Medicare
Newsletter

Medicare Area
P.O. Box 1602 • Omaha, NE 68101
mutualmedicare.com
A CMS Contracted Intermediary

February 15, 2005 Newsletter

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S Skilled Nursing Facility (SNF) Providers
O Comprehensive Outpatient Rehabilitation Facility (CORF) And Outpatient Physical Therapy (OPT) Providers
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If you have any questions regarding this newsletter, please contact your Customer Service Representative. However, some articles may contain a specific telephone number to contact for assistance.

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Mutual of Omaha Insurance Company
Medicare Area

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Update to Fiscal Year 2005 Wage Index for Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) Hospitals

Related Change Request (CR) #: 3672 **Medlearn Matters Number:** MM3672
Related CR Release Date: December 30, 2004
Related CR Transmittal #: 422
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Provider Types Affected

Providers who bill Fiscal Intermediaries (FI) for claims paid under the IPPS or OPPS

Provider Action Needed

This change request (CR) outlines updates to Fiscal Year 2005 Wage Index for IPPS and OPPS Hospitals. The corrected wage index tables have been published in the December 30, 2004 Federal Register Correction Notice to the IPPS Final Rule.

This update, based on a correction notice to the Federal Register, also updates the information published in CR 3459 and in *Medlearn Matters* article MM3459.

Please note that the corrected tables are available for download on the IPPS web site at: **http://www.cms.hhs.gov/providers/hipps/ippswage.asp**

To ensure accurate claims processing: Please review the information included here and in the corrected tables mentioned above to stay current with instructions pertaining to FY 2005 Wage Index.

The updated wage index values for the Core-Based Statistical Area (CBSA) designations are listed in Attachment 1 of CR 3672.

Attachment 2 of CR 3672 lists changes for hospitals that require a Special Wage Index. Attachment 2 includes blended wage indexes, hold harmless wage indexes and other special wage index exceptions that have changed since CR 3459 was released. Attachment 2 is also updated to include providers who are located in CBSAs listed in Attachment 1 where the changes to the wage data have caused their wage index values to change.

Providers that do not appear on Attachment 2 and/or Table 2 of the December 30, 2004 IPPS Correction Notice, will need to refer to the provider's CBSA wage index on Table 4A2 of the IPPS Correction Notice and the provider's MSA wage index on Table 4A1.

Providers reclassified under 1886(d)(8) or 1886(d)(10) should refer to Table 4C1 and 4C2 of the IPPS Correction Notice. If the CBSA wage index on table 4A2 is higher than the MSA wage index, the provider should receive the CBSA wage index.

For any providers that have an MSA wage index that is higher than the CBSA wage index a blended wage index is computed by taking: (.50*MSA Wage Index +.50* CBSA Wage Index).

In accordance with §412.316, the Geographic Adjustment Factor (GAF) under the capital PPS is based on the hospital wage index value that is applicable to the hospital under 412.63(k) (that is, the operating PPS). Therefore, if a hospital receives a "special wage index" (i.e., section 508 reclassification, 50/50 blended MSA/CBSA wage index, or the out-commuting adjustment) under the operating PPS, then its GAF is computed from that "special wage index" value. The GAF is calculated as the wage index is raised to the 0.6848 power.

Additional Information
The official instruction issued regarding this change can be found at:
http://www.cms.hhs.gov/manuals/pm_trans/R422CP.pdf

Please note that the corrected tables are also available for download on the IPPS web site at: **http://www.cms.hhs.gov/providers/hipps/ippswage.asp**

If you have any questions, please contact the Audit Supervisor assigned to your facility.

Modification to Reporting of Diagnosis Codes for Screening Mammography Claims

Related Change Request (CR) #: 3562 **Medlearn Matters Number:** MM3562
Related CR Release Date: January 14, 2005
Related CR Transmittal #: 426
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Provider Types Affected
All providers billing Medicare carriers or fiscal intermediaries for screening mammography claims

Provider Action Needed
This article modifies instructions to allow reporting of either Diagnosis code V76.11 or V76.12. Providers should note that to ensure proper coding, one of the following diagnosis codes should be reported on screening mammography claims:

- **V76.11** – "Special screening for malignant neoplasm, screening mammogram for high-risk patients" or;
- **V76.12** – "Special screening for malignant neoplasm, other screening mammography"

Background
Effective January 1, 1998, providers only reported diagnosis code V76.12 on screening mammography claims. Effective July 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will now allow reporting of either V76.11 or V76.12 as appropriate.

