

Communiqué

Part A

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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Items of Importance**IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS**

On occasion, WPS Medicare Provider Customer Service closes for brief periods so our Customer Service Representatives may participate in training sessions. We will not be closed for training during the month of January.

WPS Medicare will close for the following holidays:

Date	Holiday
March 21, 2008	Good Friday (PM Only)
May 26, 2008	Memorial Day
July 4, 2008	Independence Day
September 1, 2008	Labor Day

MEDICARE CONTRACTOR PROVIDER SATISFACTION SURVEY (MCPSS)

The Centers for Medicare & Medicaid Services (CMS) is again conducting the Medicare Contractor Provider Satisfaction Survey (MCPSS). The MCPSS represents an important opportunity for providers to be heard. Each sampled provider will receive a survey notification packet in the mail. If you received a packet and have already completed the MCPSS, thank you for your response. If you have not completed the MCPSS, we would appreciate your valuable feedback.

More information on the MCPSS is available on the following Websites:

<http://www.mcpsstudy.org>

<http://www.cms.hhs.gov/MCPSS>

If you have questions about the MCPSS and would like to speak to a study representative, please call the MCPSS Provider Helpline 1-888-863-3561. You may also contact them by e-mail at mcpss@westat.com. Thank you in advance for your participation.

2007 - 2008 Influenza (Flu) Season Resources for Health Care Professionals

The Centers for Medicare & Medicaid Services has released the following Special Edition MLN Matters article, SE0748 2007 - 2008 Influenza (Flu) Season Resources for Health Care Professionals, located at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0748.pdf>, on the CMS website.

This article provides fee-for-service Medicare providers and their staff with access to a variety of seasonal flu related educational resources that they can use during the 2007 - 2008 flu season.

Visit the Medicare Learning Network ~ it's free!

Claim Submission**2008 ANNUAL UPDATE TO THE THERAPY CODE LIST**
~ CMS MLN Matters ~

MLN Matters Number: MM5810
Related CR Release Date: November 23, 2007
Related CR Transmittal #: R1377CP

Related Change Request (CR) #: 5810
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, therapists, and providers of therapy services billing Medicare Carriers, Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for rehabilitation services

Provider Action Needed

STOP – Impact to You - One new code will be added to the therapy code list for CY 2008. Code 96125 will be used for standard cognitive performance testing per hour of a qualified health care professional's time, both face-to-face with the patient and time interpreting test results and preparing the report.

CAUTION – What You Need to Know - Code 96125 is considered “always therapy” regardless of who performs the service and will always require a therapy modifier (GN, GO, GP).

GO – What You Need to Do - Make certain your office staffs are aware of the new code.

Background

Section 1834(k)(5) of the Social Security Act requires that all claims for outpatient rehabilitation therapy services and all comprehensive outpatient rehabilitation facility services be reported using a uniform coding system. The Healthcare Common Procedure Coding System/Current Procedural Terminology, 2008 Edition (HCPCS/CPT-4) is the coding system used for the reporting of these services.

Therapy services, including “always therapy” services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 5 and the *Medicare Benefit Policy Manual*, Publication 100-2, Chapters 12 and 15. That manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information

If you have questions, please contact your Medicare Carrier, FI, RHHI, or A/B MAC at their toll-free number, which can be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip_on the CMS website.

For complete details regarding CR5810, please see the official instruction issued to your Medicare FI, RHHI, Carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/transmittals/downloads/R1377CP.pdf> on the CMS website.

**MAMMOGRAPHY: CHANGE CERTIFICATION-BASED ACTION
FROM RETURN TO PROVIDER (RTP)/RETURN AS
UNPROCESSABLE TO DENIAL**

~CMS MLN Matters~

MLN Matters Number: MM5577
Related CR Release Date: December 7, 2007
Related CR Transmittal #: R1387CP

Related Change Request (CR) #: 5577
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Providers who bill Medicare fiscal intermediaries, carriers, and Part A/B Medicare Administrative Contractors (MACs) for mammography services.

What You Need to Know

CR 5577, from which this article is taken, instructs FIs, carriers and A/B MACs to deny claims for mammography services (rather than returning them as unprocessable) if the appropriate Food and Drug Administration (FDA) certification status is not listed on the FDA-created, CMS-supplied, Mammography Quality Standard Act (MQSA) data file.

You should make sure that your billing staffs list the FDA certification status as required.

Background

Depending on which contractor you bill, FIs and A/B MACs return to provider (RTP), and carriers or A/B MACs return as unprocessable, claims for mammography services when:

- A film mammography Healthcare Common Procedure Coding System (HCPCS) code is submitted on a claim, and the facility is Food and Drug Administration (FDA)-certified for only digital mammography;
- A digital mammography HCPCS code is submitted on a claim, and the facility is FDA certified for only film mammography; or
- Either a film or digital mammography HCPCS code is submitted (*carriers/B MACs only*) on a claim and there is no FDA certification number on the claim's Mammography Quality Standard Act (MQSA) data file.

In order to ensure that the facility has a right to appeal an inappropriate denial based on the status of its FDA certification, CR 5577, from which this article is taken, instructs Medicare FIs, carriers and A/B MACs to deny all claims for screening or diagnostic mammography services (rather than return them to the provider, or return as unprocessable to the supplier), if the appropriate FDA certification status is not listed on the claim. Please note, however, that carriers/B MACs will continue to return the claim as unprocessable if the facility's FDA-assigned certification number is missing from the claim.

The MQSA requires that all facilities providing mammography services meet national quality standards, and provides the specific standards for those qualified to perform screening and diagnostic mammograms and how they should be certified.

The FDA Center for Devices and Radiological Health is responsible for collecting certificate fees and surveying mammography facilities; and effective October 1, 1994, all facilities that

provide screening and mammography services (except those in the Veterans Administration) must have an FDA-issued certificate to continue to operate.

In addition, Section 104 of the Benefits Improvement and Protection Act (BIPA) of 2000 provided new payment methodologies for both diagnostic and screening mammograms that use digital technology. Medicare pays for film mammography and digital mammography at different rates, and moreover, pays for a service only if the provider or supplier is certified by the Food and Drug Administration (FDA) to perform those types of mammograms for which payment is sought.

Medicare determines whether the mammography facility is certified to perform the mammography services billed by using data that the FDA sends to CMS on a weekly basis. This information indicates whether a mammography facility is certified to perform digital mammography.

To verify that the facility is certified by the FDA to perform mammography services, carriers/B MACs match the supplier's (i.e., independent facility) mammography certification number submitted on the claim to the 6-digit FDA-assigned certification number appearing on the file for the billing facility (in item 32 of the Form CMS-1500 for paper claims, or in the 2400 loop (REF02 segment, where 01=EW segment) of the ASC X12 837 professional claim format, version 4010A1, for electronic claims). If the facility's FDA-assigned 6-digit number is not on the claim, the carrier/B MAC will return the claim as unprocessable using remittance reason code 16 (Claim/service lacks information which is needed for adjudication.) and remark code MA128 (Missing/incomplete/invalid FDA approval number.).

Intermediaries/A MACs identify the facility using the provider number submitted on the claim and use the certification data contained on the MQSA file. In addition, both intermediaries/A MACs and carriers/B MACs look for the film indicator (designated by "1") or the digital indicator (designated by "2") on the MQSA file to verify the type of mammography (film and/or digital) that the facility is certified to perform.

