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**Items of Importance**

**ADDITIONAL REQUIREMENTS NECESSARY TO IMPLEMENT THE REVISED HEALTH INSURANCE CLAIM FORM CMS-1500**

~CMS MLN Matters – September 2006~

MLN Matters Number: MM5060  
 Related CR Release Date: July 28, 2006  
 Related CR Transmittal #: R1010CP

Related Change Request (CR) #: 5060  
 Effective Date: January 1, 2007  
 Implementation Date: January 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf>**

CMS is implementing the revised Form CMS-1500, which accommodates the reporting of the National Provider Identifier (NPI). The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007. During this transition time there will be a dual acceptability period of the current and the revised forms. A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the **split provider identifier fields**. The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field. There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

<b>January 2, 2007 – March 30, 2007</b>	Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version. <b>Note:</b> Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08-05) by January 2, 2007.
<b>April 2, 2007</b>	The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used. <b>Note:</b> All <b>rebilling</b> of claims should use the <b>revised</b> Form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12-90).

**Billing Guidelines**

- When the NPI number is effective and required (05/23/07, although it can be reported starting 01/01/07), claims will be **rejected** (in most cases with reason code 16 – “claim/service lacks information that is needed for adjudication”) in tandem with the appropriate remark code that specifies the missing information, **if**
  - The **NPI** of the billing provider or group is **not entered** on Form CMS-1500 (08-05) in items:
    - **24J** (replacing item 24K, Form CMS-1500 (12-90));
    - **17B** (replacing item 17 or 17A, Form CMS-1500 (12-90));
    - **32a** (replacing item 32, Form CMS-1500 (12-90)); and
    - **33a** (replacing item 33, Form CMS-1500 (12-90)).

**Additional Information**

**When the NPI Number is Effective and Required (May 23, 2007)**

To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim. Legacy identifiers are pre-NPI provider identifiers such as:

- PINs (Provider Identification Numbers)
- UPINs (Unique Physician Identification Numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSCs (National Supplier Clearinghouse numbers) for DMERC claims.

**Additional NPI-Related Information**

Additional NPI-related information can be found at <http://www.cms.hhs.gov/NationalProvdentStand/> on the CMS Website. The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Website at [http://www.nucc.org/images/stories/PDF/change\\_log.pdf](http://www.nucc.org/images/stories/PDF/change_log.pdf).

**ANNOUNCEMENT OF COMPETITIVE ACQUISITION PROGRAM (CAP) FOR PART B DRUGS AND BIOLOGICALS BENEFICIARY FACT SHEET**

~July 2006~

Visit <http://www.cms.hhs.gov/CompetitiveAcquisforBios> to download the Beneficiary Fact Sheet for the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals. Physicians who elect to participate in the CAP are required to provide the CAP Beneficiary Fact Sheet to Medicare beneficiaries who are receiving certain Part B physician-administered drugs.

**CMS AWARDS THE FIRST OF 15 MEDICARE ADMINISTRATIVE CONTRACTORS (MACS) TO  
PROCESS BOTH PART A & PART B MEDICARE CLAIMS**

~September 2006~

CMS announced the award of the first of 15 contracts for the combined handling in six states of both Part A and Part B Medicare claims. The winning contractor is Noridian Administrative Services, LLC, (NAS), headquartered in Fargo, N.D. As the new Part A/Part B Medicare Administrative Contractor (A/B MAC), NAS will serve as the first point-of-contact for processing and paying fee-for-service claims from hospitals and other institutional providers, physicians, and other practitioners in Arizona, Montana, North Dakota, South Dakota, Utah, Wyoming. "The contract award is a major step to improved Medicare service for beneficiaries and providers, and significant cost savings from greater efficiency in managing the original fee-for-service Medicare program," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "Noridian Administrative Services was selected through a full and open performance-based competition to administer the program as effectively and efficiently as possible." The A/B MAC contract, which has a value of \$28.9 million for the first year of performance, is the first of 15 to be awarded by 2011 to fulfill requirements of the contracting reform provisions of the Medicare Modernization Act of 2003. NAS will immediately begin implementation activities and will assume full responsibilities for the claims processing work in its six-state jurisdiction no later than March 2007. For more information, see: <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1919>

**IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS**

~July, August, and September 2006~

WPS Medicare Provider Customer Service closes on occasion for brief periods so our Customer Service Representatives may participate in training sessions. Our representatives are eager to learn more in order to serve you better. For information on these closures, visit us at [http://www.wpsmedicare.com/misc/cust-serv\\_closings.shtml](http://www.wpsmedicare.com/misc/cust-serv_closings.shtml). At these times, the IVR and C-SNAP will continue to be available for your use to check eligibility and claim status. For more information regarding C-SNAP, call 1-877-476-8116. Thank you for your patience and for allowing us this chance to serve you better.

**MEDICARE CONTRACTOR ANNUAL UPDATE OF THE ICD-9-CM**

~CMS MLN Matters – August 2006~

MLN Matters Number: MM5142  
Related CR Release Date: June 23, 2006  
Related CR Transmittal #: R990CP

Related Change Request (CR) #: 5142  
Effective Date: October 1, 2006  
Implementation Date: October 2, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5142.pdf>

Medicare has issued the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2006, as well as discharges on or after October 1, 2006, for institutional providers. Be ready to use the updated codes on October 1, 2006. CMS places the new, revised, and discontinued codes at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage) on the CMS Website. The update should be available at this site in June. The updated codes can also be viewed at the National Center for Health Statistics (NCHS) Website at: <http://www.cdc.gov/nchs/icd9.htm>. This posting should be available at this site in June.

**NEW ZIP CODE NOW INCLUDED IN CHIROPRACTIC SERVICES DEMONSTRATION AREA**

~July 2006~

Effective June 13, 2006, the Chiropractic Demonstration area is expanded to include ZIP code 60502 in Aurora, IL. Please visit our Chiropractic Services Demonstration page (<http://www.wpsmedicare.com/provider/chiro-demo-links.shtml>) for more information about this demonstration project.

**NPI INFORMATION**

~July 2006~

The National Provider Identifier (NPI) will replace the provider identification numbers that providers use today in the HIPAA standard transactions that they conduct with health plans. Those transactions include the electronic claim, eligibility inquiry and response, claim status inquiry and response, payment and remittance advice, prior authorization/referral, and coordination of benefits transactions. Providers who conduct any of those electronic

transactions must have their NPIs and be ready to use them to identify themselves, and possibly other providers, in those transactions before May 23, 2007. That is only a year from now. Some health plans might be ready to accept NPIs much earlier than next May. The health plans with whom you do business will inform you as to when you may begin using your NPIs in these electronic transactions. CMS reminds health care providers that they need to obtain their NPIs. Today, approximately 530,000 providers who are Individuals and Organizations have obtained their NPIs. Providers can obtain NPIs by:

- Going to the Web at <https://nppes.cms.hhs.gov> and filling out their application on line.
- Obtaining a paper application form, filling it out, and mailing it to the NPI Enumerator. They can obtain the paper application form (CMS-10114) by downloading it from <http://www.cms.hhs.gov/forms> or by calling the NPI Enumerator at 1-800-465-3203 and requesting a copy.
- Submitting an application through Electronic File Interchange (EFI). EFI allows an approved organization, after obtaining the permission of a provider, to send the provider's NPI application data to us in an electronic file.

Medicare organization providers are required by the NPI Final Rule to determine if they have subparts and if those subparts should have their own NPIs. Many enrolled Medicare providers are actually subparts of other enrolled Medicare providers who are their "parents." In January 2006, Medicare posted a paper about the subpart concept and its effect on Medicare organization providers (click on "Medicare NPI Implementation" on the left at <http://www.cms.hhs.gov/NationalProvidentStand>). Medicare encourages enrolled organization providers to become familiar with the contents of that paper if they have not already done so, and to use that paper in making decisions concerning subparts and their assignment of NPIs. Providers and suppliers are required to include their NPI on the 04/2006 version of the CMS-855 Medicare enrollment application when they apply to enroll in Medicare. Medicare will accept either the Medicare provider number (the legacy provider number) or the NPI and the Medicare provider number (both numbers) on the claims it receives from providers through October 2, 2006.

Beginning October 2, 2006 and continuing through May 22, 2007, Medicare will accept the NPI or the Medicare provider number (legacy provider number) on the claims it receives from providers. If there is any issue with the provider's NPI and no Medicare provider number is included on the claim, the provider might not be paid. Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare provider number (the legacy provider number) as a secondary identifier until May 22, 2007. CMS posted many documents related to the NPI, including Medicare's timetable for implementation of the NPI, on its NPI Web page: <http://www.cms.hhs.gov/NationalProvidentStand>. We urge you to visit that Website and become familiar with the NPI and how it will be used, if you have not already done so. We encourage all organizations and associations to inform their members about the need to obtain, test, and use the NPI.

**REMINDER TO ENUMERATE; COUNTDOWN HAS BEGUN**  
~ July and August 2006 ~

Countdown has begun; do you have your NPI? Don't risk disruption to your cash flow – Get your NPI now! National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. **Every** healthcare provider needs to get an NPI! Learn more about NPI and how to apply by visiting <http://www.cms.hhs.gov/NationalProvidentStand/> on the CMS Website. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A Countdown Clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted. For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative Website at <http://www.wedi.org/npioi/index.shtml> on the Web.

**RULES GOVERNING PROVIDER/CLEARINGHOUSE PROTECTION OF MEDICARE BENEFICIARY ELIGIBILITY INFORMATION**  
~ CMS MLN Matters – August 2006 ~

MLN Matters Number: MM5138  
Related CR Release Date: June 23, 2006  
Related CR Transmittal #: R991CP

Related Change Request (CR) #: 5138  
Effective Date: July 24, 2006  
Implementation Date: July 24, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5138.pdf>

CMS is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy

Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA.) This article is a reminder to physicians/providers/suppliers of the importance of protecting Medicare beneficiary information and to use it only for authorized purposes. Be sure all your representatives and employees who have authorized access to this information are aware of the importance of protecting that information as well. Change Request (CR) 5138 reiterates the responsibilities of users in obtaining, disseminating, and using beneficiary's Medicare eligibility data. The following key points outline those responsibilities:

**EDI Enrollment:** The Medicare electronic data interchange (EDI) enrollment process must be executed by each physician/provider/supplier that submits/receives EDI either directly to or from Medicare or through a third party, such as a clearinghouse. Each physician/provider/supplier that uses EDI, either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare, must sign the EDI Enrollment Form and submit it to the carrier, DMERC, or FI with whom EDI transactions will be exchanged before any transaction is conducted.

**Authenticating Data Elements for HIPAA 270/271 Eligibility Data:** Authenticating data elements for HIPAA 270/271 Eligibility Data must be provided by the inquirer (physician, provider, supplier, or other authorized third party) prior to the release of any beneficiary-specific eligibility information and must include:

- Beneficiary last name (must match the name on the Medicare card);
- Beneficiary first name or first initial (must match the information on the Medicare card);
- Assigned Medicare Claim Number (also referred to as the Health Insurance Claim Number (HICN) including both alpha and numerical characters; and
- Date of birth.

**Medicare Beneficiary as First Source of Health Insurance Eligibility Information:** The Medicare beneficiary should be your first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare beneficiary, remind them to bring, on the day of their appointment, all health insurance cards showing their health insurance coverage. This will not only help you determine who to bill for services rendered, but also provide you with the proper spelling of the beneficiary's first and last name and identify their Medicare Claim Number as reflected on the Medicare Health Insurance card. It is important to use the name as shown on the Medicare card. If the beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, encourage them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-808-0772 to request a replacement Medicare Health Insurance card from RRB.

**Authorized Purposes for Requesting Medicare Beneficiary Eligibility Information:** In conjunction with the intent to provide health care services to a Medicare beneficiary, authorized purposes include the following:

- Verify eligibility for Part A or Part B of Medicare;
- Determine beneficiary payment responsibility with regard to deductible/coinsurance;
- Determine eligibility for services such as preventive services;
- Determine if Medicare is the primary or secondary payer;
- Determine if the beneficiary is in the original Medicare plan or a Part C plan (Medicare Advantage); and
- Determine proper billing.

Medicare eligibility data is only to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

In order to obtain access to eligibility data, as a physician/provider/supplier you will be responsible for the following:

- Before you request Medicare beneficiary eligibility information and at all times thereafter, you will ensure sufficient security measures to associate a particular transaction with the particular employee.
- You will cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry.
- You will promptly inform CMS or one of CMS's contractors (your carrier/DMERC/RHHI/FI) in the event you identify misuse of "individually-identifiable" health information accessed from the CMS database.
- Each eligibility inquiry will be limited to requests for Medicare beneficiary eligibility data with respect to a patient currently being treated or served by you, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

**Note:** Medicare health benefit beneficiary eligibility inquiries are monitored. Providers identified as demonstrating aberrant behavior (e.g., high inquiry error rate or high ratio of eligibility inquiries to claims submitted) may be contacted to verify proper use of the system, made aware of educational opportunities, or when appropriate referred for investigation of possible fraud and abuse or violation of HIPAA privacy law.

**Criminal Penalties' Provisions:** Remember that a number of statutes provide for severe criminal and civil penalties for misuse of information, including:

1. **Trading Partner Agreement Violation:** 42 U.S.C. 1320d-6 authorizes criminal penalties against a person who, "knowingly and in violation of this part ... (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person." Offenders shall "(1) be fined not more than \$50,000, imprisoned not more than 1 year, or both; (2) if the offense is committed under false pretenses, be fined not more than \$100,000, imprisoned not more than 5 years, or both; and (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than \$250,000, imprisoned not more than 10 years, or both."
2. **False Claim Act:** Under the False Claims Act, **31 U.S.C. §§ 3729-3733**, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim.
3. **Health Insurance Portability and Accountability Act of 1996 (HIPAA):** HHS may impose civil money penalties on a covered entity of \$100 per failure to comply with a Privacy Rule requirement. That penalty may not exceed \$25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year... A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of \$50,000 and up to one-year imprisonment. The criminal penalties increase to \$100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to \$250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. Criminal sanctions will be enforced by the Department of Justice.

### **THERAPY CAPS EXCEPTION PROCESS**

~ CMS MLN Matters – August 2006 ~

MLN Matters Number: MM4364 Revised

Related CR Release Date: February 15, 2006

Related CR Transmittal #: R52BP, R140PI, R855CP

Related Change Request (CR) #: 4364

Effective Date: January 1, 2006

Implementation Date: No later than March 13, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4364.pdf>

**Note:** This article was revised on July 3, 2006, to modify the transmittal number and Web address for the change made to the *Medicare Benefit Policy Manual*. All other information remains the same.

Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims). Outpatient rehabilitation services include:

- **Physical therapy** - including outpatient speech-language pathology: Combined annual limit for 2006 is \$1,740; and
- **Occupational therapy** - annual limit for 2006 is \$1,740.

In 2006 Congress passed the Deficit Reduction Act (DRA), which allows CMS to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, **exceptions to therapy caps for services provided during calendar year 2006**, if these services meet certain qualifications as medically necessary services (Section 1833(g) (5) of the Social Security Act). The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.

Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:

- Meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR4364) for exception from the therapy cap; or

- Meet specific criteria for exception, in addition to those listed in the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.

Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions. You may submit a request, with supporting documentation, for a specific number (not to exceed 15 future treatment days for each discipline of occupational therapy, physical therapy, and speech language pathology services) of additional therapy visits.

### **Billing Guidelines**

- **KX Modifier:** You must include a KX modifier on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
- **Separate requests:** You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received **before** the cap is exceeded because the patient is liable for denied services based on caps.
- **Subsequent requests during the same episode of care:** To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of additional therapy treatment days, not to exceed 15, **each time** the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.
- When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using the KX modifier. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

The CR4364 transmittal that contains these codes is the one that revises the *Medicare Claims Processing Manual*, available at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> on the CMS Website.

Providers who believe that it is medically necessary for their patient to receive therapy services in excess of the therapy cap limitations (and the patient does not fall into the automatically excepted categories mentioned above) must submit documentation, sufficient to support medical necessity, in accordance with the *Medicare Benefit Policy Manual*, Pub.100-02, Ch. 15, Sec. 220.3

(<http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf>); and the *Medicare Claims Processing Manual*, Pub. 100-04, Ch. 5, Sec. 10.2 and 20 (<http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf>), with the request for treatment days in excess of those payable under the therapy cap. These manual sections contain important definitions, as well as examples of acceptable documentation, and are attached to CR4364. The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

1. **Evaluation and Certified Plan of Care** - 1-2 documents.
2. **Certification** - Physician/NPP approval of the plan required 30 days after initial treatment-or delayed certification.
3. **Clinician-signed Interval Progress Reports** (when treatment exceeds 10 treatment days or 30 days) – These must be sufficient to explain the beneficiary's current functional status and need for continued therapy with the request for therapy visits in excess of those payable under the therapy cap. This is not required to be provided daily in treatment encounter notes or for an incomplete interval when unexpected discontinuation of treatment occurs.
4. **Treatment Encounter Notes** – The Treatment Encounter Note is acceptable if it records the name of the treatment; intervention, or activity provided; the time spent in services represented by timed codes; the total treatment time; and the identity of the individual providing the intervention. These may substitute for

Progress Reports if they contain the requirements of interval progress reports at least once every 10 treatment days or once in the interval.

5. For therapy caps exceptions purposes, **records justifying services over the cap**, either included in the above or as a separate document.

When reviewing documentation, Medicare contractors will:

- Consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary;
- Consider a dictated document to be completed on the day it is dictated if the identity of the qualified professional is included in the dictation;
- Consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing purposes) if it includes a diagnosis, subjective and/or objective condition, and prognosis. This information may be included in or attached to a plan. The inclusion of this information in the documentation does not necessarily constitute a billable evaluation or reevaluation unless it represents a service; and
- Accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.

### **Medicare Contractor Decisions**

If determined to be medically necessary, your Medicare contractor will grant additional treatment days for occupational therapy, physical therapy, and speech language pathology. It is preferable that the request for exception be received before the therapy cap is actually exceeded. However, your Medicare contractor will approve additional therapy treatment days retroactively if they are deemed medically necessary, in the exceptional circumstance where a timely request for exception from the therapy cap is not received before the therapy cap is surpassed. Your Medicare contractor may also approve additional therapy visits already provided when the request is accompanied by documentation supporting medical necessity of the services.

Please note that outpatient therapy services appropriately provided by assistants or qualified personnel will be considered covered services only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment. Claims for services above the cap that are not deemed medically necessary will be denied as a benefit category denial. You will be notified as to whether or not an exception to the cap has been made (and if so, for how many additional future visits) as soon as practicable once the contractor has made its decision. This notification is not an initial determination and, therefore, does not carry with it administrative appeal rights.

### **YOU WILL BE HAPPY TO KNOW**

**~August 2006~**

The CMS-855 Medicare enrollment applications located on the CMS forms Web page can be completed on-line in a PDF fillable format or downloaded and completed by hand. All the CMS 855 forms have been posted to the CMS Forms Internet Website <http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage> The direct link for each form follows:

CMS 855A (06/06)	<a href="http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf">http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf</a>
CMS 855B (06/06)	<a href="http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf">http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf</a>
CMS 855I (06/06)	<a href="http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf">http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf</a>
CMS 855R (06/06)	<a href="http://www.cms.hhs.gov/cmsforms/downloads/cms855r.pdf">http://www.cms.hhs.gov/cmsforms/downloads/cms855r.pdf</a>
CMS 855S (06/06)	<a href="http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf">http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf</a>

### **Claim Submission**

#### **BILLING FOR IMPLANTABLE EPIDURAL/SUBARACHNOID PAIN PUMP REFILLS**

**~September 2006~**

The use of infusion pumps is covered by a National Coverage Decision (NCD) (Pub 100-03, Ch 1, sec 280.14). More specifically, implantable epidural/subarachnoid pain pumps need to be refilled approximately every 30 days. The capacity of these pumps is small (i.e., ~18 milliliters). Therefore, a highly concentrated, sterile, preservative-free solution is needed for these pump refills. These solutions are usually reconstituted/

compounded from powdered drug forms, or highly concentrated solutions, by a compounding pharmacy, based on individual patient prescription, and sent/delivered to the physician for pump refilling in the office/clinic setting. Some hospitals and medical centers have the necessary equipment and sterilization facilities to prepare these solutions.

There has been some confusion regarding billing and reimbursement for the medications used for these pain pump refills. At this time, WPS will use the protocol/guidelines listed below to reimburse providers for these drugs and the associated services. Guidelines:

1. The following seven drugs will be paid for by the method described below: baclofen (Lioresal Intrathecal Screening or Refill Kit), bupivacaine (Marcaine, Sensorcaine), clonidine (Duraclon), fentanyl (Sublimaze), hydromorphone (Dilaudid), morphine (Astramorph, Duramorph, Infumorph), sufentanil (Sufenta), and ziconotide (Prialt).
2. Use HCPCS code J3490 (Unclassified drugs), with one unit of service, and with the KD ("drug or biological infused through DME [durable medical equipment]) Modifier, for the entire compounded drug refill.
3. Drug specific "J" codes should not be used for these drug mixtures, for epidural/subarachnoid pain pump refills, as these codes do not specifically describe the actual formulations of the drugs used in this reconstituting/compounding process.
4. An invoice is required for each claim. Electronic submitters should indicate that they have an invoice available upon request by putting "DOCUMENTATION AVAILABLE UPON REQUEST" in the electronic equivalent of Item 19 of the CMS-1500 claim form. The invoice you have, which is needed by Medicare to make its payment determination, will be requested from you by way of a development letter requesting that the invoice be sent to us. If you do not indicate the availability of the invoice in item 19 or its electronic equivalent, or it is not returned in a timely fashion, the claim will be denied as unprocessable.
5. The correct CPT code for an implantable epidural/subarachnoid pain pump refill and maintenance is 95990 when performed "incident to" a physician's services, or 95991 when administered by a physician.
6. The correct CPT code for pump analysis is 62367 and 62368 for analysis with re-programming.
7. Also in item 19 on the CMS-1500 form, or its electronic equivalent, include: a. Name of the drug b. Exact total dosage (number of milligrams or micrograms) for that patient c. Route of administration, i.e., "internal pump" or the brand name of the pump
8. A4220 (Refill kit for implantable infusion pump) is considered bundled/excluded from Medicare coverage by CMS.
9. An Evaluation and Management (E/M) service is allowed, if performed at the time of pump refill for a significant, separately identifiable reason. The applicable appropriate E/M code should be billed with the -25 modifier.
10. A compounding pharmacy may supply epidural/subarachnoid pain pump refills directly to a patient's home (Place of Service/POS 12). In these circumstances, the Carrier (WPS) reimburses the pharmacy for the compounded drug mixture only. Any associated administration services (of the home health care nurse, etc.) should be billed to the appropriate Intermediary.

The dollar amounts on these invoices should be identical to those that would have been on an invoice sent to a physician's office had the identical drug mixture been supplied by that pharmacy and had been used for that patient in that physician's office.

**DRUG ADMINISTRATION CODING AND PAYMENT POLICY – UPDATE TO PUB. 100-04  
MEDICARE CLAIMS PROCESSING MANUAL  
~ CMS MLN Matters – July 2006 ~**

Medlearn Matters Number: MM5028  
Related CR Release Date: May 26, 2006  
Related CR Transmittal #: R968CP

Related Change Request (CR) #: 5028  
Effective Date: June 26, 2006  
Implementation Date: June 26, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5028.pdf>**

This article and Change Request (CR) 5028 provide specific information regarding the interim G codes that were adopted in 2005 and operational until 2006 when the new Current Procedural Terminology (CPT) codes become operational. In **2006 CPT codes replace the interim G codes**. Beginning in 2006 physicians will follow CPT coding guidelines and select codes that best represent the underlying service. Implementation of these revised coding guidelines will help Medicare make prompt and correct payments for drug administration services. Under

the Medicare Modernization Act (MMA), drug administration codes included three categories of services for which there were no work relative value units as of October 1, 2003:

- Hydration
- Therapeutic, prophylactic, and diagnostic injections and infusions
- Chemotherapy administration

The MMA established work relative value units for these codes and provided transitional payment adjustments in 2004 and 2005. Carriers have and may continue to pay for these services under the Medicare fee schedule.

**JULY UPDATE TO THE 2006 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE**  
 ~CMS MLN Matters –July 2006~

MLN Matters Number: MM5102  
 Related CR Release Date: May 26, 2006  
 Related CR Transmittal #: R963CP

Related Change Request (CR) #: 5102  
 Effective Date: January 1, 2006  
 Implementation Date: July 3, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5102.pdf>**

This article is based on Change Request (CR) 5102, which amends payment files issued to your carrier/intermediary that were based on the November 21, 2005, MPFS Final Rule. Attachment 1 of CR5102 also includes new Category II and Category III codes. The Social Security Act (Section 1848(c)(4); ([http://www.ssa.gov/OP\\_Home/ssact/title18/1848.htm](http://www.ssa.gov/OP_Home/ssact/title18/1848.htm))) authorizes CMS to establish ancillary policies necessary to implement relative values for physicians' services. CR 5102 amends payment files issued to your carrier based upon the November 21, 2005, Medicare Physician Fee Schedule (MPFS) Final Rule and includes new Category II and Category III codes. CR5102 also instructs that your carrier/intermediary should:

- Give providers 30 days notice before implementing the revised payment amounts identified in CR 5102 (Attachment 1) in accordance with the Medicare Claims Processing Manual (Pub 100-4, Chapter 23, Section 30.1; <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>). Note that unless otherwise stated in CR5102, changes will be retroactive to January 1, 2006;
- Not search their files to either retract payment for claims already paid or to retroactively pay claims; and
- Adjust claims brought to their attention.

Changes included in the July Update to the 2006 MPFS Database are as follows:

CPT/HCPCS Code	ACTION
<b>95991</b>	Non-Facility RVU = 1.50
<b>G0978</b>	Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; prostate cancer, limited to adenocarcinoma as predominant cell type; t2 or t3a† gleason 8-10 or psa > 20 at diagnosis with no evidence of disease progression, recurrence, or metastases
<b>G9125</b>	Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and /or bcr-abl positive; <i>blast phase not†</i> in hematologic, cytogenetic, or molecular remission
<b>G9127</b>	Effective for services performed on or after January 1, 2006, the long descriptor is: Oncology; disease status; chronic myelogenous leukemia, limited to philadelphia chromosome positive and /or bcr-abl positive; extent of disease unknown, under evaluation, not listed (for use in a Medicare-approved demonstration project)

In addition, effective July 1, 2006, a number of **Category II codes** will be added to the MPFSDB with a status indicator of "M." Rather than repeat all those Category II codes in this article, we refer you to Attachment 1 of CR5102, which contains the codes and their descriptors. CR5102 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R963CP.pdf> on the CMS Website.

The long descriptor for **Category II code 1000F** has been revised. **The new descriptor is effective for services performed on or after January 1, 2005** (date code was implemented).

<b>Category II Code</b>	1000F
<b>Long Descriptor:</b>	Tobacco use assessed (CAD1, CAP1, COPD1, DM4, PV1)

The descriptors for **Category II code 4015F** have been revised. The new descriptors are **effective for services performed on or after January 1, 2006** (date code was implemented).

<b>Category II Code</b>	<b>4015F</b>
<b>Long Descriptor (Revised):</b>	Persistent asthma, preferred long term control medication or acceptable alternative treatment, prescribed (Asthma1)
<b>Short Descriptor:</b>	Persist asthma medicine ctrl

Also, note that G code (G8085) was inadvertently not included in the April update. G8085 is added with a status indicator of "M" and is effective for services on or after January 1, 2006. The long descriptor for G8085 is "End-stage renal disease patient requiring hemodialysis vascular access was not an eligible candidate for autogenous AV fistula."

Effective July 1, 2006, the Category III codes of 0155T-0161T will be added to the MPFSDB. The descriptors and other indicators for these codes may also be found in Attachment 1 of CR5102.

### NEW CURRENT PROCEDURAL TERMINOLOGY (CPT) CODE

~CMS MLN Matters – July 2006~

MLN Matters Number: MM4222  
Related CR Release Date: April 21, 2006  
Related CR Transmittal #: R910CP

Related Change Request (CR) #: 4222  
Effective Date: July 1, 2005  
Implementation Date: October 2, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4222.pdf>

Effective July 1, 2005, Medicare carriers and intermediaries must use the new CPT code 90714 (*Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, for use in individuals seven years or older, for intramuscular use*) for services previously billed under CPT code 90718. Effective for services on or after July 1, 2005, if you do not use the new Current Procedural Terminology (CPT) code, 90714, reimbursements may be impacted. CR4222 provides notification of this new CPT code for tetanus and diphtheria toxoids. Your carriers and fiscal intermediaries will assign the CPT code (90714) to status indicator "E" in the Medicare Physician Fee Schedule Database. Deductible and coinsurance apply.

Effective July 1, 2005:

- CPT code 90718 is used for the tetanus and diphtheria toxoids (Td) vaccine absorbed for use in an individual seven years or older, for intramuscular use; and
- CPT 90714 is used for the tetanus and diphtheria toxoids (Tg) vaccine absorbed, preservative free, for use in individuals seven years or older, for intramuscular use.

### QUARTERLY UPDATE TO CCI EDITS, VERSION 12.2, EFFECTIVE JULY 1, 2006

~CMS MLN Matters – July 2006~

MLN Matters Number: MM5064  
Related CR Release Date: May 26, 2006  
Related CR Transmittal #: R965CP

Related Change Request (CR) #: 5064  
Effective Date: July 1, 2006  
Implementation Date: July 3, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5064.pdf>

This is a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of Correct Coding Initiative (CCI) edits will be effective on July 1, 2006. Physicians may view the current CCI edits and the current Mutually Exclusive Code (MEC) edits at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> on the CMS Website. The Website will be updated with the Version 12.2 edits as soon as they are effective.

