

# Communiqué

# Part A

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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**Items of Importance****\*WELCOME TO OUR NEW CUSTOMERS!\***

Welcome to WPS Medicare. WPS Medicare is proud to serve Part B legacy providers in Wisconsin, Illinois, Michigan, and Minnesota and Part A legacy former Mutual of Omaha Medicare providers across the country. In addition, we warmly welcome our new Part A and Part B customers in the Jurisdiction 5 (J5) Medicare Administrative Contractor (MAC) region: Iowa, Kansas, Missouri, and Nebraska. Our goal is to provide the highest quality Medicare claims administration and superior customer service.

To learn more about WPS, visit us at the following Website:  
[http://www.wpsmedicare.com/about\\_wps.shtml](http://www.wpsmedicare.com/about_wps.shtml)

**IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS**

On occasion, WPS Medicare Provider Customer Service closes for brief periods so our Customer Service Representatives may participate in training sessions. During the month of December 2007, we will NOT be closed for training.

WPS Medicare will close for the following holidays:

<b>Date</b>	<b>Holiday</b>
December 24, 2007	Christmas Eve
December 25, 2007	Christmas
January 1, 2008	New Years
March 21, 2008	Good Friday (PM Only)
May 26, 2008	Memorial Day
July 4, 2008	Independence Day
September 1, 2008	Labor Day

**NPI: HOW TO HANDLE THE NATIONAL PROVIDER IDENTIFIER (NPI) FOR ORDERING/REFERRING AND ATTENDING/OPERATING/OTHER/SERVICE FACILITY FOR MEDICARE CLAIMS  
~CMS MLN Matters~**

MLN Matters Number: MM5674 Revised  
Related CR Release Date: October 26, 2007  
Related CR Transmittal #: R225PI

Related Change Request (CR) #: 5674  
Effective Date: May 23, 2008  
Implementation Date: April 7, 2008

**Note:** This article was revised on November 1, 2007, to delete the parenthetical phrase (MD and DO) from the 8th bullet point under "Key Points." All other information remains the same.

**Provider Types Affected**

Physicians and providers who bill Medicare Carriers, fiscal intermediaries (FI), and Medicare Administrative Contractors (A/B MAC) for claims for services provided to Medicare beneficiaries.

**What Providers Need to Know**

Be cognizant of the fact that in accordance with the NPI final rule, when an identifier is reported on a claim for ordering/referring/attending provider, operating/other/service facility provider, or for any provider that is not a billing, pay-to or rendering provider, that identifier **must be an NPI. For Medicare purposes this means that submission of an NPI for an ordering/referring provider is mandatory effective May 23, 2008. Legacy numbers cannot be reported on any claims sent to Medicare on or after May 23, 2008.**

Medicare has always required that a provider identifier be reported for ordering/referring providers. Effective May 23, 2008, that number **must be an NPI**, regardless of whether that referring or ordering provider participates in the Medicare program or not or is a covered entity.

**Key Points**

- Medicare will not pay for referred/ordered services or items unless the name and NPI number of the referring/ordering/attending/operating/other/service facility provider is on the claim.
- It is the responsibility of the claim/bill submitter to obtain the ordering/referring/attending/operating/other/service facility NPI for health care providers.
- Providers whose business is largely based upon provision of services or items referred/ordered by other providers must be careful furnishing such services/items unless they first obtain the NPI of the referring/ordering individual. If they furnish services/items and do not obtain that person's NPI prior to billing Medicare, their claim will be denied.
- If the NPI is not directly furnished by the ordering/referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/her NPI prior to delivery of the services/items.
- Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/order services or items for Medicare beneficiaries.
- Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.
- Physicians and the following non physician practitioners are the only types of providers allowed to refer/order services or items for beneficiaries:
  - Nurse practitioners (NP);
  - Clinical nurse specialists (CNS);
  - Physician assistants (PA); and
  - Certified nurse midwives (CNM).
- Established NPI business requirements for beneficiary submitted (CR 5328), deceased physician (CR 5416), adjustments (CR 5416), beneficiary submitted (CR 4169), flu claims (CR 4169), foreign claims (CR 4169) and pandemic flu claims (CR 4169) remain as written.

**Background**

This article is based on Change Request (CR) 5674. Please note that the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers covered under HIPAA must comply with the requirements

of the NPI final rule (45 CFR Part 162, CMS-045-F). All entities covered under HIPAA must comply with the requirements of the NPI final rule.

**Additional Information**

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.

You may see the official instruction (CR5674) issued to your Medicare A/B MAC, FI, or carrier by going to <http://www.cms.hhs.gov/Transmittals/downloads/R225PI.pdf> on the CMS Website.

**NPI: IMPORTANT NPI UPDATES****The NPI is here. The NPI is now. Are you using it?**

Requirement to Update Information in the National Plan and Provider Enumeration System (NPPES) Health care providers who are covered entities under HIPAA are required by the National Provider Identifier (NPI) Final Rule to update their NPPES data. The Final Rule [at (162.410(a)(4))] states that covered health care providers must notify the NPPES of changes in their required NPPES data elements within 30 days of the changes. Failure to provide updated information may be considered an act of non-compliance with the NPI regulation, and a complaint may be filed against covered health care providers who do not comply with this provision, or any other provisions of the rule.

Most updates and changes can be made by health care providers over the Web, using the User IDs and passwords they selected when they first applied for their NPIs. If they applied on paper, most health care providers can submit updates or changes over the Web and can select User IDs and passwords at the time of the update. Certain changes or updates, however, must be made on paper (form CMS-10114), as they require the original signature of the health care provider or, for an organization health care provider, the signature of the Authorized Official. Such changes include:

- 1) Applications for NPIs, and all updates/changes, from individuals who do not have SSNs or who do not want to report their SSNs to NPPES;
- 2) All requests to deactivate NPIs;
- 3) All requests to reactivate NPIs;
- 4) All changes to incorrectly submitted SSNs;
- 5) All changes to incorrectly submitted dates of birth;
- 6) All changes to incorrectly submitted Employer Identifier Numbers (EINs);
- 7) All changes of EINs;
- 8) Password resetting changes due to changes to the Contact Person or Authorized Official.

**When to Contact the NPI Enumerator for Assistance**

Your health plans cannot assist you with NPI questions that should be directed to the NPI enumerator. However, the issues with which the NPI Enumerator can assist you are also limited to the following topics:

- Status of an NPI application, update, or deactivation
- Forgotten/lost NPI
- Lost NPI notification

- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application

Health care providers needing this type of assistance may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326, or e-mail the request to the NPI Enumerator at [CustomerService@NPIenumerator.com](mailto:CustomerService@NPIenumerator.com).

The NPI application is also a good source of information. Please refer to the NPI application instructions for clarification on information to be submitted in order to obtain an NPI or update your record. You can also refer to the 'Application Help' tab located on the NPPES Website for additional assistance while you are online. Resources for other kinds of questions can be found at the end of this document.

Please Note: The NPI Enumerator's operation is closed on federal holidays.

### **Important Information for Medicare Providers**

#### Medicare Announces a New "Key" NPI Date

This is an important message for physicians, other practitioners, providers, and suppliers that bill Medicare carriers, A/B Medicare Administrative Contractors (MACs), and DME MACs Using an Electronic Claim Form (ASC X12 837P) or Paper Claim Form (CMS-1500). The Centers for Medicare & Medicaid Services (CMS) is pleased to report that the vast majority of Medicare claims are being sent to Medicare with a National Provider Identifier (NPI). Moreover, the Medicare NPI crosswalk is successfully crosswalking NPIs to legacy numbers for most claims. Given these favorable results, we are taking the next step towards full implementation of the NPI in Medicare.

Effective March 1, 2008, your Medicare fee-for-service claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable beginning March 1, 2008. Until further notice, you may continue to include legacy identifiers only for the secondary fields.