Therefore, effective April 1, 2008:

- FIs/A MACs will verify that the provider number on the claim corresponds with a certified mammography facility on the MQSA file, and if it does not, they will deny the claim. In denying these claims submitted by providers not listed as certified facilities on the MQSA file, the Medicare contractor will use:
 - Medicare Summary Notice (MSN) message 16.2 (This service cannot be paid when provided in this location/facility);
 - Remittance Advice (RA) reason code B7 (This provider was not certified/eligible to be paid for this procedure/service on this date of service) and
 - RA remark code N110 (This facility is not certified for film mammography).
- Carriers/B MACs will verify that the FDA-assigned, 6 digit mammography certification number on the claim corresponds to the FDA mammography certification number appearing on the billing facility's file. They will deny the claim if:
 - The facility's certification number submitted on the claim does not match the certification number on the MQSA file;

- The facility certification number on the claim matches the facility certification number on the MQSA file, but the facility name reported on the claim does not match the facility name on the MQSA file; or
 - The facility certification number reported on the claim matches the facility certification number on the MQSA file, but the facility address reported on the claim does not match the facility address on the MQSA file.
- In denying the claim because of an invalid facility certification number, they will use MSN message 9.4 (This item or service was denied because information required to make payment is missing); and RA reason code 125 (Payment adjusted due to a submission/billing error(s).) and remark code MA128 (Missing/incomplete/ invalid FDA approval number).

Further, Medicare contractors will use the FDA certification data to verify that the billing facility is eligible to bill for the type of mammography service submitted on the claim.

They will deny the claim if the facility is not certified by the FDA to perform such service (if the HCPCS code on the claim, for either film or digital mammogram, does not match the type of certification indicated on the MQSA file).

In denying these claims because the facility is not certified by the FDA to perform either a screening or diagnostic mammography service, Medicare contractors will use:

- MSN 16.2 (This service cannot be paid when provided in this location/facility);
- RA reason code B7 (This provider was not certified/eligible to be paid for this procedure/service on this date of service), and
- Remark code N110 (This facility is not certified for film mammography).
- They will deny the claim if it contains a film mammography HCPCS code and the facility is certified for digital mammography only. In denying these claims because the facility is not certified to perform film mammography, they will use MSN message MSN 16.2. In this instance, carriers/B MACs will use RA reason code B6 (this payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty) and remark code N110 and FIs/A MACs will use reason code B7.

Similarly, Medicare contractors will deny the claim if it contains a digital mammography HCPCS code and the facility is certified for film mammography only. In denying these claims because the facility is not certified to perform digital mammography, they will again use MSN message 16.2. In this instance:

- Carriers/B MACs will use:
 - RA reason code 171 (Payment is denied when performed/billed by this type of provider in this type of facility) and
 - Remark code N92 (This facility is not certified for digital mammography).
- FIs/A MACs will use reason code B7
- Carriers/B MACs will continue to use the MQSA file to verify the facility's FDA-assigned 6-digit certification number submitted on the claim, and will return claims to the supplier as unprocessable if it does not contain the facility's certification number.

Additional Information

You can find the official instruction, CR5577, issued to your carrier, FI, or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1387CP.pdf> on the CMS website. Additionally, you can find the revised sections of the *Medicare Claims Processing Manual*, Chapter 18 (Preventive and Screening Services), Section 20.2 (HCPCS and Diagnosis Codes for Mammography Services) as an attachment to CR5577.

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

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

UPDATE TO PLACE OF SERVICE (POS) CODE SET: NEW CODE FOR TEMPORARY LODGING

~CMS MLN Matters~

MLN Matters Number: MM5777

Related CR Release Date: November 2, 2007

Related CR Transmittal #: R1366CP

Related Change Request (CR) #: 5777

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

Provider Types Affected

Providers, physicians, and suppliers who submit claims to Medicare carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services rendered to Medicare beneficiaries living in temporary lodging settings

What You Need to Know

CR 5777, from which this article is taken updates the current Centers for Medicare & Medicaid Services (CMS) place of service (POS) code set to add a new code, "16," for temporary lodging and implements the systems and local-contractor-level changes needed for Medicare to adjudicate claims with the new code.

You should make sure that your billing staffs are aware of this new POS code and also aware that (effective for claims initiated as of April 1, 2008) carriers, A/B MACs, and DME MACs will pay for covered services that are payable in the temporary lodging setting (POS code 16) at the non-facility rate.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not the date of service. Therefore, you may begin using this code, if appropriate, on claims initiated on or after April 1, 2008, regardless of date of service.

Background

Medicare, as a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, must comply (by regulation) with the statute's standards and their implementation guides. The implementation guide currently adopted for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the CMS POS code set.

One requirement of this standard's implementation guide is that each professional claim contain a valid POS code from the POS code set maintained by CMS. Under HIPAA, as a payer, Medicare complies with this requirement by itself requiring a valid POS code on each 837 professional claim it receives. Similarly, when processing professional claims, Medicare must recognize as valid all valid codes from the POS code set. In addition, although not required by HIPAA, Medicare also requires a valid POS code on professional claims submitted on paper (the CMS 1500 form).

The POS code set provides setting information necessary to pay appropriately both Medicare and Medicaid claims. Historically, Medicaid has had a greater need for POS specificity than Medicare, and many of the new codes developed over the past few years have been to meet Medicaid's needs. While Medicare does not always need this greater specificity in order to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

Effective for claims initiated on or after April 1, 2008, CMS is adding to the POS code set a new code for temporary lodging, "16," and Medicare is preparing its systems to accept and adjudicate professional claims with this code when it is in effect. Under HIPAA, the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Additional Information

You can find the official instruction, CR5777, issued to your carrier, A/B MAC, or DME MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1366CP.pdf> on the CMS website.

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

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

Skilled Nursing Facility Prospective Payment System Fact Sheet

The Skilled Nursing Facility Prospective Payment System Fact Sheet (October 2007), which provides the elements of the Skilled Nursing Facility Prospective Payment System, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network.

To place your order, visit <http://www.cms.hhs.gov/mlngeninfo/> scroll down to "Related Links Inside CMS" and select "MLN Product Ordering Page." If the URL above does not take you directly to the MLN product ordering page, please copy and paste the URL in your web browser.

Coverage – General**ADDITION TO MEDICARE TELEHEALTH SERVICES**

~CMS MLN Matters~

MLN Matters Number: MM5628
Related CR Release Date: June 29, 2007
Related CR Transmittal #: R1277CP and R74BP

Related Change Request (CR) #: 5628
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, practitioners and providers submitting claims to Medicare carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for telehealth services provided to Medicare beneficiaries

Provider Action Needed**STOP – Impact to You**

This article is based on Change Request (CR) 5628 which adds the neurobehavioral status exam (as represented by HCPCS code 96116) to the list of Medicare telehealth services.

CAUTION – What You Need to Know

Effective January 1, 2008, the telehealth modifiers “GT” (via interactive audio and video telecommunications system) and modifier “GQ” (via asynchronous telecommunications system) are valid when billed with HCPCS code 96116.

GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) announced in CR 5628 that the neurobehavioral status exam (Healthcare Common Procedure Coding System (HCPCS) code 96116) has been added to the list of Medicare telehealth services (see the final rule for the calendar year (CY) 2008 physician fee schedule (CMS-1385-FC)). Previously, CMS determined that, if the eligibility criteria, and conditions of payment are satisfied, the use of a telecommunications system may substitute for a face-to-face, “hands on” encounter for consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end stage renal disease related services, and individual medical nutrition therapy. CR5628 added neurobehavioral status exam to the list of telehealth services (bolded). Medicare telehealth services are listed below.

