



March 15, 2007

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KEY

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

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

Mutual of Omaha Insurance Company
Medicare Area

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

Part C Plan Type Description Display on Medicare's Common Working File (CWF)



Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS web site.

Related Change Request (CR) #: 5349
Related CR Release Date: February 2, 2007
Related CR Transmittal #: R1175CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

MLN Matters Number: MM5349

Provider Types Affected

Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through CWF eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).

Provider Action Needed

Be aware of the expanded list of MA Plan Type Descriptions that are being displayed by Medicare's CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in Private Fee-For-Service (PFFS) plans.

A plan directory will soon be published that contains the list of all active Medicare contracts and their corresponding plan type. The directory will be posted at the following URL no later than March 1, 2007:

http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage

Background

When you query Medicare regarding a beneficiary's entitlement and eligibility, Medicare's CWF system responds with information on the Medicare managed care contract number in which a beneficiary is enrolled, including the plan type description associated with the contract. Currently, CWF largely displays the label "HMO" for these contracts. In many cases, the "HMO" label is incorrect since the list of possible plan type values has grown far larger since the creation of the Medicare Advantage program.

For example, under the MA Part C program, Medicare beneficiaries can enroll in Private Fee-for-Service (PFFS) plans. PFFS plans are very different from the more traditional MA HMO type plan.

PFFS PLANS

PFFS plans generally have no plan specific provider network. Enrollees in a PFFS plan can obtain plan covered health care services from any Medicare FFS enrolled provider in the U.S. who is willing to furnish services to a PFFS plan beneficiary. It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan.

In most cases, a PFFS enrollee will inform a provider before obtaining a service that they are enrolled in a PFFS plan. In addition, the PFFS enrollee will have an enrollment card provided by

the PFFS plan identifying them as enrollees in a PFFS plan. The card will specify a phone number and/or a web address where the provider can obtain the PFFS plan's terms and conditions of participation.

At a minimum, the terms and conditions will specify:

- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures, including
 - The amount the provider is permitted to collect from the enrollee; and
 - Whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers in the U.S. from whom its enrollees seek health care services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a web site and also make them available upon written or phoned request.

To be paid by a PFFS organization, the provider must send their bill to the address (or electronic address) provided in the PFFS plan's terms and conditions of participation.

For more detailed information on PFFS plans as they relate to providers, see the "Provider Q&A" Downloadable document on <http://www.cms.hhs.gov/PrivateFeeforServicePlans/>.

Additional Information

If you have questions regarding the plan of a specific Medicare MA enrolled patient, you may wish to contact that plan.

To view the official instruction (CR5349) issued to your Medicare FI, carrier, MAC, DMERC or RHHI, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1175CP.pdf> on the CMS website.

To review a related article that explains Medicare's Common Working File (CWF) Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5118.pdf> on the CMS website.

Infrared Therapy Devices



Do you have your NPI? National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting <http://www.cms.hhs.gov/NationalProviderStand/> on the CMS web site.

Related Change Request (CR) #: 5421

MLN Matters Number: MM5421

Related CR Release Date: February 9, 2007

Related CR Transmittal #: R1183CP and R62NCD

Effective Date: October 24, 2006

Implementation Date: January 16, 2007

Note: This article was revised on February 9, 2007, to correct the range of ICD-9 codes shown in bold print on page 2. The range is 880.00-887.7. Originally, CR5421 and the related article incorrectly showed 880.00-887.79 for that range. The CR transmittal number, release date, and Web address for accessing CR5421 are also revised, but all other information remains the same.

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME/MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs), for the use of infrared therapy devices for treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5421. Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services (CMS) has made a National Coverage Determination (NCD) stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), **is non-covered for the treatment**, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Background

The use of infrared therapy devices has been proposed for a variety of disorders, including treatment of diabetic neuropathy, other peripheral neuropathy, skin ulcers and wounds, and similar related conditions, including symptoms such as pain arising from these conditions. A wide variety of devices are currently available. Previously there was no NCD concerning the use of infrared therapy devices, leaving the decision to cover or not cover up to local Medicare contractors.

The following requirements are in effect as of October 24, 2006

- **Effective for services performed on or after October 24, 2006**, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) **are non-covered** as DME or PT/OT services when used for the treatment of

diabetic and/or non-diabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.

- Claims will be denied with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9 codes:
 - 250.60-250.63,
 - 354.4, 354.5, 354.9,
 - 355.1-355.4,
 - 355.6-355.9
 - 356.0, 356.2-356.4, 356.8-356.9,
 - 357.0-357.7,
 - 674.10, 674.12, 674.14, 674.20, 674.22, 674.24,
 - 707.00-707.07, 707.09-707.15, 707.19,
 - 870.0-879.9,
 - **880.00-887.7,**
 - 890.0-897.7, or
 - 998.31-998.32.
- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects Types of bills (TOBs) 12X, 13X, 22X, 23X, 34X, 74X, 75X and 85X.
- If you submit a claim for one of the non-covered services, your patient will receive the Medicare Summary Notice (MSN) message stating “This service was not covered by Medicare at the time you received it”. The Spanish translation is: “Este servicio no estaba cubierto por Medicare cuando usted lo recibió.”
- If you submit a claim for one of the non-covered services you will receive a remittance advice notice that reads: Claim Adjustment Reason Code 50, “These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.”
- Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospital outpatient departments should note that **you are liable** if the service is performed, unless the beneficiary signs an Advanced Beneficiary Notice (ABN).
- DME suppliers and HHA be aware that **you are liable** for the devices when they are supplied, unless the beneficiary signs an ABN.