#### Medicare Informational Warnings to Those Who Are Not Submitting NPIs On Claims

Since October 15, 2007, Medicare physicians, non-physician practitioners and other providers and suppliers who bill carriers and Medicare Administrative Contractors (MACs) using the ASC X12 837P or CMS-1500 receive informational warnings that indicate there was no NPI shown in the primary provider fields on your claim(s). Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

Many Medicare physicians, non-physician practitioners, and other providers and suppliers are not using NPIs in their Medicare claims, even in the primary provider fields (Billing/pay-to and Rendering). While, until March 1, you may continue to submit legacy identifiers in these fields, we strongly encourage you to begin using your NPI as well. You may use the NPI/PIN pair or the NPI-only to identify the Billing/pay-to and Rendering Providers.

Medicare informational warnings, called "Provider Identification Code Qualifier Invalid Value" messages, will be labeled M389, M390, M391, and/or M392, but, again, these are only

reminders. If you receive one of these messages and you are certain that your claim was submitted with an NPI, you may wish to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

The informational warnings consist of one or more of the following messages:

M389 2010AA NM108 Billing Provider Identification Code Qualifier Invalid value. The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M390 2010AB NM108 Pay To Provider Identification Code Qualifier Invalid value. The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M391 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid value. The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M392 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid value. The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

#### Testing Claims With Only the NPI

If you already bill using the NPI/legacy pair in the primary fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI. This test will serve to assure your claims will successfully process when only the NPI alone is mandated on all claims. If the results are positive, begin increasing the number of claims in the batch. If your claims reject, first go into the NPPES Website located at <https://nppes.cms.hhs.gov> and validate that your information is correct and that you reported your Medicare legacy identifier(s) in the Other Provider Identification Numbers section. Your Medicare legacy identifier(s) would be the number(s) that you used-prior to using the NPI-as the Billing/Pay-to and Rendering Providers. If the NPPES information is correct and you reported your Medicare legacy identifier(s), call your contractor and ask that they validate what is in their system.

#### **Need More Information?**

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page at <http://www.cms.hhs.gov/NationalProvdentStand> on the CMS Website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your Web browser to view the intended information. Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the <http://www.cms.hhs.gov/NationalProvdentStand> Website.

**Getting an NPI is free - not having one can be costly.**

Visit the Medicare Learning Network ~ it's free!

## **NPI: MANDATORY REPORTING OF THE NATIONAL PROVIDER IDENTIFIER (NPI) ON ALL PART B CLAIMS**

Effective March 1, 2008, your Medicare fee-for-service claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to provider, and rendering provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., referring, ordering, and supervising) may continue to include only your legacy number, if you choose. Failure to submit an NPI in the primary provider fields will result in your claim being rejected, beginning March 1, 2008.

In addition, if you already bill using the NPI/legacy pair in the primary provider fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI in the primary provider fields. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims.

## **NPI: REJECTION OF ELECTRONIC CLAIM STATUS REQUESTS THAT LACK NATIONAL PROVIDER IDENTIFIERS (NPIs)**

~CMS MLN Matters~

**MLN Matters Number: MM5726**

**Related CR Release Date: November 2, 2007**

**Related CR Transmittal #: R302OTN**

**Related Change Request (CR) #: 5726**

**Effective Date: May 23, 2008**

**Implementation Dates: January 7, 2008 & April 7, 2008**

### **Provider Types Affected**

Physicians, providers, and suppliers who submit claims status requests using the electronic data interchange (EDI) standard Health Insurance Portability and Accountability Act (HIPAA) transactions to Medicare contractors (carriers, Fiscal Intermediaries, (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), and DME Medicare Administrative Contractors (DME MACs))

### **Provider Action Needed**

#### **STOP – Impact to You**

This article is based on CR5726, which describes policy changes that are a result of HIPAA requirements that prohibit the acceptance of EDI transactions that contain legacy provider numbers. CR5726 specifically address changes around the processing of electronic claim status requests and the responses to such requests.

#### **CAUTION – What You Need to Know**

Beginning May 23, 2008, Medicare will return to sender any electronic claim status request (X12 276 transactions) that contain legacy provider numbers instead of or in addition to the NPI number. This policy also applies to direct data entry (DDE) claim status inquiries and to Internet claim status screens operated as demonstration projects by some contractors.

#### **GO – What You Need to Do**

No later than May 23, 2008, providers should ensure that all electronic claim status requests sent to Medicare contractors contain only NPI numbers (no legacy provider numbers.)

**Background**

All electronics claim status requests submitted using the EDI standards (X12 276) adopted under HIPAA for national use must use the HIPAA-mandated NPI exclusively for provider identification no later than May 23, 2008. Those that do not are to be returned to the sender beginning May 23, 2008. All claims status responses (X12 277 transactions) will also contain only NPIs as of May 23, 2008. The same policy applies to direct data entry claim status inquiries and to those Internet claim status screens some contractors are permitted to operate under an Internet demonstration program. The absence of an NPI or the presence of a legacy number as of May 23, 2008, will result in rejection of the inquiry by these direct data entry processes.

Providers are advised that Medicare will return an NPI on the claims status response on or after May 23, 2008, even if the claim status request is received prior to May 23, 2008, using a legacy number. In returning the NPI, Medicare will use a crosswalk file that relates the legacy number to the provider's NPI. If the legacy number maps to more than one NPI, Medicare will return the first active NPI in the 277 response.

To avoid confusion, Medicare encourages providers to begin including their NPIs in their X12 276 inquiries as soon as possible prior to May 23, 2008, particularly if the provider has more than one NPI, but was assigned only one legacy number by Medicare for claims submission purposes.

**Additional Information**

The official instruction, CR5726, issued to your Medicare contractor can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R302OTN.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.

## **PAYMENT ALLOWANCES FOR THE INFLUENZA VIRUS VACCINE AND THE PNEUMOCOCCAL VACCINE WHEN PAYMENT IS BASED ON 95 PERCENT OF THE AVERAGE WHOLESALE PRICE (AWP)**

~CMS MLN Matters~

**MLN Matters Number: MM5744**  
**Related CR Release Date: October 26, 2007**  
**Related CR Transmittal #: R1357CP**

**Related Change Request (CR) #: 5744**  
**Effective Date: September 1, 2007**  
**Implementation Date: November 26, 2007**

**Provider Types Affected**

Providers who bill Medicare contractors (fiscal intermediaries (FI), carriers, and Medicare Administrative Contractors (A/B MACs)) for influenza virus and pneumococcal vaccines.

**Provider Action Needed**

Be sure your billing staff are aware of the billing rates that are effective for influenza and pneumococcal vaccines provided on or after September 1, 2007. These rates apply, **except where the vaccine is furnished in the hospital outpatient department, in which payment for the vaccine is based on reasonable cost.**

**Background**

Change Request (CR) 5744, from which this article is taken, provides the payment allowances for: Influenza Virus Vaccines (Current Procedural Terminology (CPT) codes 90655, 90656, 90657, 90658, and 90660), and Pneumococcal Vaccine (CPT 90732 and 90669); when payment is based on 95% of the AWP.

Effective September 1, 2007, the Medicare Part B payment allowance in these situations is as follows:

**Influenza vaccine payments are:**

- CPT 90655 is \$16.109;
- CPT 90656 is \$17.366;
- CPT 90657 is \$6.609;
- CPT 90658 is \$13.218; and
- CPT 90660 (FluMist, a nasal influenza vaccine) is \$21.176 and providers should note that CPT 90660 may be covered in those cases where the local Medicare contractor determines that its use is medically reasonable and necessary for the beneficiary.

**Pneumococcal vaccine payments are:**

- CPT 90732 is \$29.730; and
- CPT 90669 is \$78.803.

