

## J13 Medicare Part B News Flash Teleconference

January 15, 2008

11:30 a.m.–1:30 p.m.

Please call in to (888) 721-1407 a few minutes prior to the start time of the seminar.

The Conference ID is 79591227.

### Agenda

- J13 System Issues Update
- Medicare Program Updates
- Recent *MLN Matters Articles*
- Local Coverage Determination (LCD) Updates
- Top Claim Submission Errors
- Electronic Data Interchange (EDI) Denials
- Comprehensive Error Rate Testing (CERT) Common Errors

### Disclaimers:

- This presentation was current at the time it was compiled. Medicare policy changes frequently so links to the source documents have been provided within the presentation for your reference. This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. National Government Services employees, agents and staff make no representation, warranty or guarantee that this compilation of Medicare information is error free and will bear no responsibility or liability for the results or consequences of the use of this information. This is a general summary that explains certain aspects of the Medicare Program but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and rulings.
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## J13 Transition Issues & News

This table provides you with a summary of the current J13 transition issues and the corresponding resolutions. If you have an issue that is not mentioned, we would encourage you to contact our Customer Care Center.

Please keep in mind that Upstate New York (NY) refers to the counties formerly serviced by HealthNow. Downstate refers to those counties that were formerly serviced by Empire Medicare Services and then National Government Services. Queens County was formerly serviced by GHI and Connecticut (CT) by First Coast Service Options.

### General

<b>Region(s)</b>	<b>Issue</b>	<b>Resolution</b>
All	Claims are pulling patient paid amounts in error and the payments are being made to the beneficiaries instead of the providers.	Providers may contact the Telephone Reopening Unit (TRU) line to have the claim adjusted or may write in to appeals.
All	Provider remittance notices for non-assigned claims are not showing the correct patient responsibility amount for the limiting charge.	A mass adjustment will be performed on these claims.
All	Procedure code 80051 QW is rejecting incorrectly for lacking a CLIA number.	The claims processing system has been updated to identify the CLIA number that is submitted on the claims. The claims that were rejected in error will be reprocessed.
CT, Upstate NY, and Queens County, NY	Claims for procedure code 92577 are denying incorrectly as a CLIA required service. This procedure code does not require a CLIA number.	Affected claims are being identified and a mass adjustment will be performed.
Queens County, NY <b>NEW</b>	Procedure code 11721 is denying incorrectly with message 674 ( <i>payment adjusted because the payer deems the information submitted does not support this many/frequency of services</i> ).	The claims that denied incorrectly will be identified and reprocessed.
NY	Anesthesia services are denying incorrectly with message 106, 163, or 382 ( <i>procedure/treatment is deemed experimental or investigational by the payer</i> ) or 035 ( <i>payment adjusted because the payer deems the information submitted does not support this many/frequency of services</i> ).	The identified claims will be reprocessed.
All <b>NEW</b>	National Government Services has received an unanticipated increased volume of Medicare secondary payer (MSP) claims. Because these claims require additional time to investigate, we have experienced a backlog.	In December, a plan was established to process these claims by adding additional staff and resources to the MSP claims processing function.

Local Coverage Determination (LCD) – Diagnosis Issues

Region(s)	Issue	Resolution
All <b>NEW</b>	Claims submitted with procedure codes 90911, 51715, G0283, 64561, and 64581 denied incorrectly based on the Urinary Incontinence Treatment local coverage determination (LCD), L28183. Procedure code 95900 denied incorrectly in Downstate NY.	System updates are being done and mass adjustments will be performed on the affected claims.
All	Claims submitted with procedure codes 93965, 93970 and 93971 denied incorrectly based on LCD L28166 – Noninvasive Vascular Diagnostic Studies. <b>Note:</b> J13 LCD, L28166, was replaced by National Government Services LCD, L27355, on 11/15/08.	System updates are being done and mass adjustments will be performed on the affected claims.
All	Claims with payable diagnosis codes, per LCD L26394 – Esophagogastroduodenoscopy (EGD), have denied incorrectly. The procedure codes involved are as follows: 42300-43202, 43204, 43205, 43215-43217, 43219, 43220, 43226-43228, 43231, 43232, 43234-43251, 43255, 43556, 43258, 43259, 74235, 74350 and 74360.	System updates are being done and mass adjustments will be performed on the affected claims.
All	Claims submitted with procedure code J2469 denied incorrectly based on the diagnosis code and LCD L25820 – Drugs and Biologicals, Coverage for Label and Off-Label Uses. J2469 is not part of the policy. <b>Note:</b> The incorrect denials only occurred for dates of service prior to the transition dates for each region. Denials for dates of service after your region’s transition date are presumed correct.	Claims brought to our attention will be reprocessed. If you have incorrect denials, it may be quicker for you to resubmit the claims.
Connecticut	Procedure codes 94260 and 94360 denied incorrectly when billed with a payable diagnosis according to the Pulmonary Function Testing LCD, L28179. <b>Note:</b> The incorrect denials occurred in the Connecticut region for dates of service 08/01/08 and after. LCD L28179 retired as of 11/14/08.	System updates are being done and mass adjustments will be performed on the affected claims.
Upstate NY	Extra-cardiac angiography codes in the Cardiac Catheterization and Coronary Angiography LCD, L26880, denied incorrectly. The diagnoses should only be applied when a cardiac catheterization is performed with a coronary angiography. The procedure codes involved are as follows: 36120, 36140, 36200, 36215-36218, 36245-36248, 75625, 75630, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75710, 75716, 75722, and 75724.	System updates are being done and mass adjustments will be performed on the affected claims.
CT and Downstate NY	Procedure codes have denied in error based on a Physical Medicine and Rehabilitation LCD, L3041. The procedure codes involved are as follows:	System updates are being done and mass adjustments will be performed on the affected claims.

Region(s)	Issue	Resolution
	Downstate NY: 97760-97762; Connecticut: 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97034-97036, 97110, 97113, 97124, 97140, 97150, 97542, 97597, 97598, 97750, G0237, G0238, and G0239. <b>Note:</b> LCD L3041 was retired on 06/30/08.	
All <b>NEW</b>	Procedure codes have denied incorrectly based on LCD L28171 – Cardiac Electrophysiology Services (EPS). This issue is occurring for dates of service November 15th and after. The procedure codes involved are as follows: 93609, 93613, 93620-93624, 93650-93652, 93662, and 93631-93642. <b>Note:</b> J13 LCD, L28171, was retired on 11/14/08.	System updates are being done and mass adjustments will be performed on the affected claims.
NY <b>NEW</b>	Incorrect denials have occurred with procedure code 93350 based on LCD L28139 – Stress Echocardiography. This issue is occurring for dates of service November 15th and after. <b>Note:</b> J13 LCD, L28139, was replaced by NGS LCD, L27360 (Transthoracic Echocardiography), effective on 11/15/08.	System updates are being done and mass adjustments will be performed on the affected claims.
Downstate NY	Procedure codes 93000, 93005, and 93010 are denying incorrectly based on LCD L28189 – Electrocardiogram (ECG or EKG). This issue is occurring for dates of service November 15th and after. <b>Note:</b> J13 LCD, L28189, was replaced by NGS LCD, L27427 on 11/15/08.	System updates are being done and mass adjustments will be performed on the affected claims.
Downstate NY	Incorrect denials have occurred with procedure codes 52647 and 52648 based on the Laser Ablation of the Prostate LCD, L28128. This issue is occurring for dates of service November 15th and after. <b>Note:</b> J13 LCD, L28128, was replaced by NGS LCD, L27369, effective on 11/15/08.	System updates are being done and mass adjustments will be performed on the affected claims.
Downstate NY	Incorrect denials have occurred with procedure code 88342 based on the Immunocytochemistry LCD, L28143. This issue is occurring for dates of service November 15th and after. <b>Note:</b> J13 LCD, L28143, was replaced by NGS LCD, L27348, effective on 11/15/08.	System updates are being done and mass adjustments will be performed on the affected claims.
Downstate NY <b>NEW</b>	Incorrect denials have occurred with procedure codes 11000, 11001, and 11040-11044 based on the Debridement Services LCD, L28205. This issue is occurring for dates of service November 15th and after. <b>Note:</b> J13 LCD, L28205, was replaced by NGS LCD, L27373, effective on 11/15/08.	System updates are being done and mass adjustments will be performed on the affected claims.

