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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

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Claims Submission Instructions for Institutional Providers Billing Vaccine Claims in Cases Where a National Provider Identifier (NPI) Is Not Available



Attention Providers!

Sign up now to the listserv appropriate for you at <http://www.cms.hhs.gov/apps/maillinglists/>.

Get your Medicare news as it happens!

Related Change Request (CR) #: 4239

MLN Matters Number: MM4239

Related CR Release Date: September 8, 2006

Related CR Transmittal #: R1051CP

Effective Date: May 23, 2007

Implementation Date: May 23, 2007

This article was revised on May 8, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS website.

Provider Types Affected

Institutional providers submit affected claims to Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs).

Background

Regulations implementing the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require the use of National Provider Identifiers (NPIs) by covered health care providers and health plans (other than small plans), effective May 23, 2007. This article provides information about Medicare claim submissions for immunizations where the NPI of the attending physician may not be available.

Key Point

For claims received **on or after May 23, 2007**, where an NPI is not available for use in claims processing, institutions submitting vaccine roster bills to FIs or RHHIs must duplicate their own NPI in the Attending Physician NPI field on the claims.

Additional Information

Institutional Roster Billing – Institutions that provide covered vaccinations to groups of Medicare beneficiaries may use simplified roster billing procedures to submit a single claim form to Medicare, attaching a roster of all the beneficiaries vaccinated on a given day. Since the provider identifiers of the attending physicians of these beneficiaries are not available to the institution providing the immunizations, longstanding Medicare instructions require the use of the surrogate Unique Physician Identification Number (UPIN) “SLF000” in the UPIN field on the institutional claim. **For claims submitted on or after May 23, 2007, the provider’s own NPI is to be reported in the NPI field for the attending physician.**

The official instruction issued to your FI/RHHI regarding this change may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1051CP.pdf> on the CMS web site.

Please contact your local FI/RHHI if you have questions about this issue. To find their toll free phone number, go to <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS web site.

Flu Shot Reminder

September is the perfect time to start talking with your patients about getting the flu shot. Medicare provides coverage for the flu vaccine and its administration. Please encourage your Medicare patients to take advantage of this vital benefit. And don't forget – health care professionals and their staff benefit from the flu vaccine also. Protect Yourself. Protect Your Patients. Get Your Flu Shot.

Uniform Billing (UB-04) Implementation - UB-92 Replacement



Attention Physicians, Providers, and Suppliers!

Sign up now to the listserv appropriate for you at <http://www.cms.hhs.gov/apps/maillinglists/>.

Get your Medicare news as it happens!

Related Change Request (CR) #: 5072 MLN Matters Number: MM5072 Revised

Related CR Release Date: November 3, 2006

Related CR Transmittal #: R1104CP

Effective Date: March 1, 2007

Implementation Date: March 1, 2007

Note: This article was revised on May 3, 2007, to reference the NPI contingency plan, which extends the May 23, 2007, required date for NPI usage on claims. In addition, a reference to Attachment C of CR5072 was deleted. All other information remains the same.

Provider Types Affected

All providers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), using the UB-92

Provider Action Needed

The UB-04 is replacing the UB-92. You may begin using it on March 1, 2007, during an initial transitional period. Starting May 23, 2007, all of your paper claims must use the UB-04 since the UB-92 will no longer be acceptable.

What You Need to Know

CR5072 announces the replacement of the UB-92 by the UB-04, effective March 1, 2007. The UB-04, which is only accepted from institutional providers that are excluded from the mandatory

electronic claims submission requirements, incorporates the National Provider Identifier (NPI), taxonomy, and additional codes.

What You Need to Do

Make sure that your billing staffs are aware of this new uniform institutional provider bill form for paper claims.

Background

At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. Effective March 1, 2007, institutional claim filers such as hospitals, skilled nursing facilities, hospices, and others can begin using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007, during which time either the UB-92 or the UB-04 may be used.