### UPDATE OF RADIOPHARMACEUTICAL IMAGING AGENTS HCPCS CODES APPLICABLE TO POSITRON EMISSION TOMOGRAPHY (PET) SCAN SERVICES FOR CARRIERS

~CMS MLN Matters – September 2006~

MLN Matters Number: MM5054  
Related CR Release Date: April 28, 2006  
Related CR Transmittal #: R923CP

Related Change Request (CR) #: 5054  
Effective Date: January 1, 2006  
Implementation Date: August 1, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5054.pdf>

This article is based on CR5054, which updates Publication 100-04, *The Medicare Claims Processing Manual*, Chapter 13, Section 60.3.2 (Tracer Codes Required for PET Scans) to include two new HCPCS codes for radiopharmaceutical diagnosis imaging agents (tracers) applicable to PET scan services. A prior Change Request, CR4270, Transmittal 822, released on February 1, 2006, addressed manual updates for Medicare fiscal intermediaries (FIs), but did not update the manual for carriers.

- Effective for claims dates of service on or after January 1, 2006:
  - **A9555** (Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium RB-82, Diagnostic, Per study dose, Up To 60 Millicuries) replaces Q3000; and

- **A9552** (Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18, FDG, Diagnostic, per study dose, Up to 45 Millicuries) replaces C1775.
- Effective for dates of service on or after January 1, 2006:
  - HCPCS codes Q3000 and C1775 are deleted.
  - A9555 is a Tracer code applicable to CPT 78491 and 78492.

## Coverage

### INFORMATION ON WEBSITE

WPS publishes LMRPs, LCDs, NCPs, and NCDs, and retired LMRPs/LCDs for Medicare Part B on its Website: [http://www.wpsmedicare.com/policies/pol\\_home.shtml](http://www.wpsmedicare.com/policies/pol_home.shtml) If you cannot gain access to the Internet from your office or home, you might try one of the many public libraries that offer Internet access. You may request a hard copy of a retired LMRP by writing to our Freedom of Information (FOI) Unit.

Illinois	Michigan
WPS Medicare Freedom of Information PO Box 4433, Marion, IL 62959	WPS Medicare Freedom of Information PO Box 5533, Marion, IL 62959
Minnesota	Wisconsin
WPS Medicare Freedom of Information 8120 Penn Ave South, Ste. 200, Bloomington, MN 55431	WPS Medicare Freedom of Information PO Box 1787, Madison, WI 53701

### New Policies

Policy	Title	Policy Type	Published
CV-012	Cardiac Rehabilitation Programs	NCD	July 06
CV-040	Cardiac Rhythm Device Evaluation	LCD	September 06
GSURG-042	Bariatric Surgery for Morbid Obesity	NCD	July 06

### Policy Revisions

Policy	Title	Policy Type	Published
ASC-001	Ambulatory Surgical Centers (ASC)	NCP	August 06
CV-039	Percutaneous Transluminal Angioplasty (PTA) (Carotid Stents)	NCD	July 06
CV-033	Non-Invasive Vascular Testing	LCD	September 06
DENT-002	Dental Services	NCP	July 06
DERM-008	Removal of Benign Skin Lesions	LCD	July 06
GSURG-001	Surgery	NCP	July 06
GSURG-031	Heart and/or Lung Transplants	NCD	July 06
GSURG-035	Pancreas Transplants with Kidney Transplant and Pancreas Transplant Alone	NCD	July 06
GSURG-038	Intestinal and Multi-Visceral Transplantation	NCD	July 06
HONC-002	Chemotherapy and Drug Administration	NCP	July 06
HONC-010	Antineoplastics and their Adjuncts	LCD	July 06, August 06
INJ-019	Human Granulocyte/Macrophage Colony Stimulating Factors	LCD	September 06
INJ-033	Intra-articular Injections of Hyaluronate for Treatment of Osteoarthritis of the Knee	NCD	July 06
INJ-035	Intravenous Iron Therapy	NCD	July 06
INJ-039	Gonadotropin-Releasing Hormone Analogs	LCD	July 06, August 06
MS-004	Bone Mineral Density (BMD) Studies	LCD	August 06
OPHTH-003	Optometrist Services	LCD	August 06, September 06
OPHTH-006	Ophthalmic Biometry	LCD	July 06
OPHTH-014	Computerized Corneal Topography	LCD	July 06
OPHTH-015	Optical Coherence Tomography (OTC)	LCD	July 06
OPHTH-016	Angiography-Retinal/Choroidal with Fluorescein or Indocyanine Green	LCD	July 06

Policy	Title	Policy Type	Published
OPHTH-021	Visual Rehabilitation Programs	LCD	August 06
OPHTH-022	Blepharoplasty, Blepharoptosis and Brow Lift	LCD	September 06
PHYS-024	Supervising Physicians in Teaching Settings	NCP	August 06
PHYS-040	Influenza, Pneumococcal and Hepatitis-B Vaccinations	NCP	September 06
PHYS-072	Ambulatory Blood Pressure Monitoring	NCD	July 06
PHYS-075	Physician Supervision of Diagnostic Tests	NCP	August 06
PSYCH-002	Clinical Psychologist Services	NCP	July 06
PSYCH-014	Psychiatry and Psychology Services	LCD	July 06
RAD-016	Screening Mammography	NCP	July 06
RAD-023	Magnetic Resonance Angiography (MRA)	NCD	August 06
RAD-024	Magnetic Resonance Imaging (MRI)	LCD	July 06, August 06
RAD-026	Radiopharmaceutical Agents	LCD	August 06
RAD-027	Positron Emission Tomography (PET) Scan	NCD	July 06
RAD-033	Computerized Tomography (CAT Scans)	LCD	August 06
RAD-034	Computed Coronary Tomography Angiography	LCD	August 06

**2007 ICD-9-CM COVERAGE - POLICY REVISIONS**  
~September 2006~

Effective for claims submitted with dates of service on or after 10/01/2006, WPS will cover the new 2007 ICD-9-CM codes for the policies and procedures listed below. We will post the listed changes to these effected policies to the Website after 10/01/2006.

Policy Name/Number	Policy Procedure Code	2007 ICD-9-CM Changes
Allergy Testing & Immunotherapy ALRG-001	95004, 95010, 95024, 95027 95180	478.19, 995.20, 995.27, 995.29 995.20, 995.27, 995.29 Delete 478.1, 995.2
Cardiac Stress Testing CV-004	93015, 93016, 93017, 93018, 93350	429.83, 995.20 Delete 995.2
Cardiac Catheterization CV-006	93501, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529	Add 429.83
Myocardial Perfusion Imaging CV-017	78460-78465, 78478, 78480	429.83, 995.20 Delete 995.2
Transthoracic Echocardiography CV-026	93303, 93304, 93307, 93308, 93320, 93321, 93325	277.30, 277.31, 277.39, 429.83, 518.7, 995.20 Delete: 277.3 995.2
Non-invasive Vascular Testing CV-033	93965, 93970, 93971 93875-93872	289.83 377.43
T-Wave Alternans Testing CV-036	93025	995.20 Delete: 995.2
Foot Care FT-001	G0127, 11055-11057, 11719-11721	277.30, 277.31, 277.39 Delete 277.3
Diagnostic Pap Tests GU-020	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175	Add 616.81, 616.89, 795.06 Delete: 616.8
Antineoplastics and their Adjuncts HONC-010	J0917, J9025, J9350, J9211 J9213, J9214	238.72-238.76 238.71 Delete: 238.7
Immune Globulin INJ-012	J1566, J1567	288.09 Delete: 288.0
Botulinum Toxin INJ-018	64613, 64614, 64640	333.71, 333.72, 333.79 Delete: 333.7
Human Granulocyte/Macrophage Colony Stimulating Factors INJ-019	J1440, J1441 J2505 J2820	288.00-288.04, 238.72-238.76 288.03 288.01, 288.03, 238.72-238.76 Delete: 288.0, 238.7, 963.1

Policy Name/Number	Policy Procedure Code	2007 ICD-9-CM Changes
Erythropoiesis Stimulating Proteins INJ-023	Q0136, Q0137, J0880	238.72-238.75, 995.20 Delete 238.7, 995.2
Bone Mineral Density (BMD) Studies MS-004	76070, 76071, 76075, 76076, 76078, 76977, 78350, 78351, G0130	995.20 Delete: 995.2
Nerve Conduction Studies and Electromyography NEURO-005	51785, 92265, 95900, 95903, 95904, 95933, 95934, 95936, 95937, 95860-95874	333.71, 333.72, 333.79, 341.20-341.22 Delete: 333.7, 341.2
Optical Coherence Topography OPHTH-015	92135	377.43
Retinal/Choroidal Angiography OPHTH-016	92235 92240	377.43 995.20 Delete 995.2
Flow Cytometry PATH-016	88184-88189	238.71-238.76, 238.79, 288.00-288.04, 288.09, 288.50, 288.51, 288.59, 288.61-288.65, 288.69 Delete: 238.7, 288.0, 288.5, 288.6
Cytogenetic Studies PATH-027	88230, 88245, 88248, 88249, 88283  88237, 88239, 88262, 88271-88275, 88283	238.71-238.76, 238.79, 284.01, 284.09, 288.00-288.04, 288.09, 288.4 238.71-238.76, 238.79, 284.01, 284.89, 288.00- 288.04, 288.09, 288.4 Delete: 238.7, 284.0, 288.0
Syphilis Testing PATH-031	86592, 86593, 86781	616.81, 616.89 Delete: 616.8
Physical Medicine & Rehabilitation PHYSMED-009	97022, 97036, 97110, 97112, 97113, 97116, 97530, 97535, 97537, 97542 97124, 97140 97124 G0283, 97018, 97022, 97024, 97026, 97032, 97034, 97035, 97036, 97110, 97112, 97113, 97116, 97124, 97140, 97530	341.20-341.22  333.71, 333.72, 333.79, 519.11, 519.19 338.21, 338.29, 338.4  Delete: 338.2, 341.2, 519.1
Psychiatry and Psychological Services PSYCH-014	90802, 90804-90815-90819, 90821-90824, 90826-90829, 90846-90847, 90849, 90853, 90857, 90862, 90865, 90870, M0064	333.72, 995.20  Delete: 333.7, 995.2
Radiologic Examination of the Chest, Including Portable RAD-004	71010, 71015, 71020-71023, 71030, 71034, 71035	052.2, 053.14, 054.74, 238.71- 238.76, 238.79, 277.30, 277.31, 277.39, 284.01, 284.09, 284.1, 284.2, 289.53, 289.83, 429.83, 518.7, 519.11, 519.19, 768.7, 770.87, 770.88, 775.81, 775.89, 779.85, 780.32, 995.20-995.23, 995.27, 995.29 Delete: 238.7, 277.3, 519.1, 995.2
Radiation Oncology Including Intensity Modulated Radiation Therapy/IMRT RAD-014	77261-77470 (except 77432)	238.71-238.76, 238.79 Delete: 238.7
MRA RAD-023	71555, 73725	995.20 Delete 995.2
MRI RAD-024	70336, 70540, 70542, 70543, 70551-70553  71550-71552 72195-72197, 74181-74183 72141, 72142, 72156 72146, 72147, 72157 72148, 72149, 72158	053.14, 054.74, 323.01, 323.02, 323.41, 323.42, 323.51, 323.52, 323.61-323.63 323.71, 323.72, 323.81, 323.82, 331.83, 333.71, 333.72, 333.79, 333.85, 333.94, 341.20-341.22, 377.43, 379.60-379.63, 389.15, 389.16, 478.11, 478.19, 780.32, 784.99 238.71-238.76, 238.79, 518.7, 519.11, 519.19 277.30, 277.31, 277.39, 289.53, 629.89, 958.93 Add 793.91, 793.99 Add 793.91, 793.99 Add 793.91, 793.99 Delete: 238.7, 277.3, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, , 333.7, 478.1, 519.1, 629.8, 784.9, 793.9
Percutaneous Vertebroplasty RAD-032	22520, 22521, 22522, 22523, 22524, 22525, 22899, 76012, 76013, 76499	238.79, 995.20  Delete: 238.7, 995.2

Policy Name/Number	Policy Procedure Code	2007 ICD-9-CM Changes
Computerized Tomography (CAT Scans) RAD-033	70450, 70460, 70470, 70480-70482, 70486-70488, 70490-70492, 70496, 70498  71250, 71260, 71270 72125-72127 72128-72130 72191-72194, 74150, 74160, 74170, 74175, 75635	323.01, 323.02, 323.41, 323.42, 323.51, 323.52, 323.61-323.63, 323.71, 323.72, 323.81, 323.82, 331.83, 333.71, 333.72, 333.79, 333.85, 333.94, 341.20-341.22, 377.43, 379.60-379.63, 389.15, 389.16, 478.11, 478.19, 780.32, 784.91, 784.99  238.71-238.76, 238.79, 518.7, 519.11, 519.19  793.99  793.99  277.30, 277.31, 277.39, 289.53, 629.89, 958.93  Delete: 238.7, 277.3, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8-, 333.7, 341.2, 478.1, 519.1, 629.8, 784.9, 793.9
Brachytherapy RAD-036		238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79  Delete: 238.7
DENT-002 Dental Services, Billing and Coding Instructions	Non-Covered Services	521.81, 521.89, 523.00, 523.01, 523.10, 523.11, 523.30, 523.31, 523.32, 523.33, 523.40, 523.41, 523.42, 525.60, 525.61, 525.62, 525.63, 525.64, 525.65, 525.66, 525.67, 525.69, 526.61, 526.62, 526.63, 526.69.  Delete: 523.0, 523.1, 523.3, 523.4, 523.6

**ADDITIONAL INSTRUCTIONS FOR CLAIMS RECEIVED FROM RAILROAD RETIREMENT BOARD BENEFICIARIES**  
~CMS MLN Matters – July 2006~

MLN Matters Number: MM5079  
Related CR Release Date: May 19, 2006  
Related CR Transmittal #: R953CP

Related Change Request (CR) #: 5079  
Effective Date: October 1, 2006  
Implementation Date: October 2, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf>**

This article is based on Change Request (CR) 5079, which provides additional information and instructions for the implementation of the CAP pertaining to CAP drug categories and fee schedule as outlined in CR4064 (Transmittal 777, dated December 9, 2006). The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 303 (d); <http://www.cms.hhs.gov/MMAUpdate/>) requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis.

CMS will implement the CAP with one category of drugs and one geographic area. However, as the program evolves, additional geographic areas and additional drug categories may be created. Also, approved CAP vendors will be able to request approval for changes to the lists of drugs that they supply under the CAP. CR4064 (Transmittal 777, dated December 9, 2006) described requirements for carriers to develop provider files that list physicians who have enrolled with an approved CAP vendor and the category (or categories) of drugs that the CAP vendor will furnish under the CAP. CMS is issuing CR5079 to automate the process of updating the list of drugs paid under the CAP. CR5079 provides additional information and instructions for the implementation of the CAP pertaining to the CAP drug categories and fee schedule as outlined in:

- CR4064 (Transmittal 777, dated December 9, 2006 at <http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf>); MLN Article MM4064 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>; and
- CR4309 (Transmittal 866, dated February 6, 2006 (rescinded and replaced with transmittal 866 dated February 17, 2006 at <http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf>); MLN article MM4309 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf>.