Implementation
Implementation is July 5, 2005.

Additional Information
The official instruction issued to your carrier/intermediary regarding this change may be found at: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**

From that web page, look for CR 3562 in the CR NUM column on the right and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: **http://www.cms.hhs.gov/medlearn/tollnums.asp**

Update to Billing Requirements for Positron Emission Tomography (PET) Scans for Dementia and Neurodegenerative Diseases and Update for Special Payment Procedures for all PET Scan Services Performed in Critical Access Hospitals

Related Change Request (CR) #: 3640 **Medlearn Matters Number:** MM3640
Related CR Release Date: January 14, 2005
Related CR Transmittal #: 428
Effective Date: September 15, 2004
Implementation Date: April 4, 2005

Provider Types Affected
Providers and suppliers who bill Medicare carriers and fiscal intermediaries for PET scan services.

Provider Action Needed
Impact To You
This article explains updates to the Medicare Claims Processing Manual related to 2-deoxy-2- [F-18] fluoro-D-glucose Positron Emission Tomography (FDG-PET) Scans.

What You Need to Know
Information for the payment method for all PET scans provided in critical access hospitals has also been added to the Medicare Claims Processing Manual.

What You Need to Do
Use of the correct codes and understanding of the reimbursement methods will help Medicare make prompt and correct payments for PET Scan services.

Background
The Radiology Services and Other Diagnostic Procedures Chapter of the Medicare Claims Processing Manual has been updated in regard to billing requirements and coverage for 2-deoxy-2- [F-18] Fluoro-Dglucose Positron Emission Tomography (FDG-PET) Scans for the differential diagnosis of Front-Temporal Dementia (FTD) and Alzheimer’s Disease (AD).

There are three updates to the Medicare Claims Processing Manual related to FDG-PET Scans.

· The previous edit to allow HCPCS G0336 (PET imaging, brain imaging for the differential diagnosis of AD with aberrant features vs. FTD) to be billed no more than once in a beneficiary's lifetime has been removed.

· Medicare carriers and fiscal intermediaries must ensure that an appropriate diagnosis code accompanies the claim with HCPCS G0336. When submitting a claim for a FDG-PET Scan, one of the following diagnosis codes must accompany the HCPCS G0336 code: 290.0, 290.10 – 290.13, 290.20 – 290.21, 290.3, 331.0, 331.11, 331.19, 331.2, 331.9, 780.93. Line items with HCPCS code G0336 will be denied if one of the above diagnosis codes is not provided. Such denials will be reflected by claim adjustment reason code 11.

· The payment method for ALL PET Scan claims submitted for services provided in Critical Access Hospitals (CAHs) is as follows: CAHs under Method I have technical services paid at 101% of reasonable cost; CAHs under Method II have technical services paid at 101% of reasonable cost; and Professional services are paid at 115% of the Medicare Physician Fee Schedule Data Base.

Affected providers should issue an Advanced Beneficiary Notice to beneficiaries advising them of potential financial liability in the event that one of the appropriate diagnosis codes is not present on the claim.

All other billing requirements for PET Scans for dementia and neurodegenerative diseases remain the same.

Additional Information

The revised portion of Chapter 13, Section 60 of the Medicare Claims Processing Manual can be found as part of the official instruction issued to your carrier/intermediary regarding these changes. That instruction, CR 3640, may be found at:
http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3640 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your intermediary at their toll-free number, which may be found at: **http://www.cms.hhs.gov/medlearn/tollnums.asp**

Updated Skilled Nursing Facility (SNF) No Pay File for April 2005

Related Change Request (CR) #: 3642 **Medlearn Matters Number:** MM3642
Related CR Release Date: January 14, 2005
Related CR Transmittal #: 431
Effective Date: April 1, 2003
Implementation Date: April 4, 2005

Provider Types Affected
Providers who bill Fiscal Intermediaries

Provider Action Needed
Impact to You
HCPCS codes 94760, 94761, and Q4078 are payable in a SNF setting and these three codes have been removed from the SNF No Pay file retroactive to April 1, 2003.

