

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**NO NEED TO CALL US – JUST SEND US A CHECK****Part B**

If you receive incorrect payment, take immediate action. Complete the Voluntary Overpayment Refund form at http://www.wpsmedicare.com/mac/business/b_refundform.pdf and refund the incorrect payment.

Providers are responsible for making voluntary/unsolicited refunds to Medicare as soon as possible, without waiting for notification. Do not call Medicare asking us to request the overpayment - simply make the refund.

You can find additional information in the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network brochure "What Physicians and other Suppliers should know about Medicare Overpayment" at the following Web address:

<http://www.cms.hhs.gov/MLNProducts/downloads/Overpaymtbroch07.pdf>

REPORTING WITHHOLDING DUE TO IRS FEDERAL PAYMENT LEVY PROGRAM (FPLP) ON THE REMITTANCE ADVICE

~CMS MLN Matters~

Part A & Part B

MLN Matters Number: MM6125 Revised
Related CR Release Date: August 15, 2008
Related CR Transmittal #: R367OTN

Related Change Request (CR) #: 6125
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Note: This article was revised on August 21, 2008, to clarify the "Provider Types Affected". All other information remains the same.

Provider Types Affected

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

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

Your Medicare payments could be reduced if the Internal Revenue Service (IRS) needs to collect overdue taxes that you owe.

CAUTION – What You Need to Know

The Taxpayer Relief Act of 1997, Section 1024, requires the IRS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Should you owe such taxes and your payments are reduced, your remittance advice will reflect a provider level adjustment code (PLB) of "WU" in the PLB03-1 data field.

GO – What You Need to Do

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

Background

In July 2000, the Treasury Department's Financial Management Service and the IRS started the Federal Payment Levy Program (FPLP) which is authorized by Internal Revenue Code Section 6331 (h), as prescribed by Section 1024 of the Taxpayer Relief Act of 1997. Through this program, collection of overdue taxes through a continuous levy on certain federal payments is authorized. This includes federal payments made to contractors and vendors, including Medicare providers, doing business with the government.

IRS may reduce federal payments subject to the levy by 15 percent, or the exact amount of tax owed if it is less than 15 percent of the payment. The levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt. Each time the federal payment is levied, the Financial Management Service will send a letter of explanation, including information on which federal payment was levied, and advice on who to contact for resolution.

Effective October 1, 2008, if you owe such taxes to IRS, your Medicare payment may be adjusted accordingly. When such adjustments occur, your Medicare remittance advice will reflect the code of "WU" in the PLB03-1 data field. In addition, a 10 digit toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field. **Should this happen to you, note that under current privacy rules and regulations, only the IRS may discuss the tax issue with you. Thus, if you have questions, contact the IRS at the toll-free number just mentioned, instead of contacting your Medicare contractor.**

Additional Information

To view the official instruction (CR6125) issued to your Medicare contractor on this issue, visit <http://www.cms.hhs.gov/Transmittals/downloads/R367OTN.pdf> on the Centers for Medicare & Medicaid Services Website.

Claim Submission**2008 REMINDER FOR ROSTER BILLING AND CENTRALIZED BILLING FOR INFLUENZA AND PNEUMOCOCCAL VACCINATIONS**

~CMS MLN Matters~

Part A & Part B

MLN Matters Number: MM6121
Related CR Release Date: August 15, 2008
Related CR Transmittal #: R366OTN

Related Change Request (CR) #: 6121
Effective Date: September 15, 2008
Implementation Date: September 15, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6121 which reminds the Medicare physician community of the requirements to correctly enroll in order to conduct Mass Immunization Roster Billing and Centralized Billing of Medicare for influenza and pneumococcal immunizations. Remember that centralized billers participation is limited to one year and such billers must reapply each year they wish to be a centralized biller. The yearly reapplication process is not required for Mass Immunizer Roster Billers.

Background

The Centers for Medicare & Medicaid Services (CMS) is issuing Change Request (CR) 6121 as a reminder for Mass Immunization Roster Billing and Centralized Billing for Influenza and Pneumococcal vaccinations.

Mass immunizers are providers and suppliers who enroll in the Medicare program to offer the influenza vaccinations to a large number of individuals, and they must be properly licensed in the States in which they plan to operate influenza (flu) clinics. Enrollment for mass immunizers is ongoing and must be completed through the local A/B MAC or carrier. Mass immunizers submit their claims to the local Medicare contractor.

Centralized billers are mass immunizers who have applied to become centralized billers when they operate in at least three payment localities for which there are three different Medicare contractors processing claims. Individuals and entities must be properly licensed in the States in which they plan to operate influenza (flu) and/or pneumococcal clinics.

Providers who only offer influenza services:

- May enroll as one of two types of providers including a mass immunization roster biller (specialty provider type 73), or a Centralized Biller, and
- Must meet the guidelines for being either a mass immunizer or centralized biller.

Suppliers must enroll as a mass immunization roster biller (specialty provider type 73) with a carrier or A/B MAC to render influenza vaccination services to Medicare beneficiaries.

Mass immunization roster billers and centralized billers must enroll in the Medicare program even if mass influenza and/or pneumococcal immunizations are the only service being provided. They must:

- Accept assignment on both the vaccine and its administration,
- Bill only for influenza and/or pneumococcal vaccinations, and
- Submit claims using the roster billing process.

Participation as a centralized biller is limited to one year and must be renewed annually by contacting the CMS central office by June 1 to request participation for the upcoming year. Claims for centralized billers are processed by one Medicare specialty contractor regardless of the locality where the service was rendered. Centralized billers submit their claims to the designated specialty contractor.

Providers and suppliers must enroll using the appropriate CMS 855 provider enrollment form (See http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp on the CMS Website). Applications are available from the local contractors. Refer to the Medicare Claims Processing Manual, Chapter 18, Sections 10-10.5 at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> on the CMS Website for more information on billing requirements.

Note: Medicare Part B pays 100 percent for pneumococcal vaccines, influenza virus vaccines, and their administration. The Part B deductible and coinsurance do not apply for influenza virus and pneumococcal vaccine.

Remember the following regarding the influenza vaccine:

- Medicare allows one influenza (flu) vaccination per year;
- Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the influenza vaccine and its administration; and
- The beneficiary may receive the influenza vaccine upon request without a physician's order and without physician supervision.

Remember the following with regard to the pneumococcal vaccine, effective for services furnished on or after July 1, 2000:

- Medicare does not require for coverage purposes, that a doctor of medicine or osteopathy order the pneumococcal vaccine and its administration, and
- The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Typically, the pneumococcal vaccine is administered once in a lifetime. Claims for pneumococcal vaccines are paid for beneficiaries who:

- Are at high risk of pneumococcal disease, and
- Have not received a pneumococcal vaccine within the last five years, or
- Are revaccinated because they are unsure of their vaccination status.

Additional Information

CMS offers a number of free educational products on its Medicare Learning Network (MLN). These products are available on the MLN Preventive Services Educational Products Web page located at

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS Website.

The official instruction, CR 6121, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R366OTN.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.

BENEFICIARY SUBMITTED CLAIMS

~CMS MLN Matters~

Part A & Part B

MLN Matters Number: MM5683
Related CR Release Date: September 5, 2008

Related Change Request (CR) #: 5683
Effective Date: Claims received on or
after August 18, 2008

Related CR Transmittal #: R1588CP

Implementation Date: August 18, 2008

Note: This article was revised on September 9, 2008, to reflect changes made to CR5683. The CR was revised to emphasize that the changes apply to claims received on or after August 18, 2008, regardless of the date of service. The CR release date, transmittal number and Web address for accessing CR5683 were also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 5683 updates the procedures for processing claims submitted by Medicare beneficiaries to carriers and/or A/B MACs and serves as a reminder to providers and suppliers that they are required by law to submit claims to Medicare for services they render to Medicare beneficiaries.. These updates do not apply to beneficiary claims submitted to Durable Medical Equipment (DME) MACs.