Region(s)	Issue	Resolution
Downstate NY <b>NEW</b>	Procedure codes have denied incorrectly based on LCD L28123 – Flow Cytometry. This issue is occurring for dates of service November 15th and after. The procedure codes involved are as follows: 88182, 88184, 88185, and 88187-88189. <b>Note:</b> J13 LCD, L28123, was replaced by NGS LCD L27386, effective on 11/15/08.	System updates are being done and mass adjustments will be performed on the affected claims.
Downstate NY <b>NEW</b>	Incorrect denials have occurred with procedure code 92020 based on the Gonioscopy LCD, L28185. This issue is occurring for dates of service November 15th and after. <b>Note:</b> J13 LCD L28185 was retired on 11/14/08.	System updates are being done and mass adjustments will be performed on the affected claims.
Downstate NY <b>NEW</b>	Procedure codes have denied incorrectly based on LCD L28141 – Helicobacter Pylori (H. Pylori) Tests. This issue is occurring for dates of service November 15th and after. The procedure codes involved are as follows: 78267, 78268, 83013, 83014, 86677, and 87338. <b>Note:</b> J13 LCD L28141 was retired on 11/14/08.	System updates are being done and mass adjustments will be performed on the affected claims.
Downstate NY <b>NEW</b>	Incorrect denials have occurred with procedure codes 31720, 94640, and 94664 based on the Respiratory Therapy Services LCD, L28124. This issue is occurring for dates of service November 15th and after. <b>Note:</b> J13 LCD L28124 was retired on 11/14/08.	System updates are being done and mass adjustments will be performed on the affected claims.
Downstate NY <b>NEW</b>	Incorrect denials have occurred with procedure code 83735 based on LCD L28136 – Serum Magnesium. This issue is occurring for dates of service November 15th and after. <b>Note:</b> J13 LCD, L28136, was replaced by NGS LCD L27375, effective on 11/15/08.	System updates are being done and mass adjustments will be performed on the affected claims.
Downstate NY and Queens County NY <b>NEW</b>	In Downstate NY and Queens County NY, procedure codes denied incorrectly based on LCD L28127 – Erectile Dysfunction, Evaluation and Treatment. This issue is occurring for dates of service November 15th and after. The procedure codes involved are as follows: Downstate NY: 93975, 93976, and 93978-93981; Queens County NY: 93981. <b>Note:</b> J13 LCD, L28127, was replaced by NGS LCD L27371, effective on 11/15/08.	System updates are being done and mass adjustments will be performed on the affected claims.

#### Modifier Usage Issues

Region(s)	Issue	Resolution
Upstate NY	Providers have been receiving rejections for invalid	NGS had a temporary system fix in

Region(s)	Issue	Resolution
	<p>modifier use when billing site modifiers TA through T9 with procedure codes 11055-11057, 11719-11721, 20550, 64640, and G0127.</p> <p><b>Note:</b> Per the Surgical Treatment of Nails LCD, L26424, a site modifier (FA, F1 - F9, TA, and T1-T9) is required for procedure codes 11730, 11732, 11750, and 11765.</p>	<p>place to allow these modifiers. This temporary fix expired on 01/01/09. A mass adjustment will be performed on all affected claims. You should have discontinued use of the TA-T9 modifiers with the procedure codes listed as of 01/01/09; after this date, claims will reject for invalid modifier use.</p>
All	<p>Procedure codes 11055-11057, 11719-11721, and G0127 are rejecting in error for lacking a required modifier when submitted without a class findings modifier.</p> <p><b>Note:</b> One of the modifiers Q7, Q8, or Q9 must be billed when the coverage is based on the presence of a qualifying systemic condition. However, if the patient has evidence of diabetes with peripheral neuropathy but no vascular impairment, the use of class findings modifiers is not necessary.</p>	<p>Claims will be identified and reprocessed.</p>
All	<p>Procedure codes 11720 and 11721 are rejecting incorrectly when billed with Q7, Q8, or Q9.</p>	<p>Claims will be identified and reprocessed.</p>
All	<p>Procedure codes 25606-25609 are denying incorrectly when billed with modifier 54.</p>	<p>Claims will be identified and reprocessed.</p>
All	<p>Claims for services which do not require an Investigational Device Exemption (IDE) number have denied incorrectly when submitted with modifier Q0.</p>	<p>Claims will be identified and reprocessed.</p>
All	<p>Procedure codes 75978 and Q9967 are denying incorrectly when billed with modifier CB.</p>	<p>Claims will be identified and reprocessed.</p>
All	<p>In Ambulatory Surgical Centers (ASCs), claims submitted with procedure code 11750 and modifier T5 are rejecting incorrectly.</p>	<p>Claims will be identified and reprocessed.</p>
All	<p>ASC claims submitted with modifier 73 are denying incorrectly.</p>	<p>Claims will be identified and reprocessed.</p>
CT, Upstate NY, and Queens County NY	<p>Procedure code 92226 is rejecting incorrectly when billed with modifier 50.</p>	<p>Claims will be identified and reprocessed.</p>
NY	<p>Claims submitted with procedure code 61867 and modifier 50 in the second modifier field are rejecting incorrectly with message 216 (<i>the procedure code is inconsistent with the modifier used or a required modifier is missing</i>).</p>	<p>Claims will be identified and reprocessed.</p>
Upstate NY	<p>Claims submitted by lab providers are being denied incorrectly with message 440 (<i>this provider was not certified/eligible to be paid for this procedure/service on</i></p>	<p>Claims will be identified and reprocessed.</p>

Region(s)	Issue	Resolution
	<i>this date of service</i> ) when billed with modifier 90.	
CT NEW	Procedure code 82465 is denying incorrectly when submitted with the QW modifier.	Claims will be identified and reprocessed.