For the table defined in CR4064.1.1.2.1, when Medicare carriers receive election forms from providers, the carriers will indicate for each provider: 1) Which categories of drugs the provider has chosen to receive; and 2) From which approved CAP vendor the provider will receive CAP drugs. Approved CAP vendors will be permitted to request certain changes to the list of drugs that they supply under the CAP. Beginning in July 2006 with changes to be effective October 1, 2006, approved CAP vendors may request that CMS (or its designee) approve the following types of changes:

- **NDC Substitution(s):** Approved CAP vendor may request approval to replace one or more National Drug Codes (NDCs) in a HCPCS code supplied by the approved CAP vendor with one or more other NDCs.

- **NDC Addition(s):** Approved CAP vendor may request that CMS allow it to supply additional NDCs under a HCPCS code that the approved CAP vendor already supplies under the CAP.
- **HCPCS Addition(s):** Approved CAP vendor may request that CMS allow it to supply newly issued HCPCS codes under the CAP.
- **Orphan Drugs:** Approved CAP vendor may request that CMS allow it to supply single indication orphan drugs under the CAP.

As CMS continues to develop the CAP, additional geographical areas and additional drug categories may be created. If additional drug categories are created, certain drugs may appear in more than one drug category. Written requests for changes to the approved CAP vendor's drug list must be submitted to CMS and the CAP designated carrier. The requests must include a rationale for the proposed change, and a discussion of the impact on the CAP, including safety, waste, and potential for cost savings. If approved, changes will become effective at the beginning of the following quarter. CMS will post the changes on the CMS Website (<http://www.cms.hhs.gov/competitiveacqforbios/>) and notify the carriers and participating CAP physicians of any changes on a quarterly basis. Participating CAP physicians will be notified of changes to their approved CAP vendor's CAP drug list on a quarterly basis and at least 30 days before the approved changes are due to take effect. Physicians who participate in the CAP are required to obtain all CAP drugs, including those that have been added or otherwise updated, from the approved CAP vendor unless medical necessity requires the use of a formulation not supplied by the vendor. Please note that approved changes will apply only to the list of drugs supplied by the approved CAP vendor who submitted the request; therefore, each vendor's drug list may contain different drugs after changes to the initial drug list are approved.

The payment amount for new HCPCS codes added to an approved CAP drug vendor's drug list will be Average Sales Price (ASP) plus six percent (ASP+ 6%). Addition or substitution of NDC numbers under an existing HCPCS code supplied by an approved CAP vendor will not change the CAP single payment amount for that HCPCS code. CMS will update the single payment amount based on the approved CAP vendor's reported net acquisition costs for the category of drugs on an annual basis.

**CHANGES TO THE LABORATORY NCD EDIT SOFTWARE FOR JULY 2006**  
~CMS MLN Matters – July 2006~

MLN Matters Number: MM5108  
Related CR Release Date: May 26, 2006  
Related CR Transmittal #: R959CP

Related Change Request (CR) #: 5108  
Effective Date: July 1, 2006  
Implementation Date: July 3, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5108.pdf>**

This article is based on Change Request (CR) 5108, which communicates requirements to Medicare contractors notifying them of changes to the laboratory edit module and to update the laboratory edit module for changes in laboratory National Coverage Determination (NCD) code lists for July 2006. CR5108 informs your Medicare carrier and FI about changes in the laboratory NCD code lists for July 2006 that require updating of the laboratory edit module. The key change being made to the NCD code lists for July 2006 is that CPT code 83704 (Quantitation of lipoprotein particle numbers and lipoprotein particles subclasses) is being added to the list of HCPCS/CPT codes covered by Medicare for the Lipids Testing NCD.

**CREATION OF AUTOMATED TABLES FOR PROVIDER INFORMATION, EXPANSION OF CAP FEE SCHEDULE FILE LAYOUT, AND CORRECTION TO CR4136: NEW WAIVED TESTS**  
~CMS MLN Matters – August 2006~

MLN Matters Number: MM5131 Revised  
Related CR Release Date: June 23, 2006  
Related CR Transmittal #: R988CP

Related Change Request (CR) #: 5131  
Effective Date: January 1, 2006  
Implementation Date: July 24, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5131.pdf>**

**Note:** This article was revised on July 11, 2006, to show that the effective date is January 1, 2006 and the implementation date at the top of this page is July 24, 2006. These dates were inadvertently transposed on the original article. CR5131 corrects an incorrect Current Procedural Code (CPT) mentioned in the third sentence of the second paragraph in the background section of the Recurring Update Notification attachment for CR4136. Only this sentence has been revised. All other information remains as it is written in CR4136.

This article and CR5131 identifies the correction issued by CMS regarding the "Waived Tests:"

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

**HPCPS CORRECTION FOR THE CAFFEINE HALOTHANE CONTRACTURE TEST FOR MALIGNANT  
HYPERTHERMIA SUSCEPTIBILITY  
~CMS MLN Matters – August 2006~**

MLN Matters Number: MM5113  
Related CR Release Date: June 16, 2006  
Related CR Transmittal #: R984CP

Related Change Request (CR) #: 5113  
Effective Date: January 1, 2006  
Implementation Date: October 2, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5113.pdf>**

Effective January 1, 2006, you do not have to include a Clinical Laboratory Improvement Amendments (CLIA) number on claims that you submit for HCPCS code 89049 [Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report]. CR5113 provides that HCPCS code 89049 is not considered a test under CLIA. Therefore, performing this test does not necessitate that a facility have any CLIA certificate, nor require a CLIA number on claims for its use.

**LUMBAR ARTIFICIAL DISC REPLACEMENT (LADR)  
~CMS MLN Matters – August 2006~**

MLN Matters Number: MM5057  
Related CR Release Date: June 23, 2006  
Related CR Transmittal #: R60NCD and R992CP

Related Change Request (CR) #: 5057  
Effective Date: May 16, 2006  
Implementation Date: July 17, 2006 (carriers); October 1, 2006 (Fls)

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5057.pdf>**

**EDITOR’S NOTE:** This NCD supersedes the April 2005 *Communiqué* article entitled *Artificial Disc*.

This article and Change Request (CR) 5057 provide specific information regarding the new national coverage determination (NCD) for LADR. The message is three-pronged:

- 1) Effective May 16, 2006, the LADR with the Charite lumbar artificial disc is not covered by Medicare for beneficiaries over 60 years of age, i.e., on or after the beneficiary’s 61st birthday;
- 2) Medicare coverage under the investigational device exemption (IDE) and/or clinical trail policy for other lumbar artificial discs is not impacted by this decision and such coverage continues if the billing requirements are met and the appropriate codes are submitted; and
- 3) For patients 60 years of age and younger, there is no NCD, leaving such determinations to continue to be made by the local contractors.

This NCD focuses on the LADR with the Charite lumbar artificial disc because it is the only United States Food and Drug Administration (FDA) approved lumbar artificial disc at this time. The FDA has approved the use of the Charite artificial disc for spine arthroplasty in skeletally mature patients with degenerative or discogenic disc disease (DDD) at one level for L4 to S1. The addition of section 150.10 of Pub.100-03 is an NCD. The following are the billing requirements for LADR according to the revised *Medicare Claims Processing Manual*, Chapter 32, Section 170, which is effective May 16, 2006.

- Assuming the providers bill separately, physicians and hospitals need to **issue the appropriate liability notice**, (Advance Beneficiary Notice (**ABN**) or Hospital Issued Notice of Non-coverage (**HINN**)), to beneficiaries over 60 years of age who choose to have this procedure using the Charite lumbar artificial disc.
- The following language should be included in the ABN:
  - Under the “Items or Service” Section: Lumbar Artificial Disc Replacement (LADR) with the Charite Lumbar Artificial Disc.
  - Under the “Because” Section: After a national coverage analysis (NCA), Medicare issued a national coverage determination (NCD) (Section 150.10 of *Medicare NCD Manual*) that stated that LADR with the Charite Lumbar Artificial Disc is not reasonable and necessary for Medicare beneficiaries over 60 years of age. Therefore, LADR with the Charite lumbar artificial disc is non-covered for beneficiaries over 60 years of age. Medicare never pays for this service for this Medicare population.

- Hospitals need to have a **beneficiary who is over 60 years of age sign a HINN** if he/she wishes to have the procedure done when a Charite lumbar artificial disc is used in the procedure. If the beneficiary is not informed prior to admission that he or she is financially liable for the admission, the provider is liable.

**Information for Providers Billing Carriers**

- For patients over 60 years of age, claims submitted with Category III Codes 0091T (Single interspace, lumbar) and/or 0092T (Each additional interspace) will be denied unless performed under an approved IDE/clinical trial. (**Note:** The Charite lumbar artificial disc is the only artificial disc approved by the FDA, therefore the procedure (0091T or 0092T) would be using the Charite unless under an IDE/clinical trial.)
- For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, claims submitted with 0091T or 0092T and the modifier QA will be allowed and normal claims processing criteria for IDEs/clinical trials will be followed.

**MEDICARE TELEHEALTH SERVICES UPDATE  
~CMS MLN Matters – August 2006~**

**MLN Matters Number: MM5122**

**Related CR Release Date: July 7, 2006**

**Related CR Transmittal #: R997CP and R53BP**

**Related Change Request (CR) #: 5122**

**Effective Date: January 1, 2006**

**Implementation Date: August 7, 2006**

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5122.pdf>**

When billing for telehealth services provided on or after January 1, 2006, do not use current procedure terminology (CPT) codes 99261-99263 (hospital inpatient follow-up consultations) or 99271-99275 (confirmatory consultations). The American Medical Association (AMA) deleted CPT codes 99261 – 99263 and 99271 - 99275. Effective January 1, 2006, these CPT codes no longer exist and were removed from the physician fee schedule.

As displayed in Table 1 below, office and other outpatient consultations and initial inpatient consultations are included in Medicare telehealth consultations as described by CPT codes 99241 through 99255. The table displays the current Medicare telehealth services and CPT and HCPCS codes.

<b>Table 1: Current Medicare Telehealth Services and Associated CPT/HCPCS Codes</b>	
<b>Service</b>	<b>CPT/HCPCS Codes</b>
Consultations	99241 - 99255 as of January 1, 2006
Office or other outpatient visits	99201 - 99215
Individual psychotherapy	90804 - 90809
Pharmacologic management	90862
Psychiatric diagnostic interview examination	90801
End Stage Renal Disease (ESRD) related services	G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318
Individual Medical Nutrition Therapy	G0270, 97802, and 97803

**NESIRITIDE FOR TREATMENT OF HEART FAILURE PATIENTS  
~CMS MLN Matters – July 2006~**

**MLN Matters Number: MM4312 Revised**

**Related CR Release Date: April 7, 2006**

**Related CR Transmittal #: R218OTN and R51NCD**

**Related Change Request (CR) #: 4312**

**Effective Date: March 2, 2006**

**Implementation Date: May 22, 2006**

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4312.pdf>**

**Note:** This article was revised May 19, 2006, to clarify some of the language regarding the use of Nesiritide.

**Key Points**

- Effective for dates of service on or after March 2, 2006, CMS will deny coverage of Nesiritide for the treatment of chronic heart failure in Medicare beneficiaries. For billing guidelines about the non-covered use of Nesiritide, please refer to the *Additional Information* section of this article.
- CMS has determined that there is insufficient evidence to conclude that the use of Nesiritide for the treatment of chronic heart failure is reasonable and necessary for Medicare beneficiaries in any setting.
- This determination does not change local contractor discretion for treatment of acute(ly) decompensated heart failure consistent with the FDA labeled indication in Medicare beneficiaries who may have underlying chronic heart failure. Nor does it affect local contractor discretion for other off-label uses of Nesiritide in Medicare beneficiaries who may have underlying chronic heart failure.
- For claims submitted to FIs, the requirement to deny Nesiritide for chronic heart failure will only affect 13X and 85X Type of Bill (TOBs).

- 11X and 12X TOBs should be rejected.
- CMS recommends that FIs create medical policy parameters to deny outpatient claims for Nesiritide for chronic heart failure in the absence of acutely decompensated heart failure.
- CMS recommends that FIs reject inpatient claims where the primary diagnosis is chronic heart failure in the absence of acutely decompensated heart failure (11X and 12X) when billed with Nesiritide for chronic heart failure.
- For inpatient claims where the beneficiary is admitted with a primary diagnosis other than heart failure and Nesiritide is administered under a DRG payment, the administration of Nesiritide should not be the sole basis for denial of the entire inpatient claim.
- The provider will be held liable unless occurrence code 32 is present on the claim, or modifier GA is present on the line on an outpatient bill when Nesiritide is used to treat chronic heart failure without documented evidence of acute decompensation.
- All other indications for the use of Nesiritide not otherwise indicated as noncovered (other off-label uses or uses consistent with the current Food and Drug Administration (FDA) indication for intravenous treatment of patients with acutely decompensated congestive heart failure (CHF) who have dyspnea at rest or with minimal activity) are left to local contractor (carrier or FI) discretion.
- This addition to Chapter 1, Section 200.1, of the *Medicare National Coverage Determinations Manual*, (Publication 100-03) is a national coverage determination (NCD) made under section 1862(a)(1) of the Social Security Act (the Act).
- NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1064, effective May 1, 2005).
- An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Act.)

Claims submitted with HCPCS code J2325 (Injection, Nesiritide) with ICD-9 codes of:

- 428.0, 428.1, 428.20, 428.22, 428.30, 428.32, 428.40, 428.42, or 428.9; **and not accompanied by:**
- 428.21, 428.23, 428.31, 428.33, 428.41, or 428.43, **will be denied.**

Denied claims will be returned with the following claims adjustment codes:

- **Reason Code:** These are non-covered services because this is not deemed a “medical necessity” by the payer.
- **Remark Code M76:** Missing/incomplete/invalid diagnosis or condition.

## NON-AUTOLOGOUS BLOOD DERIVED PRODUCTS FOR CHRONIC NON-HEALING WOUNDS

~ CMS MLN Matters – August 2006 ~

MLN Matters Number: MM5123

Related CR Release Date: June 9, 2006

Related CR Transmittal #: R977CP and R59NCD

Related Change Request (CR) #: 5123

Effective Date: April 27, 2006

Implementation Date: July 10, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5123.pdf>**

This article is based on Change Request (CR) 5123 which instructs Medicare contractors (carriers, FIs, and RHHs) that claims submitted for **becaplermin**, a self-administered, non-autologous growth factor for chronic, non-healing, subcutaneous wounds **will remain non-covered**. Becaplermin, Healthcare Common Procedure Coding System (HCPCS) **S0157**, is nationally non-covered because it is usually self-administered by the patient.

After releasing a national non-coverage determination (NCD) on Autologous Blood-Derived Products for Chronic Non-Healing Wounds in December of 2003, an error was printed in the NCD Manual. To correct that error, CMS is revising Sec. 270.3 of the *NCD Manual* (Publication 100-03, Ch 1, Part 3, “Blood-Derived Products for Chronic Non-Healing Wounds”) to accurately reflect the payment policy for non-autologous blood derived products for chronic non-healing wounds, effective April 27, 2006. In this revision, the following sentence is being deleted: “Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous non-healing wounds, will remain at local carrier discretion. Becaplermin is approved by the Food and Drug Administration.” The correct statement should read: “Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous wounds, **will remain nationally non-**

covered under Part B based on §1861(s)(2)(A) and §1861(s)(2)(B) because this product is usually self-administered by the patient.”

