

Communiqué

MAC

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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Key to Indicators in Table of Contents

A	Article Applies to Part A Only
B	Article Applies to Part B Only
A/B	Article Applies to Both Part A and Part B

Items of Importance**ATTENTION PART A J5 PROVIDERS: CRNA CHARGES REMOVED
FROM COST REPORTS WITH DATES OF SERVICE PRIOR TO****10/1/07****~Part A~**

When billing the CRNA and outpatient related charges on the 85X type of bill that were removed from the cost report on the 18X type of bill, remarks should be added to the 85X type of bill stating, "Charges previously billed on 18X were disallowed." Failure to add this to the remark area of the 85X billing will result in a denial for timely filing.

CREATING A WEBSITE THAT MEETS YOUR NEEDS**~Part A & Part B~**

WPS values your opinion regarding the WPS Medicare Website and strives to continue to improve the site to meet all of your Medicare needs.

We regularly review input received through the survey administered via the Website by ForeSee Results and encourage all Website visitors to complete the survey that pops up while you are on the WPS Medicare Website (<http://www.wpsmedicare.com>).

We are hopeful that you can provide additional insight to changes that we can make to the WPS Medicare Website to increase your satisfaction by completing the survey that is accessible by selecting the link below:

http://www.surveymonkey.com/s.aspx?sm=uiSY_2b3CKxNHObY9ZFnA3gQ_3d_3d

We encourage you to complete the survey, and appreciate your valuable time.

**CRITICAL ACCESS HOSPITAL (CAH) SWING BED BILLING
CLARIFICATION****~Part A~**

After extensive research of the Federal Rules and Regulations and much discussion with the Centers for Medicare & Medicaid Services (CMS) Central and Regional Office staff on the proper billing of CAH Swing bed services, we are providing the following clarification.

CAH Swing beds are exempt from Skilled Nursing Facility (SNF) consolidated billing; however, they do need to follow the direction in the CMS Internet Only Manual (IOM), Publication 100-4, Chapter 3, Section 10.4 on bundling hospital charges. These charges should be included on the 18X type of bill.

Services provided by the CAH, while the beneficiary is inpatient in the CAH swing bed that are considered exclusions from SNF Consolidated Billing, shall be billed on an 85X type of bill. All related outpatient charges shall be included on the 85X type of bill that would typically be billed for outpatient services.

Certified Registered Nurse Anesthetists (CRNA) charges are not billable under a CAH Swing bed claim. These charges should be submitted on an 85X type of bill with the related outpatient charges. The only appropriate charge, per the IOM, Publication 100-4, Chapter 4, Section 250.3.3, billable on an 85X type of bill for a CRNA are anesthesia charges.

As stated in the IOM, Publication 100-4, Chapter 3, Section 60, swing bed services must be billed separately from inpatient hospital services. Therefore, any swing bed patient who requires inpatient hospital services must be discharged from the swing bed and admitted as a hospital inpatient.

Medicare regulation is the basis for the clarification provided. If you feel that there is Medicare regulation that contradicts this clarification, please contact our Customer Service area.

DECEASED PHYSICIANS, NON-PHYSICIAN PRACTITIONERS, AND OTHER INDIVIDUALS REPORTED ON MEDICARE ENROLLMENT FORMS

~Part B~

The death of a physician or non-physician practitioner enrolled in the Medicare program must be reported promptly to this office to ensure that the physician or non-physician practitioner's Medicare enrollment record is deactivated on a timely basis and that it reflects the provider's date of death. Group practices to which Medicare benefits are reassigned, and the representatives of physicians and non-physician practitioners in private practice, should contact Wisconsin Physicians Service's Provider Enrollment Department for information regarding the CMS-855 enrollment form and the documentation required to report that a physician or non-physician practitioner has died.

In addition, group practices and organizations are required to submit a CMS-855B change of information to delete other individuals reported on their Medicare enrollment record who have died, such as owners, managing employees, directors, officers, and authorized and delegated officials.

Questions regarding the reporting of the death of a physician, non-physician practitioner, or other individual should be directed to our Provider Enrollment Department:

Iowa, Kansas, Missouri, Nebraska
Wisconsin Physicians Service (WPS)
Medicare Part B
Provider Enrollment Department
P.O. Box 8248
Madison, WI 53708
(866) 503-7664

ENEWS PROVIDES LATEST ANNOUNCEMENTS

~Part A & Part B~

We are pleased to offer the services of WPS Medicare eNews. For those who subscribe, WPS Medicare eNews brings the latest Medicare news to the physicians and suppliers in our jurisdiction. The e-mails announce the posting of:

- Time-sensitive national and local Medicare news
- Local Coverage Decision Policies
- Provider Education and Training events
- *Communiqué* newsletters

WPS Medicare eNews brings the latest Medicare information directly to your e-mail box. If you want the details of a particular announcement, you will be directed to the full page of the WPS Website via a link within the mailing. There is no cost for WPS Medicare eNews, and you may unsubscribe at any time. To subscribe, simply go to <http://www.wpsmedicare.com/listserv> and enter your e-mail address, click "Submit," and follow the directions on the page.

HAVE YOU COMPLETED THE WEBSITE SATISFACTION SURVEY LATELY?

~Part A & Part B~

Your feedback is extremely important to the provider community, WPS Medicare, and the Centers for Medicare & Medicaid Services (CMS). The survey that pops up while you are on our Website is the Website Customer Satisfaction Survey.

This quick survey, sponsored by CMS and conducted by ForeSee, gauges your satisfaction with the WPS Medicare Website. WPS and CMS review the results of the survey regularly, and your feedback directly influences the layout, look and feel, content, and other aspects of the WPS Medicare Website. We encourage you to complete the survey, and appreciate your valuable time.

For more information on the survey, go to:
http://www.wpsmedicare.com/sat_survey.pdf

IMPORTANT CUSTOMER SERVICE AUTHENTICATION REQUIREMENT CHANGES

~Part A & Part B~

Effective April 6, 2009, all Customer Service and Interactive Voice Response (IVR) inquiries require a matching National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and Taxpayer Identification Number (TIN). Note that only the last five digits of the TIN will be required. To allow us to serve you in the timeliest manner, please have all authentication elements ready prior to any calls to the Interactive Voice Response (IVR) or Customer Service.

The new requirement is based on the Centers for Medicare & Medicaid Services (CMS) Change Request (CR) 6139, which was implemented to better safeguard your information.

OIG REVIEW OF HIGH-DOLLAR PAYMENTS FOR MEDICARE PART B CLAIMS

~Part B~

Recently, the Office of Inspector General (OIG) of Audit Services conducted national evaluations of Medicare Contractors with the objective to determine whether high-dollar Medicare payments for services were appropriate.

The objective was to determine whether high-dollar Medicare claims processed and paid to Part B providers were appropriate. Specifically, the emphasis was placed on the units billed and the quantities that were shown for different services. It was determined whether or not the actual quantities and units billed were supported in the records for those particular claims. The OIG considered these high-dollar claims to be at risk for overpayment.

The largest factor that influenced the OIG errors in the high-dollar reports includes incorrectly billing for drugs and biological 'units or service.' It is important that providers follow the Medicare guidelines for billing drugs and biological to receive payment based on the coverage criteria. Units billed should reflect the amount documented within the medical record.

Several claims were identified with billing errors and/or overpayments because;

- 1) Providers incorrectly claimed excessive units of service,
- 2) Providers dosage billed or the number of units was incorrectly billed,
- 3) Providers improperly coded claims,
- 4) Provider records contained insufficient documentation,
- 5) The per unit payment amount exceeded per unit allowed amount on the Medicare fee schedule.

As a result of the audit, some providers were identified as receiving an overpayment and needing to have monies recouped as a result of these high-dollar claims. The providers involved in the audit and affected by the overpayments have been or will be contacted by Wisconsin Physicians Service (WPS). Furthermore, as a result of the audit, WPS has determined the need to perform analysis and potential systematic editing in relation to high dollar amounts present on claims.

CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed. A provider is responsible to know the rules and regulations that apply to all services he/she bills to the Medicare program. The provider is also responsible to know the rules and regulations that are made available through publications from the carrier.

The reports are available to the public

<http://oig.hhs.gov/oas/reports/region7/70804131.pdf>

Kansas/Nebraska/Missouri (W)

<http://oig.hhs.gov/oas/reports/region6/60800029.asp>

Missouri (E)

Internet-only Manuals (IOMs)

100-04 Chapter 4 Section 20.4 <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>

100-02 Chapter 15 Section 50 <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

WANTED: MEDICARE WEBSITE USERS

~Part A & Part B~

Wanted: Medicare Website users

Mission: Provide needed input

How: Via e-mail

If you choose to accept this assignment, please read on.