Starting May 23, 2007, all institutional paper claims must be submitted on the UB-04. The UB-92 will no longer be acceptable, even as an adjustment claim, after May 22, 2007.

UB-04

The UB-04 is the basic form that CMS prescribes for the Medicare program. It is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

It incorporates the National Provider Identifier (NPI), taxonomy, and additional codes. (Please refer to the crosswalk file attached to CR5072 to show how data elements crosswalk from the UB-92 to the UB-04.)

Note that while most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change.

There are a few details that you should be aware of:

- The UB-04 (Form CMS-1450) is a uniform institutional provider bill suitable for billing multiple third party payers. A particular payer, therefore, may not need some of the data elements.
- When filing, you should retain the copy designated "Institution Copy" and submit the remaining copies to your FI, managed care plan, or other insurer.
- Instructions for completing inpatient and outpatient claims are the same unless otherwise noted.
- If you omit any required data, your FI will either ask you for them or obtain them from other sources and will maintain them on its history record. It will not obtain data that are not needed to process the claim.
- Data elements in the CMS uniform electronic billing specifications are consistent with the Form CMS-1450 (another name for the UB-04) data set to the extent that one

processing system can handle both. The definitions are identical, although in some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Further, the revenue coding system is the same for both the Form CMS-1450 and the electronic specifications.

- Also note that CMS is accepting valid NPIs on the UB-04 between March 1, 2007, and May 22, 2007, and the NPI is required as of May 23, 2007. **Important Note: Medicare Fee-for-Service has instituted a contingency plan for NPI implementation that delays the requirement for the NPI beyond May 23, 2007. For details regarding this delay, please see MLN Matters article MM5595 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS website.**

Additional Information

You can find more information about the UB-04 (Form CMS-1450) by going to CR5072, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1104CP.pdf> on the CMS web site.

Included with this CR are the following:

- A copy of the UB-04 form (front and back) in PDF format (Attachment E)
- The UB-92-to-UB-04 crosswalk (Attachment B)
- The revised portion of the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the CMS 1450 Data Set), Sections 70 (Uniform Bill - Form CMS-1450 (UB-04)) and 71 (General Instructions for Completion of Form CMS-1450 (UB-04)) (Attachment A). These sections contain very detailed instructions for completing the form.

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

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS web site.

Revised American National Standards Institute (ANSI) X12N 837 Institutional Health Care Claim Companion Document

MLN Matters Number: MM5334 *Revised*

Related Change Request (CR) #: 5334

Related CR Release Date: November 24, 2006

Effective Date: January 1, 2007

Related CR Transmittal #: R1116CP

Implementation Date: January 2, 2007

This article was revised on May 8, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS website.

Provider Types Affected

Providers submitting claims to Medicare Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5334 which informs your FI, RHHI, or A/B MAC that changes (including National Provider Identifier (NPI) and taxonomy code reporting information changes) are being made to the ANSI X12 837 Institutional Companion Document, which is included with CR 5334 as an attachment.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires that the Centers for Medicare & Medicaid Services (CMS), and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services.

The American National Standards Institute (ANSI) X12N 837 implementation guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. Implementation guides for each ANSI X12N transaction adopted as a HIPAA standard can be found at the following website: <http://www.wpc-edi.com>.

The ANSI X12 837 Institutional Companion Document includes a set of statements, which supplements the requirements (but does not contradict) the X12N 837 Institutional Implementation Guide, and it clarifies Medicare contractor (FI/RHHI/A/B MAC) expectations regarding data submission, processing, and adjudication.

Change Request (CR) 5334:

- Provides your FI, RHHI, or A/B MAC with changes needed to the ANSI X12 837 Institutional Companion Document as an attachment, and
- Instructs your FI, RHHI, or A/B MAC to use these changes (**which include adding a requirement to report, as of May 23, 2007, the National Provider Identifier (NPI) and taxonomy code reporting information**) to revise/update your ANSI X12 837 Institutional Companion document.