**OUTPATIENT THERAPY – ADDITIONAL DRA MANDATED SERVICE EDITS**

~September 2006~

Transmittal 1016, dated July 28, 2006 is rescinded and replaced with Transmittal 1019, dated August 3, 2006. This instruction is being re-issued to correct the Business Requirements that were originally issued. In BR5253.4, Medicare Summary Notice was incorrectly referred to 16.26, and corrected to 16.25. Also, BR5253.45 was listed incorrectly and corrected to BR5253.5. The Business Requirement has been revised.

**PANCREAS TRANSPLANTS ALONE (PA)**

~CMS MLN Matters – July 2006~

MLN Matters Number: MM5093

Related Change Request (CR) #: 5093

Related CR Release Date: May 19, 2006

Effective Date: April 26, 2006

Related CR Transmittal #: R56NCD and R957CP

Implementation Date: July 3, 2006 for carriers; October 2, 2006 for FIs

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5093.pdf>

This article is based on information contained in Change Request (CR) 5093, which informs physicians and providers that, effective for services performed on or after April 26, 2006, Medicare will cover Pancreas Transplants Alone (PA) for beneficiaries in the following limited circumstances:

- Facilities must be Medicare-approved for kidney transplantation (Approved centers are found at [http://www.cms.hhs.gov/ESRDGeneralInformation/02\\_Data.asp#TopOfPage](http://www.cms.hhs.gov/ESRDGeneralInformation/02_Data.asp#TopOfPage) on the CMS Website).
- Patients must have a diagnosis of Type I diabetes:
  - The patient with diabetes must be beta cell autoantibody positive; or
  - The patient must demonstrate insulinopenia, defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory’s measurement method. Fasting C-peptide levels will be considered valid only with a concurrently obtained fasting glucose <225 mg/dL.
- Patients must have a history of medically-uncontrollable labile (brittle) insulindependent diabetes mellitus with documented recurrent, severe, acutely lifethreatening metabolic complications that require hospitalization.
- These complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks.
- Patients must have been optimally and intensively managed by an endocrinologist for at least 12 months with the most medically recognized advanced insulin formulations and delivery systems.
- Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immunosuppression.
- Patients must otherwise be suitable candidates for transplantation.

**Billing and Claims Processing**

- The following ICD-9 CM codes will be recognized by FIs and carriers for pancreas transplantation alone for beneficiaries with type I diabetes when billed with **HCPCS 48554**:  
25001, 25003, 25011, 25013, 25021, 25023, 25031, 25033, 25041, 25043, 25051, 25053, 25061, 25063, 25071, 25073, 25081, 25083, 25091, and 25093.
- Carriers and FIs who receive claims for PA services that were performed in an **unapproved facility** should use the following messages upon the reject or denial:
  - **Medicare Summary Notice MSN Message** - MSN code 16.2 (*This service cannot be paid when provided in this location/facility*)
  - **Remittance Advice Message** - Claim Adjustment Reason Code 58 (*Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service*)
- Carriers and FIs who receive claims for PA services that are **not billed using the covered diagnosis/procedure codes listed** above should use the following messages upon the reject or denial:
  - **Medicare Summary Notice MSN Message** - MSN code 15.4 (*The information provided does not support the need for this service or item*)
  - **Remittance Advice Message** - Claim Adjustment Reason Code 11 (*The diagnosis is inconsistent with the procedure*)

- Modification of the current coverage policy on pancreas transplants can be found in Publication 100-03, Section 260.3 and claims processing information is located in Publication 100-04, Chapter 3, Section 90.5.1. The location of this information is listed in the *Additional Information* section of this article.

**Note:** Carriers and FIs will hold any PA claims with dates of service on or after April 26, 2006, until the claims can be processed in their systems. For FIs this date is October 2, 2006, and for carriers the date is July 3, 2006.

### PAYMENT FOR ISLET CELL TRANSPLANTATION IN NIH-SPONSORED CLINICAL TRIALS

~CMS MLN Matters – August 2006~

MLN Matters Number: MM5140  
 Related CR Release Date: June 16, 2006  
 Related CR Transmittal #: R986CP

Related Change Request (CR) #: 5140  
 Effective Date: May 1, 2006  
 Implementation Date: July 31, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5140.pdf>

CMS is updating the modifier used for claims for islet cell transplantation and for routine follow-up care related to the transplantation in NIH-sponsored clinical trials. Please note that effective for islet cell transplantation and routine follow-up services related to the islet cell transplantation on or after **May 1, 2006, the QV modifier is no longer valid. The QR modifier** (item or service provided in a Medicare-specified study) **will replace the QV modifier for services on or after May 1, 2006.**

Effective for services on or after **May 1, 2006**, Medicare will **accept the QR modifier** for payment on claims for patients who participate in an NIH-sponsored clinical trial in conjunction with:

- Islet cell transplantation; and
- Routine follow-up care related to islet cell transplantation, when:
  - Performed in an outpatient department of a hospital; and
  - Billed on type of bill (TOB) 13X or 85X.

### Electronic Data Interchange

#### ENDING THE HIPAA CONTINGENCY FOR REMITTANCE ADVICE

~CMS MLN Matters Special Edition Article SE0646 – August 2006~

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0646.pdf>

Effective October 1, 2006, Medicare will send only HIPAA-compliant Electronic Remittance Advice (ERA) transactions (transaction 835 version 004010A1) to all electronic remittance advice receivers.

#### Background

In 2003, CMS addressed compliance with the HIPAA transaction and code sets, and encouraged health plans (such as Medicare) to:

- Intensify their efforts toward compliance;
- Assess the readiness of their provider communities; and
- Determine the need to implement contingency plans to maintain the flow of payments while continuing toward compliance.

Consistent with that guidance, Medicare has aggressively worked with providers to achieve HIPAA compliance. Effective October 16, 2003, in order to ensure the continuation of normal program operations, CMS implemented a contingency plan through which Medicare continued to accept and send both HIPAA-compliant and non-HIPAA transactions from/to trading partners.

CMS ended the contingency plan that addressed **inbound** claims on October 1, 2005, and at that time began denying non-compliant electronic claims. Now, CMS is moving to end the contingency plan for Electronic Remittance Advice (ERA) transactions. Currently, 99% of all Electronic Remittance Advice (ERA) receivers (providers, clearinghouses, billing agencies, and others who receive ERAs on behalf of providers) are receiving the HIPAA compliant ERA. Further, the overall compliance rate for all Medicare providers in May, 2006, was 96%. (The rate for professional providers was 97% and for institutional providers was 93%.)

**Therefore, CMS announces that, effective October 1, 2006, it will end the contingency plan for the remittance advice transaction.** After that date, your carriers, FIs, DMERCs, DME MACs, and RHHIs will send only HIPAA-compliant remittance advice (transaction 835) to all electronic remittance advice receivers. In doing so, Medicare will stop sending electronic remittance advice in any version other than the standard HIPAA version (835 version 004010A1), or in any other format (e.g., NSF).

**HIPAA ELECTRONIC CLAIM SUBMISSION REQUIREMENTS**

~July 2006~

WPS accepts Medicare files in version 4010A1. The CMS-1500 (12-90) claim form is being revised to accommodate the reporting of the National Provider Identifier (NPI). The intent of the new form is to best accommodate the NPI with minimal changes to the current claim form. The CMS-1500 (08-05) version will be mandated for use on February 1, 2007. To assist you with implementation of the NPI, WPS has created a cross-reference guide to help users become compliant with this new requirement. It is to be used as a guide for providers to discuss billing requirements with their vendors. This does not replace or supersede the data requirements of the Implementation Guide 004010X098A1, which can be obtained at <http://www.wpc-edi.com>.

- Beginning January 3, 2006 through October 1, 2006, CMS systems will accept an NPI as long as it is accompanied by an existing legacy Medicare number.
- Beginning October 2, 2006 through May 22, 2007, CMS systems will accept an existing legacy Medicare number and/or an NPI.
- Beginning May 23, 2007, our systems will only accept an NPI.

The cross-reference guide is available at: [http://www.wpsmedicare.com/provider/pdfs/cms1500\\_xw.pdf](http://www.wpsmedicare.com/provider/pdfs/cms1500_xw.pdf)

**IMPORTANT CHANGE TO ELECTRONIC FUNDS TRANSFER (EFT) PAYMENTS**

~August 2006~

The revised Medicare enrollment applications require that providers initially enrolling in the Medicare program and providers submitting a CMS-855 change request receive payment via Electronic Funds Transfer (EFT). In the past, CMS has encouraged, but not required, providers to receive payment by EFT. In an effort to sustain compliance, Medicare contractors shall also not approve any requests to change payment method from EFT to paper check. Effectively immediately, Medicare will not accept any termination request of your EFT. However, providers may revise a current EFT authorization or make such changes necessary to continue receiving payment via EFT. Before terminating an account, please allow us time to process your EFT change. When you are making changes to your account, you must also allow a 10-15 day pre-certification period. For the 10-15 day pre-certification period only, you will receive paper checks. We will contact you when all changes have been completed. If you have any questions contact the EDI Department toll-free at: 866-380-4742.

**STAGE 2 NPI CHANGES FOR TRANSACTION 835, AND SPR ADVICE, AND CHANGES IN MEDICARE CLAIMS PROCESSING MANUAL, CHAPTER 22 – REMITTANCE ADVICE**

~CMS MLN Matters – August 2006~

MLN Matters Number: MM5081  
 Related CR Release Date: June 30, 2006  
 Related CR Transmittal #: R996CP

Related Change Request (CR) #: 5081  
 Effective Date: October 1, 2006  
 Implementation Date: October 2, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5081.pdf>**

This article instructs the Shared System Maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advice (ERA) – transaction 835, and Standard Paper Remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007. CMS has defined legacy provider identifiers to include OSCAR, National Supplier Clearinghouse (NSC), Provider Identification Numbers (PIN), National Council of Prescription Drug Plans (NCPDP) pharmacy identifiers, and Unique Physician Identification Numbers (UPINs). CMS's definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as Employer Identification Numbers (EINs) or Social Security Numbers (SSNs). Medicare has published CR4320 (<http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf>) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via Direct Data Entry screens, or on paper claim forms. The following dates outline the regulations from January 2006 forward and are as follows:

- **January 3, 2006 – October 1, 2006:** Medicare rejects claims with only NPIs and no legacy number.

- **October 2, 2006 – May 22, 2007:** Medicare will accept claims with a legacy number and/or an NPI, and will be capable of sending NPIs in outbound transaction e.g., ERA
- **May 23, 2007 – Forward:** Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

**STANDARD PAPER REMITTANCE (SPR) SUPPRESSION**  
~September 2006~

Are you receiving Medicare payments without the payment voucher attached? As of June 1, 2006, any provider who was setup to receive electronic remittance for 45 days or more was flagged for paper remittance suppression. To review all of the changes that were made, please read Special Edition Medicare Learning Network (MLN) Matters Article SE0627 - "Options for Providers/Suppliers Affected by CR 4376: Suppression of Standard Paper Remittance Advice (SPR) to Providers and Suppliers Also Receiving Electronic Remittance Advice (ERA) for 45 Days or More." This article is available at the following address on CMS' Website: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf>

Not using your electronic remittance? Not aware that you were setup for electronic remittance and would prefer the Standard Paper Remittance? Electronic Data Interchange (EDI) would like to encourage you to be aware of the EDI forms you complete and what each request will do for you. Before you call EDI, you have a couple of options: Medicare has FREE software called Medicare Remit Easy Print (MREP) that allows you to print out an Electronic Remittance Advice (ERA) in the same format as a paper Explanation of Benefits (EOB). For more information on this software go to [http://www.wpsmedicare.com/provider/easy\\_print.shtml](http://www.wpsmedicare.com/provider/easy_print.shtml)

You can download a WPS ERA Deactivation request form from the following URL: <https://www.wpsic.com/edi/pdf/eradeactivate.pdf> and fax it to EDI to save you time. If you need a copy of the Standard Paper Remittance, (SPR) complete the deactivation request form, and be sure to specify the checks and dates of the needed SPRs. The EDI fax number for IL/MI/WI is (618) 998-5170 for MN (952) 885-2899.

**General Information**

**2006 ONCOLOGY DEMONSTRATION PROJECT**  
~CMS MLN Matters – July 2006~

Medlearn Matters Number: MM4219 Revised  
Related CR Release Date: March 10, 2006  
Related CR Transmittal #: R36DEMO

Related Change Request (CR) #: N/A  
Effective Date: January 1, 2006  
Implementation Date: January 17, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4219.pdf>**

**Note:** This article was revised on March 13, 2006, to reflect revisions made to CR4219, which was reissued on March 10 as Transmittal 42. The CR4219 was revised because the specialty code for medical oncology should have shown 90 (not 83) and for hematology/oncology should have shown 83 (not 90).

This article provides information on the oncology demonstration project for 2006. Additional information and guidance is available in *Medlearn Matters* article SE0588, available at <http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0588.pdf> on the CMS Website.

**AMBULATORY SURGICAL CENTER (ASC) CLAIMS PROCESSING MANUAL CLARIFICATION**  
~CMS MLN Matters – August 2006~

MLN Matters Number: MM5026 Revised  
Related CR Release Date: June 9, 2006  
Related CR Transmittal #: R975CP

Related Change Request (CR) #: 5026  
Effective Date: June 5, 2006  
Implementation Date: June 5, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5026.pdf>**

**Note:** This article was revised on June 12, 2006, to reflect changes made to CR5026 on June 9, 2006. The article was revised to reflect a new CR release date, Transmittal number, and Web address for CR5026. All other information remains the same.

This article is for informational purposes. CR5026 revises the *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services)

and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) to clarify policy regarding the provision, coverage, and payment of services furnished in an ASC.

**CHANGES CONFORMING TO CHANGE REQUEST 3648 (CR3648) FOR THERAPY SERVICES  
~CMS MLN Matters – August 2006~**

MLN Matters Number: MM4014 Revised

Related CR Release Date: June 14, 2006

Related CR Transmittal #: R980CP and R55NCD

Related Change Request (CR) #: 4014

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4014.pdf>**

**Note:** This article was revised on June 15, 2006, to reflect changes made to CR4014, which was re-issued on June 14, 2006. The transmittal number, CR release date (see above), and the Web address for viewing CR4014 were revised. All other information remains the same.

This article is based on Change Request (CR) 4014, which updates language in the *Medicare National Coverage Determinations Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) by changing the term “speech therapy” to “speech-language pathology.” To conform to changes in CR3648, CR4014 removes from the *Medicare Claims Processing Manual* (Publication 100-04) the requirement to include the date last seen by a physician for outpatient services provided by a physical or occupational therapist or speech-language pathologist. Requirements for therapy services incident to a physician have not been changed.

**CLAIM STATUS CATEGORY CODE AND CLAIM STATUS CODE UPDATE  
~CMS MLN Matters – August 2006~**

MLN Matters Number: MM5137

Related CR Release Date: June 23, 2006

Related CR Transmittal #: R987CP

Related Change Request (CR) #: 5137

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5137.pdf>**

This article is based on CR 5137, which provides the October 2006 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHs). Medicare contractors are to use codes with the “**new as of 10/06**” designation and prior dates, and they must inform affected providers of the new codes. CR5137 applies to Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277.