At WPS Medicare, we strive to make our Website the best resource we can for our Medicare providers. Currently, we are looking at ways to enhance the navigation and search function, so that providers can find what they need as easily as possible. We would like responses from those who are new to the WPS Medicare Website as well as from those who are experienced in using the site. Please answer any or all of the questions listed below and send your responses to medicareadmin@wpsic.com; please include "Website Input" in the subject line of your e-mail.

Navigation

- What information are you looking for, and what path do you take to find it?
- Do you have suggestions for the organization of the information on our site?

Search

- What search terms do you use (i.e., what words do you enter into the Search field to find your information)?
- What abbreviations do you commonly use when searching?

Please feel free to provide any other comments about the Website not related to those listed above.

Thank you for taking the time to respond. Your feedback ensures that the WPS Medicare Website will continue to be an easy-to-use tool for our entire provider community.

Claim Submission**CLARIFICATION OF DATE OF SERVICE (DOS) OF AMBULANCE SERVICES**

~CMS MLN Matters~

~Part A & Part B~

MLN Matters Number: MM6372

Related CR Release Date: February 13, 2009

Related CR Transmittal #: R1682CP

Related Change Request (CR) #: 6372

Effective Date: March 13, 2009

Implementation Date: March 13, 2009

Provider Types Affected

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

Impact on Providers

Providers of ambulance services should note the clarifications made by CR 6372, as noted in this article. Specifically, CR6372 clarifies the proper date of service to use on claims, especially in situations where the beneficiary dies.

Background

CR 6372 provides clarification of Centers for Medicare & Medicaid Services' (CMS) policy towards dates of service (DOS) for ambulance services, especially in regard to a beneficiary's date of death.

The clarifications for providers of ambulance services are listed as follows:

- The date of service of an ambulance service is the date that the loaded ambulance vehicle (ground or air) departs the point of pickup, except in cases where the beneficiary is pronounced dead as noted below.
- In the case of a ground transport, if the beneficiary is pronounced dead after the vehicle is dispatched but before the (now deceased) beneficiary is loaded into the vehicle, the DOS is considered to be the date of the ambulance vehicle's dispatch.
- In the case of an air transport, if the beneficiary is pronounced dead after the aircraft takes off to pick up the beneficiary, the DOS is considered to be the date of the ambulance vehicle's takeoff.

Failure to code dates of service correctly in these situations could result in the denial of the claim.

Additional Information

The official instruction, CR 6372, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1682CP.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.

CLARIFICATION ON USE OF NATIONAL DRUG CODES (NDCS) IN 837 I BILLING

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6330
Related CR Release Date: February 13, 2009
Related CR Transmittal #: R446OTN

Related Change Request (CR) #: 6330
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Provider Types Affected

Hospitals, home health agencies, and other providers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), or Medicare Administrative Contractors (MAC)) for drugs, especially new drugs provided under the Outpatient Prospective Payment System (OPPS).

What You Need to Know

CR 6330, from which this article is taken, specifies how quantities of drugs are to be reported and then processed by Medicare when the NDC is used for institutional billing. Specifically, it also requires Medicare contractors to accept decimal values for NDC quantities. CR6330 also adds to prior instructions regarding the reporting of drugs that have not yet been approved by the Food and Drug Administration (FDA). Be sure your billing staff is aware of these changes.

Background

As provided by Change Request (CR) 3287 issued May 28, 2004 (*MMA-Hospital Outpatient Billing and Payment under Outpatient Prospective Payment System for New Drugs or Biologicals After FDA Approval but Before Assignment of a Product-Specific Drug/Biological HCPCS Code*); Medicare hospitals, subject to the Outpatient Prospective Payment System (OPPS), may use Healthcare Common Procedure Coding System (HCPCS) code C9399 to report drugs that have been approved by the FDA, but that do not yet have a product-specific drug/biological HCPCS code.

CR 6330, from which this article is taken, builds on those instructions and adds some additional requirements for providers. Effective July 1, 2009, hospitals billing for drugs/biologicals that have received FDA approval but which have not yet received product-specific drug/biological HCPCS codes will not only specify the NDC of the drug/biological, but will also specify the quantity of that drug/biological using the CTP segment in the ANSI X-12 837 I (in Loop 2410 LIN 03).

In addition, CR 6330 provides that the use of the Units Field, while adequate to define quantities when HCPCS codes are used to describe drugs and biologicals, is not adequate to describe the quantities of a drug or biological identified only by an NDC. Thus, CR 6330 requires Medicare contractors to accept decimals to specify the quantity in this new quantity field, and requires Medicare's systems to retain this information in the repository and forward it to a subsequent payer (although the decimals may be rounded to whole numbers for actual claims processing).

Additional Information

For further information, see the instruction issued to your FI, RHHI, or MAC regarding this issue, which can be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R446OTN.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

You might also want to review the MLN Matters article related to CR 3287, which you can find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3287.pdf> on the CMS Website.

If you have any questions, please contact your FI, RHHI, or 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 AN AMBULATORY SURGICAL CENTER (ASC)
HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)
PAYMENT INDICATOR FILE
~ CMS MLN Matters ~
~Part A & Part B~**

MLN Matters Number: MM6184
Related CR Release Date: October 17, 2008
Related CR Transmittal #: R1616CP

Related Change Request (CR) #: 6184
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

ASCs submitting claims to Medicare contractors (carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for ASC services provided to Medicare beneficiaries.

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

This article is based on Change Request (CR) 6184 which provides Medicare contractors with instructions for implementing an Ambulatory Surgical Center (ASC) Healthcare Common Procedure Coding System (HCPCS) payment indicator file.

CAUTION – What You Need to Know

CR 6184 provides instructions to your Medicare contractor(s) to modify their systems to accept the new Ambulatory Surgical Center (ASC) Healthcare Common Procedure Coding System (HCPCS) Payment Indicator File and ensure that it properly interfaces with the other ASC files in order to process ASC claims appropriately. This new file will enable your Medicare contractor(s) to enhance their ability to (1) identify all separately payable and non-separately payable (packaged) services, as well as non-payable services and (2) provide more precise messaging via remittance advice remark codes in the processing and disposition of ASC claims for all HCPCS codes submitted by ASCs.

GO – What You Need to Do

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

Background

As required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 626 of), the Centers for Medicare & Medicaid Services (CMS) implemented a revised Ambulatory Surgical Center (ASC) payment system January 1, 2008.

CMS provided in CR 5680 (Transmittal 1325, August 29, 2007; see related MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5680.pdf> on the CMS Website) supporting ASC file record layouts of the ASC facility payment file (ASCFS) and ASC Drug File to interface with the instructions issued to implement the revised ASC payment system. The ASCFS includes rates for all services that are eligible for payment under the revised ASC payment system, except separately paid drugs and biologicals, and the ASC Drug File provides the rates for all drugs and biologicals that are eligible for separate payment under the revised ASC payment system.

Using defined “payment indicators” (72 FR 67189-67190; see <http://www.gpoaccess.gov/fr/retrieve.html> on the Internet), CMS identifies each covered service that is eligible for ASC payment and the payment methodology by which the payment amount is calculated. The payment indicators also indicate which services’ costs are packaged into the payment for other services and which surgical procedures are excluded from Medicare payment.

For Calendar Year (CY) 2008, Medicare contractors did not have access to the ASC payment indicators for all services and, therefore, were unable to accurately determine the specific reason for nonpayment in all cases, though the payment decisions made on the claims were correct.

CR 6184 announces that CMS is providing a file of the ASC payment indicators that are assigned to each HCPCS code in order to enhance the ability of Medicare contractors to identify both separately payable and non-separately payable (packaged) services, as well as non-payable services. This information will enable contractors to provide detailed messaging in the processing and disposition of ASC claims for all HCPCS codes submitted by ASCs.

In addition to the ASCFS and ASC Drug File(s), CMS is providing Medicare contractors with a more comprehensive list of HCPCS codes and the payment indicator assigned to each of the codes. Beginning January 1, 2009, Medicare contractors will be able to process ASC claims using the revised ASC HCPCS Code Payment Indicator file and will provide messaging to ASCs and beneficiaries, in part, based on the “messaging” provided in CR 6184. The specific payment indicators are identified in an attachment to CR6184.

Additional Information

The official instruction, CR 6184, issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1616CP.pdf> on the CMS Website. Attachment B of CR6184 contains the list of ASC payment indicators and their respective definitions.

If you have any questions, please contact your carrier 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.

Comprehensive Error Rate Testing (CERT)**COMPREHENSIVE ERROR RATE TESTING (CERT) ALERT –
DOCUMENTATION OF TEACHING PHYSICIAN SERVICES****~Part B~**

During a recent CERT review, the CERT contractor assessed errors on a teaching physician's claim for inpatient hospital visits performed by a resident because the teaching physician did not document his active role during the inpatient hospital visits.