Background

All providers and suppliers are required to enroll in the Medicare program in order to receive payment. In addition, the Social Security Act (Section 1848 (g)(4)(A); http://www.ssa.gov/OP_Home/ssact/title18/1848.htm) requires all providers and suppliers to submit claims for services rendered to Medicare beneficiaries. The current manual requirement instructs Medicare contractors to provide education to the providers and suppliers explaining the statutory requirement, including possible penalties for repeatedly refusing to submit claims for services provided. Medicare contractors are also instructed to process beneficiary submitted claims for services that:

- 1) **Are not covered by Medicare** (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc., in accordance with its normal processing procedures; see 42 CFR 411.15 at http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr411.15.pdf for details); and
- 2) **Are covered by Medicare** when the beneficiary has submitted a complete claim (Patient's Request for Medical Payment Form CMS-1490S; <http://www.cms.hhs.gov/CMSForms/CMSForms/>) and all supporting documentation associated with the claim, including an itemized bill with the following information:
 - o Date of service,
 - o Place of service,
 - o Description of illness or injury,
 - o Description of each surgical or medical service or supply furnished,
 - o Charge for each service,
 - o The doctor's or supplier's name, address, and
 - o The provider or supplier's National Provider Identifier (NPI).

If an incomplete claim (or a claim containing invalid information) is submitted, the contractor will return the claim as incomplete with an appropriate letter. The Centers for Medicare & Medicaid Services (CMS) will be providing suggested language for that letter in a later Transmittal. In addition, contractors will manually return (to the beneficiary) beneficiary submitted claims when the beneficiary used Form CMS-1500 with instructions how to complete and return the appropriate beneficiary claims Form CMS-1490S for processing.

Note: CMS will be providing suggested language for the above mentioned letter in a later Transmittal.

When manually returning a beneficiary submitted claim (Form CMS-1490S) for a Medicare-covered service (because the claim is not complete or contains invalid information), the contractor will maintain a record of the beneficiary submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.

When returning a beneficiary submitted claim, the contractor will inform the beneficiary by letter that:

- The provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable); and
- In order to submit the claim, the provider must enroll in the Medicare program.

Medicare contractors should encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), the beneficiary should:

- 1.) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare, and
- 2.) Submit a complete Form CMS-1490S with all supporting documentation.

Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the beneficiary's claim Form CMS-1490S (and all supporting documentation), the contractor will process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare.

Contractors will maintain:

- 1.) Documentation of beneficiary complaints involving violations of the mandatory claims submission policy, and
- 2.) A list of the top 50 violators (by State) of the mandatory claim submission policy.

The instructions provided in CR 5683 do not apply to foreign claims, and they do not apply to beneficiary claims submitted to DME MACs (for durable medical equipment, prosthetics, orthotics and supplies). The processing of foreign claims will remain unchanged, and DME MACs should continue to follow procedures that are currently in place.

Additional Information

The official instruction, CR5683, issued to your carrier, A/B MAC, and DME MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1588CP.pdf> on the CMS Website.

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

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

IMPLEMENTATION OF A NEW CLAIM ADJUSTMENT REASON CODE (CARC) NO.213. "NON-COMPLIANCE WITH THE PHYSICIAN SELF-REFERRAL PROHIBITION LEGISLATION OR PAYER POLICY"

~CMS MLN Matters~

Part A & Part B

MLN Matters Number: MM6131

Related CR Release Date: August 15, 2008

Related CR Transmittal #: R1578CP

Related Change Request (CR) #: 6131

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), regional home health intermediaries (RHHI), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs (effective January 1, 2009) to use the new Claim Adjustment Reason Code (CARC) #213 when denying claims based on non-compliance with the physician self-referral prohibition.

Make sure that your billing staffs are aware of this new CARC code.

Background

Unless an exception applies (as referenced below), Section 1877 of the Social Security Act (the Act), prohibits a physician from referring a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or his/her immediate family member(s)) has a financial relationship. A "financial relationship" includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements).

The following services are DHS:

- Clinical laboratory services;
- Radiology and certain other imaging services (including MRIs, CT scans and ultrasound);
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Orthotics, prosthetics, and prosthetic devices;
- Parenteral and enteral nutrients, equipment and supplies;
- Physical therapy, occupational therapy, speech-language pathology services;
- Outpatient prescription drugs;
- Home health services and supplies; and
- Inpatient and outpatient hospital services.

Section 1877 of the Act also prohibits the DHS entity from submitting to Medicare, the beneficiary, or any entity for DHS, claims that are furnished as a result of a prohibited referral.

Note: Violations of this statute are punishable by: 1) Denial of payment for all DHS claims; 2) Refunds of amounts collected for DHS claims; and 3) Civil money penalties for knowing violations of the prohibition.

Prior to the publication of the new CARC #213 ("Non-compliance with the physician self-referral prohibition legislation or payer policy"), there was no specific code to describe claims that are denied based on "Stark" (the physician self-referral statute at Section 1877 of the Act). Therefore, so that both the DHS providers and the industry will know that claims are being denied because of non-compliance with the physician self-referral prohibitions; CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs to use the new CARC No. 213 (effective January 1, 2009) when denying claims based on non-compliance with the physician self-referral prohibition.

Your Medicare contractors will use this code any time they deny a claim because a physician (or one or more of their immediate family members) has a financial interest in a DHS provider and fails to meet one of the exceptions referenced below.

Exceptions

Please note that the statute enumerates various exceptions, including exceptions for physician ownership or investment interest in hospitals and rural providers. You can read these exceptions in Section 1877 of the Social Security Act Sec. 1877 which you can find at

http://www.cms.hhs.gov/PhysicianSelfReferral/Downloads/section_1877.pdf on the CMS Website; and in 42 C.F.R. Part 411, Subpart J.) (42 U.S.C. Section 1395nn).

Additional Information

You can find more information about CARC #213 by going to CR 6131, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1578CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Claims Processing Manual* Chapter 1 (General billing requirements Section 180 (Denial of Claims Due to Violations of Physician Self-Referral Prohibition)) as an attachment to that CR. If you have any questions, please contact DME MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenter> on the CMS Website.

PNEUMOCOCCAL PNEUMONIA, INFLUENZA VIRUS, AND HEPATITIS B VACCINES

~CMS MLN Matters~

Part B

MLN Matters Number: MM6079

Related CR Release Date: September 5, 2008

Related CR Transmittal #: R1586CP

Related Change Request (CR) #: 6079

Effective Date: October 6, 2008

Implementation Date: October 6, 2008

Provider Types Affected

Physicians and providers billing Medicare contractors (carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 6079 and notifies providers that the Centers for Medicare & Medicaid Services (CMS) revised Form CMS-1500 to accommodate the reporting of the National Provider Identifier (NPI). The current Form CMS 1500 (08-05) does not require reporting the NPI for influenza virus and pneumococcal vaccine claims submitted as roster bills. Therefore your Medicare contractor **should NOT return claims as unprocessable** to the supplier/provider of service when the rendering provider does not enter his/her NPI into 24J of Form CMS-1500 for influenza virus and pneumococcal vaccine claims submitted as roster bills.