**Please note:**

- These rates apply, except where the vaccine is furnished in the hospital outpatient department, where payment is based on reasonable cost.
- Annual Part B deductible and coinsurance amounts do not apply.
- All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.
- Your Medicare contractors will not search their files to adjust payment for claims paid prior to implementation of these changes; however, they will adjust claims that you bring to their attention.

**Additional Information**

The official instruction, CR5744, issued to your Medicare contractor is located at <http://www.cms.hhs.gov/Transmittals/downloads/R1357CP.pdf> on the Centers for Medicare & Medicaid (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.

**PROTECTED HEALTH INFORMATION AND THE MEDICARE COST REPORT**

Protected Health Information (PHI) is defined as individually identifiable health information that is transmitted or maintained in an electronic format or any other medium. An example of PHI that is commonly associated with a cost report is a provider prepared Medicare bad debt listing that supports the debts claimed on the cost report. Another example is a Medicaid day listing that hospitals use to support the disproportionate share payment claimed on the cost report.

The safeguarding of PHI is a high priority for the Centers for Medicare & Medicaid Services (CMS) and WPS Medicare. Consequently, to help prevent PHI from falling into the wrong hands, we are asking providers that submit documentation containing PHI, e.g., a bad debt listing, with their "as submitted" cost report or at the time of audit, to do so in an electronic format, preferably on a compact disk. When PHI is submitted to us electronically, we can easily password protect the disk. This provides a level of protection not available with paper should the PHI be misplaced or lost while our auditors are traveling to or from your site.

**WPS Medicare Tip of the Week**

*(Published in the 11/05/2007 General e-News Listserv)*

We have redesigned the WPS Medicare Website to better accommodate the needs of our customers, both our legacy Part B providers and our new legacy Part A and Jurisdiction 5 (J5) Medicare Administrative Contractor (MAC) providers.

You will find more information about the redesign in the article, "Welcome to the New WPSMedicare.com" on our Website at the following location:

**[http://www.wpsmedicare.com/part\\_a/publications/welcome\\_newwps.shtml](http://www.wpsmedicare.com/part_a/publications/welcome_newwps.shtml)**

To receive our Tips of the Week, sign up to receive our e-News Listserv at:

**<http://www.wpsmedicare.com/listserv>**

**Claim Submission****MEDICARE'S COMMON WORKING FILE (CWF) INFORMATIONAL  
UNSOLICITED RESPONSES FOR RDF CLAIMS OVERLAPPING  
INPATIENT HOSPITAL STAYS  
~CMS MLN Matters~**

MLN Matters Number: MM5768  
Related CR Release Date: November 2, 2007  
Related CR Transmittal #: R1364CP

Related Change Request (CR) #: 5768  
Effective Date: April 1, 2008  
Implementation Date: April 7, 2008

**Provider Types Affected**

Renal Dialysis Facilities (RDFs) 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****STOP – Impact to You**

This article is based on Change Request (CR) 5768, which changes processes for Common Working File (CWF) Informational Unsolicited Responses for RDF Claims Overlapping Inpatient Hospital Stays.

**CAUTION – What You Need to Know**

CR 5768 implements an informational unsolicited response from the CWF to prompt the Medicare systems to adjust 72x claims that have line item dates of service overlapping a subsequently received inpatient claim.

**GO – What You Need to Do**

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

**Background**

CR 5039 implemented line item billing for RDFs effective April 1, 2007. (See related MLN Matters article, MM5039 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5039.pdf> on the CMS Website.) In addition, CR 5039 (Transmittal 1084) implemented system functionality in the Medicare systems to compare line item dates of service on RDFs claims to the dates of services on other potential overlapping claims. When an incoming RDF claim (bill type 72x) includes line item dates of service(s) that are included in an inpatient claim, the line item services that are listed with dates that overlap the inpatient stay dates are rejected while allowing the remainder of the claim for dates of service that are not overlapping to be paid. RDFs may bill for and be paid for services on the admission date and discharge date of a hospital stay. Therefore, the inpatient admission date and discharge date are not considered overlapping dates of service. CR 5039 (Transmittal 1084) did not include a process for rejecting services on the RDF claim overlapping an inpatient stay when the RDF claim is received before the inpatient hospital claim.

Therefore, CR 5768 implements processes in Medicare systems to identify previously processed RDF claims received for a patient where a subsequent inpatient claim is received. When such RDF claims are identified, Medicare systems will adjust the already processed 72x claims that have line item dates of service overlapping the incoming inpatient claim.

**Additional Information**

The official instruction, CR5768, issued to FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1364CP.pdf> on the CMS Website. The revised sections of Chapter 8 of the Medicare Claims Processing Manual are attached to CR5768.

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.

**NEW PATIENT STATUS DISCHARGE CODE 70 TO DEFINE  
DISCHARGES OR TRANSFERS TO OTHER TYPES OF HEALTH CARE  
INSTITUTIONS NOT DEFINED ELSEWHERE IN THE UB-04 (CMS-  
1450) MANUAL CODE LIST  
~CMS MLN Matters~**

**MLN Matters Number: MM5764**

**Related CR Release Date: November 2, 2007**

**Related CR Transmittal #: R1361CP**

**Related Change Request (CR) #: 5764**

**Effective Date: April 1, 2008**

**Implementation Date: April 7, 2008**

**Provider Types Affected**

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

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

This article is based on Change Request (CR) 5764, which provides implementing instructions for a new patient discharge status code 70 and a definition change to existing patient discharge status code 05.

**CAUTION – What You Need to Know**

New patient discharge status code 70 was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for discharge dates on or after April 1, 2008, and patient discharge status code 05 has been redefined to indicate a discharge/transfer to a designated cancer center or children's hospital.

**GO – What You Need to Do**

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

**Background**

The UB-04 claim form includes the Patient Status Code as Field Locator 17. The Patient Status Code is a two digit code to indicate the disposition or discharge status of the beneficiary on a submitted claim, and it is a required field on all institutional claims. Several members of the NUBC participated in a workgroup to ensure the clarity of the definitions of patient discharge status codes, and as a result of the NUBC workgroup meeting, the following patient discharge status code changes are being implemented by NUBC effective April 1, 2008:

- New **patient discharge status code 70** was created in order for providers to be able to indicate discharges/transfers to another type of health care institution not defined elsewhere in the code list. This code is effective for use by providers for discharges/to dates on or after April 1, 2008.

Patient Status Code	Descriptor
70	Discharge/transfer to another type of health care institution not defined elsewhere in the code list

- **Patient discharge status code 05** has been redefined, effective April 1, 2008, to indicate a discharge/transfer to a designated cancer center or children's hospital.

**Note: For Inpatient Prospective Payment System (IPPS) hospitals, the post-acute transfer payment policy will not apply to claims that contain patient discharge status code 70.**

CR5764 also revises the *Medicare Claims Processing Manual*, Chapter 1, Section 50.2.1 (Inpatient Billing from Hospitals and SNFs), to reflect these patient status code changes and these revisions can be found in the attachment to CR5764.

**Additional Information**

The official instruction, CR5764, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1361CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

If you have any 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.

**Coverage – General****REVISIONS TO CR 4294 - LOW VISION REHABILITATION  
DEMONSTRATION  
~CMS MLN Matters~****MLN Matters Number: MM5756****Related CR Release Date: November 2, 2007****Related CR Transmittal #: R54DEMO****Related Change Request (CR) #: 5756****Effective Date: April 1, 2008****Implementation Date: April 7, 2008****Provider Types Affected**

Providers who bill Medicare fiscal intermediaries (FI), carriers, or Medicare Administrative Contractors (A/B MAC) for services provided to Medicare beneficiaries under the Medicare Low Vision Rehabilitation Demonstration.