- Consultations (CPT codes 99241 - 99275) - Effective October 1, 2001 – December 31, 2005;
- Consultations (CPT codes 99241 - 99255) - Effective January 1, 2006;
- Office or other outpatient visits (CPT codes 99201 - 99215);
- Individual psychotherapy (CPT codes 90804 - 90809);
- Pharmacologic management (CPT code 90862);
- Psychiatric diagnostic interview examination (CPT code 90801) – Effective March 1, 2003;

- End Stage Renal Disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) – Effective January 1, 2005;
- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803) (Effective January 1, 2006); and
- **Neurobehavioral status exam (HCPCS code 96116) (Effective January 1, 2008).**

In addition, effective January 1, 2008, the following modifiers are valid when billed with HCPCS code 96116:

Modifier	Descriptor
GT	Via interactive audio and video telecommunications system
GQ	Via asynchronous telecommunications system

The expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, or payment or billing methodology applicable to Medicare telehealth services as set forth in the Medicare Benefit Policy Manual (Publication 100-02, Chapter 15, Section 270) and the Medicare Claims Processing Manual (Publication 100-04, Chapter 12, Section 190).

For example, originating sites must be located in either a non- Metropolitan Statistical Area (non-MSA) county or rural Health Professional Shortage Area (HPSA) and must be one of the following:

- Physician's or practitioner's office,
- Hospital,
- Critical access hospital (CAH),
- Rural health clinic, or
- Federally qualified health center.

Also, an interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary, and as a condition of payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used.

Effective January 1, 2008, CR 5628 instructs that:

- Your local part B Carriers and or A/B MACs will pay for HCPCS code 96116 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier, and
- Your local FIs and or A/B MACs will pay for HCPCS code 96116 when submitted with a GT or GQ modifier, by CAHs that have elected Method II payment on Type of Bill (TOB) 85x.

Additional Information

To view the official instructions issued to your carrier, FI, or A/B MAC, see the two transmittals for CR5628 at

<http://www.cms.hhs.gov/Transmittals/downloads/R1277CP.pdf> and

<http://www.cms.hhs.gov/transmittals/downloads/R74BP.pdf> on the CMS website.

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

PULMONARY REHABILITATION SERVICES

~CMS MLN Matters~

MLN Matters Number: MM5834
Related CR Release Date: December 5, 2007
Related CR Transmittal #: R78NCD

Related Change Request (CR) #: 5834
Effective Date: September 25, 2007
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal Intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and DME Medicare Administrative Contractors (DME MACs)) for pulmonary rehabilitation services to Medicare beneficiaries.

Impact on Providers

The Centers for Medicare & Medicaid Services (CMS) issued CR 5834 detailing the decision regarding a national coverage determination (NCD) for Pulmonary Rehabilitation Services.

- Effective with dates of service on and after September 25, 2007, Medicare contractors will continue to process claims for pulmonary rehabilitation services using their local coverage determination (LCD) process or case-by-case adjudication.
- No changes to process or policy are made with CR5834.

Background

Currently, CMS does not cover pulmonary rehabilitation as a single entity. However, there is a limited benefit for some pulmonary rehabilitation services provided in a comprehensive outpatient rehabilitation facility (CORF). Also, certain components of pulmonary rehabilitation may fall under other existing benefit categories and may be provided independently outside of a CORF. On November 15, 2006, CMS received a request for a national coverage determination that would address components of pulmonary rehabilitation services in the hospital outpatient, physician office, and CORF settings. CR5834 communicates the findings resulting from that request. To see the complete analysis, visit http://www.cms.hhs.gov/mcd/viewnca.asp?where=index&nca_id=199 on the CMS website.

Additional Information

You may see the official instruction (CR5834) issued to your Medicare Carrier, A/B MAC, FI, DME MAC or RHHI by going to <http://www.cms.hhs.gov/Transmittals/downloads/R78NCD.pdf> on the CMS website. The actual revision to the National Coverage Determination manual containing this NCD is attached to CR5834.

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

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

Medicare Diabetes Coverage

American Diabetes Month is just about over, but the importance of talking with your Medicare patients about the seriousness of diabetes, their risk factors for the disease, and the importance of early detection and treatment remains, as millions of people in the United States are living with diabetes and don't know it. Together, we can make a difference in the lives of people with Medicare by encouraging eligible beneficiaries to take advantage of the diabetes screening services covered by Medicare. And we can help those already diagnosed with diabetes manage their condition by recommending diabetes self-management training and medical nutrition therapy services, also covered by Medicare.

To Learn More

Health care providers and their staff can learn more about Medicare's coverage of diabetes screening tests, supplies and other services for beneficiaries with diabetes, including coding, billing, and reimbursement details, by referring to the following provider education resources:

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals

http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf

Diabetes-Related Services brochure

<http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvc.pdf>

National Diabetes Education Program (NDEP)

<http://ndep.nih.gov/>

Educational literature for beneficiaries

<http://www.medicare.gov>

Thank you for helping CMS spread the word about the importance of diabetes education and the benefits covered by Medicare for the early detection and treatment of diabetes.

Coverage – Policies

INFORMATION ON WEBSITE

WPS Medicare publishes Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs), as well as and retired LCDs/Local Medical Review Policies (LMRPs) for Medicare Part A on its Website:

- **Legacy:** http://www.wpsmedicare.com/part_a/policy/index.shtml
- **MAC:** On December 15, 2007, consolidated LCDs were posted to our Website for the 45-day notice period. On day 46, these J5 MAC LCDs will be in posted as Final LCDs and will become effective. You should continue to use Blue Cross Blue Shield of Nebraska’s LCDs until the J5 LCDs become Final. This will be approximately February 1, 2008.

If you cannot gain access to the Internet from your office or home, you might try one of the many public libraries that offer Internet access. You may request a hard copy of a retired LCD/LMRP by writing to:

Legacy	MAC
WPS Medicare Medicare Medical Review Attn: Kelly Goetz, Medical Review Supervisor P.O. Box 1602 Omaha, NE 68101	WPS Medicare Part A P.O. Box 8799 Madison, WI 53708-8799

Medicare Preventive Services Series

The Centers for Medicare & Medicaid Services (CMS) has updated the following web-based (WBT) training course: **Medicare Preventive Services Series: Part 3 Expanded Benefits.**

This web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for the following services: the initial preventive physical exam (also known as, the "Welcome to Medicare" physical exam), diabetes screenings, diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as colorectal, prostate, and glaucoma screenings, and bone mass measurements. Note: CMS has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. Participants who successfully complete this course may receive .2 IACET CEU. To register, free of charge for

this course, please visit,

http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5
on the CMS website .

Visit the Medicare Learning Network ~ it's free!

Medicare Administrative Contractor (MAC)**MAC JURISDICTION 5 LOCAL COVERAGE DECISIONS (LCDS)**

The MAC Jurisdiction Part A and B LCDs are now posted to our Website at http://www.wpsmedicare.com/mac/policy/mac_lcds.shtml. Please send any feedback on these to the following e-mail address: j5policycomments@wpsic.com

All correspondence will be reviewed and taken under consideration by our Medical Policy staff.

"The ABCs of Providing the Initial Preventive Physical Examination" Quick Reference Chart

The ABCs of Providing the Initial Preventive Physical Examination quick reference chart is now available in hardcopy - This two-sided laminated chart 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). This chart identifies the components and elements of the IPPE, and provides eligibility requirements, procedure codes to use when filing claims, FAQs, suggestions for preparing patients for the IPPE, and lists references for additional information.

To order, free of charge, go to the MLN Product Ordering page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5

To download and view, go to http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf on the CMS website.