Key Point of CR6079

The requirement of an NPI for the rendering provider **does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills.**

Additional Information

To see the official instruction (CR6079) issued to your Medicare FI, carrier, or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R1586CP.pdf> on the CMS Website.

If you have questions, please contact your Medicare FI, 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.

**REVISIONS TO THE COMPETITIVE ACQUISITION PROGRAM (CAP)
FOR PART B DRUGS AND BIOLOGICALS**

~CMS MLN Matters~

Part B

MLN Matters Number: MM6124
Related CR Release Date: August 15, 2008

Related Change Request (CR) #: 6124
Effective Date: Claims processed on
or after January 5, 2009
Implementation Date: January 5, 2009

Related CR Transmittal #: R1577CP

Provider Types Affected

Physicians and other providers who bill Medicare carriers and Medicare Administrative Contractors (A/B MAC) for competitive acquisition program (CAP) claims for part B drugs and biologicals provided to Medicare beneficiaries.

What You Need to Know

CR 6124, effective with claims processed on or after January 5, 2009, revises Medicare systems to allow individual Competitive Acquisition Program (CAP) claims with different prescription order numbers to not be denied as duplicate claims though they are for the same patient, contain the same date of service, and contain the same Healthcare Common Procedure Coding System (HCPCS) drug code. This will also apply to an individual CAP claim that contains multiple lines that appear to be duplicates except for different prescription order numbers.

Background

Because of a systems error, Medicare carriers and A/B MACs may be denying CAP claims that contain the same beneficiary, date of service, and HCPCS drug code, but have different prescription order numbers.

CR 6124, effective for claims processed on or after January 5, 2009, instructs Medicare carriers, A/B MACs, and the CAP Designated Carrier to revise duplicate claim edits to allow separate CAP claims with different prescription order numbers to be considered as non-duplicative claims even though they are for the same beneficiary, date of service, and HCPCS drug code. This will also apply to an individual claim that contains multiple lines that appear to be duplicates except for different prescription order numbers. If you have claims that were incorrectly denied prior to January 5, 2009, your contractor will adjust those claims if you bring them to their attention.

Additional Information

You can view CR 6124 at <http://www.cms.hhs.gov/Transmittals/downloads/R1577CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

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.

UPDATE OF THE INTERN-TO-BED RATIO FOR METHOD II TEACHING CRITICAL ACCESS HOSPITALS (CAHS)

~CMS MLN Matters~

Part A

MLN Matters Number: MM6176
Related CR Release Date: August 29, 2008
Related CR Transmittal #: R372OTN

Related Change Request (CR) #: 6176
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

Method II teaching CAHS submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 6176 which notifies Medicare contractors that they should update the intern-to-bed ratio on the Provider Specific File for Method II teaching CAHS when the field contains zeroes. Your Medicare contractor will contact you to obtain your intern to bed ratio. An intern-to-bed ratio greater than zero is used to determine if the Method II CAH is a teaching hospital, and the Centers for Medicare & Medicaid Services (CMS) identifies teaching hospitals by an intern-to-bed ratio greater than 0.

Background

Physicians and non-physician practitioners billing on type of bill (TOB) 85X for professional services rendered in a Method II CAH have the option of reassigning their billing rights to the Critical Access Hospital (CAH). When the billing rights are reassigned to the Method II CAH, payment is then made to the CAH for professional services (revenue codes (RC) 96X, 97X or 98X).

Medicare makes payment for an assistant-at-surgery when:

- The procedure is authorized for an assistant; and
- The person performing the service is a:
 - Physician;
 - Physician assistant (PA);
 - Nurse practitioner (NP); or
 - Clinical nurse specialist (CNS).

The Social Security Act (Section 1842(b)(7)(D)); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the internet) stipulates that no payment shall be made for the services of assistant-at-surgery with respect to a surgical procedure if a hospital has a training program relating to the medical specialty required for the surgical procedure, and a qualified individual on the staff of the hospital is available to provide such services. Payment may be made for assistant-at-surgery services that are required due to exceptional medical circumstances.

Payment may be made for the services of assistants-at-surgery in teaching hospitals notwithstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances (emergency, life threatening situations such as multiple traumatic injuries, etc.) which require immediate treatment, or there may be situations in

which the medical staff may find that exceptional medical circumstances justify the services of a physician assistant-at-surgery even though a qualified resident is available.

Payment may also be made for the services of assistants-at-surgery in teaching hospitals if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

An intern-to-bed ratio greater than zero is used to determine if the Method II CAH is a teaching hospital, and the Centers for Medicare & Medicaid Services (CMS) identifies teaching hospitals by an intern-to-bed ratio greater than 0. It has been brought to the attention of the CMS that the intern-to-bed ratio located on the Provider Specific File is not being updated for Method II teaching CAHs. Therefore, CR 6176 advises Medicare contractors to contact Method II teaching CAHs to obtain their intern to bed ratio and update the intern-to-bed ratio on their Provider Specific File for Method II teaching CAHs when it contains zeroes so that teaching CAHs are properly identified for claims processing purposes.

Additional Information

The official instruction, CR 6176, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R372OTN.pdf> on the CMS Website.

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

Coverage – General**CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY
FOR OBSTRUCTIVE SLEEP APNEA (OSA)**

~CMS MLN Matters~

Part A & Part B

MLN Matters Number: MM6048 **Revised**
Related CR Release Date: August 29, 2008
Related CR Transmittal #: R94NCD

Related Change Request (CR) #: 6048
Effective Date: March 13, 2008
Implementation Date: August 4, 2008

Note: This article was revised on September 2, 2008, to reflect changes to CR 6048, which CMS revised on August 28, 2008. The CR release date, transmittal number, and the Web address for accessing CR6048 were revised. In addition, some language in item 3 on page 3 was clarified. All other information remains the same.

Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Durable Medical Equipment (DME) MACs) for OSA-related services provided to Medicare beneficiaries.

Impact on Providers

Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of CPAP therapy based upon a positive diagnosis of OSA by home sleep testing (HST), subject to the requirements of CR6048.

Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered its 2005 National Coverage Determination (NCD) for CPAP Therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with section 240.4 of the Medicare NCD Manual (see the *Additional Information* section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR6048. (Note that billing guidelines for capped rental equipment are contained in the Medicare Claims Processing Manual, Chapter 20, Section 30.5, which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf> on the CMS Website.)

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation. The apnea hypopnea index (AHI) is equal to the

average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

Key Points of CR6048

1. Coverage of CPAP is initially limited to a 12-week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12-week period.

NOTE: DME Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively. 42 CFR 424.57(c)(12). Failure to meet this standard may result in revocation of the DMEPOS supplier's billing privileges. 42 CFR 424.57(d).

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:
 - Polysomnography (PSG) performed in a sleep laboratory; or
 - Unattended home sleep monitoring device of Type II; or
 - Unattended home sleep monitoring device of Type III; or
 - Unattended home sleep monitoring device of Type IV, measuring at least 3 channels

NOTE: In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

3. A positive test for OSA is established if either of the following criteria using the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) are met:
 - AHI or RDI greater than or equal to 15 events per hour of sleep or continuous monitoring, or
 - AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour of sleep or continuous monitoring with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

Note: The AHI is equal to the average number of episodes of apnea and hypopnea per hour of sleep. The RDI is equal to the average number of respiratory disturbances per hour of continuous monitoring.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only

when provided in the context of a clinical study and when that study meets the standards outlined in the NCD manual revision attached to CR6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at section 310.1 of the NCD Manual and chapter 32 and sections 69.6-69.7 (Pub 100-04) of the Medicare Claims Processing Manual. These manuals are available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Website.