**What You Need to Know**

CR 5756, from which this article is taken, revises some of the Medicare Low Vision Rehabilitation Demonstration coverage limitations described in CR 4294 (released January 20, 2006). Specifically, it changes the limitation of services from 9 hours of rehabilitation services in one consecutive 90-day period (once in a lifetime) to 12 hours of rehabilitation services *per calendar year*. You should make sure that your billing staffs are aware of these Medicare Low Vision Rehabilitation Demonstration coverage changes, which are effective for services supplied under the demonstration on or after April 1, 2008.

**Background**

To improve participation among eye care physicians in the Low Vision Rehabilitation Demonstration and to correct unnecessary limitations in level of low vision rehabilitation coverage, CR 5756, from which this article is taken, revises CR 4294 (Revisions to CR 3816 - Low Vision Rehabilitation Demonstration), released January 20, 2006. Specifically, it changes the 90-day, once in a lifetime limitation for vision rehabilitation services to a *calendar year basis*; and increases the number of hours of covered vision rehabilitation services to which a participating beneficiary is entitled from 36 units of 15-minutes each (9 hours), to 48 units of 15 minutes each (12 hours).

**Additional Information**

You can find the official instruction conveying the revisions to the Medicare Low Vision Rehabilitation Demonstration coverage limitations by going to CR 5756, located at <http://www.cms.hhs.gov/Transmittals/downloads/R54DEMO.pdf> on the CMS Website.

If you have any questions, please contact your 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.

## Coverage – Policies

### INFORMATION ON WEBSITE

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

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

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

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

#### WPS Medicare Tip of the Week

*(Published in the 11/12/2007 General e-News Listserv)*

When navigating the new WPSMedicare.com Website, do you sometimes have a hard time remembering how to get back to your home page?

Under every page title, we have "breadcrumbs" that mark your "trail" through the site. For example, on the CMS Resources page

([http://www.wpsmedicare.com/part\\_a/selfservice/cmsresources.shtml](http://www.wpsmedicare.com/part_a/selfservice/cmsresources.shtml)), you will see Home>> Provider Part A>> Self Service>> CMS Resources under the page title.

Simply click on the title of the page you want, and you will be taken there. Try clicking on "Provider Part A," and you will automatically be taken back to the Part A Home page.

To receive our Tips of the Week, sign up to receive our e-News Listserv at:

<http://www.wpsmedicare.com/listserv>

**General Information****MEDICARE BENEFICIARIES IN STATE OR LOCAL CUSTODY**

Effective April 1, 2003, Medicare denies claims for beneficiaries who are in the custody of a State or local government under the authority of a penal statute at the time the provider rendered the service. Using Social Security records showing health insurance claim (HIC) numbers and incarceration dates, Medicare identifies and rejects these claims.

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b), respectively.

Regulations at 42 CFR 411.4(b) state that "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

**Exclusion from Coverage**

Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute, unless it is determined that the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way, and with the same vigor, as it pursues other debts. CMS presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody.

**Claims Processing Procedures**

Providers and suppliers rendering services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of the **QJ modifier** *Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b)*. This modifier indicates the state or local government agency requesting the healthcare items or services provided to the patient has notified the provider that the prisoner or patient is responsible to repay the cost of Medical services. Furthermore, the agency will pursue the collection of debts for furnishing such items and services with the same vigor and in the same manner as any other debt.

Carriers must deny claims identified by the Common Working File (CWF) as non-covered under 42 CFR 411.4(a) and 411.4(b) using Reason Code 96 *Non-covered charges*. The following Remark Code will also be used:

Remark Code	Message
N103	<i>Social Security records indicate that this beneficiary was in the custody of a state or local government when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in state or local government custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while in such custody and the State or local government pursues such debt in the same way and with the same vigor as any other debt.</i>

### **Appeals**

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) The conditions of 42 CFR 411.4(b) were met, or (2) The beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

### **WPS Medicare Tip of the Week**

*(Published in the 11/26/2007 General e-News Listserv)*

Do you have a question about Medicare for us?

Check out our education schedule (including our Ask-the-Contractor Teleconferences (ACTs)) at:

[http://www.wpsmedicare.com/part\\_a/education/teleconferences.shtml](http://www.wpsmedicare.com/part_a/education/teleconferences.shtml) (Legacy)  
and

<http://www.wpsmedicare.com/mac/education/education.shtml> (MAC)

To receive our Tips of the Week, sign up to receive our e-News Listserv at:

**<http://www.wpsmedicare.com/listserv>**

**MAC****ELECTRONIC DATA INTERCHANGE (EDI) UPDATE**

WPS Medicare and the Mutual of Omaha Medicare division, both long-time leaders in the processing of Medicare claims on behalf of the federal government, have integrated under the WPS Medicare to administer Part A and Part B Medicare claims.

What does this mean for our Medicare EDI trading partners? In order to prepare for a smooth transition to the new Jurisdiction 5 (J5) Medicare Administrative Contract (MAC), we have provided a list below with the transition dates for providers in each state. Beginning on the specified date, all of your EDI transactions will need to be conducted with WPS.

<b>Workload</b>	<b>Outgoing Contractor</b>	<b>Contract Code</b>	<b>Transition Date</b>
Nebraska Part A	BCBS Nebraska	05401	12/1/07
Iowa Part B	Noridian	05102	2/1/08
Kansas Part A	BCBS Kansas (Wheatland)	05201	3/1/08
Missouri (Western)	BC Kansas (Wheatland)	05302	3/1/08
Kansas Part B	BC Kansas (Wheatland)	05202	3/1/08
Nebraska Part B	BC Kansas (Wheatland)	05402	3/1/08
Missouri Part A	BCBS Mississippi (TriSpan)	05301	5/1/08
Iowa Part A	BCBS AL (CAHABA)	05101	5/1/08
Missouri (Eastern) Part B	BCBS Arkansas	05392	6/1/08

If you should have any questions, please contact our EDI Department at 1-866-734-6656.

**J5 MAC LOCAL COVERAGE DETERMINATIONS (LCDS)**

On December 15, 2007, consolidated LCDs will be posted to our Website for the 45-day notice period. On day 46, these Jurisdiction 5 (J5) Medicare Administrative Contractor (MAC) LCDs will be in posted as Final LCDs and will become effective.

You should continue to use Blue Cross Blue Shield of Nebraska's LCDs until the J5 LCDs become Final. This will be approximately February 1, 2008.

## Provider Education

### EDUCATION SCHEDULE

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

#### LEGACY EVENTS

##### Teleconferences

Teleconferences are held at no cost to participants. To register to attend any of the following events, visit our Website\* at:

[http://www.wpsmedicare.com/part\\_a/education/teleconferences.shtml](http://www.wpsmedicare.com/part_a/education/teleconferences.shtml)

\*If you experience technical difficulty registering online, or unable to use online registration, please contact us at 618-998-5240.