What You Need to Know
Change Request 3534 discontinued the use of the SNF No Pay File for SNF claims with dates of service on and after January 1, 2005, since the editing accomplished through the No Pay file was determined to be duplicative of other efforts. The most current No Pay File will be used for editing claims with dates of service prior to January 1, 2005, until the timely filing period expires.

What You Need to Do
To ensure accurate claims processing, please note the above changes.

Additional Information
The official instruction issued to your intermediary regarding this change may be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that page, scroll down the CR NUM column on the right to find the link for CR 3642. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your fiscal intermediary at their toll free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp

Revisions to January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File

Related Change Request (CR) #: 3695 **Medlearn Matters Number:** MM3695
Related CR Release Date: January 13, 2005
Related CR Transmittal #: 134
Effective Date: January 1, 2005
Implementation Date: January 18, 2005

Provider Types Affected

Providers who bill fiscal intermediaries and carriers (including DMERCs) for the affected drugs

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS) is replacing payment limits for the first quarter of 2005 for certain Medicare Part B drugs, effective January 1, 2005.

What You Need to Know

The revised payment limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. Please note that the related CR 3695 makes revisions to the earlier CR 3539 and that the revised payment limits in this notification supercede the payment limits for these codes in any publication published prior to this document.

What You Need to Do

To ensure accurate claims processing, please review the information included here and stay current with guidelines on Medicare Part B drugs and biologicals.

Background

Section 303(c) of the Medicare Modernization Act (MMA) of 2003 revises the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Effective January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the new Average Sale Price (ASP) drug payment methodology.

The ASP payment methodology is based on data submitted to CMS by manufacturers at the 11-digit National Drug Code (NDC) level. CMS uses published drug pricing compendia and other sources to identify the number of billable units per NDC.

Through receipt of additional data, CMS has determined that certain payment limits included in the first quarter of calendar year 2005 (1Q05) Medicare Part B Drug Pricing File require revision. The revised payment limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. The revised payment limits in this notification supercede the payment limits for these codes in any publication published prior to this document.

The affected drugs and the associated revised payment limits are contained in the following table.

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit
90747*	ENGERIX-B	40 MCG	$113.91	$113.91
J0835	Inj cosyntropin per 0.25 MG	0.25 MG	$64.60	$64.60
J1563	IV immune globulin	1 GRAM	$56.72	$56.72
J1564	Immune globulin 10 mg	10 MG	$0.57	$0.57
J1655	Tinzaparin sodium injection	1000 IU	$2.60	$2.60
J2324	Nesiritide	0.25 MG (revised)	$73.33	$73.33
J3315	Triptorelin pamoate	3.75 MG	$180.93	$180.93
J3470	Inj hyaluronidase	up to 150 units	$20.00	$20.00
J7030	Sodium Chloride	1000 CC	$0.10	$0.10
J7350	Injectable human tissue	10 MG	$4.53	$4.53
J7611	Albuterol concentrated form	1 MG	$0.07	$0.07
J8501	Oral aprepitant	5 MG	$4.62	$4.62
J9185	Fludarabine phosphate inj	50 MG	$272.09	$272.09
J9214	Intron-A	1 UNIT	$13.12	$13.12
Q0179	Zofran	8 MG	$30.86	$30.86
Q2014	Geref	0.5 MG	$8.77	$8.77

*The revised payment limit for 90747 is based on the pricing methodology for vaccines (95% AWP).

Note: The absence or presence of a HCPCS code and its associated payment limit in the ASP files does not indicate Medicare coverage of the drug or biological.

Additional Information

The official instruction issued regarding this change can be found at:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above page, scroll down the CR NUM column on the right to find the link for CR 3695. Click on the link to open and view the file for the CR.

You may also refer to the earlier CR 3539 for additional background information – CR 3695 makes revisions to information provided in CR 3539.

If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp

MMA-Diabetes Screening Tests

Related Change Request (CR) #: 3637 **Medlearn Matters Number: MM3637**
Related CR Release Date: Re-issued on January 21, 2005 **Revised**
Related CR Transmittal #: 446
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

Note: This article was revised on January 24, 2005 to reflect a new release date and transmittal number for CR 3637. CR 3637 was re-issued on January 21, 2005. The article was also revised to show that claim type 12x will also be paid in accordance with the Clinical Laboratory Fee Schedule when these services are billed on that claim type.