Per the Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Section 100.1.1, where a resident has written notes, the teaching physician's note may reference the resident's note. The teaching physician must document that he/she performed the critical or key portion(s) of the service, and that he/she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

To view Publication 100-04, Chapter 12, including other CMS Teaching Physicians Services instructions, please refer to the following Website address:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

Coverage – General**HEARTSBREATH TEST FOR HEART TRANSPLANT REJECTION**

~CMS MLN Matters~

~Part A & Part B~

MLN Matters Number: MM6366

Related CR Release Date: February 13, 2009

Related CR Transmittal #: R1683CP and R99NCD

Related Change Request (CR) #: 6366

Effective Date: December 8, 2008

Implementation Date: April 6, 2009

Provider Types Affected

Providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Medicare Administrative Contractors (MACs)) for Heartsbreath testing services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6366 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) determined that the **Heartsbreath Test is not reasonable and necessary** under section 1862(a)(1)(A) of the Social Security Act, **and is non-covered for dates of service on or after December 8, 2008**. See the Background and Additional Information Sections of this article for further details regarding this issue.

Background

On December 8, 2008, CMS issued a decision memorandum in response to a formal request for Menssana Research, Inc., to consider national coverage of the Heartsbreath test as an adjunct to the heart biopsy to detect grade 3 heart transplant rejection in patients who have had a heart transplant within the last year and an endomyocardial biopsy in the prior month. CMS determined that the evidence does not adequately define the technical characteristics of the test nor demonstrate that Heartsbreath testing to predict heart transplant rejection improves health outcomes in Medicare beneficiaries.

Key Points of CR 6366

- Effective for claims with dates of service on and after December 8, 2008, the Heartsbreath test used to predict heart transplant rejection is nationally non-covered. This coverage change to Current Procedural Terminology (CPT) Code 0085T, breath test for heart transplant rejection, will be effective with the April 1, 2009, quarterly update of the Medicare Physician Fee Schedule Database.
- Effective with the April 1, 2009, quarterly update of the Integrated Outpatient Code Editor, CPT code 0085T, breath test for heart transplant rejection, is no longer payable by Medicare.
- When denying claims for CPT code 0085T, Medicare contractors will use:
 - Medicare Summary Notice (MSN) message 16.10: Medicare does not pay for this item or service,
 - Claim Adjustment Reason Code 50: These are non-covered services because this is not deemed a medical necessity by the payer;

- Claim Adjustment Remark Code MA 51: Missing/Incomplete/Invalid Procedure Code(s); and,
- N386: This decision was based on an NCD. An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp> on the CMS Website.

(If you do not have Web access, contact your Medicare contractor to request a copy of the NCD.)

- For beneficiaries who choose to have this procedure anyway, providers shall issue an Advance Beneficiary Notice (ABN) indicating that Medicare issued an NCD at section 260.10 of the NCD Manual stating that the Heartbreath test is not reasonable and necessary for Medicare beneficiaries. Medicare never pays for this test and the beneficiary would be held financially liable. (Beginning March 1, 2009, the ABN-G will no longer be valid and providers must issue the revised ABN (CMS-R-131.)
 - Medicare Contractors will include the Group Code CO (contractor obligation) or PR (provider responsibility) depending on liability.
- For claims already processed with dates of service between December 8, 2008, and April 1, 2009, contractors will not search their files, but may go back and adjust claims that are brought to their attention.

Additional Information

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

The official instruction (CR6366) was issued to your Medicare FI, carrier or MAC via two transmittals. The first conveys the revised claims processing instructions and is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1683CP.pdf> on the CMS Website. The second transmittal conveys the change to the National Coverage Determinations Manual and that transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R99NCD.pdf> on the CMS Website.

MIST THERAPY® SYSTEM 5.0 WOUND TREATMENT DEVICE

~Part A & Part B~

The MIST Therapy® System is a wound care product designed to impact key areas of the wound repair process. Multiple providers have asked Wisconsin Physicians Service (WPS) Medicare if this service is covered using Current Procedural Terminology (CPT) code 0183T. The following is in response to these inquiries:

Ultrasonic Wound Debridement (CPT code 0183T) is a system that uses continuous low frequency ultrasonic energy to atomize a liquid and deliver continuous low frequency ultrasound to the wound bed. WPS Medicare does not consider this cleansing method to be a significantly separately payable coverable service. Therefore, MIST Therapy® (CPT code 0183T) is included in the payment for the Evaluation and Management (E/M) or wound care services.

SHIPBOARD SERVICES BILLED TO THE CARRIER AND SERVICES NOT PROVIDED WITHIN THE UNITED STATES. CHANGE REQUEST (CR) 6327 RESCINDS AND FULLY REPLACES CR 6217

~CMS MLN Matters~

~Part A & Part B~

MLN Matters Number: MM6327

Related CR Release Date: February 13, 2009

Related CR Transmittal #: R1677CP and R102BP

Related Change Request (CR) #: 6327

Effective Date: March 13, 2009

Implementation Date: March 13, 2009

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Medicare Administrative Contractors (MACs)) for billed shipboard services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6327 which clarifies payment for shipboard services billed to Medicare contractors and services not provided within the United States.

CAUTION – What You Need to Know

CR 6327 revises the Medicare Claims Processing Manual and the Medicare Benefit Policy Manual to clarify that Medicare contractors will make payment for physician and ambulance services furnished in connection with a covered foreign hospitalization, including emergency physician and ambulance services furnished during the time period immediately preceding the covered foreign hospitalization. **CR 6327 rescinds and fully replaces CR 6217.**

GO – What You Need to Do

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

Background

Medicare law prohibits payment for items and services furnished outside the United States except for certain limited services (see the Social Security Act, Section 1814(f) at http://www.ssa.gov/OP_Home/ssact/title18/1814.htm and Section 1862(a)(4) at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Internet). The law specifies **the following are exceptions to the “foreign” exclusion:**

- Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
 - The emergency arose within the U.S. or
 - The emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay, between Alaska and another State;
- Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual's residence within the U.S. than the nearest U.S. hospital that is

adequately equipped and available to treat the individual's condition, whether or not an emergency exists;

- Physician and ambulance services in connection with a foreign inpatient hospital stay that is covered in accordance with (1) or (2) above.

Note: The term "United States" includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and, for purposes of services rendered on a ship, the territorial waters adjoining the land areas of the United States.

The Medicare Claims Process Manual (Chapter 1, Section 10.1.4.7; see <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website) currently states that:

- Services furnished by a physician or supplier in U.S. territorial waters must be furnished on board vessels of American registry, and
- The physician must be registered with the Coast Guard in order for Medicare to make payment.

However, that manual language is not consistent with Medicare law. Therefore, because Section 10.1.4.7 is not consistent with Medicare law, **CMS is clarifying Section 10.1.4.7 in order to make it consistent with current Medicare law by removing the language that states:**

- The vessels must be of American registry, and
- The physician must be registered with the Coast Guard.

CMS is also clarifying Chapter 1, Sections 10.1.4, and 10.1.4.1 and Chapter 3, Section 110.1 of the Medicare Claims Processing Manual and Chapter 16, Section 60 of the Medicare Benefit Policy Manual to show **that physician and ambulance services furnished in connection with a covered foreign hospitalization are covered**. The term "**and during a period of**" covered foreign hospitalization implies that only physician and ambulance services that are furnished during the period of the covered foreign hospitalization are covered (i.e., the period after the beneficiary has been admitted to the foreign hospital), when, in fact, the emergency physician and ambulance services **are covered** both:

- During the time period immediately before the beneficiary is actually admitted to the foreign hospital, and
- During the covered foreign hospitalization itself.

You can find the revised chapters of two manuals referenced above as attachments to CR 6327.

Additional Information

The official instruction, CR 6327, was issued to your carrier, FI, and MAC via two transmittals. The first modifies the Medicare Claims Processing Manual and is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1677CP.pdf> and the second modifies the Medicare Benefit Policy Manual and that transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R102BP.pdf> on the CMS Website.

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

Coverage – Policies

INFORMATION ON WEBSITE

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

http://www.wpsmedicare.com/mac/policy/mac_lcds.shtml

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 our Freedom of Information (FOI) Unit.

Part A	
Iowa Part A	Kansas Part A
WPS Medicare Part A Freedom of Information P.O. Box 7665 Madison, WI 53707-7665	WPS Medicare Part A Freedom of Information P.O. Box 7576 Madison, WI 53707-7576
Missouri Part A	Nebraska Part A
WPS Medicare Part A Freedom of Information P.O. Box 8890 Madison, WI 53707-8890	WPS Medicare Part A Freedom of Information P.O. Box 8799 Madison, WI 53708-8799
Part B	
WPS Medicare Attn: Freedom of Information Act (FOIA) PO Box 8810 Marion, IL 62959	



New Policies for March 2009

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
CV-033	<i>Noninvasive Vascular Testing (N.I.V.T.)</i>	LCD	Click here to view	20
HONC-010	<i>Chemotherapy Drugs and their Adjuncts</i>	LCD	Click here to view	20

Revised Policies for March 2009

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
L26601	<i>Ambulance Services</i>	LCD	Click here to view	21
CV-526	<i>Transthoracic Echocardiography</i>	LCD	Click here to view	21

Coverage – New Policies**Part A & Part B****LCD Title**

Noninvasive Vascular Testing (N.I.V.T.)