Additional Information

If you have questions, please contact your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier at their toll-free number which may be found at: <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

For complete details regarding this Change Request (CR) please see the official instruction (CR5421) issued to your Medicare A/B MAC, FI, DME MAC, RHHI, or carrier. There are actually two transmittals associated with CR5421. The first is the national coverage determination transmittal, located at

<http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf> on the CMS website. In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1183CP.pdf> on the CMS site.

April Quarterly Update to 2007 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement



New from the Medicare Learning Network

The **Hospice Payment System Fact Sheet**, which provides general information about the Medicare hospice benefit, certification requirements, election periods, and payment rates, is now available in print format from the Medicare Learning Network. To place your order, just click on [MLN Product Ordering Page](#).

MLN Matters Number: MM5502

Related Change Request (CR) #: 5502

Related CR Release Date: February 9, 2007

Related CR Transmittal #: R1182CP

Effective Date: January 1, 2007

Implementation Date: April 2, 2007

Provider Types Affected

SNFs and other providers submitting claims to Medicare fiscal intermediaries (FIs) and Part A/B Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in SNFs.

What You Need to Know

Three Healthcare Common Procedure Coding System (HCPCS) codes (**96521**, **96522** and **96523**), that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS), were included in the January 2007 update to the carrier file, but not in the FI file. CR 5502, from which this article is taken, adds these three codes to the FI file.

Please refer to the Background section for more information.

Background

Quarterly, CMS updates the lists of HCPCS codes (for both FIs and carriers/DMERCs) that are subject to the consolidated billing (CB) provision of the SNF Prospective Payment System (PPS). This particular update, however, applies only to providers billing Medicare FIs, because

in the January 2007 update, these three codes were included in the carrier file, but were omitted from the FI file. CR 5502, from which this article is taken, adds these codes to the FI file only.

The following chemotherapy administration-related HCPCS codes are being added to Major Category III, EXCLUSIONS (Effective for claims with dates of service on or after January 1, 2007):

- **96521** – Refilling and Maintenance of Portable Pump;
- **96522** – Refilling and Maintenance of Implantable Pump or Reservoir for Drug Delivery, Systemic (e.g. intravenous, intra-arterial); and
- **96523** – Irrigation of Implanted Venous Access Device for Drug Delivery Systems.

Remember that:

- With the exception of SNFs, Medicare will not pay providers for services appearing on this list when they are included in SNF CB.
- Conversely, Medicare will pay non- SNF providers for beneficiary services excluded from SNF PPS and CB, even when in a SNF stay.
- SNF CB applies to non-therapy services only when furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.
- FIs and A/B MACs will not search their files for claims affected by this change to either retract payment for claims already paid or to retroactively pay claims, but will adjust such claims that you bring to their attention.

Additional Information

You can find the official instruction, CR5502, issued to your FI or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1182CP.pdf> on the CMS website. In addition, you can view the 2007 Annual Update file for FIs on the CMS website at http://www.cms.hhs.gov/SNFConsolidatedBilling/01a_SNFCBforFIs.asp#TopOfPage on the CMS site.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

Reporting Your National Provider Identifier (NPI) On Medicare Claims

As we work toward a smooth transition to the National Provider Identifier, we have found that many providers have obtained NPIs but are not utilizing them when submitting their claims. If you have received your NPI, we **strongly encourage** you to begin including both your legacy number (OSCAR number) and the NPI when submitting claims to Mutual of Omaha-Medicare. Submitting your claims in this manner will help in validating the NPI process during Stage 2 to determine any potential problems or issues that may occur, allow everyone time to make corrections or install fixes prior to May 23, 2007 (Stage 3), and reduce your risk of potential interrupted claim payments.

If you have not obtained your NPI by now you should do so immediately, as once you obtain your NPI it is estimated that it will take 120 days to do the remaining work to use it. This includes working on your internal billing systems, coordinating with billing services, vendors, and clearinghouses, and testing with payers. If you delay applying for your NPI, you risk your cash flow and that of your health care partners as well.

You can apply for an NPI online at: <https://nppes.cms.hhs.gov/> or can call the NPI enumerator to request a paper application at (800) 465-3203.

Information and education on the NPI can be found on the CMS Web site at the CMS NPI page: <http://www.cms.hhs.gov/NationalProvIdentStand>

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

"MIP Tip"

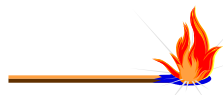
This tip is brought to you from our Claims Appeals Department.

Appeals for 54NCD Denials

Recent analysis of claim appeals data indicates that several claims are being appealed due to National Coverage Determination denials. These denials show reason codes 52NCD, 53NCD and 54NCD. Of these reason codes, 54NCD had the highest volume of appeals reversed. The Health Care Procedure Coding System (HCPCS) codes identified as most often appealed were 85610 and 85730. Our most recent 6 month trending identified that 78% of denials for these codes were reversed on appeal because documentation supported that the service was payable.

Final analysis has determined that these denials could have been prevented had all the appropriate ICD-9-CM coding been used on the claims submitted. Prior to submitting an appeal for a 54NCD denial, please review your documentation to verify that all coding to support the service has been submitted on the claim. If you identify an omission or error occurred, please submit an adjustment instead of an appeal to correct the omission or error.

Further information regarding the NCD edits can also be found in our November 15, 2006 Newsletter, "Coding Guidelines for National Coverage Determination (NCD) Edits".



Please stay tuned for more hot tips!