#### Place of Service (POS) Issues

Region(s)	Issue	Resolution
All	Procedure codes 93016 and 93018 are denying incorrectly when submitted with POS 22 or 23.	The affected claims will be identified and reprocessed.
All	Procedure codes 93225 and 93231 are denying incorrectly when billed with place of service (POS) 31 or 32. POS 31 and 32 are acceptable per article A45925 associated with LCD L26409 – Dynamic Electrocardiography (EKG, ECG).	The affected claims will be identified and reprocessed.
All	Procedure codes 88311 and 88313 billed with modifier 26 are rejecting incorrectly when billed in POS 81.	The affected claims will be identified and reprocessed.
All	Procedure code 26852 are denying incorrectly when billed in POS 24 with modifier AS.	The affected claims will be identified and reprocessed.
All	Procedure codes 11200-17340, from LCD L27362 – Removal of Benign Skin Lesions, are denying incorrectly when billed in POS 24.	The affected claims will be identified and reprocessed.
CT, Upstate NY, and Queens County NY	Procedure codes 11402, 11403, 11422, and 11443 are denying incorrectly when billed in POS 24.	The affected claims will be identified and reprocessed.

#### Resources:

- J13 Transition Link: [www.ngsmedicare.com/NGSMedicare/PartB/J13/J13PartB.aspx](http://www.ngsmedicare.com/NGSMedicare/PartB/J13/J13PartB.aspx)
- National Government Services Contact Information: [www.ngsmedicare.com/NGSMedicare/PartB/Resources/ContactInformation/IndexContactInfoPartB.aspx](http://www.ngsmedicare.com/NGSMedicare/PartB/Resources/ContactInformation/IndexContactInfoPartB.aspx)
- To sign up for the Listserv: [www.ngsmedicare.com/NGSMedicare/PartB/newsandpublications/listserv/indexlistservpartb.aspx](http://www.ngsmedicare.com/NGSMedicare/PartB/newsandpublications/listserv/indexlistservpartb.aspx)
- “What’s New” section: [www.ngsmedicare.com/NGSMedicare/PartB/NewsandPublications/WhatsNew/IndexWhatsNewPartB.aspx?CategoryID=All&CategoryName=All](http://www.ngsmedicare.com/NGSMedicare/PartB/NewsandPublications/WhatsNew/IndexWhatsNewPartB.aspx?CategoryID=All&CategoryName=All)
- Customer Care Survey: [www.surveymonkey.com/s.aspx?sm=Wk\\_2bx2GxVKuvzeNkXv8id1Q\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=Wk_2bx2GxVKuvzeNkXv8id1Q_3d_3d)

## Medicare Program Updates

Change requests are the official program instructions to the Medicare contractors published by the Centers for Medicare & Medicaid Services (CMS) on their Web site at [www.cms.hhs.gov](http://www.cms.hhs.gov). To locate change requests:

- Use the Search box –
  - Enter the change request number (listed below) in the search box at the top of the page and click the “Search” button.
  - From the search results page, choose the link for the change request (usually listed in blue as “CMS Manual System” with the link on the fourth line beginning with “[www.cms.hhs.gov/Transmittals/Downloads/](http://www.cms.hhs.gov/Transmittals/Downloads/)”).
- Under the Regulations and Guidance tab –
  - Click the link for “Transmittals” in the center of the page and then “2008 Transmittals” from the left navigation bar.
  - In the search area in the center of the page, check the “Show only” circle and the “Show only items containing the following word” circle.
  - Enter the change request number in the box after “Show only items containing the following word” and hit the “Show Items” button.
  - Click the transmittal number link (usually a combination of numbers and letters) to get to the Details page. Scroll down and click the transmittal number link on this page to view the change request, or the link that begins with MM to view the *MLN Matters* article for this change request.

Please note that the documents will load in Adobe Acrobat format (.pdf), so you may need to download the free Adobe Reader software from [www.adobe.com/products/acrobat/readstep2.html](http://www.adobe.com/products/acrobat/readstep2.html) in order to read them.

## Implementation of New Provider Authentication Requirements for Medicare Contractor Provider Telephone and Written Inquiries

Change Request 6139

MLN Matters Article MM6139

Effective Date: 03/01/09

Implementation Date: 01/05/09

- New authentication element as of March 1, 2009 - last five (5) digits of provider’s tax identification number (TIN).
- As of the effective date, in order for providers to use the Interactive Voice Response Unit (IVR) or speak to a customer service representative, they must provide the following three elements for identification:
  - NPI
  - Provider Transaction Access Number (PTAN)
  - Last five (5) digits of the TIN
- Providers will only be allowed three attempts to successfully authenticate their identity.

## Date of Service (DOS) for Clinical Laboratory and Pathology Specimens

Change Request 6018

MLN Matters Article MM6018

Effective Date: 01/01/09

Implementation Date: 01/05/09

- General rule - For a clinical laboratory test or technical component of a physician pathology service, DOS of test/service must be date specimen was collected
  - If specimen collected over period that spans two calendar days, then DOS must be date collection ended
- Exception – For tests/services performed on specimens stored for less than or equal to 30 calendar days from collection date, DOS is date test/service was performed only if:
  - Test/service ordered by patient’s physician at least 14 days following the date of patient’s hospital discharge,
  - Specimen collected while patient was undergoing hospital surgical procedure,
  - It would be medically inappropriate to have collected the sample other than during hospital procedure for which patient admitted,
  - Results of test/service do not guide treatment provided during hospital stay, and
  - Test/service was reasonable and medically necessary for treatment of an illness
- Exception – For tests/services performed on specimens stored for more than 30 calendar days from collection date, specimen is considered to have been archived and DOS is date specimen obtained from storage
- Exception – For chemotherapy sensitivity tests/services performed on live tissue, DOS is date the test/service was performed only if:
  - Decision regarding specific chemotherapeutic agents to test made at least 14 days following date of patient’s hospital discharge,
  - Specimen collected while patient was undergoing hospital surgical procedure,
  - It would be medically inappropriate to have collected the sample other than during hospital procedure for which patient admitted,
  - Results of test/service do not guide treatment provided during hospital stay, and
  - Test/service was reasonable and medically necessary for treatment of an illness

## New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services

Change Request 6129 (REVISED)

MLN Matters Article MM6129

Effective Date: 01/01/09

Implementation Date: 01/05/09

- As of January 1, 2009, the ordering/referring physician name and National Provider Identifier (NPI) must be reported on claims for diagnostic radiology services billed with modifier TC and submitted by Ambulatory Surgical Centers (ASCs).

- This CR was revised due to a typographical error – for electronic billers, certain referring NPI information is placed in data loop 2310A (not 2310B as originally written).
- If the ordering/referring provider NPI cannot be obtained by the billing provider and cannot be found in the online NPI Registry, the billing or service provider may be used in the ordering/referring field on a temporary basis.
  - NPI Registry - <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

## Medicare Physicians and Non-Physician Practitioners Internet-Based Medicare Enrollment Now Available for CT & NY Providers

CMS LearnResource e-mail 200812-34

- Internet-based Provider Enrollment, Chain and Ownership System (PECOS) allows physicians and nonphysician practitioners to use a secure Web site (<https://pecos.cms.hhs.gov>) to:
  - Enroll in Medicare
  - Make a change in Medicare enrollment
    - Changes include change in practice location, ownership, or final adverse action (e.g., medical license suspension or revocation)
    - For additional information about the types of changes that must be reported, go to the download section of [www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll).
  - View Medicare enrollment information on file with Medicare
  - Check on the status of a Medicare enrollment application via the Internet
- Fast! By submitting your initial Medicare enrollment application through Internet-based PECOS, your enrollment application can be processed as much as 50 percent faster than by paper.
- Secure! Internet-based PECOS meets all required Government security standards in terms of data entry, data transmission, and the electronic storage of Medicare enrollment information.
  - Only authorized individuals (including physicians and non-physician practitioners) can enter enrollment information into PECOS or view PECOS data from the Internet.
  - User IDs and passwords protect the access to your enrollment information. After creating User IDs and passwords or changing your password, you should keep this information secure and not share it with anyone.
- Easy! Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens.
  - Complete and submit only the information necessary to enroll or make a change in your Medicare enrollment record.
- For additional information about Internet-based PECOS, including important information that physicians and nonphysician practitioners should know before submitting a Medicare enrollment application via Internet-based PECOS, go to [www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll).