Note: The following HST portable monitoring G codes effective March 13, 2008, are provided for your information only, are not included in the CPAP for OSA NCD at section 240.4 of the NCD Manual, and do not necessarily convey coverage, which is determined at local contractor discretion.

G0398: Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.

G0398 Short Descriptor: Home sleep test/type 2 Porta

G0399: Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation

G0399 Short Descriptor: Home sleep test/type 3 Porta

G0400: Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

G0400 Short Descriptor: Home sleep test/type 4 Porta

Additional Information

To see the official instruction (CR6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R94NCD.pdf> on the CMS Website.

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

ELECTROCARDIOGRAM (EKG OR ECG) TESTING DONE PREOPERATIVELY

Part B

EKGs (ECGs) are used in the diagnosis of disorders of cardiac rhythm, anatomy, coronary blood flow, myocardial function and symptoms related to such disorders. They are also used as an adjunct to the diagnosis of certain drug toxicities and metabolic disorders.

Not all patients require a preoperative ECG. The decision to perform an ECG should be determined by medical necessity such as patient age, known risk factors for heart disease, symptoms, the surgical procedure planned and the length of time since the patient's most recent EKG without intervening symptoms. Hospital policy, hospital by-laws, or departmental policy are not acceptable reasons for a preoperative EKG when there is no medical necessity.

EKGs performed as part of a pre-operative evaluation to assist in identifying potentially serious cardiac disorders could be considered medically necessary in appropriate patients for the following circumstances;

1. In the presence of pre-existing heart disease such as: congestive heart failure, prior myocardial infarction, angina, coronary artery disease, dysrhythmias; and/or
2. In the presence of known co-morbid conditions such as: chronic pulmonary disease, peripheral vascular disease, diabetes, renal impairment, etc.; and/or
3. The patient is a male over the age of 40 or a female over the age of 50 **and**
4. The surgery being performed is considered major, e.g. aortic and major vascular, peripheral vascular, prolonged cases with fluid shifts, carotid endarterectomy, head and neck, intraperitoneal intrathoracic major orthopedic, major urologic, or major gynecologic, etc.

EKGs performed pre-operatively are not covered for the following circumstances;

1. In the absence of heart disease or signs and symptoms of heart disease,
 - prior to minor surgery,
 - surgeries or procedures performed under local anesthesia
2. As part of routine protocols not associated with clinical evaluation of the patient and his or her need for further evaluation.
3. When performed as part of a pre-operative examination for a non-covered surgical procedure.

The following italicized paragraphs are direct language from **Medicare Claims Processing Manual 100.4, 12 §30.6.6.1**

Preoperative Testing

Tests performed to determine a patient's perioperative risk and optimize perioperative care. Preoperative diagnostic tests are payable if they are medically necessary and meet any other applicable requirements.

When billing under the Physician Fee Schedule, preoperative diagnostic tests performed by, or at the request of, the physician performing preoperative examinations, do not fall within the statutory exclusion articulated in §1862(a)(7) of the Act. These diagnostic tests are payable if they are medically necessary (i.e., they may be denied under §1862(a)(1)(A)).

ICD Coding Requirements for Preoperative Services.--All claims for preoperative medical examination and preoperative diagnostic tests (i.e., preoperative medical evaluations) must be accompanied by the appropriate ICD-9 code for preoperative examination (e.g., V72.81 through V72.84). Additionally, the appropriate ICD-9 code for the condition(s) that prompted surgery must also be documented on the claim. Other diagnoses and conditions affecting the patient should also be documented on the claim, if appropriate. The ICD-9 code that appears in the line item of a preoperative examination or diagnostic test must be the code for the appropriate preoperative examination (e.g., V72.81 through V72.84).

Medical Necessity Determination.-- Medical necessity for specific preoperative services is determined by any applicable national coverage decisions. In the absence of a national coverage determination, medical necessity is determined by carrier discretion.

WPS is charged with compliance of **Title XVIII of the Social Security Act sections: §1862(a)(1)(A)**. This section excludes coverage and payment for items and services that are not considered reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the function of a malformed body member.

Therefore, WPS does not pay for tests solely because they are required by a third party such as a hospital. There needs to be a medical reason to perform an EKG: the patient must have some symptom or history of heart disease or the surgery itself is associated with the heart, the vascular system or is described as major as outlined above. The second code listed should be one that indicates the medical necessity of the EKG. A list of diagnosis codes that document medical necessity can be found within LCD Electrocardiogram (ECG or EKG) under the section entitled ICD-9 Codes That Support Medical Necessity.

**FLUORODEOXYGLUCOSE (FDG) POSITRON EMISSION
TOMOGRAPHY (PET) IMAGING FOR INFECTION AND
INFLAMMATION**
~CMS MLN Matters~
Part A & Part B

MLN Matters Number: MM6099
Related CR Release Date: June 27, 2008
Related CR Transmittal #: R84NCD

Related Change Request (CR) #: 6099
Effective Date: March 19, 2008
Implementation Date: July 28, 2008

Provider Types Affected

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

Impact on Providers

This article is based on Change Request (CR) 6099 instructing that the Centers for Medicare & Medicaid Services (CMS) is continuing its national non-coverage policy for the off-label indications of fluorodeoxyglucose (FDG) Positron emission tomography (PET) imaging for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin.

Background

CMS was asked to reconsider the current, de facto non-coverage for FDG PET imaging in the Medicare National Coverage Determinations (NCD) Manual (Section 220.6), for the following off-label uses (instead of bone, leukocyte, and/or gallium scintigraphy):

1. Suspected chronic osteomyelitis in patients with:
 - previously documented osteomyelitis with suspected recurrence, or
 - symptoms of osteomyelitis for more than 6 weeks (including diabetic foot ulcers);
2. Investigation of patients with suspected infection of hip prosthesis; and
3. Fever of unknown origin in patients with:
 - a febrile illness of >3 weeks duration,

- a temperature of >38.3 degrees Centigrade on at least two occasions, and
- uncertain diagnosis after a thorough history, physical examination, and 1 week of proper investigation.

Based upon its review, CMS determined that the evidence is inadequate to conclude that FDG PET for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin improves health outcomes in the Medicare populations, and therefore is not reasonable and necessary under the Social Security Act (section 1862(a)(1)(A) (See that provision at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the internet.)

Additionally, CMS determined that this request for coverage is not appropriate for the Coverage with Evidence Development (CED) paradigm.

Additional Information

The official instruction, CR 6099, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R84NCD.pdf> on the CMS Website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free numbers, 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 General Correspondence P.O. Box 7665 Madison, WI 53707-7665	WPS Medicare Part A General Correspondence P.O. Box 7576 Madison, WI 53707-7576
Missouri Part A	Nebraska Part A
WPS Medicare Part A General Correspondence P.O. Box 8890 Madison, WI 53707-8890	WPS Medicare Part A General Correspondence P.O. Box 8799 Madison, WI 53708-8799
Part B	
Iowa	Kansas
WPS Medicare Part B General Correspondence P.O. Box 8550 Madison, WI 53708-8550	WPS Medicare Part B General Correspondence P.O. Box 7238 Madison, WI 53707-7238
Missouri (Western)	Missouri (Eastern)
WPS Medicare Part B General Correspondence P.O. Box 7128 Madison, WI 53707-7128	WPS Medicare Part B General Correspondence P.O. Box 14260 Madison, WI 53708-0260
Nebraska	
WPS Medicare Part B General Correspondence P.O. 8667 Madison, WI 53708	



Revised Policies for October 2008

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
NA	<i>2009 ICD-9-CM Coverage - MAC J5 Policy Revisions Iowa, Kansas, Missouri, Nebraska</i>	NA	Click here to view	22
CV-504	<i>Cardiovascular Stress Testing</i>	LCD	Click here to view	25
OPHTH-515	<i>Optical Coherence Tomography (OCT)</i>	LCD	Click here to view	26

Coverage – Revised Policies**2009 ICD-9-CM COVERAGE - MAC J5 POLICY REVISIONS IOWA,
KANSAS, MISSOURI, NEBRASKA****Part B**

Effective for claims submitted with dates of service on or after 10/01/2008, WPS will cover the new 2009 ICD-9-CM codes for the policies and procedures listed below. The listed changes to these affected policies will be posted to the Websites after 10/01/2008.