Contractor's Determination Number

CV-033

Effective Date

04/16/2009

This is a new policy. Please read this policy in its entirety at the following Website:

Part A:

http://www.cms.hhs.gov/mcd/results_index.asp?from='lmrpcontractor'&contractor=143&name=Wisconsin+Physicians+Service+Insurance+Corporation+%2805101%2C+MAC+%2D+Part+A%29&letter_range=4

Part B:

http://www.cms.hhs.gov/mcd/results_index.asp?from='lmrpcontractor'&contractor=148&name=Wisconsin+Physicians+Service+Insurance+Corporation+%2805202%2C+MAC+%2D+Part+B%29&letter_range=4

**Part A & Part B****Contractor Number**

00951, 00952, 00953, 00954
05101, 05201, 05301, 05401, 05102, 05202, 05392, 05302, 05402

Contractor Type

Carrier
MAC A
MAC B

LCD Title

Chemotherapy Drugs and their Adjuncts

Contractor's Determination Number

HONC-010

Original Determination Effective Date

04/16/09

This is a new LCD. Please read this policy in its entirety on the following Web pages:

MAC A http://www.wpsmedicare.com/mac/policy/a_mac_lcds.shtml

MAC B http://www.wpsmedicare.com/mac/policy/b_mac_lcds.shtml

Coverage – Revised Policies**Part A****LCD Policy Revision**

Contractor's Policy Number
L26601

LCD Title
Ambulance Services

Primary Geographic Jurisdiction
MAC Part A

Revision Effective Date
03/13/2009

Revision to policy regarding CR #6372 on Clarification of Date of Service (DOS) of Ambulance Services for Ground and Air Transport.

GROUND TRANSPORT

- If the beneficiary is pronounced dead after the vehicle is dispatched but before the (now deceased) beneficiary is loaded into the vehicle, then the date of service is the date of dispatch (Pub. 100-2, Chapter 10, 10.2.6).
 - *If a claim is received with a date of service (DOS) one or more days beyond the beneficiary's date of death (DOD) (according to the Master beneficiary Record (BMR) within the Common Working File (CWF)), the claim is denied. (Pub. 100-02, Chapter 10, 10.2.6)

AIR TRANSPORT

- If the beneficiary is pronounced dead after the aircraft takes off to pick up the beneficiary then the date of service (DOS) is the date of takeoff (Pub. 100-02, Chapter 10, 10.4.9).
 - *If a claim is received with a date of service (DOS) one or more days beyond the beneficiary's date of death (DOD) (according to the Master beneficiary Record (BMR) within the Common Working File (CWF)), the claim is denied. (Pub. 100-02, Chapter 10, 10.2.6, 10.4.1, 10.4.9)

**Part A & Part B****LCD Policy Revision**

Contractor's Policy Number
CV-526

LCD Title
Transthoracic Echocardiography

Primary Geographic Jurisdiction

Iowa, Kansas, Missouri, Nebraska

Revision Effective Date

01/01/2009

*93306 *Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording; when performed, complete, with spectral or color doppler echocardiography

New for 2009 CPT code 93306 was inadvertently omitted from CV-526 with the 2009 CPT coding updates.

Electronic Data Interchange (EDI)**GET PAID FASTER AND POST PAYMENTS FASTER: SOUND LIKE A GOOD PLAN?****~Part B~**

If this sounds like a good idea, there are very easy ways to make this happen. PS EDI offers the ability to send your Medicare claims electronically. Providers have the option of using billing services, vendors or clearinghouses, or even Medicare's own FREE software program to send their Medicare claims to WPS Medicare. Did you know that electronically submitted claims get paid faster than paper submitted claims? Please visit the Websites below for more information on claim submission and resources available:

http://www.wpsic.com/edi/get_started.shtml

<http://www.wpsic.com/edi/pcacepro32.shtml>

http://www.wpsic.com/edi/pdf/medicare_connection.pdf

For more information or if you just need to have general questions answered, please contact helpful WPS EDI staff members at (866) 503-9670.

If you would like to get your Medicare EOB faster, there is an option to receive them electronically. Your electronic remit would be available on our Bulletin Board to download and there is the option of using a vendor or clearinghouse to help with that. Another option is to get set up to download them on your own and use the CMS software product, Medicare Remit Easy Print (MREP), that allows for creating the electronic remit (ERA) into a readable and printable option. As always, feel free to call WPS EDI staff for questions or assistance. More information is available at the Websites listed below:

http://www.wpsic.com/edi/edi_ern_medb.shtml

<http://www.wpsic.com/edi/tools.shtml> (scroll down to the MREP portion)

Last, but not least, you can have your Medicare Funds directly deposited into your bank account, thus getting your actual money much faster than postal mail. It's a very simple process to sign up for Electronic Funds Transfer (EFT). Please contact the EFT staff at 1-866-380-4742 (Option 2 for EDI/EFT) for any questions and assistance. To print out the form and instructions please go to the Website below:

http://www.wpsic.com/edi/pdf/cms588_elec_funds.pdf

Our EDI staff members are always here to help out with any questions you may have. Please don't hesitate to contact us for your Medicare needs.

MEDICARE REMIT EASY PRINT: FEBRUARY 9, 2009 UPDATE**~Part B~**

(Code Group revised 1-29)

There is no update to the MREP software (current version 2.5) for the January release; however, the Code Group information has been updated. You can download the Code Group

information (11-1-08) from the site listed below. Instructions to Update the Code Group are on page 65 - 67 of the MREP Manual.

If you are an electronic biller who does not receive the Electronic Remittance Advice (ERA) and would like to, please download the ERA information sheet at http://www.wpsic.com/edi/pdf/edi_ern_medb.pdf and submit it to our office.

If you already receive the ERA and want to try the MREP software, please download the MREP software at <http://www.wpsmedicare.com/mac/business/mrep.shtml>. If you are not an electronic biller and want to receive an ERA to use the MREP software, you will also need to submit an EDI enrollment form. Please label MREP only. You can download this form at http://www.wpsic.com/edi/pdf/medb_enroll.pdf.

For assistance, please contact EDI at (866)-503-9670.

Take advantage of this software. Begin using MREP today!

General Information**CENTRALIZED BILLING PERIOD FOR FLU, PPV****~Part B~**

According to the Centers for Medicare & Medicaid Services (CMS), the yearly enrollment period for centralized billing of influenza and Pneumococcal (PPV) immunizations is changed to September 1 through August 31, rather than October 1 through September 30.

When an application for centralized billing from an individual or entity is approved, the approval is limited to the 12-month period from September 1 through the following August 31. The revised period more closely reflects the annual immunization pattern.

It is the responsibility of the centralized biller to reapply to the CMS central office (CO) for approval each year by June 1. TrailBlazer Health Enterprises, which is the carrier selected to process the centralized billing claims, will not process claims for a centralized biller without permission from CMS CO.

Centralized billing is a process in which a provider, who provides mass immunization services for influenza and PPV immunizations, can send all claims to a single carrier for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers, or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the flu and PPV vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare Physician Fee Schedule (MPFS) for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals, which is based on the lower of cost or 95 percent of the Average Wholesale Price (AWP).

Individuals and entities interested in centralized billing must contact the CMS CO, in writing, at the following address by June 1 of the year in which they wish to centrally bill.

Division of Practitioner Claims Processing
Provider Billing and Education Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop C4-12-18
Baltimore, Maryland 21244

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

Criteria for Centralized Billing

1. To qualify for centralized billing, an individual or entity providing mass immunization services for flu and pneumonia must provide these services in at least three payment localities for which there are at least three different carriers processing claims.
2. Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the immunizations are given.

3. Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the flu and PPV benefit, accepting assignment means that Medicare beneficiaries can not be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary \$10 for an influenza vaccination and give the beneficiary a coupon for \$10 to be used in the drugstore. This practice is unacceptable.
4. The carrier assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The carrier assigned for this year is TrailBlazer Health Enterprises.
5. The payment rates for the administration of the vaccinations will be based on the MPFS for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, the payments received may vary based on the geographic locality where the service was performed. Payment will be made at the assigned rate.
6. The payment rates for the vaccines will be determined by the standard method used by Medicare for reimbursement of drugs and biologicals which is based on the lower of cost, or 95 percent of the AWP. Payment will be made based on the assigned rate.
7. Centralized billers must submit their claims on roster bills in an Electronic Media Claims standard format using the HIPAA ANSI X12N 837 (version 4010). Paper claims will not be accepted.
8. Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. TrailBlazer must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare Health Insurance Claim Number) as the carrier will not be able to process incomplete or incorrect claims.
9. Centralized billers must obtain an address for each beneficiary so that an Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) can be sent to the beneficiary by the carrier. Beneficiaries are sometimes confused when they receive an EOMB or MSN from a carrier other than the carrier that normally processes their claims, which results in unnecessary beneficiary inquiries to the Medicare carrier. Therefore, centralized billers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the processing carrier. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.
10. Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. TrailBlazer can provide this information.
11. Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from TrailBlazer. This can

be done by completing Form CMS-855 (Provider Enrollment Application), which can be obtained from TrailBlazer.

12. If an individual or entity's request for centralized billing is approved, the approval is limited to the 12-month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. TrailBlazer will not process claims for any centralized biller without permission from CMS CO.
13. Each year the centralized biller must contact TrailBlazer to verify understanding of the coverage policy for the administration of the PPV vaccine, and for a copy of the warning language that is required on the roster bill.
14. The centralized biller will be responsible for providing the beneficiary with a record of the PPV vaccination.

The information requested in items 1 through 6 below must be included with the individual or entity's annual request to participate in centralized billing:

1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations;
2. Estimates for the number of beneficiaries who will receive PPV vaccinations;
3. The approximate dates for when the vaccinations will be given;
4. A list of the states in which flu and PPV clinics will be held;
5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse); and
6. Whether the nurses who will administer the flu and PPV vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering flu and PPV vaccinations.

For additional information, please visit the CMS Website at http://www.cms.hhs.gov/AdultImmunizations/02_Providerresources.asp

CHANGE IN THE AMOUNT IN CONTROVERSY REQUIREMENT FOR ADMINISTRATIVE LAW JUDGE HEARINGS AND FEDERAL DISTRICT COURT APPEALS

~CMS MLN Matters~

~Part A & Part B~

MLN Matters Number: MM6295
Related CR Release Date: January 30, 2009
Related CR Transmittal #: R1676CP

Related Change Request (CR) #: 6295
Effective Date: May 4, 2009
Implementation Date: May 4, 2009

Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B MACs (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 6295, which notifies Medicare contractors of the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2009.

The amount remaining in controversy requirement for **ALJ hearing requests** made before January 1, 2009, is \$120. The amount remaining in controversy requirement for requests made on or after January 1, 2009, is \$120.

For **Federal District Court** review, the amount remaining in controversy goes from \$1,180 for requests **on or after January 1, 2008**, to \$1,220 for requests **on or after January 1, 2009**.

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6295 modifies the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 29, Section 330.1 and Section 345.1) to update the AIC required for an ALJ hearing or judicial court review.

Additional Information

The official instruction (CR6295) issued to your Medicare Carrier, A/B MAC, DME MAC, FI, and/or RHHI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1676CP.pdf> on the CMS Website.

If you have questions, please contact your Medicare contractor 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 NEW PROVIDER AUTHENTICATION REQUIREMENTS FOR MEDICARE CONTRACTOR PROVIDER TELEPHONE AND WRITTEN INQUIRIES

~CMS MLN Matters~

~Part A & Part B~

MLN Matters Number: MM6139 **Revised**
Related CR Release Date: February 10, 2009
Related CR Transmittal #: R23COM

Related Change Request (CR) #: 6139
Effective Date: April 6, 2009
Implementation Date: April 6, 2009 for providers

Note: This article was revised on February 11, 2009, to reflect the revised CR 6139, which CMS re-issued on February 10, 2009. The effective and implementation dates for providers have been changed to April 6, 2009. Also, the CR release date, transmittal number, and the Web address of the CR have been changed. All other information remains the same.

Provider Types Affected

CR 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to Interactive Voice Response (IVR) systems.

What You Need to Know

CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a Customer Service Representative (CSR).

Effective April 6, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication: 1) Your National Provider Identifier (NPI); 2) Your Provider Transaction Access Number (PTAN); and 3) The last 5-digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background

In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last 5-digits of the provider's TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last 5-digits of the TIN are correct and belong to you before providing the information you request.

Note: You will only be allowed three attempts to correctly provide your NPI, PTAN, and last 5-digits of your TIN.

As a result of CR 6139, the *Disclosure Desk Reference* for Provider Contact Centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to reflect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

- **Authentication of Providers with No NPI**

Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

- **Beneficiary Authentication**

Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication:

- 1) Last name,
- 2) First name or initial,
- 3) Health Insurance Claim Number (HICN), and
- 4) Either date of birth (eligibility, next eligible date, Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim)) **or** date of service (claim status, CMN/DIF (post-claim)).

- **Written Inquiries**

In general, three data elements (NPI, PTAN, and last 5-digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received without letterhead (including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs)),

The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice location and name on the letterhead must match the contractor's file for this provider. (However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either the NPI, the PTAN, or last 5-digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last 5-digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

- **Overlapping Claims**

When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that

provider by verifying his/her name, NPI, PTAN, last 5-digits of the TIN, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional Information

You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at <http://www.cms.hhs.gov/Transmittals/downloads/R23COM.pdf> on the CMS Website.

If you have any questions, please contact your Medicare contractor (carrier, FI, RHHI, 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.

NEW...IMPROVED....STREAMLINED...WPS MEDICARE (PART B) APPEALS REDETERMINATION FORM

~Part B~

To ensure your appeal has all the required information when submitted, we highly recommend you begin using the NEW WPS Medicare Part B Redetermination Request Form today. Completing the form aids in the efficient processing of the request.

WPS Medicare will continue to process complete Redetermination requests, whether you use the CMS form 20027 or the WPS form. If you choose to request a redetermination WITHOUT a form, the following information MUST be included:

- Beneficiary name
- Medicare Health Insurance Claim Number (HICN)
- Date(s) of service for which initial determination was issued
- Which item(s), if any, and/or service(s) are at issue in the appeal
- Name and signature of the party or representative of the party
- Reason(s) you disagree with the initial claim(s) determination

Incomplete or missing information will delay or dismiss your redetermination.

The new WPS Medicare Redetermination Form is available on the WPS Medicare Website: http://www.wpsmedicare.com/mac/business/b_appeals.shtml

PHYSICIAN SIGNATURE REQUIREMENTS FOR DIAGNOSTIC TESTS

~CMS MLN Matters~

~Part A & Part B~

MLN Matters Number: MM6100 Revised
Related CR Release Date: August 29, 2008
Related CR Transmittal #: R94BP

Related Change Request (CR) #: 6100
Effective Date: January 1, 2003
Implementation Date: September 30, 2008

Note: This article was revised on February 6, 2009, to remove a parenthetical statement from the first paragraph of page 2 of this article. All other information remains the same.

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors (A/B MAC)) for diagnostic laboratory services provided to Medicare beneficiaries.

What You Need to Know

CR 6100, from which this article is taken, updates the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests) Subsection 80.6.1 (Definitions); to incorporate language previously contained in Section 15021 of the *Medicare Carriers Manual*, but inadvertently omitted when the *Medicare Benefit Policy Manual* was published.

Specifically, it notes that a physician's signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

Make sure that your office, billing, and/or laboratory staffs are aware of this updated guidance regarding the signature requirement for diagnostic tests.

Additional Information

You can find more information about physician signature requirements for diagnostic tests by going to CR 6100, located at <http://www.cms.hhs.gov/Transmittals/downloads/R94BP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests), Subsection 80.6.1 (Definitions) as an attachment to CR6100.

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.

Provider Education**EDUCATION SCHEDULE****~Part A & Part B~**

Be sure to visit the WPS Medicare Education Schedule at <http://www.wpsmedicare.com/mac/education/schedule.shtml> to learn more about the educational events we have scheduled for the upcoming months.

Some of the educational events WPS Medicare is hosting include the following:

Part A Seminars and Webinar

- Outpatient Prospective Payment System (OPPS) Billing Seminar
- Skilled Nursing Facility Billing Seminar
- Using C-SNAP Webinar

Part B Teleconference and Webinar

- Ask-the-Contractor Teleconference (ACT)
- Using C-SNAP Webinar

We hope you can join us to learn more about the Medicare program.

ELECTRONIC DATA INTERCHANGE (EDI) ASK-THE-CONTRACTOR TELECONFERENCES (ACTS)**~Part A & Part B~**

WPS Medicare is pleased to announce the 2009 schedule for our Electronic Data Interchange (EDI) Ask-the-Contractor Teleconference (ACT). The calls will be for Legacy Part A (institutional providers who joined WPS in November 2007) & Part B (IL, MI, WI, & MN) as well as MAC J5 A and B states (IA, KS, MO & NE).