General Information**QUARTERLY PROVIDER UPDATE**

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare, including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at:
<http://www.cms.hhs.gov/QuarterlyProviderUpdates/>

We encourage you to bookmark this Website and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update Listserv (electronic mailing list) at:
<http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1>

UPDATE TO REQUIREMENT TO SUBMIT NATIONAL PROVIDER IDENTIFIER (NPI) NOTIFICATION
~CMS MLN Matters~

MLN Matters Number: MM5795
Related CR Release Date: November 2, 2008
Related CR Transmittal #: R227PI

Related Change Request (CR) #: 5795
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier, (hereinafter collectively referred to as "providers") who bill Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs) and Regional Home Health Intermediaries (RHHIs)) for claims for services provided to Medicare beneficiaries

What Providers Need to Know

Providers, except DMEPOS suppliers, are no longer required to submit to the Medicare contractor a copy of the NPI notification received from the National Plan and Provider Enumeration System (NPPES), unless requested to do so by the contractor. Similarly, if the provider, except DMEPOS supplier, obtained the NPI via the Electronic File Interchange (EFI) mechanism, the provider need not submit a copy of the notification received from the

EFI Organization (EFIO), unless requested to do so by the contractor. If paper documentation of a provider's NPI is requested by the contractor, the contractor may accept a copy of the provider's NPI Registry's Details Page in lieu of a copy of the NPI notification.

Additional Information

If you have questions, please contact your Medicare A/B MAC, FI, 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.

You may see the official instruction (CR5795) issued to your Medicare A/B MAC, FI, RHHI, or carrier by going to **<http://www.cms.hhs.gov/Transmittals/downloads/R227PI.pdf>** on the CMS website.

Medicare Provides Coverage for Many Preventive Services and Screenings

The Centers for Medicare & Medicaid Services has released the following Special Edition MLN Matters article, SE0752 ***Medicare Provides Coverage for Many Preventive Services and Screenings***, located at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0752.pdf>
on the CMS Website.

This article serves as a reminder of the many preventive services and screenings now covered by Medicare and provides a list of related provider educational resources developed by the Centers for Medicare & Medicaid Services (CMS) to inform FFS health care professionals and their staff about the preventive services and screenings now covered by Medicare.

Provider Education**EDUCATION SCHEDULE**

Reminder: The intention of our seminars and teleconferences is to educate all attending providers on the topics outlined in the course descriptions, in the handouts, and in the handbooks. Please note that your specific coding questions are best handled by coding professionals. WPS Medicare Policy, Medical Review, and Provider Outreach & Education staff are not professional coders.

LEGACY EVENTS**SEMINARS****On-line Educational Seminar Registration**

A fair and reasonable cost will be charged for education seminars. Costs will be based on the charges incurred per event; therefore, costs may vary per seminar. Payment must be received by the date indicated in the registration in order to receive confirmed seating. Please use the Payment Form for the specific seminar to submit payment to our office. Once payment is received, a confirmation will be sent via e-mail to the address given in the registration. There will be no admission without a confirmation notification.

Due to contractual arrangements with meeting facilities, we must be notified of cancellations no later than twenty-one (21) days prior to the scheduled event. No refunds will be issued for cancellations received after this date. To request a cancellation, or for questions about a seminar, please contact the field office sponsoring the educational event.

Thank you for not videotaping the educational activity.

WEST SCHEDULE**Skilled Nursing Facility Billing Seminar**

Date: February 19, 2008

Registration: 8:30 A.M. - 9:00 A.M.

Seminar: 9:00 A.M. - 4:00 P.M.

Phone: (402) 351-3975

Cost per attendee: \$54.00 (includes lunch)

A completed payment form and payment must be received by 02/05/2008 in order to receive confirmed seating. The payment form is available at

http://www.wpsmedicare.com/part_a/education/snf_seminar_regform.pdf

SEATING IS LIMITED TO THE FIRST 75 PARTICIPANTS.

Knott's Berry Farm Resort and Hotel

7675 Crescent Ave.

Buena Park, CA 90620

(714) 995-1111

Agenda Topics:

- SNF PPS Consolidated Billing

- SNF Benefits Exhaust & No-Pay Billing
- Billing and Coding; Claims Examples
- SNF Part B & Other Billing Issues

For questions about a seminar, please phone the sponsoring Field Office listed for each event. Please check our on-line Education Schedule

(http://www.wpsmedicare.com/part_a/education/seminars.shtml) regularly or sign up for the Medicare e-News to receive up-to-date information about new educational events.

TELECONFERENCES

"Ask-the-Contractor" Skilled Nursing Facility Consolidated Billing (CB) Open Forum Discussion

January 23, 2008

Teleconference times:

8:00 a.m. - 9:30 a.m. Pacific Time

9:00 a.m. - 10:30 a.m. Mountain Time

10:00 a.m. - 11:30 a.m. Central Time

11:00 a.m. - 12:30 p.m. Eastern Time

Dial-In Number and Confirmation Number will be provided via e-mail two (2) days prior to the teleconference.

Agenda Topics:

- Open discussion relating to CB Issues
- This teleconference is intended for skilled nursing facility and hospital billing and coding staff.

MAC EVENTS

TELECONFERENCES

Electronic Data Interchange (EDI) Ask the Contractor Teleconference (ACT)

WPS Medicare will host an "Ask the Contractor Teleconference" (ACT) to respond to your Electronic Data Interchange (EDI) questions regarding your implementation.

We especially encourage the Kansas Part A & Part B, Western Missouri Part B and Nebraska Part B providers leaving Wheatland on March 1, 2008 to attend. WPS Medicare is hosting EDI ACTs for other J5 implementation segments.

Please Note: No Registration is Necessary

Iowa Part B Implementation

EDI Teleconference

Wednesday, January 9, 2008

Time: 1:00 - 2:30 pm (CST)

Toll-free phone number: 877-290-9695 (US & Canada)

Conference ID/Password: 24672173

Nebraska Part A J5 MAC Providers Formerly Serviced by BCBS of Nebraska

WPS Medicare will host an "Ask the Contractor Teleconference" (ACT) for Nebraska Part A J5 MAC providers formerly serviced by BCBS of Nebraska. Agenda topics for this ACT include:

- Current WPS Part A Medical Review edits
- ADR messages/documentation requirements
- How to submit documentation for review
- When WPS edits will be in effect

Nebraska Part A J5 MAC Providers Formerly Serviced by BCBS of Nebraska

Tuesday, January 15, 2008

Chairperson: Mary Sue Gardner, RN

Times: Please click on your time zone below to register for this call

11:00 a.m.-12:30 p.m. Pacific Time

12:00 p.m.-1:30 p.m. Mountain Time

1:00 p.m.-2:30 p.m. Central Time

2:00 p.m.-3:30 p.m. Eastern Time

We will provide the Dial-In and Confirmation numbers via e-mail two (2) days prior to the teleconference.

Jurisdiction 5 Implementation**Iowa Part B Implementation**

WPS Medicare will host "Ask the Contractor Teleconferences" (ACT) regarding the implementation of Jurisdiction 5 (J5) workload and operations. These one and one-half hour ACTs will begin at 9:00 am, Central Standard Time.

We will model the calls much in the same way the Centers for Medicare & Medicaid Services (CMS) conducts their valuable Open Door Forums. This format promotes a forum that is less structured, and encourages providers and billing staff to ask questions that pertain to the implementation of J5 operations and workload to WPS Medicare. We look forward to your participation in these calls!

WPS Medicare will schedule future ACTs for other segments of J5 in the upcoming weeks and months. We will advertise these calls on this portion of the Website. WPS Medicare encourages all stakeholders to participate in these important educational activities. We will publish a recording of each teleconference on this Website after the event.

Please Note: No Registration is Necessary

Iowa Part B Implementation

Thursday, January 17, 2008

Time: 9:00 -10:30am (CST)

Toll-free phone number: 877-290-9695 (US and Canada)

Conference ID/Password: 22437789

Reimbursement**FEE SCHEDULE UPDATE FOR 2008 FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES**
~CMS MLN Matters~

MLN Matters Number: MM5803
Related CR Release Date: December 7, 2007
Related CR Transmittal #: R1388CP

Related Change Request (CR) #: 5803
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 5803, which provides the annual update to the 2008 DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure your billing staff are aware of these changes.