Policy Name/Number	Policy Procedure Code	2009 ICD-9-CM Changes
Application of Bioengineered Skin Substitutes GSURG-537 L26650	J7340, J7342	707.20 -707.25
Cardiovascular Stress Testing CV-504 L26622	93015, 93016, 93017, 93018	249.00- 249.91
Cardiac Monitoring (Long Term Holter) CV-516 L26625	93224, 93225, 93226, 93227, 93230, 93231, 93233, 93235, 93236, 93237	414.3
Chronic Wound Care GSURG-551 L26653	11040, 11041, 11042, 11043, 11044, 16025, 97597, 97598, 97605, 97606	707.20-707.25 998.30, 998.33
Complex Cataract Surgery OPHTH-520 L26674	66982	364.82
Cytogenetic Studies PATH- 527 L26684	88230, 88233, 88235, 88237, 88239, 88240, 88241, 88245, 88248, 88249, 88261, 88262, 88263, 88264, 88267, 88269, 88271, 88272, 88273, 88274, 88275, 88280, 88283, 88285, 88289, 88291, 88299	203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92
Flow Cytometry	88184, 88185,	203.02, 203.12, 203.82, 204.02, 204.12.

Policy Name/Number	Policy Procedure Code	2009 ICD-9-CM Changes
PATH-516 L26683	88187, 88188, 88189	204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 238.77, 279.51, 279.52 279.53
Colonoscopy, Diagnostic GI-508 L26646	44388-44394, 44397, 45355, 45378, 45379, 45380-45387, 45391, 45392	209.10-209.17, 209.50-209.57, 209.67, 558.42
Immune Globulin, Intravenous INJ-512 L26713	J1561, J1566, J1568, J1569 J1572, Q4097, G0332	203.02, 204.12
Injection of Spinal Canal NEURO-507 L26711	01996, 62280, 62281, 62282, 62310, 62311, 62318, 62319, 77003	199.2, 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82 208.02, 208.12, 208.22, 208.82, 208.92
Magnetic Resonance Angiography (MRA) RAD-523 L26696	70544, 70545, 70546, 70547, 70548, 70549	339.00-339.89, 346.92, 346.93
MRI and CT Scans of the Brain and Its Related Structures Policy RAD-524 L26697	70450, 70460, 70470, 70551, 70552, 70553	136.21, 136.29, 199.2, 208.92, 337.00, 339.00-339.89, 346.92, 346.93, 780.60- 780.65
MRI and CT Scans of the Cervical, Thoracic and Lumbar Spine RAD-533 L26700	72125-72127, 72141, 72142, 72156 72128, 72129, 72130, 72146, 72147, 72157 72131, 72132, 72133, 72148, 72149, 72158	136.21, 136.29, 199.2, 208.92, 337.00, 337.01, 337.09 136.21, 136.29, 199.2, 208.92, 337.00, 337.01, 337.09 136.21, 136.29, 199.2, 208.92, 337.00, 337.01, 337.09,
MRI and CT Scans of Thorax,/Chest (Except Heart) RAD-553 L26709	71250, 71260, 71270, 71550, 71551, 71552	199.2, 208.92, 998.30, 998.33
Nerve Conduction Studies	95900, 95903,	249.60 – 249.61

Policy Name/Number	Policy Procedure Code	2009 ICD-9-CM Changes
and Electromyography NEURO-505 L26663	95904, 95933, 95934, 95936, 95937, 92265, 95860, 95861, 95863, 95864, 95867, 95868, 95869, 95870, 95872	337.00-337.09
Non-invasive Vascular Studies CV-533 L26636	93922, 93923, 93924, 93925, 93926, 93930, 93931	249.70-249.71
Optical Coherence Tomography (*Formerly Scanning Laser Glaucoma Tests) OPHTH-515 L26676	92135	249.50-249.51, 362.20-362.27, 364.82
Physical Medicine and Rehabilitation Procedures PHYSMED-509 L26688	97022, 97036	707.20-707.25
Pulmonary Function Testing PULM-502 L26693	94010, 94060, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94400, 94450, 94680, 94681, 94690, 94720, 94750 94770	203.02, 482.42, 511.81, 511.89
Pulse Oximetry PULM-501 L26692	94760, 94761	482.42, 511.81, 511.89, 997.31, 997.39
Radiation Oncology: External Beam /Teletherapy RAD-514 L26694	77261-77470 (except 77432)	199.2, 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30

Policy Name/Number	Policy Procedure Code	2009 ICD-9-CM Changes
Routine Foot Care FT-501 L26642	G0127, 11055, 11056, 11057, 11719-11721	249.00 - 249.91
Transesophageal Echocardiography; CV-507 L26624	93312, 93313, 93314, 93315, 93316, 93317, 93318, 93320, 93321, 93325	038.12, 780.60 – 780.65
Transrectal Echography GI-512 L26648	76872	569.44
Transthoracic Echocardiography (TTE) CV-526 L26632	93303, 93304, 93307, 93308, 93320, 93321, 93325, 93350	780.60-780.65
Upper Gastrointestinal Endoscopy (Diagnostic and Therapeutic) GI-511 L26647	43200, 43201, 43202, 43204, 43205, 43215, 43216, 43217, 43219, 43220, 43226-43228, 43231, 43232, 43234-43251, 43255, 43256, 43258, 43259 43261-43265, 43267, 43268 43269, 43271, 43272	530.13; 535.70, 535.71, 558.41
Visual Fields OPHTH-554 L26682	92081, 92082, 92083	346.92, 349.93, 362.20, 362.22-362.27, 364.82,

**Part B****LCD Title**

Cardiovascular Stress Testing

Contractor's Determination Number

CV-504

- E. Pharmacologic ECG stress testing is indicated only when the patient is unable to exercise adequately for medical reasons. These reasons may include physical limitations (e. g., arthritis, amputation, severe peripheral vascular disease, severe COPD) and those individuals with a baseline left bundle branch block of unknown origin. Documentation in the patient's record must clearly indicate that the patient is unable to

exercise, as well as the reason(s) why the patient cannot undergo exercise stress testing. (A review of records may be performed to determine if drugs are being used appropriately.) The drugs used in cardiovascular testing are potent drugs with many side effects and must be used with appropriate caution.

Stress testing by multiple modalities (e.g., treadmill ECG, echocardiogram, SPECT) for the same clinical event is covered only when the first modality was inconclusive or uninterpretable.

Pharmacologic stress agents may be appropriate for those patients who are unable to reach 75 - 100 percent of their age-predicted maximum heart rate by physiologic exercise. Vasodilation can be achieved with the use of either Dipyridamole or Adenosine. Dobutamine may be used to effect stress through its inotropic effect.