We have scheduled our EDI ACT for 2009. These teleconferences will last one and one half hours. We encourage providers, billing staff, vendors and clearinghouses to call with any Medicare EDI questions they deem appropriate.

We will approach the call much in the same way CMS approaches their valuable Open Door Forums, promoting a forum that is less structured, and encourages participants to ask whatever they choose, as long as it pertains to Medicare EDI. We look forward to your participation in these calls!

What are Ask-the-Contractor Teleconferences (ACTs)?

The Medicare Modernization Act (MMA) requires Medicare contractors to hold Ask-the-Contractor Teleconferences (ACTs). This requirement is based on CMS' goal of giving those who provide service to beneficiaries, the information they need to: understand the Medicare program; be informed often and early about changes; and, in the end bill correctly.

The ACT promotes valuable interaction between the Medicare Contractor (WPS) and EDI customers. As stated previously, we modeled our ACTs after CMS Open Door Forums. **Participants are encouraged to ask questions and raise concerns.** EDI staff is available during the call to provide education, program updates, answer questions, and take feedback. In addition, we will provide necessary follow-up to any issues that cannot be resolved during the call time.

WPS Medicare encourages providers to participate in this important educational activity. You can access a recording of the EDI ACT teleconference on this Website approximately one week following the event.

Please Note: No Registration is Necessary

EDI Ask the Contractor Teleconference

We will conduct our 2009 EDI Ask the Contractor Teleconference (ACT) on dates below. You will need the following information to participate in the call:

Date	Time	Dial In	ID
March 12, 2009	1 pm CST	800-305-2862	70745451
May 14, 2009	1 pm CST	800-305-2862	70745640
July 9, 2009	1 pm CST	800-305-2862	70745908
September 10, 2009	1 pm CST	800-305-2862	70746156
November 12, 2009	1 pm CST	800-305-2862	70746399

* Remember you can access a recording of this session on our Website approximately one week following the teleconference.

SELF-SERVICE (ARTICLE 6) – MEDICARE REMIT EASY PRINT (MREP) SOFTWARE

~Part B~

This is the sixth in a series of articles about Self-Service Technology. The article today will focus on the free Medicare Remit Easy Print (MREP) Software.

The Centers for Medicare & Medicaid Services (CMS) has developed software called Medicare Remit Easy Print (MREP) that enables physicians and suppliers to view and print Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 835s from their own computers. Remittance advices printed from the MREP software are similar to the current Standard Paper Remittance Advice (SPR) format.

This software offers important capabilities that allow physicians and suppliers to:

- View, search, and print remittance information
- Print and export reports containing remittance information

The MREP software also allows physicians and suppliers to run several useful reports.

- Adjusted Service Lines Report: Shows claims within a single remittance that have a claim status 22 (reversed claim).

- Denied Service Lines Report: Shows only claim service lines that have an allowed amount of zero *and* are associated with a claim that does not have a claim status 22 (reversed claim).
- Deductible/Coinsurance Service Lines Reports: Shows claim service lines that have a deductible and/or a coinsurance amount.
- Coordination of Benefits (COB)/Non-COB Claims Reports: Shows claims by their COB status. Providers may view all claims that were crossed over, or all those that were not crossed over.
- Other Adjustments Report: Shows claims that had some type of adjustment, including claims that have late filing and interest charges and remittances that have withholding or a forwarding balance.

Prints Information for Use by Other Payers

The MREP software gives physicians and suppliers the ability to print remittance information for individual or multiple selected claims. This allows them to forward only those claims that are needed by other payers for secondary/tertiary payment. Physicians and suppliers may view and/or print as many or as few claims as needed.

Easy to Navigate and View Remittance Information

The MREP software presents remittance information that is organized and easy to view. The MREP software provides separate tabs that include the following information:

- A list of claims
- Details for individually selected claims
- Summary information
- Glossary information containing Claim Adjustment Reason Codes, Remittance Advice Remark Codes, and their definitions
- A data view that allows physicians and suppliers to look at the various loops and segments containing data in the HIPAA 835
- A search function to find claims containing specific information

Allows Quick and Easy Access to Claim Information

The MREP software features a search function that allows physicians and suppliers to find a claim (or multiple claims) based on customized search criteria. Physicians and suppliers may search by names, numbers, and even portions of information, such as:

- Adjusted Lines
- Beneficiary Account Number
- Beneficiary Last Name
- COB/Non-COB Claims
- Deductible/Coinsurance Lines
- Denied Lines
- Health Insurance Claim Number (HICN)
- Internal Control Number (ICN)
- National Drug Code (NDC)
- Other Adjustments
- Procedure Code
- Rendering Provider Number
- Service Date

Caution

Providers using clearinghouses or vendors that alter the HIPAA 835 report before sending to your office may not be able to use the MREP software.

For more information, visit <http://www.cms.hhs.gov/ElectronicBillingEDITrans/> on the CMS Website.

SELF-SERVICE (ARTICLE 7) – INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

~Part B~

This is the seventh in a series of articles about Self Service Technology. The article today will focus on the Interactive Voice Response (IVR) System.

How to reach the IVR:
IA, KS, MO, NE – (866) 590-6702

The IVR offers the provider community quick and easy access to Medicare-related information 24 hours a day. By simply calling the toll-free telephone number listed above, you will have the ability to access Medicare claims information and patient eligibility.

You can access the IVR by either speaking the required information or entering it using your telephone number pad. For complete instructions and helpful hints on using the IVR visit: <http://www.wpsmedicare.com/mac/transition/ivr.pdf>

What's available on the IVR?

Touch-tone Option	Vocal Option
1	Eligibility
2	Claim Status
3	Provider Summary
4	Checks
5	Deductibles
6	Pricing
7	Questions

When is the IVR available?

The IVR is available 24 hours a day, 7 days a week. However, the standard hours of operation when all IVR functions are available are:

Monday – Friday 6:00 am – 6:00 pm CT**

** Please note that the functions which require a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN) to be entered, such as eligibility and claim status, have limited hours due to system availability. The hours vary by state and option.

Remember: Customer Service Representatives are prohibited from giving you information that can be obtained using IVR. However, they will assist you with more complex inquiries.

SELF-SERVICE (ARTICLE 8) – COMPUTER-BASED TRAININGS (CBT)

~Part B~

This is the eighth in a series of articles about Self-Service Technology. The article today will focus on Computer-Based Trainings (CBTs).

CBTs are self-study courses designed to increase knowledge of the Medicare program. The Centers for Medicare & Medicaid Services (CMS) and Wisconsin Physicians Service (WPS) Medicare have developed CBTs for providers' use.

WPS Medicare CBTs are located on our Website at:

http://www.wpsmedicare.com/mac/education/b_cbt.shtml

The CBTs consist of two different formats.

1. Recorded audiovisual presentations have a speaker presenting material. The information is also available in written format for people unable to view the audio-visual format by selecting "read the script".
2. Slideshow format allows the user to move through the presentation at his/her own pace. This format does not contain audio and is read-only.

CMS CBTs consist of the slideshow format only and are located at:

http://cms.meridianksi.com/kc/ilc/course_info_enroll_inlfrm_f1.asp?lgnfrm=wbt&table=crs&function=course_info_enroll&strBuildingID=5&strFunctionID=37&strFunctionPath=37&strFrom=Search&topic=All&keywords.

CBTs are available for a wide variety of topics and are ideal for staff that is new to Medicare. We encourage you to take control of your Medicare education by using the Computer-Based Trainings (CBTs) today!

Reimbursement**CORRECTIONS TO THE INPATIENT PROSPECTIVE PAYMENT
SYSTEM WAGE INDEX FOR FISCAL YEAR (FY) 2009**

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6363
Related CR Release Date: February 13, 2009
Related CR Transmittal #: R447OTN

Related Change Request (CR) #: 6363
Effective Date: October 1, 2008
Implementation Date: May 18, 2009

Provider Types Affected

Inpatient Acute Care hospitals who bill Medicare fiscal intermediaries (FIs) or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries. See below for the list of affected hospitals.

Provider Action Needed

This change only impacts hospitals which chose to notify CMS that they wished to revise the decision that CMS made on their behalf regarding their FY 2009 wage index. (See the Background section of this article for more details and a list of specific hospitals affected.) Please note that FIs and MACs will reprocess any claims with discharge dates on or after October 1, 2008, that were previously processed using an incorrect wage index. **You need take no action to initiate the reprocessing of the claims.** You should notify your billing office staff that adjustments to payments will be made within the next 90 days.