## International Classification of Diseases, 10th Edition, Clinical Modification/Procedural Coding System (ICD-10-CM/PCS)

- Proposed replacement for ICD-9-CM (procedure codes).
- Educational resources available at [www.cms.hhs.gov/ICD10/05\\_Educational\\_Resources.asp](http://www.cms.hhs.gov/ICD10/05_Educational_Resources.asp).
- CMS has updated the ICD-10 download files by posting the 2009 version of the following documents at [www.cms.hhs.gov/ICD10/02\\_ICD-10-PCS.asp](http://www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp):
  - ICD-10 General Equivalence Mappings (these refer to procedure codes)
  - Reimbursement mappings and guides for the use of the Mappings
  - 2009 version of ICD-10 Procedure Coding System (PCS)
  - ICD-10 version of the digestive Medicare Severity Diagnosis Related Groups (MS-DRG)
- The 2009 ICD-10-CM (Diagnosis codes) General Equivalence Mappings have been posted at [www.cms.hhs.gov/ICD10/03\\_ICD\\_10\\_CM.asp](http://www.cms.hhs.gov/ICD10/03_ICD_10_CM.asp).
- The 2009 version of ICD-10-Clinical Modifications (CM), Diagnoses, will be posted by the end of December 2008 on the following sites:
  - [www.cdc.gov/nchs/icd9.htm](http://www.cdc.gov/nchs/icd9.htm)
  - [www.cms.hhs.gov/ICD10/03\\_ICD\\_10\\_CM.asp](http://www.cms.hhs.gov/ICD10/03_ICD_10_CM.asp)

## Physician Quality Reporting Initiative (PQRI) Program Updates

- Reporting year 2007:
  - Incentive payments issued July 2008 to TIN on file.
  - Feedback report available via IACS - refer to *MLN Matters Special Edition* article SE0830.
- Reporting year 2008:
  - For claims-based reporting, claims must reach National Claims History file by February 28, 2009 to be included in analysis for 2008 incentive payment.
- Reporting year 2009:
  - Medicare Physician Fee Schedule (MPFS) Final Rule published in the November 19, 2008 Federal Register ([www.access.gpo.gov/su\\_docs/fedreg/a081119c.html](http://www.access.gpo.gov/su_docs/fedreg/a081119c.html) - scroll down to "Centers for Medicare & Medicaid Services" area and click "TEXT" or "PDF").
  - The specification documents for each of the 153 quality measures for 2009 list are currently available on CMS Web site at [www.cms.hhs.gov/PQRI/15\\_MeasuresCodes.asp](http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp).

## E-Prescribing Incentive Program

- New incentive program beginning January 1, 2009.
- To be eligible, professionals must meet all of the following:
  - Be authorized under state practice laws to prescribe.
  - Have and use qualified e-prescribing system.

- Have at least ten percent of their Medicare Part B covered services be made up of codes that appear in denominator of e-prescribing measure.
- To participate beginning January 1, 2009, simply submit the appropriate e-prescribing G-code on each Medicare Part B claim that contains a denominator code.
  - No specific diagnosis requirements for reporting.
- Providers will be deemed to be “successful e-prescribers” where one (1) e-prescribing measure is reported in at least 50% of cases where the measure is applicable during the reporting period (calendar year).
- A two percent incentive payment will be sent to 2009 reporting period “successful e-prescribers.”
  - Incentive payment based on the total estimated allowed Medicare Part B charges for professional services during the reporting period.
- For more information, visit the e-Prescribing section of the CMS Web site at [www.cms.hhs.gov/PQRI/03\\_EPrescribingIncentiveProgram.asp](http://www.cms.hhs.gov/PQRI/03_EPrescribingIncentiveProgram.asp).

## Preventive Services Reminders

### January Flu Shot Reminder - It's Not Too Late to Get the Flu Shot!

- We are in the midst of flu season and a flu vaccine is still the best way to prevent infection and the complications associated with the flu. Re-vaccination is necessary each year because flu viruses change each year. So please encourage your Medicare patients who haven't already done so to get their annual flu shot--and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends.
- **Remember** - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug.
- Health care professionals and their staff can learn more about Medicare's coverage of the influenza vaccine and other Medicare Part B covered vaccines and related provider education resources created by the CMS Medicare Learning Network (MLN), by reviewing *MLN Matters Special Edition* article SE0838 [www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf](http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0838.pdf) on the CMS Web site.

### January is National Glaucoma Awareness Month

In recognition of National Glaucoma Awareness Month the Centers for Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of a comprehensive annual glaucoma screening exam for seniors and others with Medicare at high risk for developing glaucoma. Glaucoma is a leading cause of blindness in the United States and while anyone can develop glaucoma, the risk of glaucoma increases with age. Early detection and treatment of glaucoma, before it causes major vision loss, is the best way to control the disease.

- Medicare Coverage

- Medicare beneficiaries in one of the following high risk groups are eligible for an annual glaucoma screening covered by Medicare:
  - Individuals with diabetes mellitus;
  - Individuals with a family history of glaucoma;
  - African-Americans age 50 and older; and
  - Hispanic-Americans age 65 and older.
- A covered glaucoma screening includes:
  - A dilated eye examination with an intraocular pressure (IOP) measurement; and
  - A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.

**For More Information** - CMS has developed a variety of educational products and resources to help health care professionals and their staff learn more about coverage, coding, billing, and reimbursement for preventive services and screenings covered by Medicare:

- The MLN Preventive Services Educational Products Web Page ~ provides descriptions and ordering information for all provider specific educational products related to preventive services. The Web page is located at [http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp) on the CMS Web site.
- Glaucoma Screening Brochure ~ this tri-fold brochure provides health care professionals with an overview of Medicare's coverage of glaucoma screening services. To view online go to <http://www.cms.hhs.gov/MLNProducts/downloads/glaucoma.pdf> on the CMS Web site. To order copies of the brochure, go to the CMS Medicare Learning Network (MLN) Product Ordering System located 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)
- The CMS Web site ~ provides information for preventive service covered by Medicare. Go to <http://www.cms.hhs.gov>, select "Medicare", scroll down to the "Prevention" section.
- For information to share with your Medicare patients, visit <http://www.medicare.gov>
- For more information about glaucoma, visit The National Eye Institute <http://www.nei.nih.gov/index.asp>
- For more information about National Glaucoma Awareness Month, please visit <http://www.preventblindness.org/>

Thank you for helping CMS protect the vision of Medicare beneficiaries who are at higher risk for glaucoma by joining in the effort to educate beneficiaries about glaucoma, and the importance of early detection by taking advantage of the annual glaucoma screening benefit covered by Medicare.