*Regadenoson (Lexiscan) may be used as a pharmacologic stress agent

- HCPCS code J3490 – Unclassified Drug (06/24/2008)
- Recommended dose of Regadenoson (Lexiscan) is 5mL (0.4 mg Regadenoson) by rapid (approximately 10 seconds) injection; followed immediately by saline flush and radiopharmaceutical. Regadenoson (Lexiscan) is indicated for radionuclide myocardial perfusion imaging (MPI) in patients unable to undergo adequate exercise stress.



Part B

LCD Revision Article

Contractor's Policy Number

OPHTH-515

LCD Title:

Optical Coherence Tomography (OCT)

Effective Date: 10/01/2008

Note: The title and contractor policy number for Optical Coherence Tomography has been changed. The previous name was Scanning Laser Glaucoma Tests and the previous contractor policy number was OPHTH-524. This change does not affect coverage.

Electronic Data Interchange (EDI)**CLAIMS ADJUSTMENT REASON CODES AND REMITTANCE ADVICE
REMARK CODES****Part B**

The claims adjustment reason codes and remittance advice remark codes are updated quarterly and are available on the Washington Publishing Company's (WPC) Website at: <http://www.wpc-edi.com/codes>

The WPC Website lists the latest descriptions for the Remittance Advice reason and Remark Codes found on the Medicare Electronic Remittance Advice (ERA).

PC-ACE PRO32 BILLING SOFTWARE FOR VACCINATION BILLING**Part B**

WPS Medicare has a HIPAA-compliant software product, PC-Ace Pro32, available for vaccination billing. This software has the ability to submit roster billing and will allow you to submit your Medicare claims electronically.

Please review the minimum requirements to ensure you will be able to use PC-Ace.

PC-Ace Pro32 for Windows***Minimum System Requirements***

Before you install PC-Ace Pro32 software, your computer must meet these minimum requirements.

- IBM-compatible Pentium 133 MHz processor
- Windows 95, 98, 2000, ME, XP, or NT 4.0 Operating System
- CD-ROM drive
- 64 MB system memory
- Hayes-compatible modem with minimum speed (baud) of 9600
- SVGA monitor with minimum resolution of 800 X 600 (VERY IMPORTANT)
- Adobe Acrobat Reader Version 4.0 or later

Software Cost

PC-Ace Pro32 is free to use for Medicare billers. WPS will provide:

- Telephone support by WPS Electronic Data Services staff
- User Manual updates
- Periodic software updates

PC-Ace Pro32 software can now be downloaded from our Website.

If you are interested in using PC-Ace Pro32, download the PC-Ace request form from: <http://www.wpsic.com/edi/pdf/medbpcace.pdf> or call the EDI Hotline at 866-503-9670.

If you are currently using the PC-Ace Pro32 billing software, you can now download the most current upgrade at: <http://www.wpsic.com/edi/pcacepro32.shtml>

PC-ACE PRO32 BILLING SOFTWARE UPGRADE VERSION 1.94 NOW AVAILABLE ONLINE

Part B

If you are currently using the PC-Ace Pro32 billing software, you can now download the latest upgrade online. You can download this information at:

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

Now available online is:

- The upgrade to the latest version of PC-Ace, Version 1.94
- Instructions related to the upgrade
- Users Guides/Manuals

If you are not using the version listed above, it is very important that you update your software immediately.

It is important that each user update their software program in a timely manner. As software upgrades are received, please download/install the upgrades to update your program.

If you are NOT currently using this program but you are interested in using this HIPAA-compliant software, please contact our EDI Hotline at 866-503-9670 or download the PC-Ace request form from: <http://www.wpsic.com/edi/pdf/medbpcace.pdf>

General Information**CLAIMS INVOLVING BENEFICIARIES WHO HAVE ELECTED
HOSPICE COVERAGE
Part A & Part B**

Medicare beneficiaries entitled to Hospital Insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare-certified hospice is covered under the hospice benefit provisions. Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the hospice patient's lifetime.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of the terminal illness during any period the beneficiary's hospice benefit election is in force, except for professional services of an "attending physician." For purposes of administering the hospice benefit provisions, an "attending physician" means a physician who:

- Is a doctor of medicine or osteopathy; and
- Is identified by the individual, at the time the individual elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.
- Is a nurse practitioner. For further explanation, see the CMS MLN Matters article at: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3226.pdf>

The beneficiary may designate and use an attending physician who is not employed by the hospice for professional services furnished in addition to the services of hospice-employed physicians. The professional services of an attending physician that are reasonable and necessary for the treatment and management of a hospice patient's terminal illness are not considered hospice services. Provided he or she does not furnish the services under a payment arrangement with the hospice, the services of the attending physician are billed to Medicare Part B with **modifier GV**, *Attending physician not employed or paid under agreement by the patient's hospice provider*. If a substitute or locum tenens physician provides services, the services are billed by the designated attending physician under the reciprocal or locum tenens billing instructions by use of **modifier GV** in conjunction with either the **Q5** or the **Q6 modifier**. Payment is made to the attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service. Services not related to the hospice patient's terminal condition are coded with the **GW modifier**, *Service not related to the hospice patient's terminal condition*.

If a private attending physician furnishes services related to a hospice patient's terminal condition under a payment arrangement with the hospice, such services are considered "hospice services" and are billed by the hospice to Medicare Part A. Hospice physician services are paid by the hospice intermediary, Part A, at 100% of Medicare-approved charges.

**PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)
QUARTERLY DRUG UPDATE**

~CMS MLN Matters~

Part B

MLN Matters Number: MM6158
Related CR Release Date: August 15, 2008
Related CR Transmittal #: R1576CP

Related Change Request (CR) #: 6158
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians billing Medicare Administrative Contractors (A/B MAC) and carriers for Medicare Part B drugs, and approved CAP vendors billing the CAP designated carrier.

What Providers Need to Know

This article is based on Change Request (CR) 6158, which provides notice that there will be a Part B CAP Quarterly Drug List Update effective October 1, 2008. When available, the October 2008 list of drugs supplied under the CAP will be posted at http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopofPage on the Centers for Medicare & Medicaid Services (CMS) Website.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Section 303 (d)), which can be found at <http://www.cms.hhs.gov/MMAUpdate> on the Centers for Medicare & Medicaid Services (CMS) Website) required the implementation of a CAP for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians were given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process.

Key Points of CR6158

- A quarterly update of the CAP drug list will become effective on October 1, 2008.
- Payment amounts for drugs added to the CAP drug list as a result of the update will be implemented for claims with dates of service beginning October 1, 2008 per the new file.

Additional Information

To see the official instruction (CR6158) issued to your Medicare A/B MACs and carriers visit <http://www.cms.hhs.gov/Transmittals/downloads/R1576CP.pdf> on the CMS Website.

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

For more information about the Competitive Acquisition for Part B Drugs & Biologicals, refer to <http://www.cms.hhs.gov/CompetitiveAcquisforBios> on the CMS Website.

PHYSICIAN SIGNATURE REQUIREMENTS FOR DIAGNOSTIC TESTS ~CMS MLN Matters~ Part A & Part B

MLN Matters Number: MM6100
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

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 (including x-ray, laboratory, and other 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.

PROVIDERS RESPONSIBLE FOR KNOWING GUIDELINES

Part A & Part B

A provider is responsible to know the rules and regulations that apply to all services billed by the provider to the Medicare program.