The revised/updated ANSI X12N 837 Institutional Companion Document will be available through your Medicare FI, A/B MAC, or RHHI.

Implementation

The implementation date for CR5334 is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your FI, RHHI, or A/B MAC regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1116CP.pdf> on the CMS web site.

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

Proper Use of Modifier “-59”

If you treat a Medicare Advantage enrolled beneficiary and you have questions about their Medicare Advantage Plan, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at <http://www.cms.hhs.gov/MCRAdvPartDENrolData/> on the CMS website. CMS updates this site on a monthly basis.

MLN Matters Number: SE0715
Related CR Release Date: N/A
Related CR Transmittal #: N/A

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

Provider Types Affected

Physicians and providers submitting claims to Medicare carriers, or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This special edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to clarify the proper use of modifier “-59”. The article only clarifies existing policy.

Background

Under certain circumstances, a physician may need to indicate that a procedure or service was distinct or independent from other services, and modifier “-59” may be appropriate depending on the circumstances. Modifier “-59” is used to identify procedures/services that are not normally reported together, and this include the following procedures/services that are not ordinarily encountered or performed on the same day by the same physician:

- A different
 - Session or patient encounter,
 - Procedure or surgery,
 - Site or organ system, or
- A separate
 - Incision/excision,
 - Lesion, or
 - Injury (or area of injury in extensive injuries)

When another already established modifier is appropriate, it should be used rather than modifier “-59”. Modifier “-59” is an important National Correct Coding Initiative (NCCI) associated modifier that is often used incorrectly, and it should only be used if no more descriptive modifier is available or when its use best explains the circumstances.

For the NCCI, the primary purpose of modifier “-59” is to indicate that two or more procedures are performed at different anatomic sites or during different patient encounters. It should only be used if no other modifier more appropriately describes the relationships of the two or more procedure codes.

NCCI edits define when two procedure Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes may not be reported together except under special circumstances.

If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together if the two procedures are performed at:

- Different anatomic sites, or
- Different patient encounters.

Medicare carrier and MAC Part B claim processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit.

Modifier “-59” and other NCCI-associated modifiers **should NOT be used** to bypass an NCCI edit unless the proper criteria for use of the modifier is met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.

One of the misuses of modifier “-59” is related to the portion of the definition of modifier “-59” allowing its use to describe “different procedure or surgery.” The code descriptors of the two codes of a code pair edit usually represent different procedures or surgeries. The related NCCI edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter. **The provider cannot use modifier “-59” for such an edit based on the two codes being different**

procedures/surgeries. However, if the **two procedures/surgeries are performed at separate anatomic sites** or at **separate patient encounters on the same date of service**, modifier “-59” may be appended to indicate that they are different procedures/surgeries on that date of service.

Use of modifier “-59” to indicate different procedures/surgeries does not require a different diagnosis for each HCPCS/CPT coded procedure/surgery. Additionally, different diagnoses are not adequate criteria for use of modifier “-59”. The HCPCS/CPT codes remain bundled unless the procedures/surgeries are performed at different anatomic sites or separate patient encounters.

From an NCCI perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, **it does not include treatment of contiguous structures of the same organ.** For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site. Treatment of posterior segment structures in the eye constitute a single anatomic site.

EXAMPLES OF MODIFIER “-59” USAGE

Following are some examples developed to help guide physicians and providers on the proper use of Modifier “-59”:

Example 1: Column 1 Code/Column 2 Code 11055/11720

- CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
- CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

Policy: Mutually exclusive procedures

Modifier “-59” is:

- Only appropriate if procedures are performed for lesions anatomically separate from one another or if procedures are performed at separate patient encounters.
- Don’t report CPT codes 11055-11057 for removal of hyperkeratotic skin adjacent to nails needing debridement.