The updated Claim Status Category and Claim Status codes list is posted three times a year (after each Health Care Code Maintenance Committee X12 trimester meeting) at the Washington Publishing Company Website at <http://www.wpc-edi.com/codes>. At this Website, select “Claim Status Codes” or “Claim Status Category Codes” to access the updated code list. Included in the code lists are specific details, including the date when a code was added, changed or deleted. All code changes approved in June 2006 are to be listed to this Website approximately thirty (30) days after the meeting concludes. For this update, Medicare will begin using the codes in place as of October 2006 in claim status responses issued on or after October 2, 2006.

**COLLECTION OF FEE-FOR-SERVICE PAYMENTS MADE DURING PERIODS OF MANAGED CARE  
ENROLLMENT – MANUALIZATION  
~CMS MLN Matters – August 2006~**

MLN Matters Number: MM5105 Revised

Related CR Release Date: July 3, 2006

Related CR Transmittal #: R100FM

Related Change Request (CR) #: 5105

Effective Date: October 1, 2003

Implementation Date: June 26, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5105.pdf>**

**Note:** This article was revised on July 6, 2006, to reflect revisions made to CR5105, which CMS released on July 3, 2006. The Transmittal number, CR release date, and Web address for accessing CR5105 have been changed. In addition, some references to MA (Medicare Advantage) have been changed to refer to managed care plans. All other information remains the same.

This article is based on Change Request (CR) 5105, which was issued to manualize the process that ensures that any duplicate payments for services rendered to Medicare beneficiaries are collected. CR5105 ensures that any fee-for-service claims that were approved for payment during a period when the beneficiary was enrolled in

a Managed Care Organization are submitted to the normal collection process used by the Medicare contractors (carriers/DMERCs/FIs) for overpayments.

### Background

CMS pays for a beneficiary's medical services more than once when a specific set of circumstances occurs. When CMS data systems recognize a beneficiary has enrolled in a MA Organization, the MA Organization receives capitation payments for the Medicare beneficiary. In some cases, enrollments with retroactive payments are processed.

The result is that Medicare may pay for the services rendered during a specific period twice:

- First, for the specific service that was paid by the fee-for-service Medicare contractor to the provider; and
- Second, by the MA Payment Systems in the monthly capitation rate paid to the MA plan for the beneficiary.

### Overview of the MA plan Enrollment Process

When an MA plan enrollment is processed retroactively:

- Fee-for-service claims with dates of service that fall under the managed care plan enrollment period are identified by Medicare's Common Working File (CWF); and
- An Informational Unsolicited Response (IUR) record is created.

In essence, the retroactive enrollment triggers a search for fee-for-service claims that were incorrectly paid for services rendered when the beneficiary was covered by the managed care plan. If such claims are found, the system generates an adjustment and initiation by Medicare systems of overpayment recovery procedures. The current policy/procedures, as outlined in CR2801 (Transmittal AB-03-101, dated July 18, 2003) and CR 5105, dictates that:

- Claims paid in error (due to enrollment or disenrollment corrections) will be adjusted; and
- Medicare contractors will initiate overpayment recovery procedures.

Because of the inherent retroactivity in the enrollment process, (e.g., beneficiaries can enroll in plans up to the last day of the month, and the effective date would be the first of the following month), the CWF may receive this information after the enrollment is effective. For this reason, these kinds of adjustments occur routinely.

A variety of the CMS systems issues over the past 18 months have prompted CMS to recently synchronize MA enrollment and disenrollment information for the period September 2003 to April 2006. As a result, providers may have claims that were affected by this synchronization. For details of the impact of this synchronization on providers, please see *MLN Matters* article, SE0638, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0638.pdf> on the CMS Website.

When claims are identified as needing payment recovery, the related remittance advice for the claim adjustment will indicate Reason Code 24, which states: "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan." Upon receipt, providers are to contact the managed care plan for payment.

- Providers who bill carriers will be alerted by their carrier (via letter or alternate method) of the following:
  - That the beneficiary was in a managed care plan on the date of service;
  - That the provider should bill the managed care plan;
  - What the plan identification number is; and
  - Where to find the plan name and address associated with the plan number on the CMS Website.
- For providers who bill FIs, the adjustment will occur automatically and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly.

**Note:** To associate plan identification numbers with the plan name, go to [http://www.cms.hhs.gov/HealthPlansGenInfo/claims\\_processing\\_20060120.asp#TopOfPage](http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage)

In summary, CMS issued CR5105 to:

- Ensure that any fee-for-service claims that were approved for payment erroneously are submitted to the normal collection process used by the Medicare contractors (carriers, DMERCs, FIs, and RHHIs) for overpayments; and

- Instruct Medicare contractors to follow the instructions outlined in the *Medicare Financial Management Manual* (Publication 100-06, Chapter 3, Section 190), which is included as part of CR5105. Instructions for accessing CR5105 are in the *Additional Information* section of this article.

**DISCLOSURE DESK REFERENCE FOR PROVIDER CONTACT CENTERS**

~CMS MLN Matters – September 2006~

MLN Matters Number: MM5089  
 Related CR Release Date: July 21, 2006  
 Related CR Transmittal #: R16COM

Related Change Request (CR) #: 5089  
 Effective Date: October 1, 2006  
 Implementation Date: October 2, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5089.pdf>**

When you call or write a Medicare fee-for-service provider contact center (PCC) to request beneficiary protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA), will authenticate your identity prior to disclosure.

CR5089 revises *Medicare Contractor Beneficiary and Provider Communications Manual*, Ch. 3, Sec. 30, and Ch. 6, Sec. 80, to update the guidance to PCCs for authenticating providers who call or write to request beneficiary protected health information, and to clarify the information they may disclose after authentication.

Be prepared to supply the required authentication information when contacting a PCC to request protected health information. Below is the authentication guidance that the PCCs will be using:

**Telephone Inquiries**

**Provider Authentication**

**CSR Telephone Inquiries** - Through May 22, 2007, Customer Service Representatives (CSR) will authenticate providers using provider number and provider name.

**Interactive Voice Response (IVR) Telephone Inquiries** - Through May 22, 2007, IVRs will authenticate providers using only the provider number.

**Written Inquiries**

**Provider Authentication**

Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider number and provider name. At this point, there are some specific details about provider authentication in written inquiries of which you should be aware.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider's official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider's name and address are included in the letterhead and clearly establish the provider's identity.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered to be written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you.

Rather, they will send you the requested information by regular mail, or respond to these requests by telephone. In either of these response methods, or if they elect to send you an automated e-mail reply (containing no beneficiary-specific information), they will remind you that such information cannot be disclosed electronically via email or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

And lastly, inquiries received without letterhead, including hardcopy, fax, e-mail, pre-formatted inquiry forms, or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs), will be

authenticated the same as written inquiries,(explained above) using provider name and the provider number.

### **Insufficient or Inaccurate Requests**

You should also understand that for any protected health information request in which the PCC determines that the authentication elements are insufficient or inaccurate, you will have to provide complete and accurate input before the information will be released to you.

Such requests that are submitted in written form and those on pre-formatted inquiry forms, will be returned in their entirety by regular mail, with a note stating that the requested information will be supplied upon submission of all authentication elements, and identifying which elements are missing or do not match the Medicare record. Alternatively, if you sent the request by e-mail (containing no protected health information), the PCC may return it by e-mail, or may elect to respond by telephone to obtain the rest of the authentication elements.

### **Beneficiary Authentication**

Regardless of the type of telephone inquiry (CSR or IVR) or written inquiry, PCCs will authenticate four beneficiary data elements before disclosing any beneficiary information:

1) Last name; 2) First name or initial; 3) Health Insurance Claim Number; and 4) Either date of birth (eligibility, next eligible date, Certificate of Medical Necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) [pre-claim]) or date of service (claim status, CMN/DIF [post-claim]).

Please refer to the disclosure charts attached to CR5089 for specific guidance related to these data elements as well as details on the beneficiary information that will be made available in response to authenticated inquiries. CR5089 is available at

<http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf> on the CMS Website.

### **Special Instances**

Below are three special instances that you should know about.

#### **Overlapping Claims**

Overlapping claims (multiple claims with the same or similar dates of service or billing period) occur when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

Sometimes this happens when the provider is seeking to avoid have a claim be rejected, for example:

- When some End State Renal Disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated, thus allowing the facility to code the claim appropriately and bill around the inpatient hospital stay/stays; or
- Skilled nursing facility and inpatient hospital stays.

These situations fall into the category of disclosing information needed to bill Medicare properly, and information can be released as long as all authentication elements are met.

#### **Pending Claims**

A pending claim is one that is being processed, or has been processed and is pending payment. CSRs can provide information about pending claims, including Internal Control Number (ICN), pay date/amount or denial, as long as all authentication requirements are met. Providers should note, however, that until payment is actually made or a remittance advice is issued, the information provided could change.

#### **Deceased Beneficiaries**

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, PCCs will comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

More information will be provided in a future MLN Matters article about authentication on and after May 23, 2007, the implementation date for the National Provider Identifier (NPI).

**FACILITATING YOUR MEDICARE ENROLLMENT**  
~CMS MLN Matters Special Edition Article SE0634 – July 2006~

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0634.pdf>

On May 1, 2006, CMS issued the revised CMS-855 Medicare enrollment applications. Providers and suppliers should begin to use the new Medicare enrollment applications immediately. Initially, these applications will be available only from the CMS provider enrollment Website (<http://www.cms.hhs.gov/MedicareProviderSupEnroll/>).

To ensure timely processing of your application, make certain to completely fill out the application and provide all required supporting documentation at the time of filing. Section 17 of the Medicare enrollment application lists the types of supporting documentation that you will need to submit with your enrollment application. In addition to providing the documentation previously required, all applicants are required to:

- Submit their National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application; and
- Complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT - making a change to their enrollment information.

To obtain a list of specific supporting documentation that you must submit with your enrollment application, contact the designated Medicare fee-for-service contractor serving your area before submitting your application.

At any time during the enrollment process, your carrier or FI may request documentation to support or validate information that you have reported on your application. Applicants are responsible for providing this documentation in a timely manner. Failure to provide documentation in a timely manner may delay your enrollment into the Medicare program.

Medicare contractors will continue to accept the 11/2001 version of the Medicare enrollment applications through June 2, 2006, as long as the application is complete and contains the NPI notification from NPPES. In addition, providers and suppliers who choose to use the 11/2001 version of the 855 will be required to complete and submit Section 1 or Section 4 (completed by the provider) of the 04/06 version of the CMS-855. Providing this information will ensure that Medicare is able to link existing Medicare identification number(s) to the NPI that the provider or suppliers plan to use for billing purposes. Specifically, Section 1 must be completed by Physician Assistants and providers reassigning all of their benefits, as this is where NPI data is reported. All other providers must furnish the NPI and Medicare Identification Number in Section 4 of the CMS-855; this is the only data that must be reported in Section 4.

All applications received on or after June 5, 2006, must be filed using the 04/06 version of the CMS-855 and contain all supporting documentation, including the NPI notification and the CMS-588.

**INFORMATION ON NPI AND THE REVISED CMS 855 MEDICARE PROVIDER ENROLLMENT APPLICATIONS**  
~July 2006~

On May 1, 2006, CMS introduced the revised CMS 855 Medicare provider enrollment applications. As part of the revised enrollment process, initial enrollees and existing enrollees making changes to their enrollment information must include their National Provider Identifier (NPI) number and a copy of the National Plan and Provider Enumeration System (NPPES) NPI notification with the enrollment application. No initial application can be approved and no updates to existing enrollment information can be made without this NPI information. All health care providers and suppliers who bill Medicare are required to obtain their NPI in advance of enrolling in or changing their Medicare enrollment data.

If you are an individual or sole proprietor, who furnishes health care, you are eligible for one and only one NPI. If you are an individual who is a health care provider and who is incorporated, you may need to obtain an NPI for yourself and an NPI for your corporation or LLC. If you are an organization that furnishes health care, you may determine that you have components, called "subparts," that need their own NPI. For additional information about the NPI, please go to <http://www.cms.hhs.gov/NationalProvidentStand/>

If you have not yet obtained your NPI number, CMS encourages you to do so soon even if you are not enrolling or making a change to your Medicare enrollment information. An information sheet designed to provide basic information about the NPI, including the three different ways to apply for your NPI is available at [http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/EnrollmentSheet\\_WWWWWH.pdf](http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/EnrollmentSheet_WWWWWH.pdf). Whatever method you use to obtain your NPI, be sure to keep this information, share it with your health care partners, and update your information with NPPES whenever any of the information used to get your NPI changes.

Starting May 23, 2007, the NPI will replace all of your existing provider numbers that you use to bill Medicare, Medicaid, and other health care payers. Although this date is still a year away, you should begin sharing this information with Medicare, other payers, and your other health care partners in order to make the transition to NPI as smooth as possible. For more information about the revised provider enrollment process, please contact your Medicare contractor or go to <http://www.cms.hhs.gov/MedicareProviderSupEnroll>

### LABORATORY COMPETITIVE BIDDING DEMONSTRATION

~CMS MLN Matters – September 2006~

MLN Matters Number: MM5205  
 Related CR Release Date: August 1, 2006  
 Related CR Transmittal #: R49DEMO

Related Change Request (CR) #: 5205  
 Effective Date: January 1, 2007  
 Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5205.pdf>

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires CMS to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule. Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable. The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

This article and Change Request (CR) 5205 provides instructions for the implementation of a laboratory competitive bidding demonstration. CR5205 is being implemented in multiple phases. The requirements specified in this article and CR5205 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

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

#### **Required Bidders**

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

#### **Passive Laboratories**

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

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

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

**MODIFICATION TO ONLINE MEDICARE SECONDARY PAYER QUESTIONNAIRE -  
FULL REPLACEMENT OF AND RESCINDING CHANGE REQUEST (CR) 3504  
~ CMS MLN Matters – August 2006 ~**

MLN Matters Number: MM4098 Revised  
Related CR Release Date: October 21, 2005  
Related CR Transmittal #: 41

Related Change Request (CR) #: 4098  
Effective Date: January 21, 2006  
Implementation Date: January 21, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4098.pdf>**

This article was revised on June 15, 2006, because CR4098, on which this article is based, has been superseded by CR5087. To view modifications to the online Medicare Secondary Payer Questionnaire that are effective as of September 11, 2006, please see MLN Matters article MM5087, available below and at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5087.pdf> on the CMS Website.

**MODIFICATION TO ONLINE MEDICARE SECONDARY PAYER QUESTIONNAIRE:  
THIS CR RESCINDS AND REPLACES CR4098  
~ CMS MLN Matters – July 2006 ~**

MLN Matters Number: MM5087  
Related CR Release Date: June 9, 2006  
Related CR Transmittal #: R53MSP

Related Change Request (CR) #: 5087  
Effective Date: September 11, 2006  
Implementation Date: September 11, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5087.pdf>**

**Provider Types Affected**

Medicare physicians/providers/suppliers that, upon providing services to a Medicare patient, use a questionnaire to determine other insurance coverage that may be primary to Medicare.

**Provider Action Needed**

Questions have arisen over Part V of the model Medicare Secondary Payer Questionnaire. CR5087 provides clarification regarding Part V, provides major revisions to other parts of the model Medicare Secondary Payer Questionnaire, and rescinds and replaces CR4098. You should replace any previous versions of the model questionnaire with the new version, available as an attachment to CR5087.