According to the *Medicare Claims Processing Manual*, Chapter 30, Section 40.1:

“In accordance with regulations at 42 CFR 411.406, evidence that the provider, practitioner, or other supplier did, in fact, know or should have known that Medicare would not pay for a service or item includes:

- A Medicare contractor’s prior written notice to the provider, practitioner, or other supplier of Medicare denial of payment for similar or reasonably comparable services or items;
- Medicare’s general notices to the medical community of Medicare payment denial of services and items under all or certain circumstances (such notices include, but are not limited to, manual instructions, bulletins, carriers’ written guides, and directives); and
- Provision of the services and items was inconsistent with acceptable standards of practice in the local medical community (refer to §40.1.3 and §40.1.4).

If any of the circumstances described above exists, a provider, practitioner or other supplier is held to have knowledge.”

The provider is responsible to know the rules and regulations that are made available through publications from the Medicare carriers and fiscal intermediaries, which include, but are not limited to, the WPS Medicare newsletter (the *Communiqué*), information published on the WPS Medicare Website, and mailings sent periodically to all or individual providers. The WPS Medicare monthly newsletter, the *Communiqué*, is available electronically through the WPS Medicare Website at

http://www.wpsmedicare.com/mac/publications/newsletter_archive.shtml

For those providers unable to use the electronic *Communiqué*, a quarterly paper copy is available by subscription. Information on the subscription is available in the monthly September *Communiqué*.

To access these publications

(http://www.wpsmedicare.com/mac/publications/newsletter_archive.shtml), you must first accept the AMA Copyright Statement.

QUARTERLY PROVIDER UPDATE

Part A & Part B

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

- Inform providers about new developments in the Medicare program;

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

The Quarterly Provider Update can be accessed at:

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

We encourage you to bookmark this Website and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update Listserv at:

http://subscriptions.cms.hhs.gov/service/subscribe.html?code=USCMS_460

REVISED FORM CMS-R-131 ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE

~CMS MLN Matters~

Part A & Part B

MLN Matters Number: MM6136

Related CR Release Date: September 5, 2008

Related CR Transmittal #: R1587CP

Related Change Request (CR) #: 6136

Effective Date: March 3, 2008

Implementation Date: March 1, 2009

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6136, from which this article is taken announces that, effective March 3, 2008, the Centers for Medicare & Medicaid Services (CMS) implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN); which combines the general Advance Beneficiary Notice (ABN-G) and laboratory Advance Beneficiary Notice (ABN-L) into a single form, with form number (CMS R-131).

You should be aware that beginning March 3, 2008 and prior to March 1, 2009, your contractors will accept either the current ABN-G and ABN-L or the revised ABN as valid notification. **However, beginning March 1, 2009, Medicare contractors will accept only a properly executed revised ABN (CMS R-131) as valid notification.**

Make sure that your billing staffs are aware of these ABN form changes.

Background

Prior to March 3, 2008, physicians, providers, practitioners, and suppliers paid under Part B, and hospice providers and religious non-medical health care institutions paid under Part A; were instructed to use the general Advance Beneficiary Notice (ABN-G) or laboratory

Advance Beneficiary Notice (ABN-L) to inform beneficiaries of their potential liability in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act.

Beginning on March 3, 2008, however, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN). This revised ABN combines the ABN-G and the ABN-L into a single notice, with the same form number (CMS R-131).

The *Medicare Claims Processing Manual* Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) has been substantially updated to reflect these changes. 85 subsections have been deleted from this chapter, and 47 are either new or have been revised. Attached to CR6136 is the updated Chapter 30 and the Web address for viewing CR6136 is contained in the "Additional Information" section of this article.

Some key points from the updated Chapter 30 are as follows:

1. The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program for items and services that they provide under Medicare Part A (hospice and religious non-medical healthcare institutions only) and Part B. It may not be used for items or services provided under the Medicare Advantage (MA) Program, or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).
2. The revised ABN (which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and Notice of Exclusion from Medicare Benefits (NEMB) (CMS-20007)) will now be used to fulfill both mandatory and voluntary notice functions.

Note: Once the revised SNFABN is implemented, Skilled Nursing Facilities must use the revised SNFABN for all items and services billed to Part A and Part B.

3. The following situations require by statute that an ABN be issued:
 - Care is not reasonable and necessary;
 - There was a violation of the prohibition on unsolicited telephone contacts;
 - Medical equipment and supplies supplier number requirements not met;
 - Medical equipment and/or supplies denied in advance;
 - Custodial care; and
 - A hospice patient who is not terminally ill.
4. In the following situations ABN use is voluntary

ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification).

Additionally, the ABN can also be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as:

- Care that fails to meet the definition of a Medicare benefit as defined in Section 1861 of the Social Security Act;
 - Care that is explicitly excluded from coverage under Section 1862 of the Social Security Act. Examples include:
 - Services for which there is no legal obligation to pay;
 - Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
 - Services required as a result of war;
 - Personal comfort items;
 - Routine physicals (except the initial preventive physical or “Welcome to Medicare” physical examination) and most screening tests;
 - Routine eye care;
 - Dental care; and
 - Routine foot care.
5. ABN issuers (who may be physicians, practitioners, providers (including laboratories), suppliers, Medicare contractors, or utilization review committees for the care provider) are collectively known as “**notifiers**”. Be aware that the notifier may direct an employee or a subcontractor to actually deliver an ABN, however, the notifier remains ultimately responsible for its effective delivery.

Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three “**triggering events**” during a course of treatment (initiation, reduction, and termination).

Notifiers must give an ABN to “**recipients**” (FFS Medicare beneficiaries or their representatives), including beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible). You should note that notifiers’ inability to give notice to a beneficiary or his/her representative does not allow them to shift financial liability to the beneficiary, unless they have exhausted all attempts to issue the notice and such attempts are clearly documented in the patient’s record and undisputed by the beneficiary.

Medicare Claims Processing Manual Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) also contains specific information about ABN Preparation Requirements such as the number of pages, fonts and form reproduction, completion and retention of the form, delivery requirements; and what to do in particular situations such as emergencies, or if a beneficiary changes his/her mind or refuses to complete or sign the notice.

It also discusses potential beneficiary and provider liability; requirements for advance coverage determinations; the collection of funds and refunds; and issues specific to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), hospice, and Comprehensive Outpatient Rehabilitation Facility (CORF).

Additional Information

You can find more information about the revised ABN Form (CMS-R-131) by going to CR 6136, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1587CP.pdf> on the CMS Website. There you will find the updated *Medicare Claims Processing Manual* Chapter

30(Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) as an attachment to that CR.

If you have any questions, please contact your 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.

Additional information on the revised ABN and other limitation of liability notices can be found on the Beneficiary Notice Initiatives Website at <http://www.cms.hhs.gov/bni> on the CMS Website. Questions regarding the revised ABN can be emailed to RevisedABN_ODF@cms.hhs.gov.

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.

Coming up, we will host events such as:

Part B

- Chiropractic Care
- Save Dollars, Avoid Denials

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

Reimbursement**2009 ANNUAL UPDATE FOR THE HEALTH PROFESSIONAL
SHORTAGE AREA (HPSA) BONUS PAYMENTS**

~CMS MLN Matters~

Part A & Part B

MLN Matters Number: MM6150
Related CR Release Date: August 29, 2008
Related CR Transmittal #: R1582CP

Related Change Request (CR) #: 6150
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

Physicians and other providers who bill Medicare Carriers, Fiscal Intermediaries (FI), or Medicare Administrative Contractors (A/B MAC) for services provided to Medicare beneficiaries in Health Professional Shortage Areas (HPSA).