Background

This recurring update notification, CR5803, provides specific instructions regarding the 2008 annual update for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained at 42 CFR 414.102.

The update process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 60; <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>) on the Centers for Medicare & Medicaid Services (CMS) website. Other information on the fee schedule, including access to the DMEPOS fee schedules is at http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp on the CMS website.

Key Points

- The following codes are being **deleted** from the HCPCS effective January 1, 2008, and are therefore being removed from the DMEPOS and PEN fee schedule files:

B4086	L3800	L3850	L3926	L3946
E2618	L3805	L3855	L3928	L3948
K0553	L3810	L3860	L3930	L3950
K0554	L3815	L3907	L3932	L3952
K0555	L3820	L3910	L3934	L3954
L0960	L3825	L3916	L3936	L3985
L1855	L3830	L3918	L3938	L3986
L1858	L3835	L3820	L3940	
L1870	L3840	L3922	L3942	
L1880	L3845	L3924	L3944	

- The payment category for code K0730 is revised to move the controlled dose inhalation drug delivery system from the DME payment category for capped rental items to the DME payment category for inexpensive and routinely purchased items, effective January 1, 2008. The total payment for inexpensive and/or routinely purchased items may not exceed the fee schedule amount for purchase of the equipment. In the case of controlled dose inhalation drug delivery systems furnished on a purchase basis on or after January 1, 2008, the allowed payment amount will be reduced by the total rental payments previously made for the item.
- The fee schedule amounts established for HCPCS codes K0553, K0554 and K0555 will directly crosswalk to new HCPCS codes A7027, A7028 and A7029, respectively.
- As of the July 2007 HCPCS Quarterly Update, the following composite dressing HCPCS codes are non-covered by Medicare, effective July 1, 2007: A6200, A6201 and A6202. To reflect this change, the fee schedule amounts for codes A6200, A6201 and A6202 will be removed from the fee schedule file as part of this update. Medicare Contractors will deny claims for A6200, A6201 and A6202 with dates of service July 1, 2007 through December 31, 2007.
- CMS will establish fee schedule amounts for the following HCPCS codes : B4087, B4088, E2312, E2312KC, E2373, E2313, L1846, L3808, L3923, L3764, L3763, L3925, L3929, and L3931. These fee schedule amounts will be added to the fee schedule file on January 1, 2008, and are effective for claims with dates of service on or after January 1, 2008. The existing fee schedule amounts for HCPCS code E2373 will become the full replacement E2373 KC fees, effective January 1, 2008.
- Suppliers are to submit the KC modifier when billing for the full replacement of HCPCS power wheelchair interface codes E2373 and E2312.
- Note that HCPCS codes E0328 and E0329 are rarely appropriate for Medicare billings, payment for pediatric beds represented by these codes will be based on individual Medicare contractor consideration.
- As part of this update, CMS is implementing the 2008 national monthly payment rates for stationary oxygen equipment, (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2008. CMS is revising the fee schedule file to include the new 2008 monthly payment rate of \$199.28 for stationary oxygen equipment. As required by statute, these payment rates are adjusted annually to

assure budget neutrality on the addition of the new oxygen generating portable equipment class. Accordingly, a reduction to the national monthly payment amount for stationary oxygen equipment for 2008 that is necessary to offset payments under the new class will be slightly lower (\$0.56) (from \$199.84 to \$199.28) than previously announced.

- As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.
- The following are the new HCPCS codes, effective January 1, 2008:

A4252	A9276	E0329	L3925	L7614
A5083	A9277	E0856	L3927	L7621
A6413	A9278	E2227	L3929	L7622
A7027	A9283	E2228	L3931	V2787
A7028	B4087	E2312	L7611	
A7029	B4088	E2313	L7612	
A9274	E0328	E2397	L7613	

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.

You may see the official instruction (CR5803) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going to
<http://www.cms.hhs.gov/Transmittals/downloads/R1388CP.pdf> on the CMS website.

FISCAL YEAR (FY) 2008 INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS), LONG TERM CARE HOSPITAL (LTCH) PPS, AND INPATIENT PSYCHIATRIC FACILITY (IPF) PPS CHANGES
 ~CMS MLN Matters~

MLN Matters Number: MM5748
Related CR Release Date: November 7, 2007

Related Change Request (CR) #: 5748
Effective Date: Discharges on or after October 1, 2007
Implementation Date: October 18, 2007

Related CR Transmittal #: R1374CP

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries And paid under the IPPS, the LTCH PPS, or the IPF PPS.

Provider Action Needed

This article is based on Change Request (CR) 5748, which announces changes to the IPPS and LTCH PPS payment policies based on the FY 08 IPPS Final Rule. It also includes the ICD-9-CM coding changes that affect the IPF PPS comorbidity adjustment. The FY 08 IPPS Final Rule also established a new diagnosis-related group (DRG) system, the Medicare Severity DRGs, or MS-DRGs, effective October 1, 2007. Be sure billing staff are aware of the changes.

Background

The Centers for Medicare & Medicaid Services (CMS) annually updates the Inpatient Prospective Payment System (IPPS), and CR5748 announces changes for the IPPS hospitals for Fiscal Year (FY) 2008. The policy changes for FY 2008 appeared in the Federal Register on August 22, 2007

(http://www.access.gpo.gov/su_docs/fedreg/a070822c.html) and the final IPPS rates are available on the CMS website. All items covered in CR5748 are effective for hospital discharges occurring on or after October 1, 2007, unless otherwise noted.

The FY 08 IPPS Final rule established a new DRG system, the MS-DRGs, effective October 1, 2007. By better taking into account severity of illness in Medicare payment rates, the MS-DRGs encourage hospitals to improve their coding and documentation of patient diagnoses. To assure that improvements in coding and documentation do not lead to an increase in the aggregate payments without corresponding growth in actual patient severity, the final rule established a documentation and coding adjustment of -1.2 percent for FY 2008. However, Section 7 of the "TMA, Abstinence Education, and QI Programs Extension Act of 2007" limits that adjustment to -0.6 percent for discharges occurring in FY 2008. This -0.6 percent adjustment is not being applied to the hospital-specific rates in the Pricer. This is consistent with the policy established in the IPPS notice issued on November 1, 2007.

CR 5748 also addresses new GROUPER and diagnosis-related group (DRG) changes that are effective October 1, 2007 for hospitals paid under the IPPS, as well as under Long Term Care Hospital (LTCH) PPS. LTCH PPS rate changes occurred on July 1, 2007. (Please refer to CR 5652 (Transmittal 1268, published on June 15, 2007 at <http://www.cms.hhs.gov/transmittals/downloads/R1268CP.pdf> or its corresponding MLN Matters articles MM5652 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5652.pdf> on the CMS website for LTCH policy changes).

The Inpatient Psychiatric Facility (IPF) PPS is affected only by the ICD-9-CM changes that affect the comorbidity adjustment effective October 1, 2007. Rate changes occurred on July 1, 2007. Please refer to CR 5619 (Transmittal 1256, published on May 25, 2007 at <http://www.cms.hhs.gov/transmittals/downloads/R1256CP.pdf> or its corresponding MLN Matters article MM5619 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5619.pdf> on the CMS website) for IPF PPS policy changes.

ICD-9-CM coding changes are effective October 1, 2007. The new ICD-9-CM codes are listed, along with their DRG classifications in Tables 6A and 6B of the August 22, 2007, Federal Register, and the ICD-9-CM codes that have been replaced by expanded codes or other codes, or have been deleted are included in Tables 6C and 6D. You can also find the revised code titles in Tables 6E and 6F. See the August 22, 2007 Federal Register (Pages

47129-48175) at <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-3820.htm> on the Internet.