## New & Revised Medicare Learning Network Materials

CMS LearnResource emails 200812-33, 200812-37, 200812-38, 200901-04, 200901-06, 200901-08, 200901-10 & 200901-13

- Revised materials now available to order in print format (to place your order, visit [http://www.cms.hhs.gov/MLNProducts/01\\_Overview.asp](http://www.cms.hhs.gov/MLNProducts/01_Overview.asp), scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”):
  - ***Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals (October 2008)*** – Guide which offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare reimbursement, Medicare payment policies, evaluation and management services, protecting the Medicare Trust Fund, inquiries, overpayments, and appeals.
  - ***Adult Immunizations (October 2008)*** - Tri-fold brochure that provides fee-for-service health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration.
  - ***Medicare Billing Information for Rural Providers, Suppliers, and Physicians (revised October 2008)*** - Charts that provide Medicare billing information for Rural Health Clinics, Federally Qualified Health Centers, Skilled Nursing Facilities, Home Health Agencies, Critical Access Hospitals, and Swing Beds.
- Revised materials now available in downloadable format:
  - ***The ABC's of Providing the Initial Preventive Physical Examination (January 2009)*** – This quick reference tool can be used by Medicare fee-for-service physicians and qualified non-physician practitioners as a guide when providing the initial preventive physical examination (IPPE) (also known as the "Welcome to Medicare" Physical Exam or the "Welcome to Medicare" Visit). The two-sided reference identifies the components and elements of the IPPE; provides eligibility requirements, procedure codes to use when filing claims, FAQs, and suggestions for preparing patients for the IPPE; and lists references for additional information. To view, download and print this resource, please go to the CMS Medicare Learning Network at [www.cms.hhs.gov/MLNProducts/downloads/MPS\\_QRI\\_IPPE001a.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf).
  - ***Expanded Benefits Brochure (January 2009)*** - This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of three preventive services: the initial preventive physical examination (IPPE), also known as the Welcome to "Medicare Physical" Exam or the "Welcome to Medicare" visit, ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests. To view, download and print the brochure please go to the CMS Medicare Learning Network (MLN) at [www.cms.hhs.gov/MLNProducts/downloads/Expanded\\_Benefits.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf).
  - ***Medicare Preventive Services Quick Reference Information (January 2009)*** - This two-sided resource gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services. To view, download, and print this resource, please go to the CMS Medicare Learning Network (MLN) at [www.cms.hhs.gov/MLNProducts/downloads/MPS\\_QuickReferenceChart\\_1.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf).

- New materials available via CD-ROM:
  - *The Medicare Learning Network (MLN) Resources for Indian Health Care Professionals* CD ROM, which provides descriptions of and links to various MLN products that can help Indian health care professionals and their staff gain a better understanding of the Medicare fee-for-service program is now available to order. To view a downloadable file of the content found on the CD ROM, please go to the CMS **Medicare Learning Network (MLN)** at [www.cms.hhs.gov/MLNProducts/downloads/wIndianHealthFS102908f.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/wIndianHealthFS102908f.pdf). To order a copy, free of charge, visit [http://www.cms.hhs.gov/MLNProducts/01\\_Overview.asp](http://www.cms.hhs.gov/MLNProducts/01_Overview.asp), scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.”

## MLN Matters Articles

*MLN Matters* articles consist mostly of high-level summaries of change requests targeted to the provider community. These articles can be found on the National Government Services Web site or the CMS Web site using the instructions below:

- From [www.NGSMedicare.com](http://www.NGSMedicare.com) –
  - Select your business type (Part B) and region (Connecticut or New York) and click the “GO” button.
  - Click the “Accept” button on the Attestation Page (if appears).
  - In the search box at the top of the Provider Specific Portal Home Page, enter the article number (listed below) and click the “GO” button.
  - From the search results page, choose the link that begins with the article number in order to view the article. In order to read the document without scrolling (left to right) or to print the page, click the “View full screen or print this page” link in the uppermost right-hand corner of the Web page.
- From [www.cms.hhs.gov](http://www.cms.hhs.gov) –
  - Enter the article number (listed below) in the search box at the top of the page and click the “Search” button.
  - From the search results page, choose the link for the article (usually listed as “Bulletin Number: xxxxxx”).
  - Note - *MLN Matters* articles are published in Adobe Acrobat format (.pdf) on the CMS Web site. If you do not have the free Adobe Reader software, you can download it from [www.adobe.com/products/acrobat/readstep2.html](http://www.adobe.com/products/acrobat/readstep2.html).

**Please note - *MLN Matters* articles marked with an asterisk (\*) have not been published as of the date of finalization of these materials. Please keep checking the Web site for when these articles are posted.**

### Coverage

Article #	Description	Effective Date	Implementation Date
MM6130	Expansion of Medicare Telehealth Services*	01/01/09	01/05/09
MM6223	Update to the Initial Preventive Physical Examination (IPPE) Benefit	01/01/09	01/05/09
MM6291	Thermal Intradiscal Procedures (TIPs)	09/29/08	01/05/09

### Competitive Acquisition Program for Part B Drugs & Biologicals (CAP)

Article #	Description	Effective Date	Implementation Date
MM6124	Revisions to the Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals	01/05/09	01/05/09
MM6210	Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals Vendor Identification Number, Physician Election, and Iron Dextran Payment Update	01/05/09	01/05/09

Coding & Billing

Article #	Description	Effective Date	Implementation Date
MM6217	Shipboard Services Billed to the Carrier and Services Not Provided Within the United States*	01/05/09	01/05/09
MM6220	2009 Annual Update of HCPCS Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) for the Common Working File (CWF), A/B MACs, Medicare Carriers and Fiscal Intermediaries (FIs)	01/05/09	01/05/09
MM6254	2009 Annual Update to the Therapy Code List	01/01/09	01/05/09
MM6287	New Waived Tests	01/01/09	01/05/09
MM6313	<b>REVISED</b> - Correction to Prothrombin Time (PT/INR) Monitoring for Home Anticoagulation Management	03/19/08	02/09/09

Claims Processing

Article #	Description	Effective Date	Implementation Date
MM6128	Revision to Skilled Nursing Facility (SNF) Common Working File (CWF) Editing	01/05/09	01/05/09
MM6131	Implementation of a New Claim Adjustment Reason Code (CARC) No.213. "Non-compliance with the Physician Self-referral Prohibition Legislation or Payer Policy"	01/01/09	01/05/09
MM6184	Implementation of an ASC HCPCS Payment Indicator File*	01/01/09	01/05/09
MM6211	Instructions For Utilizing 837 Professional Claim Adjustment (CAS) Segments for Medicare Secondary Payer (MSP) Part B Claims	07/01/09	07/01/09
MM6229	Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update	01/01/09	01/05/09
MM6245	End-Stage Renal Dialysis (ESRD) Medicare Claims Processing Manual Clarification	01/01/09	02/02/09
MM6262	Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement	01/01/09	01/05/09
MM6290	Quarterly Update to Correct Coding Initiative (CCI) Edits, Version 15.0, Effective January 1, 2009	01/01/09	01/05/09
MM6304	Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2009	01/01/09	01/05/09
MM6328	Claim Status Category Code and Claim State Code Update	01/01/09	01/05/09

Payment

Article #	Description	Effective Date	Implementation Date
MM6052	Physician Payment Amounts When Physicians Furnish Excluded Procedures in Ambulatory Surgical Centers (ASCs)	01/01/08	01/05/09