What You Need to Know

CR 6150, from which this article is taken provides your carriers, FIs, and A/B MACs with the names of the test and final files for the Health Professional Shortage Area (HPSA) bonus payments for 2009 and alerts providers that the 2009 file will be posted to the Centers for Medicare & Medicaid Services (CMS) Website when it is available.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors in early December of each year. CR 6150, from which this article is taken, provides them the names of the test and final 2009 HPSA bonus payment files which contractors will use for the automated bonus payment for claims with dates of service on or after January 1, 2009, through December 31, 2009.

You will find the annual HPSA bonus payment file (as it becomes available) and other important HPSA information at <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/> on the CMS Website. You should also review the CMS Website to determine whether a HPSA bonus will automatically be paid for services provided in your ZIP code area or whether a modifier must be submitted. You can determine if you are eligible for the automated payment by going to <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf> on the CMS Website and following the instructions on the page.

Additional Information

You can find the official instruction, CR 6150, issued to your carrier, FI, or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1582CP.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.

CLINICAL LABORATORY FEE SCHEDULE—MEDICARE TRAVEL ALLOWANCE FEES FOR COLLECTION OF SPECIMENS

~CMS MLN Matters~

Part A & Part B

MLN Matters Number: MM6195
Related CR Release Date: September 5, 2008
Related CR Transmittal #: R1584CP

Related Change Request (CR) #: 6195
Effective Date: July 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Clinical laboratories submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for clinical laboratory services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6195, which **revises and clarifies payment** of travel allowances that are based on either a per mileage basis (P9603) or on a flat rate basis (P9604) for calendar year (CY) 2008. The new rates are \$1.035 per mile (P9603) and \$9.55 per flat-rate trip (P9604).

CAUTION – What You Need to Know

Note that Medicare contractors will not re-process claims that were processed before the new rates were implemented unless you bring such claims to their attention.

GO – What You Need to Do

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

Background

Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act and payment is made based on the clinical laboratory fee schedule. (See Section 1833(h)(3) of the Social Security Act at http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet.) Furthermore, the travel codes allow for payment of the travel allowance either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604), and payment of the travel allowance is made only if a specimen collection fee is also payable.

The travel allowance is intended to cover estimated travel costs of collecting the specimen (including the laboratory technician's salary and travel expenses), and Medicare contractors have the discretion to choose:

- Either a flat rate or a mileage basis, and
- How to set each type of allowance.

The per flat rate trip basis travel allowance (P9604) is \$9.55, and the per mile travel allowance (P9603) is \$1.035 cents per mile and is used in situations where the average trip to the patients' homes is:

- Longer than 20 miles round trip, and
- To be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip.

As of August 1, 2008, the per mile allowance rate of \$1.035 cents per mile was computed using the Federal mileage rate of \$0.585 cents per mile for automobile expenses plus an additional \$0.45 cents per mile to cover the technician's time and travel costs. Medicare contractors have the option of establishing a higher per mile rate in excess of the minimum of \$1.035 cents per mile if local conditions warrant it.

Under either method (i.e., flat rate allowance or per mile travel allowance), when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip (for both Medicare and non-Medicare patients) either at the time the claim is submitted by the laboratory or when the flat rate is set by the Medicare contractor.

The following are examples to further clarify the new allowances:

Example 1: On August 2, 2008, a laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be \$62.10 (60 miles x 1.035 cents a mile), plus the specimen collection fee.

Example 2: On August 2, 2008, a laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, and then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or \$41.40 (40 x 1.035), plus the specimen collection fee.

Note: Some Medicare contractors have established local policy to pay based on a flat rate basis only.

Example 3: A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x \$9.55 for a total trip reimbursement of \$19.10, plus the specimen collection fee.

Example 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x \$9.55 = \$57.30). Each of the claims submitted would be for \$11.46 (\$57.30 / 5 = \$11.46). Since one of the patients is non-Medicare, four claims would be submitted for \$11.46 each, plus the specimen collection fee for each.

Example 5: A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The \$9.55 flat rate is multiplied by two to cover the return trip to the laboratory (2

x \$9.55 = \$19.10) and then divided by five (1/5 of \$19.10 = \$3.82). Since one of the patients is non-Medicare, four claims would be submitted for \$3.82 each, plus the specimen collection fee.

At no time will a laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

Additional Information

To see the official instruction (CR6195) issued to your Medicare A/B MACs and carriers visit <http://www.cms.hhs.gov/Transmittals/downloads/R1584CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

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

INPATIENT REHABILITATION FACILITY (IRF) ANNUAL UPDATE: PROSPECTIVE PAYMENT SYSTEM (PPS) PRICER CHANGES FOR FY 2009 ~CMS MLN Matters~ Part A

MLN Matters Number: MM6166
Related CR Release Date: September 5, 2008
Related CR Transmittal #: R1585CP

Related Change Request (CR) #: 6166
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Inpatient rehabilitation facilities (IRFs) submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6166 which provides updated rates used to correctly pay IRF PPS claims for FY 2009. Be sure billing staff are aware of these changes.

Background

The FY 2009 IRF PPS Final Rule published on August 1, 2008, sets forth the prospective payment rates applicable for IRFs for FY 2009. A new IRF PRICER software package will be released prior to October 1, 2008, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2008 through September 30, 2009. Medicare systems will install the new revised Pricer program in a timely manner to ensure accurate payments for the IRF PPS claims with discharges occurring on or after October 1, 2008 through September 30, 2009.

PRICER Updates - For IRF PPS FY 2009, (October 1, 2008 – September 30, 2009):

- The standard Federal rate is: \$12,958
- The fixed loss amount is: \$10,250

- The labor-related share is: 75.464%
- The non-labor related share is: 24.536%
- Urban national average CCR is: 0.490
- Rural national average CCR is: 0.619

Additional Information

The official instruction, CR 6166, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1585CP.pdf> on the CMS Website.

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

**OCTOBER UPDATE TO THE 2008 MEDICARE PHYSICIAN FEE
SCHEDULE DATABASE (MPFSDB)
~CMS MLN Matters~
Part A & Part B**

MLN Matters Number: MM6180
Related CR Release Date: August 22, 2008
Related CR Transmittal #: R1580CP

Related Change Request (CR) #: 6180
Effective Date: January 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians and providers who submit claims to Medicare Carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for services rendered to Medicare beneficiaries paid based on the MPFSDB.

Key Points of CR 6180

- Changes in the October Update to the 2008 MPFSDB are as follows:

CPT/HCPCS Codes	Action
15878 and 15879	Bilateral indicator = 1
92557 and 92567	PC/TC Indicator = 9
93660—26	Multiple Procedure Indicator= 2
G0398, G0399, and G0400	PC/TC Indicator = 1

- Changes effective March 13, 2008 for G0398–TC, G0398–26, G0399-TC, G0399-26, G0400-TC, and G0400-26 are as described in Attachment 1 of CR 6180.
- An editorial change was made to the long descriptor of G0250 as noted in Attachment 1 of CR6180.

Make certain your billing staffs are aware of these changes. Your Medicare contractor will retroactively adjust claims if you bring such claims to their attention.

Background

This article is based on CR 6180, which states that payment files were issued to contractors based upon the 2008 MPFS Final Rule. CR 6180 amends those payment files.

Additional Information

If you have questions, please contact your Medicare 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.

You may see the official instruction (CR6180) issued to your Medicare Carrier or A/B MAC, by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1580CP.pdf> 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
Nebraska	
WPS Medicare Part B General Correspondence P.O. 8667 Madison, WI 53708 (866) 503-3807	

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