A new DRG Grouper, Version 25, software package is effective for discharges on or after October 1, 2007. GROUPER 25.0 assigns each case into a DRG on the basis of the diagnosis and procedure codes and demographic information (that is age, sex, and discharge status) and is effective with discharges occurring on or after October 1, 2007. The Medicare Code Editor (MCE) 24.0 uses the new ICD-9-CM codes to validate coding for discharges on or after October 1, 2007. Key changes in CR5748 are as follows:

A. Furnished Software Changes

The following software programs were issued for FY 2008:

IPPS PRICER 08.0

The IPPS Pricer, version 08.0, will be used for discharges occurring on or after October 1, 2007. The IPPS Pricer 08.0 also processes bills with discharge dates on or after October 1, 2002.

Rates

Standardized Amount Update Factor	1.033 1.013 (for hospitals that do not submit quality data)
Hospital Specific Update Factor	1.033 1.013 (for hospitals that do not submit quality data)
Common Fixed Loss Cost Outlier Threshold	\$22,185.00
Federal Capital Rate	\$426.14
Puerto Rico Capital Rate	\$201.67
Outlier Offset-Operating National	0.948983
Outlier Offset-Operating Puerto Rico	0.964060
Indirect medical education (IME) Formula	1.35*[(1 + resident-to-bed ratio)**.405-1]
MDH/SCH Budget Neutrality Factor	0.995743

Operating Rates:

Rates With Full Market Basket & Wage Index Greater than 1

	Labor Share	Non-Labor Share
National	3478.45	1512.15
Puerto Rico/ National	3478.45	1512.15
Puerto Rico Specific	1462.27	896.23

Rates With Full Market Basket & Wage Index Less Than 1

	Labor Share	Non-Labor Share
National	3094.17	1896.43
Puerto Rico/ National	3094.17	1896.43

Puerto Rico Specific	1384.44	974.06
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Rates With Reduced Market Basket & Wage Index Greater Than 1

	Labor Share	Non-Labor Share
National	3411.10	1482.87

Rates With Reduced Market Basket & Wage Index Less Than 1

	Labor Share	Non-Labor Share
National	3034.26	1859.71

Cost-of-Living Adjustment Factors - Alaska and Hawaii Hospitals:

Area	Cost of Living Adjustment Factor
Alaska:	
City of Anchorage and 80-kilometer (50-mile) radius by road	1.24
City of Fairbanks and 80-kilometer (50-mile) radius by road	1.24
City of Juneau and 80-kilometer (50-mile) radius by road	1.24
Rest of Alaska	1.25
Hawaii:	
City and County of Honolulu	1.25
County of Hawaii	1.17
County of Kauai	1.25
County of Maui and County of Kalawao	1.25

Postacute Care Transfer Policy

The Diagnosis Related Groups (DRGs) determined in the post acute care transfer policy have been modified due to Medicare Severity Diagnosis Related Groups (MS-DRGs). See Section B (Grouper 25.0) below regarding MS-DRGs.

The special pay DRGs are paid at 50% of the appropriate PPS rate for the first day of the stay and 50% of the amount calculated for the rest of the stay. These special pay DRGs are as follows:

028	029	030	040	041
042	219	220	221	477
478	479	480	481	482
492	493	494	500	501
502	515	516	517	956

Note: See attachment A of CR5748 for list of the postacute care transfer DRGs.

New Technology Add-On Payment

Effective for discharges on or after October 1, 2007, there will be no continuing add-on payments from last year and no new ones starting for this year.

Burn DRGs

Burn DRGs receive 90 percent of costs exceeding the outlier threshold instead of the 80 percent that other DRGs receive. The Burn DRGs for FY08 are 927, 928, 929, 933, 934 and 935. These have been updated for MS-DRGs.

B. GROUPER 25.0

For discharges occurring on or after October 1, 2007,, PRICER calls the appropriate GROUPER based on discharge date. This version of Grouper will include logic to group to MS-DRGS. Grouper will have increased field lengths for the diagnosis and procedure codes and dates and fields for the Present on Admission (POA) indicator. The Medicare Severity DRGs or MS-DRGs are modifications of the CMS-DRGs to better account for severity of illness and resource consumption for Medicare patients. The MS-DRGs increase the number of DRGs by 207 to a total of 745, while maintaining the reasonable patient volume in each DRG. There are three levels of severity in the MS-DRGs based on the secondary diagnosis codes: MCC (Major Complication/Comorbidity), CC (Complication/Comorbidity), and non-CC. Diagnosis codes classified as MCCs reflect the highest level of severity. The next level of severity includes diagnosis codes classified as CCs. The lowest level is for non-CCs. Non-CCs are diagnosis codes that do not significantly affect severity of illness and resource use. Therefore, secondary diagnoses that are non-CCs do not affect the DRG assignment under either the CMS DRGs or the MS-DRGs.

C. Medicare Code Editor (MCE) 24.0

For discharges occurring on or after October 1, 2007, the MCE selects the proper internal tables based on discharge date. Effective October 1, 2007, MCE will have increased field lengths for diagnosis and procedure codes, fields for the POA indicator, other new edits and retroactivity.

D. Provider Specific Information

Tables 8A and 8B of Section VI of the addendum to the PPS final rule contain the FY 2008 Statewide average operating and capital cost-to-charge ratios, respectively, for urban and rural hospitals for calculation of cost outlier payments when the FI is unable to compute a reasonable hospital-specific cost-to-charge ratio (CCR). The operating CCR ceiling is 1.238 and the capital ceiling is 0.152. See the August 22, 2007 Federal Register (Pages 47129-48175) at

<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-3820.htm> on the Internet.

Core-Based Statistical Area (CBSA) Designations

Attachment B of CR5748 shows the IPPS providers that will be receiving a "special" wage index for FY 2008 (i.e., receives an out-commuting adjustment under section 505 of the Medicare Modernization Act (MMA)).

For any provider with a Special Wage Index from FY 2007, Fiscal Intermediaries (FIs) shall remove that special wage index, unless they receive a new special wage index as listed in Attachment B of CR5748.

Micropolitan areas are "rural" areas, but hospitals in these areas were given an urban area wage index for 3 years (known as the hold harmless provision. This provision expired on September 30, 2007 and these hospitals now receive 100 percent of their wage index based upon the CBSA configurations.

Low Volume Hospitals

Hospitals considered low volume will receive a 25% bonus to the operating final payment. To be considered “low volume” the hospital must have fewer than 200 discharges and be located at least 25 road miles from another hospital. The discharges are determined from the latest cost report. Hospitals shall notify FIs if they believe they are a low volume hospital.

The Low Volume hospital status should be re-determined at the start of the federal fiscal year. The most recent filing of a provider cost report can be used to make the determination. If the hospital is no longer low volume, the 'Y' indicator should be removed. If the hospital does meet the low volume criteria, a 'Y' should be inserted into the low volume indicator field.

Hospital Quality Initiative

The hospitals that will receive the quality initiative bonus are listed at <http://www.qualitynet.org> on the Internet. Attachment C of CR5748 includes the list of providers that did not meet the criteria for FY 08. Should a provider later be determined to have met the criteria after publication of this list, they will be added to the website and FIs must update the provider file as needed.

For new hospitals, FIs will provide information to the appropriate Quality Improvement Organization (QIO) as soon as possible so that the QIO can follow through with ensuring provider participation with the requirements for quality data reporting. This allows the QIOs the opportunity to contact new facilities earlier in the fiscal year to inform them of the Hospital Quality Initiative.