Background

Due to the extension of section 508 in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Centers for Medicare & Medicaid Services (CMS) stated in its final rule, published August 19, 2008, that due to the timing of the extension, CMS would be unable to recompute the FY 2009 wage index for any hospital reclassified under section 508 and special exception hospitals in time for inclusion in the FY 2009 wage index. Instead, CMS stated that we would publish the final wage FY 2009 wage index in a separate notice and that it would analyze the data for hospitals in areas affected by the MIPPA extension and make decisions on behalf of hospitals that we believe would result in the highest FY 2009 wage index for which they are eligible. Hospitals were allowed 15 days from the date of the separate notice, published October 3, 2008, to notify CMS if they wished to revise the decision that CMS made on their behalf.

The following list shows the provider numbers of hospitals who requested a reversal of the decision that CMS made on its behalf and their new wage index and Geographic Adjustment Factor (GAF):

050069, 050168, 050173, 050193, 050224, 050226, 050230, 050348, 050426, 050526, 050543, 050548, 050551, 050567, 050570, 050580, 050589, 050603, 050609, 050678, 050693, 050720, 050744, 050745, 050746 and 050747 have a new wage index of 1.2032 and a GAF of 1.1351. Hospital 250078 has a new wage index of 0.8418 and a GAF of 0.8888 and hospital 260110 has a corrected wage index of 0.8992 and a corrected GAF of 0.9298.

Additional Information

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

The official instruction (CR6363) issued to your Medicare MAC and/or FI is available at <http://www.cms.hhs.gov/Transmittals/downloads/R447OTN.pdf> on the CMS Website.

PAYMENT FOR CO-SURGEONS IN A METHOD II CRITICAL ACCESS HOSPITAL (CAH)**~CMS MLN Matters~****~Part A~****MLN Matters Number: MM6319****Related CR Release Date: January 30, 2009****Related CR Transmittal #: R1672CP****Related Change Request (CR) #: 6319****Effective Date: January 1, 2008****Implementation Date: July 6, 2009****Provider Types Affected**

Method II CAHs billing Medicare Administrative Contractors (A/B MACs) and/or fiscal intermediaries (FIs) for physicians that have reassigned their billing rights to the CAH on type of bill 85X with revenue codes 96X, 97X, or 98X with modifier 62 for co-surgeon services rendered in a Method II CAH to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6319 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR6319 to highlight the revisions to the Medicare Claims Processing Manual, Chapter 4 dealing with payment for co-surgeons in a Method II CAH.

Physicians billing on type of bill 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the CAH. When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue codes 96X, 97X or 98X). Medicare makes a payment for a co-surgeon when the procedure is authorized for a co-surgeon and the person performing the surgery is a physician. CR 6319 **implements the reduction in payment for co-surgeon services**. See the "Key Points" section for specifics regarding the revisions and the impact on claims for co-surgeon services in a Method II CAH.

Background

When the billing rights are reassigned to the Method II CAH, payment is made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X). Under some circumstances, the skills of two surgeons (**each in a different specialty**) are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition.

Co-surgery refers to a single surgical procedure which requires the skill of two surgeons, each in a different specialty, performing parts of the same procedure simultaneously. It is not always co-surgery when two doctors perform surgery on the same patient during the

same operative session. **Co-surgery has been performed if the procedure(s) performed is part of and would be billed under a single surgical procedure code.**

Medicare uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code. The MPFSDB is located at http://www.cms.hhs.gov/apps/ama/license.asp?file=/pfslookup/02_PFSsearch.asp on the CMS Website.

The revised *Medicare Claims Processing Manual* Chapter 4 (attached to CR 6319) outlines changes that impact five areas as follows:

1. Coding Co-surgeon Services Rendered in a Method II CAH;
2. Use of Payment Policy Indicators for Determining Procedures Eligible for Payment of Co-surgeons;
3. Payment of Co-surgeon Services Rendered in a Method II CAH;
4. Co-surgeon Medicare Summary Notice (MSN) and Remittance Advice (RA) Messages; and
5. Review of Supporting Documentation for Co-surgeon Services in a Method II CAH.

Key Points Regarding Claims for Co-Surgeon Services in a Method II CAH

- Medicare will accept claims for co-surgeon services submitted on type of bill 85X with revenue code 96X, 97X, or 98X if it contains either one claim line with a surgical HCPCS/CPT code and has the 62 modifier or two claim lines with the same surgical HCPCS/CPT code with the same line item date of service, and the 62 modifier on each line.
- In the situation just described where co-surgeon services are reported on two claim lines within the same claim, both lines must have the 62 modifier. Where only one line has the 62 modifier, Medicare will deny the line without the 62 modifier with the following messages:
 - Medicare Summary Notice (MSN) 16.10 indicating Medicare does not pay for this item or service;
 - Remittance Advice (RA) Remark Code M78, indicating Missing/incomplete/invalid HCPCS modifier;
 - Group Code of CO showing contractual obligation; and
 - Claim Adjustment Reason Code (CARC) 4 denoting that the procedure code is inconsistent with the modifier used or a required modifier is missing.
- When billing for co-surgeon services, remember that Medicare will pay only when the services are rendered by two surgeons, each with a different specialty, and the claim carries modifier 62 to show there were two surgeons for co-surgery.
- The MPFSDB must reflect an acceptable payment policy indicator for the associated HCPCS/CPT code in order for the claim to be considered for payment. If the payment policy indicator is "0" indicating that co-surgeons are not permitted for that procedure, Medicare will deny the claim with the following:
 - MSN message 15.12, indicating Medicare does not pay for two surgeons for this procedure;
 - RA Remark Code N431 to show "service is not covered with this procedure";

- A group code of PR, showing patient responsibility; and
- A CARC of 54 to show “Multiple physicians/assistants are not covered in this case.”
- Medicare contractors will develop co-surgeon services on TOB 85X with RC 96X, 97X or 98X and modifier 62 for the supporting documentation needed to establish medical necessity when the HCPCS/CPT code has a payment policy indicator of ‘1’ showing that co-surgeons could be paid depending on supporting documentation.
- Medicare contractors will define the appropriate supporting documentation needed to establish medical necessity for co-surgeon services when the HCPCS/CPT code has a payment policy indicator of ‘1’.
- Method II CAHs should remember that they will be liable for non-covered co-surgeon services unless they issue an appropriate advance beneficiary notice (ABN) when the payment policy indicator is ‘1’.
- Medicare contractors will deny co-surgeon services when the supporting documentation does not establish medical necessity when the payment policy indicator is ‘1’.
- Medicare contractors will use the following messages when denying medically unnecessary co-surgeon services with a payment policy indicator of ‘1’ when an ABN was issued:
 - An MSN message 36.1 - Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review.
 - An RA Remark Code of M38 - The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
 - A group code of PR – Patient Responsibility
 - A CARC code of 54 – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will use the following messages when denying medically unnecessary co-surgeon services with a payment policy indicator of ‘1’ when an ABN was not issued:
 - MSN message 36.2 - It appears that you did not know that we would not pay for this service, so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things: (1) a copy of this notice, (2) your provider’s bill, and (3) a receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility.
 - RA Remark Code M27 - 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.
- Group code CO – Contractual Obligation.
 - CARC code 54 – Multiple physicians/assistants are not covered in this case.
- Medicare contractors will develop co-surgeon services on type of bill (TOB) 85X with RC 96X, 97X or 98X and modifier 62 to establish that the two specialty requirement is met when the HCPCS/CPT code has a payment policy indicator of '2'.
 - Medicare contractors will deny co-surgeon services when the two specialty requirement is not met, i.e., the two co-surgeons each have the same specialty. When denying such claims, Medicare will use the following messages:
 - MSN Message 21.21 – This service was denied because Medicare only covers this service under certain circumstances.
 - RA Remark Code N95 – The provider type/provider specialty may not bill this service.
 - Group code PR – Patient Responsibility.
 - CARC code 54 – Multiple physicians/assistants are not covered in this case.
 - Medicare contractors will return to provider (RTP) co-surgeon services submitted on TOB 85X with RC 96X, 97X or 98X when the HCPCS/CPT code billed with the 62 modifier has a payment policy indicator of '9', indicating the co-surgeon concept does not apply.
 - Medicare contractors will determine if a clinician or a non-clinician medical reviewer should review the supporting documentation submitted for co-surgeon services.
 - Medicare contractors will not search for and adjust claims that have been paid prior to the implementation date. However, they will adjust such claims that you bring to their attention.
 - Finally, when Medicare pays for co-surgeon services, payment is the lesser of the actual charge or 62.5% of the MPFS payment minus deductible and coinsurance. Where payment rights are reassigned to a Method II CAH, that CAH is paid 115% of that lesser payment amount.

Additional Information

If you have questions, please contact your Medicare 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.

The official instruction (CR6319) issued to your Medicare FI or A/B MAC is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1672CP.pdf> on the CMS Website.