Article #	Description	Effective Date	Implementation Date
MM6070	<b>REVISED</b> - Calendar Year (CY) 2009 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment	01/01/09	01/05/09
MM6106	Health Professional Shortage Area (HPSA) Bonus Payment Policy Changes	01/01/09	01/05/09
MM6113	Ambulance Inflation Factor for CY 2009	01/01/09	01/05/09
MM6150	2009 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments	01/01/09	01/05/09
MM6206	Improved Access to Ambulance Services Payment Rates for Effective Dates of Service July 1, 2008, through December 31, 2009	07/01/08	01/12/09
MM6208	Adjustment for Medicare Mental Health Services	07/01/08	02/02/09
MM6221	Reasonable Charge Update for 2009 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses	01/01/09	01/05/09
MM6270	Fee Schedule Update for 2009 for Durable Medical Equipment, Prosthetics, Orthotics and Supplies	01/01/09	01/05/09
MM6277	Annual Clotting Factor Furnishing Fee Update	01/01/09	01/05/09
MM6288	January 2009 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files	01/01/09	01/05/09
MM6297	Changes in Payment for Oxygen Equipment as a Result of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 and Additional Instructions Regarding Payment for DMEPOS	01/01/09	01/06/09
MM6349	Summary of Policies in the 2009 Medicare Physician Fee Schedule (MPFS) and the Telehealth Originating Site Facility Fee Payment Amount	01/01/09	01/05/09
MM6351	Emergency Update to the 2009 Medicare Physician Fee Schedule Database (MPFSDB)*	01/01/09	01/05/09

#### Miscellaneous

Article #	Description	Effective Date	Implementation Date
MM6136	Revised Form CMS-R-131 Advance Beneficiary Notice of Noncoverage	03/03/08	03/01/09
MM6228	Reporting Non-Tax Withholding Due to Federal Payment Levy Program*	01/01/09	01/05/09
MM6258	Update to Medicare Deductible, Coinsurance and Premium Rates for 2009	01/01/09	01/05/09
MM6261	Signature and Date Stamps for DME Supplies-CMNs and DIFs	02/02/09	02/02/09

## Local Coverage Determination (LCD) Updates

LCDs that are in draft, in the comment period, in the in-notice period, active or archive/retired can be found on the National Government Services Web site.

- To view LCDs:
  - Go to [www.NGSMedicare.com](http://www.NGSMedicare.com), select your business type (Part B) and region (Connecticut or New York) and click the “GO” button.
  - Click the “Accept” button on the Attestation Page (if appears).
  - From the Provider Specific Portal Home Page, click “Local Coverage Determinations” from the Quick Links section, or in the drop-down box under the Coverage tab.
  - From the LCD page, click the specialty/specialties you are interested in (or leave as default “all specialties”) and the LCD status and click the “Search” button.
- When researching LCDs, please note that LCDs are listed in alphabetical order. In addition, for each LCD there are two links – one for the actual LCD (clinical policy and applicable codes) and one for the LCD Article (additional billing information).

### **New LCDs effective 01/01/09**

- L28539 Abdominal/Pelvic Ultrasound (replaces L28073)
- L28451 Allergy Immunotherapy (replaces L28138)
- L28482 Bariatric Surgery (replaces L28202)
- L28433 Brachytherapy (replaces L28149, L28152, & L28199)
- L28516 Computed Tomography (replaces L28191)
- L28470 Extracorporeal Shock Wave Therapy (ESWT) For Musculoskeletal Indications (replaces L28133)
- L28490 Incision and Drainage of Abscess of Skin, Subcutaneous and Accessory Structures (replaces L28206)
- L28529 Pain Management (replaces L28196, L28117, L28150, L28154, L28161, L28164, L28187 & L28186)
- L28497 Panretinal (Scatter) Laser Photocoagulation (replaces L28198)
- L28443 Parathormone - Parathyroid Hormone, PTH, Immunoreactive PTH (replaces L28126)
- L28395 Percutaneous Coronary Intervention (replaces L28129)
- L28463 RAST Type Tests (replaces L28137)
- L28488 Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI) (replaces L28200)
- L28437 Surveillance of Implantable Cardioverter Defibrillators (ICDs): Office, Hospital, Web, or Non-Web Based
- Syphilis Tests (replaces L28151)
- L28459 Venipuncture Necessitating Physician’s Skill for Specimen Collection (replaces L28158)
- L28427 Viral Hepatitis Serology Tests (replaces L28197)

**LCDs retired as of 12/31/08 and replaced by Coverage Articles:**

- L28183 Urinary Incontinence Treatment, replaced by article A48292
- L28210 Filgrastim, Pegfilgrastim (e.g., Neupogen®, Neulasta™), replaced by article A48208
- L28211 Health and Behavior Assessment/Intervention, replaced by article A48209
- L28195 Initial Hospital Visits, replaced by article A48210
- L28217 Thyrotropin Alfa (Thyrogen®), replaced by article A48211
- L28218 Vitamin B-12 Injections, replaced by article A48213

**Top Claim Submission Errors**

One of the responsibilities of the National Government Services Provider Outreach and Education team is to offer education on the high-volume claim submission errors that result in unprocessable, rejected, and in some instances, denied claims. To reduce the claim submission error rate—and to support our goal of having claims submitted correctly—we are including this information in our monthly call along with helpful hints to resolve these errors. You should make it a goal to reduce the number of claim submission errors by taking extra time to review your claims before submission to ensure that all required information is included on each claim.

Error	How to Avoid Error
<p><b>Medicare Advantage Plan deny</b> Denial jurisdiction</p>	<p>This error occurs when the patient is enrolled in a Medicare Advantage Plan.</p> <p>To verify that you are billing the correct insurance, you can check the eligibility of your patient through the Interactive Voice Response system (IVR) and ask the patient (especially at the beginning of the year) whether their insurance has changed.</p> <p>For tips on how to use the IVR go to the National Government Services Web site under the resources tab on the contacts link, click on the Interactive Voice Response link. This link will give you information regarding the IVR’s telephone numbers and hours of availability. Also available for you to download are other helpful documents such as Part B IVR User Guide, Part B IVR Navigation, Part B Touch-Tone Card/Eligibility Checklist.</p> <p><a href="http://www.ngsmedicare.com/NGSMedicare/PartB/Resources/ContactInformation/Interactive%20Voice_%20Response_ContactInfo_PartB.aspx">www.ngsmedicare.com/NGSMedicare/PartB/Resources/ContactInformation/Interactive%20Voice_%20Response_ContactInfo_PartB.aspx</a></p> <p>There will be two Interactive Voice Response (IVR) Teleconferences hosted by National Government Services on:</p> <p>January 29, 2009 - 10:00 –11:00 a.m. February 26, 2009 - 1:00–2:00 p.m.</p> <p>Please visit our events calendar on the National Government Services Web site (<a href="http://www.NGSMedicare.com">www.NGSMedicare.com</a>) for additional information regarding these informative calls.</p>