Provider Types Affected
All Medicare providers, Medicare carriers, or intermediaries for diabetes screening tests

Provider Action Needed

Impact to You
This article notifies providers that Medicare will permit coverage for the following diabetes screening tests for services performed on or after January 1, 2005 for individuals who satisfy the eligibility requirements of being at risk for diabetes:

- Fasting plasma glucose test; and
- Post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults or a two-hour post glucose challenge test alone).

What You Need to Know
Coverage will be provided for two screening tests per calendar year for individuals diagnosed with pre-diabetes, and one screening test per year for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested. This coverage does not apply to individuals previously diagnosed as diabetic.

What You Need to Do
Please refer to the *Background* and *Additional Information* sections of this instruction for further details.

Background
This coverage is mandated by Section 613 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA).

Initially, coverage was limited to a fasting plasma glucose test. However, coverage is now provided for the following two screening blood tests:

• Fasting plasma glucose test, and

• Post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults, or a two-hour post-glucose challenge test alone).

Any individual with **one (1) of the following individual risk factors for diabetes is eligible** for this new benefit:

• Hypertension,

• Dyslipidemia,

• Obesity (with a body mass index greater than or equal to 30 kg/m2), or

• Previous identification of elevated impaired fasting glucose or glucose intolerance.

Or, an individual with any **two (2) of the following risk factors for diabetes is also eligible** for this new benefit:

• Overweight (a body mass index >25, but<30kg/m2),

• A family history of diabetes,

• Age 65 years or older, or

• A history of gestational diabetes mellitus or giving birth to a baby weighing > 9 lb.

Effective for services performed on or after January 1, 2005, Medicare will pay for diabetes screening tests under the Medicare Clinical Laboratory Fee Schedule. To indicate that the purpose of the test(s) is for diabetes screening, a screening diagnosis code is required in the diagnosis section of the claim:

• Two screening tests per calendar year are covered for individuals diagnosed with pre-diabetes.

• One screening test per year is covered for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested.

Those providers billing fiscal intermediaries should note the following:

• The diabetes screening tests will be paid only when submitted on types of bills (TOB) 12x, 13x, 14x, 22x, 23x, and 85x.

• Claims submitted on TOBs 12x, 13x, 14x, 22x, and 23x will be paid in accordance with the Clinical Laboratory Fee Schedule.

• Critical Access Hospitals (TOB 85x) will be paid based on reasonable cost.

- Maryland hospitals submitting Part B claims to fiscal intermediaries on TOBs 12x, 13x, or 85x will be paid according to the Maryland Cost Containment plan.

Nationally Non-Covered Indications

- No coverage is permitted under the MMA benefit for individuals previously diagnosed as diabetic.

- Other diabetes screening blood tests for which Medicare has not specifically indicated national coverage continue to be non-covered.

Implementation

The implementation date is January 3, 2005 and applies to services furnished on or after January 1, 2005.

Related Instructions

The official instruction issued to your carrier or intermediary can be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3637 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, contact your carrier or intermediary at their toll free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp

Updating the Common Working File (CWF) Editing for Pap Smear (Q0091) and Adding a New Low Risk Diagnosis Code (V72.31) for Pap Smear and Pelvic Examination

Related Change Request (CR) #: 3659 **Medlearn Matters Number:** MM3659
Related CR Release Date: January 21, 2005
Related CR Transmittal #: 440
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

Provider Types Affected

Physicians billing Medicare carriers and providers billing Medicare fiscal intermediaries for screening Pap smears and pelvic examinations.

Provider Action Needed

Impact to You

Medicare is modifying its claims processing edits for claims for screening Pap smears and pelvic examinations.

What You Need to Know

To ensure accurate Medicare processing of claims for these services, effective July 1, 2005, Medicare is establishing a separate edit for HCPCS code Q0091 (screening Papanicolaou (Pap) smear, obtaining, preparing and sending cervical or vaginal smear to laboratory) to prevent incorrectly paying for claims submitted outside of the frequency, one screening every two years for low risk beneficiaries and one screening every year for high risk beneficiaries. Also, Medicare will accommodate a new diagnosis code, V72.31, in Medicare system edits that are in place for Pap smear and pelvic examination for low risk beneficiaries.