#### Central Region - Omaha Office

##### "Ask the Contractor" Teleconference - SNF Benefits Exhaust and No-Pay Billing

Date	Time	Chairperson	Dial-In/Confirmation Number
12/11/07	11:00 a.m. - 12:30 p.m. Pacific Time 12:00 p.m. - 1:30 p.m. Mountain Time 1:00 p.m. - 2:30 p.m. Central Time 2:00 p.m. - 3:30 p.m. Eastern Time	Tanya Hoagland	Dial-In Number and Confirmation Number will be provided via e-mail two (2) days prior to the teleconference

##### AGENDA TOPICS:

- Review of rules
- Helpful hints
- Open Q & A

##### "Ask the Contractor" Teleconference - Use of the 59 Modifier

Date	Time	Chairperson	Dial-In/Confirmation Number
12/18/07	11:00 a.m. - 12:30 p.m. Pacific Time 12:00 p.m. - 1:30 p.m. Mountain Time 1:00 p.m. - 2:30 p.m. Central Time 2:00 p.m. - 3:30 p.m. Eastern Time	Aileen Sigler	Dial-In Number and Confirmation Number will be provided via e-mail two (2) days prior to the teleconference

##### AGENDA TOPICS:

- Overview of the Correct Coding Initiative Edits
- Definitions
- Discussion

**Northeast Region - Hartford, CT Field Office****"Ask-the-Contractor" Present on Admission Indicator for Acute Hospitals  
Teleconference**

<b>Date</b>	<b>Time</b>	<b>Facilitator</b>	<b>Dial-In/Confirmation Number</b>
12/12/07	7:30 a.m. - 9:00 a.m. Pacific Time 8:30 a.m. - 10:00 a.m. Mountain Time 9:30 a.m. - 11:00 a.m. Central Time 10:30 a.m. - 12:00 a.m. Eastern Time	John Wrynn	Dial-In Number and Confirmation Number will be provided via e-mail two (2) days prior to the teleconference

**AGENDA TOPICS:**

- POA Reporting Requirements
- POA Codes & Definitions
- POA Billing
- Hospital Acquired Conditions FY 2008

**MAC EVENTS**

Please watch our Website at <http://www.wpsmedicare.com/mac/index.shtml> for upcoming events.

**WPS Medicare Tip of the Week**

*(Published in the 11/19/2007 General e-News Listserv)*

Are you viewing the WPS Medicare Website using the recommended computer settings?

To check for the recommended settings, read our "Helpful Hints" document at the following location:

<http://www.wpsmedicare.com/hints.pdf>

To receive our Tips of the Week, sign up to receive our e-News Listserv at:  
<http://www.wpsmedicare.com/listserv>

**Reimbursement****AMBULANCE INFLATION FACTOR FOR CY 2008**

~CMS MLN Matters~

MLN Matters Number: MM5801  
 Related CR Release Date: November 9, 2007  
 Related CR Transmittal #: R1375CP

Related Change Request (CR) #: 5801  
 Effective Date: January 1, 2008  
 Implementation Date: January 7, 2008

**Provider Types Affected**

Providers and suppliers of ambulance services who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for those services

**What You Need to Know**

CR 5801, from which this article is taken provides the Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2008. The AIF for CY 2008 is 2.7%.

**Background**

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services.

Specifically, this section of the Act provides for a 2008 payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the previous year. The resulting percentage is referred to as the ambulance inflation factor (AIF).

CR 5801, from which this article is taken furnishes the CY 2008 AIF, which will be 2.7%. The following table displays the AIF for CY 2008 and for the previous 5 years.

<b>Ambulance Inflation Factor by CY</b>	
2008	2.7%
2007	4.3%
2006	2.5%
2005	3.3%
2004	2.1%
2003	1.1%

The national fee schedule for ambulance services was phased in over a five-year transition period beginning April 1, 2002. Further, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) established that the ground ambulance base rate (for services furnished during the period July 1, 2004 through December 31, 2009) is subject to a "floor amount."

Payment will not be less than this "floor," which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule.

Some key issues related to the AIF include:

**National or Regional Fee Schedules**

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division's fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate.

**Payments Based on Blended Methodology**

During the five-year transition period, your payments have been based on a blended methodology. For CY 2008, this blend is 20% regional ground base rate and 80% national ground base rate.

Before January 1, 2006, for each ambulance provider or supplier, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional (if it applied)), and to the reasonable cost or charge portion of the blended payment amount. Then, these two amounts were added together to determine each provider or supplier's total payment amount.

As of January 1, 2006, the total payment amount for air ambulance providers and suppliers is based on 100% of the national ambulance fee schedule. As of January 1, 2008, the total payment amount for ground ambulance providers and suppliers is based on either 100% of the national ambulance fee schedule or 80% of the national ambulance fee schedule and 20% of the regional ambulance fee schedule, whichever is greater.

**Part B Coinsurance and Deductible Requirements**

Part B coinsurance and deductible requirements apply.

**Additional Information**

You can find more information about the 2008 ambulance inflation factor by going to CR 5801 located at <http://www.cms.hhs.gov/transmittals/downloads/R1375CP.pdf> on the Centers for Medicare & Medicaid (CMS) Website. There you will find updated *Medicare Claims Processing Manual*, Chapter 15 (Ambulance), Section 20.6.1 (Ambulance Inflation Factor (AIF)) as an attachment to that CR.

If you have any questions, please contact your Medicare 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.

**CORRECTION TO CALCULATION OF COINSURANCE FOR INDIAN  
HEALTH SERVICE CRITICAL ACCESS HOSPITALS (IHS CAHS)**

~CMS MLN Matters~

MLN Matters Number: MM5769  
Related CR Release Date: November 2, 2007  
Related CR Transmittal #: R1362CP

Related Change Request (CR) #: 5769  
Effective Date: April 1, 2007  
Implementation Date: April 7, 2008

**Provider Types Affected**

Indian Health Service Critical Access Hospitals (IHS CAHs) that bill Medicare Fiscal Intermediaries (FIs) or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries

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

Change Request (CR) 5769 corrects the calculation of Medicare Part B coinsurance for IHS CAHs.

**CAUTION – What You Need to Know**

The calculation of coinsurance for IHS CAHs for services paid on the facility-specific per visit rate is to be based solely on billed charges, not on the payment amount for the particular IHS CAH.

On April 7, 2008, Medicare systems will be corrected to calculate coinsurance for IHS CAHs accordingly. FIs or MACs will not search their claims histories to find and correct claims processed by Medicare since April 1, 2007 through April 6, 2008, **but will correct any claims that you bring to their attention.**

**GO – What You Need to Do**

Make certain that your billing staffs are aware of this change.

**Background**

The change directed in CR5769 corrects an error in the Medicare system that calculates Part B coinsurance for IHS CAHs on claims processed since April 1, 2007.

**Additional Information**

For complete details regarding this Change Request (CR), please see the official instruction (CR5769) issued to your Medicare A/B MAC or FI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1362.pdf> on the CMS Website.

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

**IMPLEMENTATION OF 2008 AMBULATORY SURGICAL CENTER  
(ASC) PAYMENT SYSTEM CHANGES****~CMS MLN Matters~**

**MLN Matters Number: MM5680**  
**Related CR Release Date: August 29, 2007**  
**Related CR Transmittal #: R77BP and R1325CP**

**Related Change Request (CR) #: 5680**  
**Effective Date: January 1, 2008**  
**Implementation Date: January 7, 2008**

**Provider Types Affected**

Providers who bill contractors (Fiscal Intermediaries, carriers, and Medicare Administrative Contractors (A/B MAC) for ambulatory surgical center services for Medicare Beneficiaries.

**What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) is required to implement a new Ambulatory Surgical Center (ASC) payment system no later than January 1, 2008. An overview of the new system has already been provided in the MLN Matters article SE0742, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> on the CMS Website. CR 5680, from which this article is taken, provides additional information on the background, policy, and instructions that your Medicare contractor will use to implement this revised payment system.

**Background**

Section 626 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to implement a new Ambulatory Surgical Center (ASC) payment system not later than January 1, 2008. In part, the law requires that ASCs be paid the lesser of the actual charge or the ASC fee schedule payment rates. See MLN Matters article SE0742 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> for an overview of the new ASC payment system.

In addition to the new payment instructions, ASCs will be paid a reduced amount for certain procedures when you receive a partial credit for more than 50 percent of the cost of a medical device. You will need to include an FC modifier on certain procedure codes that include payment for a device, to report that you received a partial credit for more than 50 percent of the cost of the device. For those procedure codes where the FC modifier may be applicable, CMS will provide Medicare contractors with a price for the procedure code, both with and without, the FC modifier.

CR 5680 also includes a number of changes to two Medicare manuals as summarized below. (Only the key changes/revisions are included in this article). These revised manual instructions are attached to CR5680.