E. Other Changes**Capital PPS Adjustment for Hospitals Located in Large Urban Areas**

In the FY 2008 final rule, the capital PPS 3.0 percent “large urban add-on” was eliminated effective for discharges on or after October 1, 2007. That is, the regulations at §412.316(b) were revised to specify that beginning in FY 2008 and after, there will no longer be any additional payment under the capital PPS for hospitals located in large urban areas, as currently provided under that section. The PRICER has been updated to reflect this policy change.

Capital PPS Payment for Providers Redesignated Under Section 1886(d)(8)(B) of the Act

Under this section of the Act, certain rural counties (commonly referred to as “Lugar counties”) adjacent to one or more urban areas are redesignated as urban for the purposes of payment under the IPPS. Hospitals located in these “Lugar counties” are deemed to be located in an urban area and they receive the Federal payment amount for the urban area to which they are redesignated. Such hospitals, however, may decline this redesignation and retain their rural status.

Treatment of Certain Urban Hospitals Reclassified as Rural Hospitals Under §412.103 for purposes of Capital PPS payments

Hospitals reclassified as rural under 42 CFR 412.103

(http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html) are not eligible for the capital DSH adjustment since these hospitals are considered rural under the capital PPS (see 42 CFR 412.320(a)(1));

http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr412_04.html). Similarly, the

Geographic Adjustment Factor (GAF) for hospitals reclassified as rural under 42 CFR 412.103 is determined from the applicable statewide rural wage index.

F. LTCH Changes

A new patient classification system is being adopted under the LTCH PPS , beginning in FY 2008. It is the same as the one being adopted under the IPPS (i.e., MS-DRGs), but under LTCH, the DRGs are referred to as “MS-LTC-DRGs”. The LTCH PRICER has been updated with the MS-LTC-DRG table and weights.

In the IPPS computation of the “IPPS Comparable Amount” for LTCH Short-Stay Outlier (SSO) cases, in the calculation of the Capital IPPS comparable payment amount, the 3% large urban add-on has been eliminated effective with discharges occurring on or after October 1, 2007.

G. Inpatient Psychiatric Facility Changes

Coding Changes -DRG Adjustment Update:

The IPF PPS has DRG specific adjustments for 15 DRGs. CMS provides payment under the IPF PPS for claims with a principal diagnosis included in Chapter Five of the ICD-9-CM or the DSM-IV-TR. However, only those claims with diagnoses that group to a psychiatric DRG will receive a DRG adjustment and all other applicable adjustments. Although the IPF will not receive a DRG adjustment for a principal diagnosis not found in one of CMS’ identified 15 psychiatric DRGs, the IPF will still receive the Federal per diem base rate and all other applicable adjustments.

Since the IPF PPS uses the same GROUPER as the IPPS, including the same diagnostic code set and DRG classification system, the IPF PPS is adopting IPPS’ new MS DRG coding system in order to maintain that consistency. The updated codes are effective October 1 of each year. Although the code set is being updated, please note these are the same adjustment factors in place since implementation.

Based on changes to the IPPS, the following changes are being made to the principal diagnosis DRGs under the IPF PPS. Below is the crosswalk of current DRGs to the new MS- DRGs, which will be effective October 1, 2007.

(version 24) DRG	(version 25) MS-DRG	MS-DRG Descriptions	Adjustment Factor
12	056 057	Degenerative nervous system disorders w MCC Degenerative nervous system disorders w/o MCC	1.05
023	080 081	Nontraumatic stupor & coma w MCC Nontraumatic stupor & coma w/o MCC	1.07
424	876	O.R. procedure w principal diagnoses of mental illness	1.22
425	880	Acute adjustment reaction & psychosocial dysfunction	1.05
426	881	Depressive neuroses	0.99
427	882	Neuroses except depressive	1.02
428	883	Disorders of personality & impulse control	1.02

(version 24) DRG	(version 25) MS-DRG	MS-DRG Descriptions	Adjustment Factor
429	884	Organic disturbances & mental retardation	1.03
430	885	Psychoses	1.00
431	886	Behavioral & developmental disorders	0.99
432	887	Other mental disorder diagnoses	0.92
433	894	Alcohol/drug abuse or dependence, left AMA	0.97
521- 522	895	Alcohol/drug abuse or dependence w rehabilitation therapy	1.02
523	896 897	Alcohol/drug abuse or dependence w/o rehabilitation therapy w MCC Alcohol/drug abuse or dependence w/o rehabilitation therapy w/o MCC	0.88

Comorbidity Adjustment Update:

The IPF PPS has 17 comorbidity groupings, each containing ICD-9-CM codes of co-morbid conditions. Each comorbidity grouping will receive a grouping-specific adjustment. Facilities receive only one comorbidity adjustment per comorbidity category, but may receive an adjustment for more than one comorbidity category. The IPFs must enter the full ICD-9-CM codes for up to 8 additional diagnoses if they co-exist at the time of admission or develop subsequently.

Co-morbidities are specific patient conditions that are secondary to the patient's primary diagnosis and require treatment during the stay. Diagnoses that relate to an earlier episode of care and have no bearing on the current hospital stay are excluded and should not be reported on IPF claims. Co-morbid conditions must co-exist at the time of admission, develop subsequently, and affect the treatment received, the length of stay or both treatment and length of stay.

As explained above, the IPF PPS is adopting the new MS-Severity DRG coding system in order to maintain consistency with the IPPS, which are effective October 1 of each year. Although the code set will be updated, the same adjustment factors are being maintained. The FY 2008 GROUPER, Version 25.0, is effective for discharges occurring on or after October 1, 2007.

There are two tables in CR5748 listing the FY 2008 new ICD-9-CM diagnosis codes and the one invalid FY 2008 ICD diagnosis code, respectively, which group to one of the 17 comorbidity categories for which the IPF PPS provides an adjustment. These tables are only a listing of FY 2008 changes and do not reflect all of the currently valid and applicable ICD-9-CM codes classified in the DRGs.

One table in CR5748 is an extensive table that lists the FY 2008 new ICD-9-CM diagnosis codes that impact the comorbidity adjustment under the IPF PPS. The table only lists the FY 2008 new codes and does not reflect all of the currently valid ICD codes applicable for the IPF PPS comorbidity adjustment. CR5748 can be accessed at <http://www.cms.hhs.gov/Transmittals/downloads/R1374CP.pdf> on the CMS website.

There is one ICD-9-CM codes no longer applicable for the comorbidity adjustment. This code is:

Diagnosis Code	Description	Comorbidity Category
233.3	Carcinoma in situ, other and unspecified female genital organs	Oncology Treatment

Additional Information

The official instruction (CR5748) issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1374CP.pdf> on the CMS website.

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

IMPLEMENTATION OF CHANGES IN END STAGE RENAL DISEASE (ESRD) PAYMENT FOR CALENDAR YEAR (CY) 2008 ~CMS MLN Matters~

MLN Matters Number: MM5827

Related CR Release Date: December 7, 2007

Related CR Transmittal #: R1389CP

Related Change Request (CR) #: 5827

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for ESRD services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You - This article is based on Change Request (CR) 5827 which provides payment updates for ESRD facilities.

CAUTION – What You Need to Know - ESRD facilities payment changes include a growth update to the drug add-on adjustment to the composite rate and an update to the wage index adjustments to reflect current wage data, including a revised budget neutrality adjustment. CR 5827 also clarifies weight calculation instructions for double amputee dialysis patients.

GO – What You Need to Do - See the Background and Additional Information Sections of this article for further details regarding these updates and clarifications.

Background

The Social Security Act (Section 1881(b)), as amended by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 623), directed revisions to the

composite rate payment system as well as payment for separately billable drugs furnished by ESRD facilities.

For calendar year (CY) 2008, the Centers for Medicare & Medicaid Services (CMS) did not propose any significant changes to composite rate payment methodology.