Example 2: Column 1 Code/Column 2 Code 11719/11720

- CPT Code 11719 – Trimming of nondystrophic nails, any number
- CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

Policy: Mutually exclusive procedures

Modifier “-59” is only appropriate if the trimming and the debridement of the nails are performed on different nails or if the two procedures are performed at separate patient encounters

Example 3: Column 1 Code/Column 2 Code 17000/11100

- CPT Code 17000 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion
- CPT Code 11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Policy: HCPCS/CPT coding manual instruction/guideline

Modifier “-59” is only appropriate if procedures are performed on separate lesions or at separate patient encounters.

Example 4: Column 1 Code/Column 2 Code 38221/38220

- CPT code 38221 - Bone marrow; biopsy, needle or trocar
- CPT code 38220 - Bone marrow; aspiration only

Policy: Standards of medical/surgical practice

Use of “-59” modifier should be uncommon but appropriate for these circumstances:

- Different sites - contralateral iliac crests; iliac crest and sternum;
- Different incisions - same iliac crest; or
- Different encounters.

Example 5: Column 1 Code/Column 2 Code 45385/45380

- CPT Code 45385 - Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique CPT Code 45380 - Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

Policy: More extensive procedure

Modifier “-59” is only appropriate if the two procedures are performed on separate lesions or at separate patient encounters.

Example 6: Column 1 Code/Column 2 Code 47370/76942

- CPT Code 47370 – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
- CPT Code 76942 – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

Policy: HCPCS/CPT coding manual instruction/guideline

Modifier “-59” is only appropriate if the ultrasonic guidance service 76942 is performed for a procedure done unrelated to the surgical laparoscopic ablation procedure.

Example 7: Column 1 Code/Column 2 Code 93015/93040

- CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report

Policy: More extensive procedure

Modifier “-59” is only appropriate if the rhythm ECG service 93040 is performed unrelated to the cardiovascular stress test procedure at a different patient encounter.

Example 8: Column 1 Code/Column 2 Code 93529/76000

- CPT Code 93529 – Combined right heart catheterization and left heart catheterization through existing septal opening (with or without retrograde left heart catheterization)
- CPT Code 76000 – Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

Policy: Standards of medical/surgical practice

Modifier “-59” is only appropriate if the fluoroscopy service 76000 is performed for a procedure done unrelated to the cardiac catheterization procedure.

Example 9: Column 1 Code/Column 2 Code 95903/95900

- CPT Code 95903 – Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study
- CPT Code 95900 - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study

Policy: More extensive procedure

Modifier “-59” is only appropriate if the two procedures are actually performed on different nerves or in separate patient encounters.

Example 10: Column 1 Code/Column 2 Code 97140/97530

- CPT Code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Policy: Mutually exclusive procedures

Modifier “-59” is only appropriate if the two procedures are performed in distinctly different 15 minute intervals. **The two codes cannot be reported together if performed during the same 15 minute time interval.**

Example 11: Column 1 Code/Column 2 Code 98942/97112

- CPT Code 98942 – Chiropractic manipulative treatment (CMT); spinal, five regions
- CPT Code 97112 – Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

Policy: Standards of medical/surgical practice

Modifier “-59” is only appropriate if the physical therapy service 97112 is performed in a different region than the CMT and the provider is eligible to report physical therapy codes under the Medicare program.

Additional Information

If you have any questions, please contact your Medicare carrier or MAC at their toll-free number, which may be found on the CMS website at

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

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 Medicare Secondary Payer Department.

Use of Value Code 44

Value code 44 is to be used when the primary insurance payment is less than the amount of total charges and the amount of the contractual obligation. The value code 44 amount must be greater than the amount paid by the primary insurance.

Condition code 77 should be used in situations where the obligated amount is paid by the primary insurance. However, value code 44 should not be used when a contract does not exist with the primary insurance.

Please ensure that the appropriate value code is used when reporting the actual payment received from the primary insurance.



Please stay tuned for more hot tips!