What You Need to Do

Be aware of the specifics in this article to assure accurate and timely processing of your Medicare claims for screening Pap smears and pelvic examination.

Background

Medicare pays for one screening Pap smear every two years for low risk beneficiaries and one screening Pap smear every year for high risk beneficiaries.

Currently, HCPCS code Q0091 is not part of the Medicare system editing for screening Pap smear claims. Since Medicare only pays for **one screening Pap smear every two years for low risk beneficiaries,** claims billed outside of this frequency have been processed incorrectly. This has happened on those occasions when physicians perform a screening Pap smear (Q0091) that should not be covered by Medicare because the low risk patient has already received a covered screening Pap smear (Q0091) in the past 2 years but requests that the physician perform a screening Pap smear each year. Beginning for dates of service on and after July 1, 2005, these types of claims will deny appropriately. Medicare is establishing a separate edit for Q0091 to capture and reject claims submitted outside of this frequency.

In instances where unsatisfactory screening Pap smear specimens have been collected and sent to the clinical laboratory and the clinical laboratory is unable to interpret the test results, another specimen is needed. When billing for sending another specimen to the clinical laboratory, the physicians should use HCPCS code Q0091 along with modifier 76, which will bypass the frequency editing and allow payment to be made for reconveyance of the specimen.

Effective for services rendered on and after July 1, 2005, where physicians must perform a screening Pap smear that they know will not be covered by Medicare because the low risk beneficiary has already received a covered screening Pap smear in the past two years, the physicians can bill Q0091. The claim will be denied appropriately as being not reasonable and necessary. Thus, in these instances, the physician/provider should be aware that an Advance Beneficiary Notice (ABN) is necessary, since the claim will be denied. The physician/provider should use the GA modifier on the claim to indicate that an ABN has been obtained.

Finally, physicians/providers should note that a new diagnosis code V72.31 will be added to the edits in Medicare system for low risk beneficiaries. The V72.31 diagnosis code is to be used on Pap Smear and Pelvic Examination claims to indicate the beneficiary is a low risk patient, but only when a full gynecological examination is performed.

The following chart lists the diagnosis codes that Medicare recognizes for low risk or high risk patients for screening Pap smear services with V72.31 recognized as of July 1, 2005.

Low Risk Diagnosis Codes	Definitions
V76.2	Special screening for malignant neoplasms, cervix
V76.47	Special screening for malignant neoplasm, vagina
V76.49	Special screening for malignant neoplasm, other sites **NOTE**: providers use this diagnosis for women without a cervix.
V72.31	Routine gynecological examination **NOTE**: This diagnosis should only be used when the provider performs a full gynecological examination.
High Risk Diagnosis Code	
V15.89	Other

Implementation Date
The implementation date for this instruction is July 5, 2005.

Additional Information
The official instruction issued to your carrier/intermediary regarding this change may be found by going to:

http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3659 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/intermediary on their toll free number, which may be found at:

http://www.cms.hhs.gov/medlearn/tollnums.asp

Local Coverage Determination Update

The Mutual of Omaha Medicare Local Medical Review Policy (LMRP) web page has undergone several improvements. These changes were made to make the Mutual Medicare web site more user friendly and to provide valuable information to our providers and other interested parties.

As required by The Centers for Medicare & Medicaid Services (CMS) our LMRPs have been converted to Local Coverage Determination's (LCD's). Some of the existing policies have been archived. Archived LCD's are:

> “Policies that have been retired and are no longer effective, or policies that have been replaced by an updated or revised version.”

Services performed while the policy was in effect are subject to the guidelines identified in that policy.

The conversion of the existing policies from LMRP to LCD does not change the original effective dates of the policies.

With the conversion to LCDs the reasons for denial and coding sections have been removed from the policies. In some of the policies the coding comments have been added to the utilization guideline section(s). The language in the “Indications and Limitations” section remains unchanged.