Error	How to Avoid Error
<p><b>Charges incurred during non-entitled period</b></p> <p>Denial Eligibility</p>	<p>This error occurs when the claim is submitted when the patient is not entitled to Medicare Part B Benefits when the services were rendered. Please remember to check the patient's eligibility through the National Government Services' Interactive Voice Response (IVR).</p> <p>For tips on how to use the IVR go to the National Government Services Web site under the resources tab on the contacts link, click on the interactive voice response link. This link will give you information regarding the IVR telephone numbers and hours of availability. Also available for you to download are other helpful documents such as Part B IVR User Guide, Part B IVR Navigation, Part B Touch-Tone Card/Eligibility Checklist.</p> <p><a href="http://www.ngsmedicare.com/NGSMedicare/PartB/Resources/ContactInformation/Interactive%20Voice_%20Response_ContactInfo_PartB.aspx">www.ngsmedicare.com/NGSMedicare/PartB/Resources/ContactInformation/Interactive%20Voice_%20Response_ContactInfo_PartB.aspx</a></p>
<p><b>Missing/ Incomplete/ Invalid group practice information</b></p> <p>Return to provider</p>	<p>This error is received when the Providers Group NPI is not properly entered in Item 33a of the CMS 1500 (08/05) or its electronic equivalent. For instructions on completing the Form CMS-1500 (08/05) go to the National Government Services Web site under the Education and Support Tab on the Tools and Materials link click on the CMS-1500 Claim Form Version 08/05 Completion Instructions.</p> <p><a href="http://www.ngsmedicare.com/NGSMedicare/PartB/EducationandSupport/ToolsandMaterials/CMS_ClaimFormInst.aspx">www.ngsmedicare.com/NGSMedicare/PartB/EducationandSupport/ToolsandMaterials/CMS_ClaimFormInst.aspx</a></p>
<p><b>According to Medicare hospice requirements, this service is not covered because the service was provided by a non-attending physician</b></p>	<p>The claim submitted is for a patient in a hospice period of coverage.</p> <p>Medicare Part B only reimburses the services of the attending physician selected by the patient at the initiation of hospice coverage. These services are billed with modifier GV. Any other service provided to a hospice patient is the responsibility of the hospice and should be submitted to that hospice plan. When a provider renders services to a beneficiary that is enrolled in a hospice and the service rendered is not related to the beneficiary's terminal illness the provider should submit the service with modifier GW.</p> <p>Information regarding whether a patient is in enrolled in a hospice period of coverage is available through the IVR.</p>
<p><b>Missing/ Incomplete/ Invalid referring provider primary identifier</b></p>	<p>Referring physician name and identification number (NPI) missing, incomplete or invalid in Item 17 and 17b of the CMS-1500 (08/05) claim form or its electronic equivalent.</p> <p>Enter the name of the referring or ordering physician in Item 17 and his/her National Provider Identifier in Item 17b, if the service or item was ordered or referred by a physician. As of May 23, 2008 Item 17a is not to be reported.</p> <ul style="list-style-type: none"> <li>• Referring Physician: A physician who requests an Item or service for the beneficiary for which payment may be made under the Medicare program.</li> <li>• Ordering Physician: A physician or, when appropriate, a nonphysician practitioner who orders nonphysician services for the patient.</li> </ul> <p>For instructions on completing the Form CMS-1500 (08/05) go to the National Government Services Web site under the Education and Support Tab on the Tools and Materials link click on the CMS-1500 Claim Form Version 08/05 Completion</p>

Error	How to Avoid Error
	<p>Instructions.  <a href="http://www.ngsmedicare.com/NGSMedicare/PartB/EducationandSupport/ToolsandMaterials/CMS_ClaimFormInst.aspx">www.ngsmedicare.com/NGSMedicare/PartB/EducationandSupport/ToolsandMaterials/CMS_ClaimFormInst.aspx</a>                      To look up an NPI, use the NPI Registry -  <a href="https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do">https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do</a></p>
<p><b>The provider of this service is not eligible to receive Medicare payments</b></p>	<p>Providers that are sanctioned or not enrolled in the Medicare program are not eligible to submit claims to the Medicare program.</p>
<p><b>Missing/ incomplete/ invalid information where services were furnished</b>  Return to provider</p>	<p>In Item 32 of the CMS-1500 (08/05) or its electronic equivalent, enter the name and address, and ZIP code if the service(s) were furnished in an office, hospital, clinic, laboratory, physician’s office or facility other than the patient’s home (place of service 12). For home visits rendered in a place other than the patient’s mailing address, enter the patient’s mailing address in Item 5 and the complete address, including ZIP code to reflect where the service was rendered in Item 32.</p>
<p><b>Missing/ incomplete/ invalid diagnosis or condition</b></p>	<p>This error is received when the ICD-9 code is not properly entered in Item 21 of the CMS-1500 (08/05) or its electronic equivalent.</p> <p>Enter the patient’s diagnosis/condition. With the exception of claims submitted by Ambulance suppliers (specialty type 59), all physician and non-physician specialties use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order.</p> <p>Truncated diagnosis codes are not acceptable. Many Medicare policies are diagnosis-specific. ICD-9-CM code listings cover a range and include truncated codes. It is the provider’s responsibility to avoid truncated codes by selecting a code(s) carried out to the highest level of specificity and selected from the ICD-9-CM codebook appropriate to the year in which the claim is submitted. Many diagnosis codes are deleted, added or made more specific each year. It is very important that you have the current ICD-9-CM book in your office.</p> <p>It is recommended that you bill the ICD-9 CM code(s) that you are treating at the time of the visit. All other conditions should be noted in the medical record.</p>
<p><b>The procedure code is inconsistent with the modifier used or a required modifier is missing.</b>  Return to provider</p>	<p>Check the validity of the procedure code/modifier combination in the following resources (this is not an all inclusive list):</p> <ul style="list-style-type: none"> <li>▪ CPT guidelines</li> <li>▪ National Government Services local cover determination (if applicable)</li> <li>▪ CMS Physician Fee Schedule Look up located on the CMS Web site at <a href="http://www.cms.hhs.gov/PFSlookup">www.cms.hhs.gov/PFSlookup</a></li> </ul> <p><b>Note:</b> Please read the Medicare provider bulletins, especially at the end of each year, as Medicare list all the additions, deletions, and code changes for the following year.</p>

Error	How to Avoid Error
<b>Claim lacks information which is needed for adjudication</b>  Return to provider	The claim form did not contain all information needed to adjudicate the claim. Review the claim following the CMS-1500 instructions for completion to determine what required information is missing. Please contact the National Government Services' Customer Care Contact Center if you are unsure of the specific information that is missing.

## Electronic Data Interchange (EDI)

### Top EDI Denials

Per the Electronic Data Interchange (EDI) Call Center, the recent top EDI Denials for J13 for New York and Connecticut are as follows:

#### 1. M012 - Billing Provider Not on File (Loop 2010AA, REF02)

- **Tip:** Prior to billing electronically for a provider, an EDI Agreement must be submitted to the EDI Department so we can link the provider number to your electronic submitter number. Please note if you are billing for a group we only link the group electronically one time. If you add additional providers you do not need a separate agreement, as long as they have been linked to the group through our Provider Enrollment Department.