**QUARTERLY MEDICARE SUMMARY NOTICE (MSN) PRINTING CYCLE  
~ CMS MLN Matters – July 2006 ~**

MLN Matters Number: MM5062 Revised  
Related CR Release Date: May 12, 2006  
Related CR Transmittal #: R955CP

Related Change Request (CR) #: 5062  
Effective Date: Carriers-June 12, DMERCs July 1, FIs- September 1  
Implementation Date: Carriers, June 12, DMERCs, July 3, FIs-Sept. 1

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5062.pdf>**

**Note:** This article was revised May 24, 2006, to correct the implementation date for DMERCs. That date should have been July 3, 2006. The transmittal number also changed, since Transmittal R945 (dated 05/12/06) was rescinded and replaced with Transmittal R955 (dated 05/19/06). All other information remains the same.

This article is based on Change Request (CR) 5062, which instructs Medicare contractors (carriers, DMERCs, FIs, and RHHIs) to print and mail No-Pay Medicare Summary Notices (MSNs) on a quarterly schedule (rather than the current monthly schedule).

**Background**

Current CMS instructions require all Medicare contractors to issue a MSN to each beneficiary for whom a claim was processed during the last 30 days (possibly for services received more than 30 days ago) to inform the beneficiary of the disposition of all claims (i.e., a record of services received, the status of any deductibles, and appeal rights).

In an effort to reduce overall operating costs, CR5062 instructs your intermediary/carrier to change from their current monthly (30 day) No-Pay MSN mailing schedule to a quarterly (90 day) No-Pay MSN mailing schedule. All MSN information should continue to print; however, summations will occur on a quarterly basis as opposed to a monthly basis.

No-Pay MSNs are the standard, system-generated MSNs produced for beneficiaries in which Medicare did not issue payment to the beneficiary for the respective claim. Beneficiaries often need these MSNs in order to obtain payment from another payer/insurer.

In those situations where a No-Pay MSN is needed or lost by a beneficiary, they can request a No-Pay MSN by calling 1-800 Medicare. On-demand requests will be generated and mailed once the request is made.

In summary, CR5062 provides the following instructions:

- Beginning no later than October 1, 2006, Medicare contractors will issue No-Pay MSNs on a quarterly/90-day mailing cycle as opposed to the previous monthly/30-day mailing cycle;
- MSNs with checks will continue to be mailed out as processed; and
- If a beneficiary requests a monthly No-Pay MSN (as opposed to the quarterly MSN), then Medicare contractors must generate and mail out the MSN at the time of the request.

**QUARTERLY PROVIDER UPDATE**  
~July 2006~

The Quarterly Provider Update is a comprehensive resource published by CMS on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare, including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The Quarterly Provider Update can be accessed at: <http://www.cms.hhs.gov/QuarterlyProviderUpdates/>. We encourage you to bookmark this Website and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update listserv (electronic mailing list) at: <https://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1>

**UPDATE TO THE HEALTHCARE PROVIDER TAXONOMY CODES (HPTC) VERSION 5.1**  
~CMS MLN Matters – July 2006~

Related Change Request (CR) #: 4072  
Related CR Release Date: September 30, 2005  
Effective Date: October 30, 2005

Medlearn Matters Number: MM4072  
Related CR Transmittal #: 694  
Implementation Date: October 30, 2005

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4072.pdf>

This article is based on Change Request (CR) 4072, which includes details regarding the Version 5.1 HPTC update. CR4072 advises your carrier and/or DMERC to obtain the Healthcare Provider Taxonomy Code list Version 5.1 and use it to update their internal HPTC tables to process your claim(s) correctly. To summarize the changes in Version 5.1, the following taxonomy codes are added:

- 170300000X
- 171000000X
- 1710I1002X
- 1710I1003X

**Program Safeguards**

**SANCTIONED AND REINSTATED PROVIDERS**  
~July, August, and September 2006~

The Medicare and Medicaid Patient and Program Protection Act provides the Department of Health and Human Services with the authority to exclude health care providers, individuals and businesses from receiving Medicare payment for services otherwise payable. This sanction practice represents the full range of administrative remedies and actions available to deal with questionable, improper or abusive practices of providers under the Medicare program. WPS will not issue payments for services performed, ordered or referred by these providers after the indicated changes. Current listings of sanctioned and reinstated providers are published in the monthly *Communiqué*. Complete lists are available at: <http://oig.hhs.gov/fraud/exclusions/listofexcluded.html>

**Provider Education**

**LET CMS KEEP YOU UP-TO-DATE!**  
~August 2006~

In the fast-paced, ever-changing world in which we live, it's all too easy to find yourself inundated with information. CMS offers a way for you to receive consistent and accurate information regarding recent news, policy changes, and updates: CMS Mailing Lists. Also referred to as listservs, these electronic mailing lists enable you to receive e-mails about the latest CMS Fee-for-Service (FFS) initiatives. All that is required to subscribe is your name and a valid e-mail address, and you can start receiving electronic updates automatically!

A fact sheet about CMS Listservs may be obtained at [http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists\\_FactSheet.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf). Hardcopies can also be ordered by going to the MLN Products Ordering Page at [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) and then click on the first item under 'Informational Resources.'

**PROVIDER EDUCATION EVENTS AVAILABLE!**  
~July, August, and September 2006~

Take advantage of a Medicare Education event in your area. Provider Outreach and Education are offering free educational events. Sign up today by going to [http://www.wpsmedicare.com/provider/proved\\_seminar.shtml](http://www.wpsmedicare.com/provider/proved_seminar.shtml) and clicking on the course number for the seminar that you are interested in attending.

**Reimbursement**

**2007 ANNUAL UPDATE FOR THE HPSA BONUS PAYMENTS**  
~CMS MLN Matters – September 2006~

MLN Matters Number: MM5237  
Related CR Release Date: August 4, 2006  
Related CR Transmittal #: R1021CP

Related Change Request (CR) #: 5237  
Effective Date: January 1, 2007  
Implementation Date: January 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5237.pdf>**

This article is based on Change Request (CR) 5237, which alerts affected physicians, providers, carriers, and FIs that the new HPSA bonus payment information for 2007 will soon be available. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Section 413(b)) mandated an annual update to the automated HPSA bonus payment files, and CMS creates these new automated HPSA bonus payment files annually. CR5237 instructs carriers and FIs to use the new HPSA bonus payment file for the automated bonus payment for claims with dates of service on or after January 1, 2007, through December 31, 2007. In addition, CMS is notifying affected physicians/providers that it will post the new HPSA information to the CMS Website on or about October 1, 2006.

**CLARIFICATION REGARDING EFFECTIVE DATES FOR CARRIER CLAIM ADJUSTMENTS: DENIED REPLACEMENT DEFIBRILLATOR CLAIMS LACKING A QR MODIFIER**  
~CMS MLN Matters – September 2006~

MLN Matters Number: MM5104  
Related CR Release Date: June 2, 2006  
Related CR Transmittal #: R971CP

Related Change Request (CR) #: 5104  
Effective Date: April 1, 2005  
Implementation Date: September 5, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5104.pdf>**

If you have a claim for a replacement Implantable Cardiac Defibrillator (ICD) that was denied solely because it lacked a QR modifier, you may request an adjustment for that claim for any date of service for which the replacement ICD was otherwise covered. CR5104 clarifies CR4273 to establish that your carrier will consider any payable date of service when you seek an adjustment of a replacement ICD claim previously denied solely because it did not contain a QR modifier. Make sure your billing staff are aware that they can seek an adjustment for your replacement ICD claim denied due to lack of the QR modifier for any date of service for which the claim would otherwise have been payable.

CR3604 (Transmittal 497), effective January 27, 2005, gave CMS carriers instructions on how to process Automatic Implantable Cardiac Defibrillator (ICD) claims for services provided under expanded coverage for new indications. One of these instructions was the requirement that the patient be enrolled in a data collection system. Such patient enrollment is noted on the claim by the QR modifier, which identifies services covered under a clinical study, and is required as a condition for payment on claims for ICD services rendered as:

- Part of the new indications (effective on January 27, 2005); or
- For any other ICD services rendered as a primary prevention of cardiac arrest (i.e., no history of induced or spontaneous arrhythmias).

To identify these instances, CMS systems maintainers created an edit to check the diagnosis code on the claim. If the diagnosis code was not a secondary prevention diagnosis code, then the QR modifier was required in order to cover the services.

Carriers turned on this edit, effective April 1, 2005. In order to ensure that the QR modifier was being applied to the extent possible to claims for ICD services rendered for the primary prevention of cardiac arrest, carriers were instructed to turn on the original edit such that claims with dates of service prior to April 1, 2005, would also be checked for this modifier as appropriate.

**Note:** When any of the secondary prevention diagnosis codes appear on an ICD claim, the QR modifier is not required. However, you can append the QR modifier for secondary prevention diagnoses when it is appropriate, i.e., when the data is submitted to a data collection registry.

After CR3604's publication, CMS became aware of additional possible diagnoses which show neither primary nor secondary prevention of cardiac arrest, for example when the ICD is replaced, due to ICD recall or device complication (such as the end of battery-life).

Since claims such as these should not be denied because they lack a QR modifier, on January 27, 2006, CMS issued CR4273 (Transmittal 819). CR4273 added two new ICD-9-CM diagnosis codes to the list of those that do not require a QR modifier and which do not, by themselves, represent a condition where primary or secondary prevention can be ascertained:

- **996.04**, Mechanical complication of cardiac device, implant, and graft, due to automatic implantable cardiac defibrillator; and
- **V53.32**, Fitting and adjustment of other device, automatic implantable cardiac defibrillator.

To ensure that replacement ICD claims are not erroneously denied for a lack of QR modifier, the new edit accompanying CR4273 affects claims with dates of service on and after April 1, 2005. However, because the original carrier edit considered all dates of services as it checked for a QR modifier, including dates prior to April 1, 2005, it is possible that there will be replacement ICD claims erroneously denied with dates of service prior to April 1, 2005.

For this reason, when this issue is brought to their attention, Medicare carriers are to consider for possible adjustment all payable dates of service for replacement ICD claims when these claims have been denied solely for the lack of a QR modifier.

CR5104, from which this article is taken, makes this clarification and instructs carriers to inform you that you may have had claims for replacement ICDs erroneously denied for lack of a QR modifier and requiring such an adjustment. Be aware, however, that the carriers do not have to search their files to retroactively pay claims, nor does this instruction apply to claims submitted to fiscal intermediaries (FIs), who implemented the original and revised edits according to dates of service.

### DEFICIT REDUCTION ACT OF 2005 – NINE DAY PAYMENT HOLD

~August 2006~

This message is a reminder for all providers and physicians who bill Medicare contractors for their services. A brief hold will be placed on Medicare payments for all claims during the last 9 days of the Federal fiscal year (September 22 through September 30, 2006). These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or

individual by reason of this one-time hold on payments. All claims held during this time will be paid on October 2, 2006. This policy only applies to claims subject to payment. It does not apply to full denials, no-pay claims, and other non-claim payments such as periodic interim payments, home health requests for anticipated payments, and cost report settlements.

**INTEREST RATE ON CLEAN CLAIMS NOT PAID TIMELY**  
 ~August 2006~

Per Change Request (CR) 3557, carriers and fiscal intermediaries (FIs) that do not pay clean claims in a timely manner (i.e., 30 days after the day of receipt of a claim) must pay interest. Interest accrues until and including the day of late payment. For the Period beginning July 1, 2006, and ending December 31, 2006, the rate of interest applicable for the purpose of the cited sections is 5.75% (5.75 per centum) per annum. This rate was published in the Federal Register, Volume 71, Number 126, Pages 37638-37639 on Friday, June 30, 2006. To read more about how CMS defines a clean claim and how to calculate interest payments, please refer to the transmittal, available at: <http://www.cms.hhs.gov/transmittals/Downloads/R416CP.pdf>

**JULY 2006 QUARTERLY AVERAGE SALES PRICE (ASP) MEDICARE PART B DRUG PRICING FILE, EFFECTIVE JULY 1, 2006, AND REVISIONS TO JANUARY 2006 AND APRIL 2006 QUARTERLY ASP MEDICARE PART B DRUG PRICING FILES**  
 ~CMS MLN Matters – August 2006~

MLN Matters Number: MM5110 Revised  
 Related CR Release Date: June 9, 2006  
 Related CR Transmittal #: R974CP

Related Change Request (CR) #:5110  
 Effective Date: July 1, 2006  
 Implementation Date: July 3, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5110.pdf>**

This article was revised July 17, 2006, to include an additional Web address in the “Additional Information” section. This address houses Part B Drug information and the quarterly ASP Medicare Drug Pricing Files.

CR5110 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective July 1, 2006 through September 30, 2006, as well as revised payment files for the January 2006, and April 2006 Quarterly ASP Medicare Part B Drug Pricing Files. Certain Medicare Part B drug payment limits have been revised and CMS updates the payment allowance quarterly. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR5110.

**Background**

According to Section 303(c) of the Medicare Modernization Act of 2004 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis. As mentioned in previous articles (see MM4319 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf>), beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on **106 percent** of the ASP.

Pricing for compounded drugs is performed by the local Medicare contractor.

**ESRD Drugs**

Additionally, in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, are paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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

Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on **106 percent** of the ASP. CMS will update the payment allowance limits quarterly.

**Exceptions**

There are exceptions to these general rules and those exceptions are outlined in MLN Matters article MM4319, which can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf>. With regard to the exceptions listed in MM4319, note that the payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP, unless the drug is compounded.

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

Physicians (or other authorized practitioners) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to do so. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir, is determined under the ASP methodology.

Note that the use of the implantable pump or reservoir must be found medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service. If a physician or other practitioner is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if:

- The medication administered is accepted as a safe and effective treatment of the patient’s illness or injury;
- There is a medical reason that the medication cannot be taken orally; and
- The skills of the nurse are needed to infuse the medication effectively.

**How the ASP Is Calculated**

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter:

- The revised January 2006 payment allowance limits apply to dates of service 01/01/06, through 03/31/06.
- The revised April 2006 payment allowance limits apply to dates of service 04/01/06, through 06/30/06.
- The July 2006 payment allowance limits apply to dates of service July 1, 2006, through September 30, 2006.

The absence or presence of a HCPCS (Healthcare Common Procedure Coding System) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The carrier processing your claim will make these determinations.

**JULY QUARTERLY UPDATE FOR 2006 DMEPOS FEE SCHEDULE**

~CMS MLN Matters – July 2006~

MLN Matters Number: MM5017 Revised  
 Related CR Release Date: April 28, 2006  
 Related CR Transmittal #: R928CP

Related Change Request (CR) #: 5017  
 Effective Date: July 1, 2006  
 Implementation Date: July 3, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5017.pdf>**

**Note:** This article was revised on June 2, 2006, to show that codes K0734-K0737 are added to the fee schedule file and are effective for claims submitted with dates of service on or after July 1, 2006, not January 1, 2006.

