD claims that satisfy the requirements of section 1834(a)(1)(E)(iv) of the SSA.

Based on the Appropriations Act, CMS is instructing fiscal intermediaries and carriers to hold claims that contain G0372. These claims must be held through March 31, 2006. Carriers will begin to release physician claims for processing on April 3, 2006.

Implementation

The implementation date for this instruction is no later than two weeks after release of CR4372 or March 24, 2006.

Additional Information

For additional information regarding PMDs you may want to review the following Medlearn Matters articles:

- MM4121: *MMA - New G Code for Power Mobility Devices (PMDs)*
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4121.pdf>
- MM3952: *MMA - Evidence of Medical Necessity: Power Wheelchair and Power Operated Vehicle (POV)/Power Mobility Device (PMD) Claims*
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3952.pdf>

The official instructions issued to your carrier, DMERC, FI, or RHHI regarding this change can be found at

<http://www.cms.hhs.gov/Transmittals/downloads/R215OTN.pdf> on the CMS web site.

If you have questions, please contact your Medicare carrier, DMERC, FI, or RHHI at their toll-free number, which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.

Announcing a new Name for Medicare's Provider Education Articles – MLN Matters

MLN Matters Number: SE0620
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

The Medicare Learning Network is pleased to announce a new name for our very popular provider education articles. To more closely associate these articles with the Medicare Learning Network, i.e., the official educational information source for Medicare Fee-for-Service (FFS) providers, the articles previously known as “Medlearn Matters” articles will now be known as “*MLN Matters*” articles (the MLN standing for “Medicare Learning Network”).

You will also notice a new logo at the top of the articles indicating the name change. The Centers for Medicare & Medicaid Services (CMS) knows that you have come to rely on these articles to help you more easily understand new or changed Medicare policy and to help you gain quick access to accurate Medicare program information.

The articles can now be accessed from <http://www.cms.hhs.gov/MLNMattersArticles> on the CMS web site. If you have previously bookmarked the “Medlearn Matters” page, please update your bookmark to the new URL.

We hope that you will continue to utilize these articles that are always prepared with the affected provider audience in mind.

In conjunction with the above referenced change, the urls for the Medicare Learning Network (MLN) web pages have also been changed. You can reach our MLN web pages from the cms.hhs.gov main page - just click on “Outreach and Education.” The full URLs to access the various MLN sections on the CMS web site are:

MLN General Information – <http://www.cms.hhs.gov/MLNGenInfo>

MLN Products – <http://www.cms.hhs.gov/MLNProducts>

Additional Information

Also, note that if you know the specific number of an article you are after, such as SE0620, you can go directly to the specific URL for an article by using the format below.

For example, the web site for SE0620 is

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0620.pdf>

For any other article, just substitute its number for the SE0620 in this URL to go directly to the PDF version of the article on the CMS web site.

Drug Coverage Materials for Health Care Professionals

NEW! Visit www.cms.hhs.gov/center/provider.asp and scroll down to “Part D Tools for Health Care Professionals” for a comprehensive list of links to agency-wide resources for providers on Medicare Rx coverage. These resources can help providers and office staff access direct phone numbers to a Medicare drug plan’s coverage determination staff, as well as obtain model forms that will help speed the process. Additionally, a new fact sheet, as well as other educational products for the FFS community, is now available at www.cms.hhs.gov/medlearn/drugcoverage.asp on the CMS website.

To our providers....keep informed of Medicare Integrity Program issues as they arise by reading the MIP Tip in every issue.

"MIP Tip"

This tip is brought to you from our Claims Department.

Line Item Modifiers

Electronic billing of claims allows the use of four modifiers per line item. For those providers who submit their claims via Direct Data Entry (DDE), there is the capacity to append five modifiers per line item. In DDE, you must enter the first two modifiers from Claim Page 2, and then to enter any additional modifiers you must press F11. By pressing F11, you will be directed to a claim entry screen (MAP171A) that allows you to insert the additional modifiers.



Please stay tuned for more hot tips!