Medicare contractors (Fiscal Intermediaries and Carriers) are required to place all draft and final LCD’s on the CMS web site, therefore, the format of the Mutual Medicare policies has been changed to match the CMS LCD data base format. When accessing a final or draft policy on the Mutual Medicare web site you will be linked to that policy on the CMS web site. This will prevent any inconsistencies between the policies

Because you are linking to the CMS data base you may be required to initially accept the security alert to access the CMS site.

Some of the policies were updated during the conversion process, however of the updates to the policies necessitated a new notice and comment period.

Policies with revisions not requiring a comment period are:

1. Ambulance Services	11/5/04 update of HCPCS codes with addition of A888, Q3019, Q3020, addition of information on ABN's and NEMB, addition of information related to fee schedule payment criteria. Clarification of information and addition of codes expanding coverage do not require a comment period.
2. Blepharoplasty	11/5/2004 removal of Revenue codes 45X, 70X, 75X
3. Cardiovascular Stress Testing	Removal of radiopharmaceutial code C9503-11/15/2004.
4. Cataract Surgery	11/10/2004 clarification of visual accuity documentation needs in Indications and limitations section. No notice necessary, none given.
5. MRA	10/1/2004 removal of ICD-9 codes151.0-151.9,152.0-152.9,153.0-153.9,154.0,155.0-155.2,156.0-156.9,157.0-157.9,158.0-158.9,159.0-159.9,188.0-189.9,198.0,223.0, 223.1,233.9,236.90-236.99 from the code that would support

MRA of the abdomen and addition of ICD-9 code 593.9*.
10/1/2004 addition of ICD 9 code 747.64 MRA pelvis.

6. Observation Services	11/15/04 addition of HCPCS code 99217, addition of language regarding Condition code 44 from change request 3444 in the Utilization Guidelines section. No notice required, none given. Addition of HCPCS code 99217. No notice required, none given.
7. PET Scans	11/16/2004 correction of typographical error for ICD-9 code V10.03, corrected to V10.3. Addition of information regarding coverage of PET for AD and FTD, addition of ICD-9 code 331-331.19.
8. Single Photon Emission Computed Tomography	11/15/2004 For HCPCS code 78205-78206, addition of ICD-9 codes 155.0,197.7, 211.5, 230.8, 235.3, 239.0. For HCPCS code 78803 addition of ICD-9 185.0,198.82.

You can access the new LCD page by visiting our web site at www.mutualmedicare.com and clicking on LCD. To stay informed of LCD updates, drafts, finals and CMS bulletins sign up for the electronic mail list (EML) at http://www.mutualmedicare.com/signup/index.html

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

"MIP Tip"

This tip is brought to you from our Audit and Reimbursement Department.

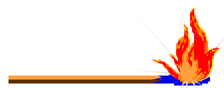
Listing Sub Units on the Form CMS 855A

When submitting the Form CMS 855A, it is helpful for applicants to explain all sub units pertaining to the enrolling entity on Section 2G of the Form CMS 855A, even though separate applications are necessary for most sub units. For example, if an acute care hospital with an inpatient rehabilitation unit, an inpatient psychiatric unit, and a swing bed unit is applying for a change of ownership, the enrolling hospital should list the other provider numbers on Section 2G of the Form CMS 855A. Hospitals do not need to complete separate applications for inpatient rehabilitation units, inpatient psychiatric units, and swing bed units. Enrolling hospitals should complete separate applications for all other sub unit types (skilled nursing units, rural health clinics, home health agencies, hospice, etc.).

During a change of ownership where the applicant is not accepting assignment of the existing provider agreement and will therefore be assigned a new provider number, the applicant should list their previous provider number in Section 2G, as well as disclosing all existing sub units and their previous numbers.

If the applicant is a new sub unit of an existing hospital, the applicant should also explain this in Section 2G and list the provider number of the hospital.

If the sub units are not listed in Section 2G (or for sub unit applications, if the main provider number and other sub units are not listed), the applicant may be contacted by the Provider Enrollment Analyst to request that this portion be completed. For questions regarding this process, please contact Carey Miller, Provider Enrollment Supervisor, at 1-866-734-9444 x 2178 or Krystal Wyatt, Lead Provider Enrollment Analyst, at 1-866-734-9444 x 6238.



Please stay tuned for more hot tips!