**Revisions to the Medicare Claims Processing Manual**

(These revisions are attached to CR5680 at <http://www.cms.hhs.gov/Transmittals/downloads/R1325CP.pdf> on the CMS Website.)

Key revisions are:

**Chapter 1 (General Billing Requirements)**

**Section 30.3.1 (Mandatory Assignment on Carrier Claims)**

For colorectal cancer screening colonoscopies (G0105 and G0121), there is no deductible and a 25 percent coinsurance. Effective January 1, 2008, for service G0104, there will be no deductible and the 25 percent coinsurance rate will apply.

**Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPSS))**

**Section 120 (General Rules for Reporting Outpatient Hospital Services)**

Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on TOB 83X for ASCs. All ASC providers (including Indian Health Service providers) must submit their claims to the designated carrier or A/B MAC.

**Section 180.1 (General Rules)**

Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on TOB 83X for ASCs. All ASC providers (including Indian Health Service providers) must submit their claims to the designated carrier or A/B MAC.

**Chapter 14 (Ambulatory Surgical Centers)**

**Section 10 (General)**

Beginning January 1, 2008, Medicare will:

- Pay ASCs (under Part B) for all surgical procedures except those that CMS determines may pose a significant safety risk to beneficiaries or that are expected to require an overnight stay when furnished in an ASC;
- Pay ASCs (under Part B) for certain ancillary services such as certain drugs and biologicals, pass through devices, brachytherapy sources, and radiology procedures;
- Continue to pay ASCs for new technology intraocular lenses and corneal tissue acquisition as it did prior to January 1, 2008; and
- Not pay ASCs for procedures that are excluded from the list of covered surgical procedures or covered ancillary services.

To be paid under this provision, a facility must be certified as meeting the requirements for an ASC and must enter into a written agreement with the Centers for Medicare & Medicaid Services (CMS). The *State Operations Manual*, which you can find at <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS1201984&intNumPerPage=10> describes the certification process.

**Section 10.2. (Ambulatory Surgical Center Services on ASC List)**

Under the new payment system, ASC services for which payment is included in the ASC payment include, but are not limited to:

- Nursing technician, and related services;
- Use of the facility where the surgical procedures are performed;
- Any laboratory testing performed under a clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate waiver;
- Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);

- Medical and surgical supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42>;
- Equipment;
- Surgical dressings;
- Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42>);
- Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR located at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42>;
- Splints and casts and related devices;
- Radiology services for which separate payment is not allowed under the OPSS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;
- Administrative, recordkeeping and housekeeping items and services;
- Materials, including supplies and equipment for the administration and monitoring of anesthesia; and
- Supervision of the services of an anesthetist by the operating surgeon.

In addition, Medicare will pay ASCs separately for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. The services are:

- Brachytherapy sources;
- Certain implantable items that have pass-through status under the Outpatient Prospective Payment System (OPSS);
- Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue;
- Certain drugs and biologicals for which separate payment is allowed under the OPSS; and
- Certain radiology services for which separate payment is allowed under the OPSS.

Beginning January 1, 2008, the ASC facility payment for drugs and biologicals includes those that are not usually self-administered, and are considered to be packaged into the payment for the surgical procedure under the outpatient prospective payment system (OPSS). Beginning January 1, 2008, Medicare makes separate payment to ASCs for drugs and biologicals that are furnished integral to an ASC covered surgical procedure and are separately payable under the OPSS.

#### **Section 10.4. (Coverage of Services in ASCs, Which Are Not ASC Facility Services) Physician Services**

Includes most covered services performed in ASCs, which are not considered ASC facility services. Consequently, physicians who perform covered services in ASCs may bill and receive separate payment under Part B. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to beneficiaries in ASC's and the beneficiaries' recovery from the anesthesia.

**Implantable Durable Medical Equipment (DME)**

If the ASC furnishes items of implantable DME items to beneficiaries, the ASC bills and receives payment from the local carrier or A/B MAC for the surgical procedure and the implantable device. When the surgical procedure is not on the ASC list, the physician bills the carrier or A/B MAC for both the surgical procedure and the implanted device, coding the ASC as the place of service (POS code 24) on the bill.

**Non-Implantable DME**

If the ASC furnishes items of non-implantable DME to beneficiaries, it is treated as a DME supplier, and all the rules and conditions ordinarily applicable to DME are applicable, including obtaining a supplier number and billing the DME MAC where applicable.

**Services of Independent Laboratory**

As noted in the *Medicare Claims Processing Manual*, Chapter 14, *Section 10.2.*, only very limited numbers and types of diagnostic tests are considered ASC facility services and are included in the ASC facility payment rate. Since *Section 1861(s)* of the Act limits coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics, or hospitals to those that meet the statutory definition of an independent laboratory, in most cases, diagnostic tests that an ASC performs directly are not considered ASC facility services and not covered under Medicare.

The ASC's laboratory must be CLIA certified and will need to enroll with the carrier or A/B MAC, as a laboratory and the certified clinical laboratory must bill for the services provided to the beneficiary in the ASC. Otherwise, the ASC must make arrangements with a covered laboratory or laboratories for laboratory services, as set forth in 42CFR416.49 located at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=737c29dc4bb9dd89c5b72ca82f9b40c5&rgn=div8&view=text&node=42:3.0.1.1.3.3.1.10&idno=42> on the Internet.

**Section 20 (List of Covered Ambulatory Surgical Center Procedures)**

The complete lists of ASC covered surgical procedures and ASC covered ancillary services; the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations; and the wage adjusted payment rates, and wage indices are available at <http://www.cms.hhs.gov/ASCPAYMENT> on the CMS Website.

**Section 20.1 (Nature and Applicability of ASC List)**

The ASC list of covered procedures indicates procedures, which are covered and paid for if performed in the ASC setting. It does not require the covered surgical procedures to be performed only in ASCs. The decision regarding the most appropriate care setting for a given surgical procedure is made by the physician based on the beneficiary's individual clinical needs and preferences. In addition, all the general coverage rules requiring that any procedure be reasonable and necessary for the beneficiary are applicable to ASC services in the same manner as all other covered services.

**Section 20.2. (Types of Services Included on the List)**

The Medicare approved procedures are all considered "surgical procedures" for purposes of ASC coverage, regardless of the use of the procedure. For example, many of the "oscopy" procedures listed - bronchoscopy, laryngoscopy, etc., may be employed for either diagnostic or therapeutic purposes, or even both at the same time, such as when the "oscopy" permits

both detection and removal of a polyp. Those procedures are considered “surgical procedures” within the context of the ASC provision. In addition, surgical procedures are commonly thought of as those involving an incision of some type, whether done with a scalpel or (more recently) a laser, followed by removal or repair of an organ or other tissue.

In recent years, the development of fiber optics technology, together with new surgical instruments using that technology, has resulted in surgical procedures that, while invasive and manipulative, do not require incisions. Instead, the procedures are performed without an incision through various body openings. Those procedures, some of which include the “oscopy” procedures mentioned above, are also considered surgical procedures for purposes of the ASC provision, and several are included in the list of covered procedures.

The ASC list of covered surgical procedures is comprised of surgical procedures that CMS determines do not pose a significant safety risk and are not expected to require and overnight stay following the surgical procedure.

Surgical procedures are defined as Category I CPT codes within the surgical range of CPT codes, 10000 through 69999. Also considered to be included within that code range are Level II HCPCS and Category III CPT codes that crosswalk to or are clinically similar to the Category I CPT codes in the range.

The surgical codes that are included on the ASC list of covered surgical procedures are those that have been determined to pose no significant safety risk to Medicare beneficiaries when furnished in ASCs and that are not expected to require active medical monitoring at midnight of the day on which the surgical procedure is performed (overnight stay).