However, with CR 5827, CMS makes the following payment changes (effective January 1, 2008) to ESRD facilities, and upon the implementation of CR 5827, these payment changes will be applied to all Medicare certified ESRD facilities:

- **Update the drug add-on adjustment to the composite rate for 2008 of 0.5 percent. As a result, the drug add-on adjustment to the composite payment rate for 2008 will increase from 14.9 percent to 15.5 percent; and**
- **Update the wage data, and implement the third year of the wage index transition using a 25/75 blended wage adjusted composite rate.**

Wage Index Transition Example:

An ESRD facility has a wage-adjusted composite rate (without regard to any case-mix adjustments) of \$135.00 per treatment in CY 2007. Using Core Based Statistical Area (CBSA) based geographic area designations, the facility's CY 2008 wage-adjusted composite rate, reflecting its wage index value would be \$145.00. During the third year (CY 2008) of the 4-year transition period to the new CBSA based wage index values, this facility's blended rate would be calculated as follows: CY 2008: $(0.25 \times \$135.00) + (0.75 \times \$145.00) = \$142.50$.

CR 5827 also clarifies weight calculation instructions for double amputee dialysis patients. Previously reported in CR 4196, the requirement for value code A8 (Weight) is that it should be calculated with pre-amputation weight. In CR 4196, the formula for pre-amputation weight was incorrectly stated as actual weight x 1.5. The correct formula for pre-amputation weight is actual weight x 1.15. Through CR 5827, the instruction for how to calculate the height and weight of double amputee dialysis patients is being placed into Publication 100-04, which is the Medicare Claims Processing Manual.

Additional Information

The official instruction, CR 5827, issued to your Medicare FI and A/B MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1389CP.pdf> on the CMS website.

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> on the CMS website.

**REMITTANCE ADVICE REMARK CODE (RARC) AND CLAIM
ADJUSTMENT REASON CODE (CARC) UPDATE**
~CMS MLN Matters~

Editor's Note: Please verify that your office is utilizing the most up-to-date software in conjunction with the latest update of codes.

MLN Matters Number: MM5800
Related CR Release Date: November 30, 2007
Related CR Transmittal #: R1384CP

Related Change Request (CR) #: 5800
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Impact on Providers

CR 5800, from which this article is taken, announces the latest update of Remittance Advice Remark Codes used in electronic and paper remittance advice and Claim Adjustment Reason Codes used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective January 1, 2008. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits transactions.

The remittance advice remark code list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at <http://wpc-edi.com/codes> on the Internet. The lists at the end of this article summarize the latest changes to the remark code lists, as announced in CR 5800, effective on January 1, 2008. As a reminder, CMS notes that the claim adjustment reason code of A2 (Contractual adjustment) is deactivated effective January 1, 2008.

CMS has developed a new website to help navigate the RARC database more easily. A tool is provided to help search if you are looking for a specific category of code. At this site, you can find some other information that is also available from the Washington Publishing Company (WPC) website. The new website address is <http://www.cmsremarkcodes.info/> on the Internet.

Note that this website does not replace the Washington Publishing Company (WPC) site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You may see the official instruction (CR5800) issued to your Medicare Carrier, A/B MAC, FI, DME MAC or RHHI by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1384CP.pdf> on the CMS website.

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

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* at: http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Comment
N388	Missing/incomplete/invalid prescription number. Note: (New Code 8/1/07)	Medicare initiated
N389	Duplicate prescription number submitted. Note: (New Code 8/1/07)	Medicare initiated
N390	This service cannot be billed separately. Note: (New Code 8/1/07)	Medicare initiated
N391	Missing emergency department records. Note: (New Code 8/1/07)	Not Medicare initiated
N392	Incomplete/invalid emergency department records. Note: (New Code 8/1/07)	Not Medicare initiated
N393	Missing progress notes or report. Note: (New Code 8/1/07)	Not Medicare initiated
N394	Incomplete/invalid progress notes or report. Note: (New Code 8/1/07)	Not Medicare initiated
N395	Missing laboratory report. Note: (New Code 8/1/07)	Not Medicare initiated
N396	Incomplete/invalid laboratory report. Note: (New Code 8/1/07)	Not Medicare initiated
N397	Benefits are not available for incomplete service(s)/undelivered item(s). Note: (New Code 8/1/07)	Not Medicare initiated
N398	Missing elective consent form. Note: (New Code 8/1/07)	Not Medicare initiated
N399	Incomplete/invalid elective consent form. Note: (New Code 8/1/07)	Not Medicare initiated

Code	Current Narrative	Comment
N400	Alert: Electronically enabled providers should submit claims electronically. Note: (New Code 8/1/07)	Not Medicare initiated
N401	Missing periodontal charting. Note: (New Code 8/1/07)	Not Medicare initiated
N402	Incomplete/invalid periodontal charting. Note: (New Code 8/1/07)	Not Medicare initiated
N403	Missing facility certification. Note: (New Code 8/1/07)	Not Medicare initiated
N404	Incomplete/invalid facility certification. Note: (New Code 8/1/07)	Not Medicare initiated
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service. Note: (New Code 8/1/07)	Not Medicare initiated
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service. Note: (New Code 8/1/07)	Not Medicare initiated
N407	You are not an approved submitter for this transmission format. Note: (New Code 8/1/07)	Medicare Initiated
N408	This payer does not cover deductibles assessed by a previous payer. Note: (New Code 8/1/07)	Not Medicare initiated
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident. Note: (New Code 8/1/07)	Not Medicare initiated
N410	This is not covered unless the prescription changes. Note: (New Code 8/1/07)	Not Medicare initiated
N411	This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N412	This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N413	This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N414	This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated

Code	Current Narrative	Comment
N415	This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N416	This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N417	This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) Note: (New Code 8/1/07)	Not Medicare initiated
N418	Misrouted claim. See the payer's claim submission instructions. Note: (New Code 8/1/07)	Not Medicare initiated
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change. Note: (New Code 8/1/07)	Not Medicare initiated
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery. Note: (New Code 8/1/07)	Not Medicare initiated
N421	Claim payment was the result of a payer's retroactive adjustment due to a Peer Review Organization decision. Note: (New Code 8/1/07)	Not Medicare initiated
N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. Note: (New Code 8/1/07)	Not Medicare initiated
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program. Note: (New Code 8/1/07)	Not Medicare initiated
N424	Patient does not reside in the geographic area required for this type of payment. Note: (New Code 8/1/07)	Medicare initiated
N425	Statutorily excluded service(s). Note: (New Code 8/1/07)	Medicare initiated
N426	No coverage when self-administered. Note: (New Code 8/1/07)	Medicare initiated
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery. Note: (New Code 8/1/07)	Medicare initiated
N428	Service/procedure not covered when performed in this place of service. Note: (New Code 8/1/07)	Medicare initiated
N429	This is not covered since it is considered routine. Note: (New Code 8/1/07)	Medicare initiated

***NOTE:** Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, in some cases another/other remark code(s), for an adjustment. Codes that are informational will have “Alert” in the text to identify them as informational rather than explanatory codes. For example, this informational code is sent per state regulation, but does not explain any adjustment:

N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

These informational codes will be used only if specific information needs to be communicated but not as default codes

Modified Codes

Code	Current Modified Narrative	Comment
M27	Alert: The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07
M70	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
MA14	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
M62	Alert: This is a telephone review decision.	Modified 4/1/07, 8/1/07

Code	Current Modified Narrative	Comment
N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.)	Modified 8/1/07
N84	Alert: Further installment payments are forthcoming.	Modified 4/1/07, 8/1/07
N85	Alert: This is the final installment payment.	Modified 4/1/07, 8/1/07
N129	Not eligible due to the patient's age.	New Code 10/31/02, Modified 8/1/07

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