#### 2. M379 - Invalid TIN vs. NPI for Billing Providers (Loop 2010AA, REF02)

- **Tip:** Make sure you are using the correct tax identification number or social security number that Medicare has on file for your billing provider. You must check your software also has this information. Be sure the information on file with NPPES NPI registry is the same as your Medicare information. To view the registry, go to <https://nppes.cms.hhs.gov/NPPES/Welcome.do>.
- If you need to update any information on the Medicare Provider Files you must complete an enrollment application. For more information about provider enrollment, visit the Information and Tools page of the Enrollment section of the Web site:  
[www.ngsmedicare.com/NGSMedicare/PartB/Enrollment/InformationandTools/IndexInfoandToolsPartB.aspx](http://www.ngsmedicare.com/NGSMedicare/PartB/Enrollment/InformationandTools/IndexInfoandToolsPartB.aspx).

#### 3. M384 - Invalid Value (MSP totals not balancing) (Loop 2300, CLM02)

- **Tip:** Make sure the amounts you are entering for Claim Level Adjustments on your MSP claim are equal to your total charges. Instructions for the electronic submission of MSP claims are included in the "837 version of the 4010A1 Professional Implementation Guide." The Implementation Guide is available at: <http://www.wpc-edi.com>.

#### 4. Edit Code 3001 - Unable to Determine Route (Loop 1000A)

- **Tip:** July 18, 2008 we became a J13 MAC contractor and it required a change to your contractor/payer ID number in your software. You will need to change the receiver ID in the ISA08, GS03, and NM109 fields.

**5. M402 - Billing Provider Secondary ID needs to be removed (Loop 2010AA, REF01-1C, 1D, 1G)**

- **Tip:** Effective May 23, 2008 we are only accepted your NPI numbers. Make sure your software does not contain any PIN/PTAN/UPIN numbers on your provider records.

**Attention Electronic Claim Submitters Currently Using PC-ACE Pro32 Claim Submission Software**

An updated version of the PC-ACE Pro32 claim submission software, version 1.98, will be available soon on our Web site at [www.NGSMedicare.com](http://www.NGSMedicare.com). Once the new version is available, previous versions of the PC-ACE Pro32 will no longer be supported.

- For Downstate New York providers (those providers previously serviced by Empire Medicare Services), the new version 1.98 will no longer support claim submission for Empire Blue Cross Blue Shield or Commercial Insurance claims through PC-ACE Pro32. You must contact the Wellpoint Help Desk at 866-889-7322 for information on how to bill these claim types. This new software is a Medicare-only program!
- For Queens County providers (those providers previously serviced by GHI Medicare) you must upgrade to the new 1.98 version of PC ACE Pro 32.
- For Connecticut Part B providers (those providers previously serviced by First Coast Service Options) must upgrade to the new 1.98 version of PC ACE Pro 32.
- For Upstate New York providers (those providers previously serviced by HealthNow), you may start using PC-ACE Pro32 anytime. We will be converting all Medicare Claims Express (MCE) users at a later date.
- If you are currently using PC ACE Pro 32 to submit claims to both Part A and Part B, you will now be able to utilize the 1.98 software for all Medicare lines of business

## Comprehensive Error Rate Testing (CERT) Common Errors

### Top Three Error Codes

#### 1. Service Incorrectly Coded:

- Evaluation and Management services makes up a significant portion of National Government Services CERT errors. The documentation of the service in the medical record, when reviewed, does not support the level of service being billed. This is the major portion of this error rate.
- **Tip:** Be sure you are coding to the correct level of evaluation and management codes appropriately. History, Exam, and Medical decision making are considered key components and are required in selecting a level of E/M service. Presenting problem, counseling, and coordination of care are considered contributing factors in the majority of encounters.
- **References:**
  - Coding guidelines in the E/M section of published CPT books
  - CMS IOM 100-04, Chapter 12, Section 30.6  
[www.cms.hhs.gov/manuals/downloads/clm104c12.pdf](http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf)
  - CMS Evaluation & Management Services Guide, 1995 Guidelines & 1997 Guidelines  
[www.cms.hhs.gov/MLNEdWebGuide/25\\_EMDOC.asp](http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp)

#### 2. Insufficient Documentation

- Insufficient documentation errors are greatly impacting our CERT Part B error rate. Physical therapy services are contributing to a high number of insufficient documentation errors due to missing information for the initial evaluation/re-evaluation, treatment plan and plan of care. Please be sure to include all the documentation for all of the dates of service billed.
- **Tip:** Some examples of what types of documentation should be included -
  - Original Initial evaluation/re-evaluation
  - Physician orders for dates of service billed
  - Discharge notes
  - History and physical
  - Nurse's notes
  - Operative reports
  - Therapy progress notes
  - Lab results

Please make sure records are legible. Do not forget to include the following in your patient records:

- ICD-9 code(s)
- Diagnostic tests results
- Office records
- Operative reports
- Discharge summaries

Remember the billing provider is responsible for gathering all documentation from hospitals, nursing homes, clinics, and labs, when applicable. Be sure to submit your documentation timely when asked, to ensure appropriate review decisions that will help eliminate unnecessary appeals.

▪ **References:**

- Physical Therapy guidelines – CMS IOM 100-02, Chapter 15, Section 220 “Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services)”
- L26884-Outpatient Physical and Occupational Therapy Services  
[www.ngsmedicare.com/NGSMedicare/lcd/L26884\\_active\\_lcd.htm](http://www.ngsmedicare.com/NGSMedicare/lcd/L26884_active_lcd.htm)

### 3. Medically Unnecessary Service or Treatment

- These are services that do not have documentation to support the medical necessity for the service. Some examples are:
  - A laboratory test submitted without a history of a condition relating to the reason for the test.
  - A physical therapist billing without evidence he/she has a treatment plan on file.
- Tip: Ensure that you are familiar with the documentation requirements for services which have LCDs associated with them. LCDs can be found on our Web site at [www.ngsmedicare.com/NGSMedicare/PartB/Coverage/LCD/IndexLCDPartB.aspx](http://www.ngsmedicare.com/NGSMedicare/PartB/Coverage/LCD/IndexLCDPartB.aspx).
- **References:**
  - CMS IOM 100-04, Chapter 12, Section 30.6.1 “Selection of Level of Evaluation and Management Service”

#### Other Tips:

- Lastly, we are seeing an increase in CERT errors caused by inaccurate keying. Please ensure that the correct date of service is billed along with the correct beneficiary information.
- **We have many learning tools available to you on our Web site.** For further information regarding CERT and for a computer based training (CBT) course please access the URL [www.ngsmedicare.com/ngsmedicare/partb/reviewprocess/cert/certtools.aspx](http://www.ngsmedicare.com/ngsmedicare/partb/reviewprocess/cert/certtools.aspx).

## Medicare University

Medicare University Training Event Number **09013TBAGF1**

Topic: Medicare Part B News Flash Teleconference for Jurisdiction 13 (CT & NY providers)

Medicare University Credits (MUCs) = 2

# of Sessions = 1

To earn Medicare University Credits (MUCs), you must self-report your attendance after this training event has ended. It's a quick and easy process. Simply:

- Go to [www.NGSMedicare.com](http://www.NGSMedicare.com) and follow directions to go to the main portal page for your contract.
- On the right hand side, select the Medicare Learning Management System (this logo will soon be changed to Medicare University Computer Based Training logo. It will say "click&learn" Medicare University)
- Log on onto the NGS Medicare University site.
- Click on the link for "Course Catalog" from the left navigation menu.
- Select the course titled "Self-Reporting of..." and the title of the training event you attended.
- Enter the Training Event Number shown above and follow directions to exit this course.
- Users can print a Report Card to show all completed training received from NGS Medicare University.