Procedures that are included on the inpatient list used under Medicare’s hospital outpatient prospective payment system and procedures that can only be reported by using an unlisted Category I CPT code are deemed to pose significant safety risk to beneficiaries in ASCs and are not eligible for designation and coverage as covered surgical procedures.

### **Section 30 (Rate-Setting Policies)**

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- The cost of the physician’s professional services for performing the procedure; and,
- The cost of services furnished by the facility where the procedure is performed (e.g., surgical supplies and equipment and nursing services). For a discussion of the ASC payment methodology, see MLN Matters article SE0742 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> on the CMS Website.

### **Section 40.3. (Payment for Intraocular Lens (IOLs))**

Beginning January 1, 2008, the Medicare payment for the IOL is included in the Medicare payment for the associated surgical procedure. Consequently, no separate payment for the IOL will be made, except for a new technology IOL as discussed under the *Medicare Claims Processing Manual*, Chapter 14, Section 40.3.1. If an ASC bills for a new technology IOL that is provided in association with a covered ASC procedure, the contractor will make a separate payment adjustment of \$50 for the new technology IOL. The payment for the new technology IOL is subject to beneficiary coinsurance but is not wage adjusted. The hard

coded system logic that excludes the \$150 for IOLs for multiple surgery reduction will not apply effective for dates of services on or after January 1, 2008.

#### **Section 40.4 (Payment for Terminated Procedures)**

Facilities use a 73 modifier to indicate that the procedure terminated prior to induction of anesthesia.

Prior to January 1, 2008, carriers or A/B MACs deduct the allowance for an unused IOL prior to calculating payment for a terminated IOL insertion procedure.

Beginning January 1, 2008, payment for an IOL is included in the payment for the surgical procedure to implant the lens.

Beginning January 1, 2008, Medicare contractors will apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia. Facilities use the -52 modifier to indicate the discontinuance of these applicable procedures.

Beginning January 1, 2008, ASC surgical services billed with the -52 or- 73 modifiers are not subject to the multiple procedure discount.

#### **Section 40.5. (Payment for Multiple Procedures)**

Each surgical procedure has its own CPT-4 code. When more than one surgical procedure is performed in the same operative session, special payment rules apply even if the services have the same CPT-4 code number.

When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors base the ASC facility payment rate on 100% of the highest paid procedure, plus 50 percent of applicable wage adjusted rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session.

The multiple procedure payment reduction is the last pricing routine applied beginning January 1, 2008 to applicable ASC procedure codes. In determining the ranking of procedures for application of the multiple procedure reduction, contractors shall use the lower of the billed charge or the ASC payment amount. The ASC surgical services billed with modifier -73 and -52 will not be subjected to further pricing reductions (i.e., the multiple procedure price reduction rules will not apply). Payment for an ASC surgical procedure billed with modifier -74 may be subject to the multiple procedure discount if that surgical procedure is subject to the multiple procedure discount.

#### **Section 40.6 (Payment for Extracorporeal Shock Wave Lithotripsy (ESWL))**

Beginning January 1, 2008 with the revised ASC payment system, contractors may pay for any of the ESWL services that are included on the ASC list of covered surgical procedures.

#### **Section 40.7 (Offset for Payment for Pass-Through Devices Beginning January 1, 2008)**

Under the revised payment system, there can be situations where contractors must reduce (cut back) the approved payment amount for specifically identified procedures when provided in conjunction with a specific pass-through device. This reduction would only be applicable when services for specific pairs of codes are provided on the same day by the

same provider. Code pairs subject to this policy would be updated quarterly. The CMS will inform Medicare contractors of the code pairs and the percent reduction taken from the procedure payment rate through a “look-up” table.

**Section 40.8 (Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008)**

Contractors pay ASCs a reduced amount for certain specified procedures when a device is furnished without cost or for which either a partial or a full credit is received (e.g., device recall). For specified procedure codes that include payment for a device, ASCs are required to include an FB modifier on the procedure code when a device is furnished without cost or for which full credit is received.

If the ASC receives a partial credit for the device, the ASC is required to include the FC modifier on the procedure code. A single procedure code should not be submitted with both a FB and a FC modifier. The pricing determination related to the FB and FC modifiers is performed prior to the application of the multiple procedure pricing reductions.

**Section 40.9 (Payment for Presbyopia Correcting IOLs (P-C IOLs and Astigmatism Correcting IOLs (A-C IOLs)**

CMS payment policies and recognition of P-C IOLs and A-C IOLs are contained in Transmittal 636 (CR3927) and Transmittal 1228 (CR5527) respectively. See <http://cms.hhs.gov/center/asc.asp> for a current list of CMS recognized P-C IOL and A-C IOL lenses.

**Section 50 (ASC Procedures for Completing the Form CMS-1500)**

The Place of Service (POS) code is 24 for procedures performed in an ASC.

Prior to January 1, 2008, Type of Service (TOS) code is “F” (ASC Facility Usage for Surgical Services) is appropriate when modifier SG appears on an ASC claim. Otherwise TOS “2” (surgery) for professional services rendered in an ASC is appropriate.

Beginning January 1, 2008, ASCs no longer are required to include the SG modifier on facility claims in Medicare. Modifier – TC is required unless the code definition is for the technical component only.

**Section 60 (Medicare Summary Notices (MSN), Claim Adjustment Reason Codes, Remittance Advice Remark Codes (RAs)****Section 60.1 (Applicable messages for NTIOLs)**

Carriers or A/B MACs will return, as unprocessable, any claims for NTIOLs containing Q1003 alone or with a code other than one of the procedure codes listed in Section 40.5.2, Chapter 14, of the *Medicare Claims Processing Manual*. They will use the following messages for these returned claims:

- Claim Adjustment Reason Code 16 - Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate;
- RA Remark Code M67 - Missing/Incomplete/Invalid other procedure codes; and
- RA Remark Code MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Carriers or A/B MACs will deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC and use the following messages when denying these claims:

- MSN 16.2 - This service cannot be paid when provided in this location/facility; and
- Claims Adjustment Reason Code 58 - Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Carriers or A/B MAC will deny payment for Q1003 if billed by an entity other than a Medicare-approved ASC and use the following messages when denying these claims:

- MSN 33.1 - The ambulatory surgical center must bill for this service; and
- Claim Adjustment Reason Code 170 - Payment is denied when performed/billed by this type of provider.

Carriers or A/B MACs shall deny payment for Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011) and use the following messages when denying these claims:

- MSN 21.11 - This service was not covered by Medicare at the time you received it; and
- Claim Adjustment Reason Code 27 - Expenses incurred after coverage terminated.

### **Section 60.2 (Applicable messages for ASC 2008 payment changes effective January 1, 2008)**

Contractors shall deny services not included on the ASC facility payment files (ASCFS and ASC DRUG files) when billed by ASCs (specialty 49) for POS 24 using the following messages:

- Claim Adjustment Reason Code 8 - The procedure code is inconsistent with the provider type/specialty;
- RA Remark Code N95 - This provider type/provider specialty may not bill this service; and
- MSN 26.4 – This service is not covered when performed by this provider.

If there is no approved ASC surgical procedure on the same date for the billing ASC in history, contractors will return pass-through device claims/line items, brachytherapy claims/line items, drug code (including C9399) claims/line items, and any other ancillary service claims/line items such as radiology procedure claim/line items on the ASCFS list or ASC DRUG list as unprocessable using the following messages:

- Claim Adjustment Reason Code 16 - Claim/service lacks information, which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate;
- RA Remark Code MA 109 - Claim processed in accordance with ambulatory surgical guidelines; and
- RA Remark Code M16 - Please see our Website, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

Contractors shall deny all ancillary services (e.g., radiology technical component) on the ASCFS list billed by specialties other than specialty 49 provided in an ASC setting (POS 24) using the following messages:

- MSN 16.2 – This service cannot be paid when provided in this location/facility;

- Claim Adjustment Reason Code 171 - Payment is denied when performed/billed by this type of provider in this type of facility;
- RA Remark Code M97 - Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility; and
- RA Remark Code M16 - Please see our Website, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

Contractors shall deny separately billed implantable devices using the following messages:

- MSN 16.32 - Medicare does not pay separately for this service;
- RA Remark Code M97 – Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility;
- RA Remark Codes M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed;
- MA 109 - Claim processed in accordance with ambulatory surgical guidelines; and
- M16 - Please see our Website, mailings or bulletins for more details concerning this policy/procedure/decision (contractor discretion).