**PAYMENT FOR REPAIR, MAINTENANCE AND SERVICING OF
OXYGEN EQUIPMENT AS A RESULT OF THE MEDICARE
IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT (MIPPA) OF
2008**

~CMS MLN Matters~

~Part B~

MLN Matters Number: MM6296

Related CR Release Date: February 13, 2009

Related CR Transmittal #: R443OTN

Related Change Request (CR) #: 6296

Effective Date: April 1, 2009

Implementation Date: April 6, 2009

Provider Types Affected

Providers and suppliers submitting claims to Medicare DME Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for repair, maintenance and servicing of oxygen equipment provided to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 6296 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is providing instructions regarding repair, maintenance, and servicing of oxygen equipment resulting from implementation of Section 144(b) of the MIPPA. The 36-month cap noted in MIPPA applies to stationary and portable oxygen equipment furnished on or after January 1, 2006. **Therefore, the 36-month cap may end as early as January 1, 2009, for beneficiaries using oxygen equipment on a continuous basis since January 1, 2006.**

CMS has determined that, for services furnished during calendar year 2009, it is reasonable and necessary to make payment for periodic, in-home visits by suppliers to inspect certain oxygen equipment and provide general maintenance and servicing after the 36-month rental cap. These payments only apply to equipment falling under HCPCS codes E1390, E1391, E1392, and K0738, and only when the supplier physically makes an in-home visit to inspect the equipment and provide any necessary maintenance and servicing. Payment may be made every 6 months, beginning 6 months after the 36-month rental cap (as early as July 1, 2009, in some cases), and the allowed payment amount for each visit is equal to the 2009 fee for code E1340 (K0739 for dates of service on or after April 1, 2009) multiplied by 2, for the state in which the in-home visit takes place.

Suppliers should use the HCPCS code for the equipment E1390, E1391, E1392, and/or K0738 along with the MS modifier in order to bill and receive payment for these maintenance and servicing visits. For example, if the supplier visits a beneficiary's home in Pennsylvania to perform the general maintenance and servicing on a portable concentrator, the supplier would enter E1392MS on the claim and the allowed payment amount would be equal to the lesser of the supplier's actual charge or two units of the allowed payment amount for K0739 in Pennsylvania. If the supplier visits the beneficiary's home to provide the periodic maintenance and servicing for a stationary concentrator (E1390 or E1391) and a transfilling unit (K0738), payment can be made for maintenance and servicing of both units (E1390MS or E1391MS, and K0738MS). If the supplier visits the beneficiary's home to provide the periodic maintenance and servicing for a portable concentrator (E1392),

payment can only be made for maintenance and servicing of the one unit/HCPCS code (E1392MS).

CMS will issue further instructions in the future regarding continuation of these payments for dates of service on or after January 1, 2010.

Background

Section 144(b) of MIPPA repeals the transfer of ownership provision established by the Deficit Reduction Act (DRA) of 2005 for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36-month payment cap. Initial instructions related to implementation of these changes were issued as part of the January 2009 Durable Medical Equipment Prosthetics Orthotics & Supplies (DMEPOS) Fee Schedule Update, CR 6297. The MLN Matters article related to CR6297 may be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6297.pdf> on the CMS Website.

Key Points in CR6296

- To distinguish between the repair or nonroutine service of beneficiary-owned DME and oxygen equipment, two new “K” codes are effective for claims with dates of service on or after April 1, 2009. Those “K” codes are:
 - K0739 – Repair or Nonroutine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes
 - K0740 – Repair or Nonroutine Service for Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes
- The new non-covered code K0740 should be used by suppliers to indicate the labor associated with the repair of stationary or portable oxygen equipment.
- The existing E1340 HCPCS code is invalid for Medicare claims, effective April 1, 2009. The revised 2009 labor payment rates, provided in CR 6297, map directly to the new K0739 code and will be used to pay claims for code K0739 with dates of service on or after April 1, 2009.
- **Note that the two new codes are not yet final and should not be used until effective on April 1, 2009.**
- DME MACs and RHHIs:
 - Deny claims with dates of service on or after April 1, 2009 for HCPCS code K0740.
 - Will deny claims with dates of service on or after January 1, 2009, for claims received on or after April 6, 2009, for replacement parts billed using a HCPCS code and the "RB" modifier when the part is replaced in conjunction with the repair of oxygen equipment identified by HCPCS codes E0424, E0431, E0434, E0439, E1390, E1391, E1392, E1405, E1406, or K0738.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 6296) issued to your Medicare DME MAC, or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R443OTN.pdf> on the CMS Website.

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

PAYMENTS TO INSTITUTIONAL PROVIDERS WITH MULTIPLE SERVICE DELIVERY LOCATIONS

~CMS MLN Matters~

~Part A~

MLN Matters Number: MM6300

Related CR Release Date: February 13, 2009

Related CR Transmittal #: R1681CP

Related Change Request (CR) #: 6300

Effective Date: October 1, 2007

Implementation Date: July 6, 2009

Provider Types Affected

Hospitals and other institutional providers who bill Medicare Administrative Contractors (MACs) or Fiscal Intermediaries (FIs) for providing services, which are paid under the Medicare Physician Fee Schedule (MPFS), to Medicare beneficiaries.

What You Need to Know

CR 6300, from which this article is taken, instructs your MAC or FI to assign payment localities based on the ZIP code of the actual service facility location, rather than the main provider address, when such services are paid under the MPFS. On such claims submitted via the 837 institutional claim to MACs or FIs, Medicare will use the nine-digit ZIP code reported in the 2310E loop, when present, to determine the payment locality to apply to payments for MPFS and anesthesia services. See the Background section, below, for details.

Background

Since institutional providers have historically operated from a single physical location, the provider files in Medicare's Fiscal Intermediary Shared System (FISS) contain only a provider's single master address. Where a nine-digit ZIP code is required, this master address has been used to determine the fee amount for services that are paid under the Medicare Physician Fee Schedule (MPFS).

Increasingly, however, hospitals are operating off-site outpatient facilities and other institutional outpatient service providers are operating multiple satellite offices. Sometimes these facilities are in different payment locations than the parent provider. In order for MPFS and anesthesia payments to be accurate, the nine-digit ZIP code of the off-site or satellite facility should be used to determine the locality.

Change Request (CR) 5243 (released January 2007) instructed Medicare outpatient service providers to report the nine-digit ZIP code of the actual service facility location in the 2310E loop of the 837 Institutional claim transaction; however, because there is no corresponding field in its internal claim record to carry a service facility nine-digit ZIP code, FISS has not been able to implement this change.

CR 6300, from which this article is taken, instructs FISS to map the nine-digit service facility ZIP code reported in data element N403 of loop 2310E of an incoming 837 institutional claim

to a payer-only value code in order to capture the ZIP code of the service facility when it differs from the main provider address. This will make the data available to the payment logic in FISS so proper payment can be made based on the MPFS.

Notes: 1) Medicare contractors will pay MPFS and anesthesia services using the nine-digit service facility ZIP code (described above) for claims that you submit electronically via the institutional 837, but will continue to use the ZIP code associated with your master address to determine the payment location on claims that you submit via Direct Data Entry or paper formats.

2) When you bring to your MAC or FI's attention timely claims that were paid inaccurately because the service facility ZIP code was lacking, your MAC or FI will adjust the claims by appending the value code and the service facility ZIP code that you specify.

Additional Information

The official instruction, CR6300, issued to your MAC or FI is located at <http://www.cms.hhs.gov/Transmittals/downloads/R1681CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. If you have any questions, please contact your MAC or FI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

WPS MEDICARE PROVIDER SERVICES

For additional information on the content of this newsletter, changes in policy or procedures, how to obtain a hardcopy of an LMRP/LCD, or if you experience difficulties obtaining a policy on our Website, please contact a customer service representative at the telephone numbers/addresses listed below.

Part A	
Iowa Part A	Kansas Part A
WPS Medicare Part A General Correspondence P.O. Box 7665 Madison, WI 53707-7665 (866) 518-3285	WPS Medicare Part A General Correspondence P.O. Box 7576 Madison, WI 53707-7576 (866) 518-3285
Missouri Part A	Nebraska Part A
WPS Medicare Part A General Correspondence P.O. Box 8890 Madison, WI 53707-8890 (866) 518-3285	WPS Medicare Part A General Correspondence P.O. Box 8799 Madison, WI 53708-8799 (866) 518-3285
Part B	
Iowa	Kansas
WPS Medicare Part B General Correspondence P.O. Box 8550 Madison, WI 53708-8550 (866) 503-3807	WPS Medicare Part B General Correspondence P.O. Box 7238 Madison, WI 53707-7238 (866) 503-3807
Missouri (Western)	Missouri (Eastern)
WPS Medicare Part B General Correspondence P.O. Box 7128 Madison, WI 53707-7128 (866) 503-3807	WPS Medicare Part B General Correspondence P.O. Box 14260 Madison, WI 53708-0260 (866) 503-3807
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