This article is based on CR 5017 and provides specific information regarding the quarterly update for the July 2006 DMEPOS Fee Schedule. The DMEPOS fee schedules are updated quarterly to implement fee schedule amounts for new codes and revise any fee schedule amounts for existing codes that were calculated in error. Payment on a fee schedule basis is required for:

- DME, prosthetic devices, orthotics, prosthetics and surgical dressings by the Social Security Act; and
- Parenteral and Enteral Nutrition (PEN) by regulations contained in the Code of Federal Regulations.

Changes made in this update include the following:

- The fee schedule amounts for the following HCPCS codes are added to the fee schedule file as part of this update and are effective for claims with dates of service on or after January 1, 2006:

L0624, L0629, L0632, L0634, L2034, L2387, L3671, L3672, L3673, L3702, L3763, L3764, L3765, L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975, L3976, L3977, L3978,

L5703, L5858, L5971, L6621, L6677, L6883, L6884, L6885, L7400, L7401, L7402, L7403, L7404, L7405, E1238, E1812, E2291, E2292, E2293, E2294

- The fee schedule amounts for HCPCS code **K0733**, *Power wheelchair accessory, 12 to 24 amp hour sealed lead acid battery, each (e.g., gel cell, absorbed glass mat)* are added to the fee schedule file on 07/01/06, and is effective for claims with dates of service on or after 07/01/06.
- The fee schedule amounts for HCPCS code **E0762**, *Transcutaneous electrical joint stimulation device system, includes all accessories*, are added to the fee schedule file on 07/01/06, and are effective for claims submitted with dates of service on or after January 1, 2006. In addition, the payment category for code **E0762** is being revised to move the joint stimulation device from the DME payment category for capped rental items to the DME payment category for inexpensive and routinely purchased items, effective 07/01/06.
- The fee schedule amounts for HCPCS codes **L6694** and **L6698** are added to the fee schedule file on 07/01/06, and are effective for claims with dates of service on or after 01/01/05.
- The fee schedules for HCPCS code **L2232**, *Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only*, are added to the fee schedule file on 07/01/06, and are effective for claims with dates of service on or after 01/01/05.
- **Code E0705** (Transfer Board or Device, Any Type, Each) was added to the HCPCS effective 01/01/06. The payment category for E0705 is being revised to the inexpensive and routinely purchased payment category and the fee schedule amounts for previous HCPCS code E0972 will be crosswalked to code E0705 for use in paying claims with dates of service on or after 01/01/06.
- The fee schedules for HCPCS code **K0606** (Automatic External Defibrillator, With Integrated Electrocardiogram Analysis, Garment Type) are added to the fee schedule file on 07/01/06, and are effective for claims submitted with dates of service on or after 01/01/06.
- The fee schedule amounts for HCPCS code **E1812** (Dynamic Knee, Extension/Flexion Device with Active Resistance Control) are added to the fee schedule file on 07/01/06, and are effective for claims submitted with dates of service on or after 01/01/06.
- As part of this update, the common working file category for HCPCS code **B4185** will be switched from CWF category 9 to CWF category 20, effective 01/01/06. B4185 was added to the HCPCS on 01/01/06, to replace codes B4184 and B4186 and describes parenteral nutrients (CWF category 20) as opposed to enteral nutrients (CSF category 9).
- Per CR4267, the following four codes are added to the HCPCS, effective 07/01/06:
  - ❖ **K0734** - Skin Protection Wheelchair Seat Cushion, Adjustable, Width Less Than 22 Inches, Any Depth
  - ❖ **K0735** - Skin Protection Wheelchair Seat Cushion, Adjustable, Width 22 Inches or Greater, Any Depth
  - ❖ **K0736** - Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width less than 22 Inches, Any Depth.
  - ❖ **K0737** - Skin Protection and Positioning Wheelchair Seat Cushion, Adjustable, Width 22 Inches or Greater, Any Depth.
- The fee schedule amounts for the above codes, K0734, K0735, K0736, and K0737, are added to the fee schedule file on 07/01/06, and are effective for claims submitted with dates of service on or after 07/01/06.
- HCPCS codes A6531 and A6532 were added to the HCPCS 01/01/06, to replace L8110 and L8120; therefore, all billing and payment requirements for HCPCS codes L8110 and L8120 crosswalk directly to A6531 and A6532, including the requirement to bill modifier AW when items are furnished for use as surgical dressings (see transmittal AB-03-100).

**NON-APPLICATION OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS**

~CMS MLN Matters – September 2006~

MLN Matters Number: MM5127  
Related CR Release Date: July 21, 2006  
Related CR Transmittal #: R1004CP

Related Change Request (CR) #: 5127  
Effective Date: January 1, 2007  
Implementation Date: January 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5127.pdf>**

Effective January 1, 2007, Medicare will waive the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS codes listed in the following chart. While the deductible will be waived, and will not apply for colorectal cancer screening test services furnished on or after January 1, 2007, the Medicare Part B coinsurance still applies for these screening tests.

HCPCS Screening Code	Code Description
G0104	Colorectal cancer screening: Flexible sigmoidoscopy
G0105	Colorectal cancer screening: Colonoscopy on individual at high risk

HCPCS Screening Code	Code Description
G0121	Colorectal cancer screening: Colonoscopy on individual not meeting criteria for high risk
G0106	Colorectal cancer screening: Barium enema as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening: Barium enema as an alternative to G0105, screening colonoscopy

**NON-PHYSICIAN PRACTITIONER (NPP) PAYMENT FOR CARE PLAN OVERSIGHT (CPO)**

~ CMS MLN Matters – September 2006 ~

MLN Matters Number: MM4374 Revised  
 Related CR Release Date: July 14, 2006  
 Related CR Transmittal #: R999CP

Related Change Request (CR) #: 4374  
 Effective Date: January 1, 2005  
 Implementation Date: October 2, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4374.pdf>**

This article was revised July 17, 2006, to reflect a correction made to related CR4374. CR4374 was corrected to show, in one statement, that HCPCS code G0182 refers to hospice oversight services, not home health services. This article was revised to replace “home health” to “hospice” in the 4th bullet point on page 3. The CR release date, transmittal number and Web address were also changed.


This article is based on Change Request (CR) 4374 which clarifies the policy associated with Non-Physician Practitioners (NPPs) billing for physician home health care plan oversight (CPO). The manual revision in CR4374 effectuates a revision to the policy that the same provider that signs the plan of care does not have to be the same provider that bills for physician care plan oversight. Effective January 1, 2005, NPPs must meet certain conditions to be eligible for payment for home health care plan oversight services even though they may not sign the plan of care. This CR clarifies those conditions.

CR4374 clarifies the policy associated with NPPs billing for physician hospice CPO and clarifies the HCPCS codes for CPO. It temporarily waives the requirement to include the Home Health Agency (HHA) or hospice provider number on a CPO claim since there is currently no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number. CR4374 also states that the physician who bills CPO must be the same physician who signs the plan of care.

**Background**

Physician CPO is paid under the Medicare Physician Fee Schedule (MPFS), and due to a provision in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 12, Section 180), Non-Physician Practitioners (NPPs) have been prohibited from billing for this service in a home health setting. The current manual section (Section 180) provides that the physician who signs the plan of care for home health services must be the same person that bills for physician CPO. Since only a physician can sign the plan of care for home health services, NPPs have been unable to bill for physician home health CPO. Under the Final Physician Fee Schedule Rule, published in the *Federal Register* on November 15, 2004, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs), practicing within the scope of state law, may bill for CPO.

The intention of CMS, as outlined in later portions of the *Medicare Claims Processing Manual*, was to allow NPPs to bill for physician CPO within their state scope of practice. The current inconsistency in Section 180 will not allow NPPs to be paid for this service. CR4374 revises the policy that states that the same provider that signs the plan of care does not have to be the same provider that bills for physician CPO. In addition, the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 11, Section 40.1.3.1) has been revised to clarify CPO billing requirements for beneficiaries who have elected the hospice benefit.



Currently there is no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number required for a CPO claim. For this reason, the requirement to include the HHA or hospice provider number on a CPO claim is temporarily waived until a new version of this electronic standard format is adopted under HIPAA and includes a place to provide the HHA and hospice provider numbers for CPO claims.

For services furnished on or after January 1, 2005, your carrier will allow NPPs to bill for physician home health CPO even though they cannot 1) certify a patient for home health services and 2) sign the plan of care. For beneficiaries who have elected the hospice benefit, physicians or NPPs who have been identified by a beneficiary to be his or her attending physician may submit claims for CPO.

**Note:** For physicians or NPs who are employed by a hospice agency, CPO is not separately payable.

CR4374 instructs your carrier to:

- Pay for physician home health CPO services (HCPCS code G0181) when billed by an NPP for dates of service on or after January 1, 2005;
- Pay for physician home health plan CPO services (HCPCS code G0181) no more than once per calendar month per patient;
- Pay for physician hospice CPO services (HCPCS code G0182 with GV modifier) when billed by a nurse practitioner for dates of service on or after January 1, 2005;
- Pay for physician hospice CPO services under HCPCS code G0182 no more than once per calendar month per patient;
- Re-open and adjust any erroneously denied claims with practitioner CPO services brought to their attention;
- Not require the provider numbers of the home health agency or hospice for CPO claims effective for dates of service on or after January 1, 2005.

**PAYMENT FOR EVALUATION AND MANAGEMENT (E/M) SERVICES PROVIDED DURING GLOBAL PERIOD OF SURGERY**

~CMS MLN Matters – July 2006~

MLN Matters Number: MM5025  
Related CR Release Date: May 19, 2006  
Related CR Transmittal #: R954CP

Related Change Request (CR) #: 5025  
Effective Date: June 1, 2006  
Implementation Date: August 20, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5025.pdf>**

**Key Points**

- CMS has clarified the documentation requirements and policy requirements for the use of CPT modifier -25 used with Evaluation and Management (E/M) services. Please refer to the manual attachment to CR5025, *The Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 30.6.6, for revisions regarding the use of CPT modifier - 25.
- Physicians and qualified nonphysician practitioners (NPP) should use CPT modifier -25 to designate a significant, separately identifiable E/M service provided by the same physician/qualified NPP to the same patient on the same day as another procedure or other service with a global fee period.
- CPT modifier -25 identifies a significant, separately identifiable E/M service. It should be used when the E/M service is above and beyond the usual pre- and postoperative work of a procedure with a global fee period performed on the same day as the E/M service.
- Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service with a global fee period. Modifier -25 is added to the E/M code on the claim.
- Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified NPP in the patient's medical record to support the need for Modifier -25 on the claim for these services, even though the documentation is not required to be submitted with the claim.
- Your carrier will not retract payment for claims already paid or retroactively pay claims processed prior to the implementation of CR5025. But, they will adjust claims brought to their attention.
- Carriers will not pay for an E/M service reported with a procedure having a global fee period unless CPT modifier -25 is appended to the E/M service to designate it as a significant and separately identifiable E/M service from the procedure. Such payment will be denied with the following messages:
  - **Claim Adjustment Reason Code: 97** - Payment is included in the allowance for another service/procedure.
  - **Remittance Advice Remark Code: M144** - Pre-/post-operative care payment is included in the allowance for the surgery/procedure.

**PAYMENT FOR PET SCANS IN CMS-APPROVED CLINICAL TRIALS AND COVERAGE WITH EVIDENCE DEVELOPMENT - USE OF QR AND QV MODIFIERS**

~CMS MLN Matters – July 2006~

MLN Matters Number: MM5124  
 Related CR Release Date: May 19, 2006  
 Related CR Transmittal #: R956CP

Related Change Request (CR) #: 5124  
 Effective Date: January 28, 2005  
 Implementation Date: June 19, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5124.pdf>

Effective January 28, 2005, for certain FDG PET indications, rather than the **QV** modifier previously required, you must use the **QR** modifier on all carrier claims to identify that this service is provided in a Medicare-specified study. CR5124 revises Transmittal 527 (CR 3741) to require that you use the appropriate CPT code and the **QR** modifier (item or service provided in a Medicare-specified study), rather than the **QV** modifier (other than inpatient), on carrier claims for services for dementia and neurodegenerative diseases, and a broad range of cancer indications listed as “coverage with evidence development.” For cancers listed as “coverage with evidence development” in section 220.6 of the NCD Manual, CMS has determined that (effective for services performed on or after January 28, 2005) FDG PET scans are reasonable and necessary only when the provider is participating in, and patients are enrolled in:

- A clinical trial that meets the requirements of Food and Drug Administration (FDA) category B investigational device exemption (42 CFR 405.201); or
- An FDG PET clinical study that is designed to collect additional information at the time of the scan to assist in patient management.

CR3741, released April 15, 2005, indicated that there is adequate evidence to conclude that an FDG PET scan for the detection of pre-treatment metastases (i.e., staging) in newly-diagnosed cervical cancer (after conventional imaging that is negative for extra-pelvic metastasis), is reasonable and necessary as an adjunct test, and it expanded coverage to include FDG PET for certain indications of cervical cancer. CR3741 also designated **QV** as the correct modifier to be used in carrier claims for beneficiaries participating in CMS-approved clinical trials utilizing FDG PET scans for dementia and neurodegenerative diseases.

CR5124, upon which this article is based, revises CR3741 to provide that (effective for services on or after January 28, 2005) you will be reimbursed for the use of FDG PET services for:

- Dementia and neurodegenerative disease (see NCD Manual (100.03) section 220.6.13);
- Certain indications for cancers of the cervix, lung (including small cell), esophagus, colon and rectum, head and neck, breast, thyroid, brain, ovary, pancreas, and testes; and lymphoma, melanoma, and soft tissue sarcoma (as listed in sections 220.6.2-220.6.7 and 220.6.10-220.6.14); and
- All other cancer indications not previously specified (as listed in section 220.6.15);
- **Only** if these scans were performed as part of a CMS-approved clinical trial.

**REQUIREMENTS FOR DIAGNOSTIC X-RAY, DIAGNOSTIC LABORATORY, AND OTHER DIAGNOSTIC TESTS; CLINICAL PSYCHOLOGIST SERVICES**

~CMS MLN Matters – August 2006~

MLN Matters Number: MM4400  
 Related CR Release Date: June 23, 2006  
 Related CR Transmittal #: R51BP

Related Change Request (CR) #: 4400  
 Effective Date: January 1, 2005  
 Implementation Date: September 21, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4400.pdf>

CR4400 alerts providers that Medicare may now pay for the services of a clinical psychologist when they supervise the performance of diagnostic psychological testing. Under the physician supervision level of four, Medicare’s physician supervision policy is modified so the policy does not apply when the procedure is furnished under the general supervision of a clinical psychologist. Medicare carriers are not required to retroactively process claims for the period between January 1, 2005, and the implementation date. Carriers are to reprocess claims that are brought to their attention that have been denied with dates of service on or after January 1, 2005.

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The Quarterly *Communiqué* Satisfaction Survey is an effort by WPS Medicare to improve the quality of information provided to Medicare physicians and suppliers. The purpose of this survey is to measure and evaluate your ability to access information included within the Quarterly *Communiqué*. We would like to determine if it would be more beneficial to mail CD-ROM's with entire Communiqué's or if you would like to continue to receive paper copies of the *Communiqué* with partial articles and references to the Internet if further information is desired. The survey should take approximately five minutes to complete. Participation in this survey is strictly voluntary and all information is completely confidential. Please complete the following survey, fold, and return to the address indicated.

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