If there is a related, approved surgical procedure for the billing ASC for the same date of service, they will also include the following message:

- MSN 16.8 - Payment is included in another service received on the same day.

### **Chapter 19 (Indian Health Services)**

#### **Section 40.2.1 (Provider Enrollment with FI or AB MAC - Ambulatory Surgical Services)**

For dates of service prior to January 1, 2008, IHS providers that want to bill for surgeries on the ambulatory surgical center (ASC) list and receive the ASC rate must contact their designated FI or AB MAC. IHS providers are certified by one of several national accrediting organizations recognized by the Centers for Medicare & Medicaid Services (CMS) and meet the conditions for performing ASC procedures.

IHS hospital outpatient departments are not certified as separate ASC entities. The ASC indication merely means that CMS approved them to bill for ASC services and be paid based on the ASC rates for services on the ASC list. In order to bill for ASC services, the hospital outpatient department must meet the conditions of participation for hospitals defined in 42CFR482 located at [http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&tpl=/ecfrbrowse/Title42/42cfr482\\_main\\_02.tpl](http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&tpl=/ecfrbrowse/Title42/42cfr482_main_02.tpl) on the Internet.

Authority for Medicare to pay IHS hospital outpatient departments using the freestanding ASC rates was incorporated into Public Health Service (PHS) regulations on December 27, 1989. The first IHS hospital requested and received approval from CMS to bill separately for ASC procedures at the appropriate ASC group payment amount for dates of service on or after October 1, 1987. Previously, the hospital was reimbursed for ASC procedures at the Office of Management and Budget (OMB) negotiated all-inclusive rate (AIR) for outpatient hospital services. The rationale for approving this request was that the hospital was already JCAHO certified; encompassing the ability to perform outpatient surgical procedures, and that acute care hospitals providing surgical inpatient or outpatient services can perform any surgical procedures within their capacity and capability.

Effective for dates of service on or after January 1, 2008, the FI or A/B MAC no longer processes claims for IHS ASCs. All IHS ASC providers, including hospital outpatient departments requesting payment based on freestanding ASC rates and ASCs affiliated with a hospital but operating as a distinct entity for the purpose of performing outpatient surgical services must enroll with and submit their claims to the designated carrier or A/B MAC.

#### **Chapter 26 (Completing and Processing Form CMS-1500 Data Set)**

##### **Section 10.7 (Type of Service (TOS))**

Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare ASC services. ASC providers will no longer be required to bill the SG modifier on Medicare ASC facility claims.

#### **Revisions to the Medicare Benefit Policy Manual**

Changes to this manual are basically the same, as appropriate, as those made to the *Medicare Claims Processing Manual*. The revised portions of the *Medicare Benefits Policy Manual* are also attached to CR5680 at

<http://www.cms.hhs.gov/Transmittals/downloads/R77BP.pdf> on the CMS Website.

#### **Additional Information**

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

The two transmittals related to CR5680 are at

<http://www.cms.hhs.gov/Transmittals/downloads/R1325CP.pdf> and

<http://www.cms.hhs.gov/Transmittals/downloads/R77BP.pdf> on the CMS Website.

Attached to these transmittals are the revised manual chapters discussed in this article.

These transmittals are the official instructions issued to your Medicare contractor. Also, the MLN Matters article providing an overview of the new ASC payment system is at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> on the CMS Website.

#### **WPS Medicare Tip of the Week**

*(Published in the 10/15/2007 General e-News Listserv)*

To ensure WPS Medicare resolves your inquiry quickly and accurately, when you call our Provider Contact Center, please be sure to have the following information on hand:

~ Provider number(s) ~

~ Patient's Medicare number(s) ~

~ Date(s) of service~

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**REASONABLE CHARGE UPDATE FOR 2008 FOR SPLINTS, CASTS,  
DIALYSIS SUPPLIES, DIALYSIS EQUIPMENT, AND CERTAIN  
INTRAOCULAR LENSES****~CMS MLN Matters~**

**MLN Matters Number: MM5740 Revised**  
**Related CR Release Date: September 28, 2007**  
**Related CR Transmittal #: R1344CP**

**Related Change Request (CR) #: 5740**  
**Effective Date: January 1, 2008**  
**Implementation Date: January 7, 2008**

**Note:** This article was revised on November 7, 2007 to change the title to the chart showing the payment limits. That chart should have read "2008" and not "2007." All other information is unchanged.

**Provider Types Affected**

Physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis equipment, and certain intraocular lenses.

**Provider Action Needed**

Affected providers may want to be certain their billing staffs know of these changes.

**Background**

For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change Request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at:

<http://www.gpoaccess.gov/cfr/retrieve.html> on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The MLN Matters article related to CR 5382 can be viewed at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf> on the CMS Website.

For intraocular lenses, payment is made **only on a reasonable charge basis for lenses implanted in a physician's office**. Change Request 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

#### Dialysis Supplies Billed With AX Modifier

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

#### Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

#### Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639
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#### Dialysis Equipment Billed Without AX Modifier

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes. **Contractors** will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008 through December 31, 2008. **Those 2008 payment limits are in Attachment A at the end of this article.**

#### Additional Information

Detailed instructions for Calculating:

- Reasonable charges are located in Chapter 23 (Section 80) of the *Medicare Claims Processing Manual*;
- Customary and prevailing charge are located in Section 80.2 and 80.4 of Chapter 23 of the *Medicare Claims Processing Manual*; and
- The IIC (Inflation Indexed Charge) are located in Section 80.6 of Chapter 23 of the *Medicare Claims Processing Manual*. The IIC update factor for 2008 is 2.7 percent.

You can find Chapter 23 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Website.

For complete details regarding this Change Request (CR) please see the official instruction (CR5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf> on the CMS Website.

If you have questions, please contact your Medicare FI, carrier, DME MAC, 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.

#### 2008 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit
A4565	\$7.38	Q4025	\$32.45
Q4001	\$42.01	Q4026	\$101.30
Q4002	\$158.81	Q4027	\$16.23
Q4003	\$30.18	Q4028	\$50.66
Q4004	\$104.49	Q4029	\$24.81
Q4005	\$11.12	Q4030	\$65.31
Q4006	\$25.08	Q4031	\$12.41
Q4007	\$5.58	Q4032	\$32.65
Q4008	\$12.54	Q4033	\$23.14
Q4009	\$7.43	Q4034	\$57.56
Q4010	\$16.72	Q4035	\$11.57
Q4011	\$3.71	Q4036	\$28.79
Q4012	\$8.36	Q4037	\$14.12
Q4013	\$13.52	Q4038	\$35.37
Q4014	\$22.81	Q4039	\$7.08
Q4015	\$6.76	Q4040	\$17.68
Q4016	\$11.40	Q4041	\$17.16
Q4017	\$7.82	Q4042	\$29.30
Q4018	\$12.47	Q4043	\$8.59
Q4019	\$3.91	Q4044	\$14.66
Q4020	\$6.24	Q4045	\$9.96
Q4021	\$5.78	Q4046	\$16.03
Q4022	\$10.44	Q4047	\$4.97
Q4023	\$2.91	Q4048	\$8.02
Q4024	\$5.22	Q4049	\$1.82

**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.

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