

Communiqué

Part A

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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May 2008

Items of Importance**ANNOUNCING THE NEW FORMS WEBPAGE**

Are you having trouble finding the Medicare forms you need? Please visit our new Forms page at: http://www.wpsmedicare.com/part_a/selfservice/forms.shtml

This page provides "one-stop shopping" for Medicare forms. To serve our provider community better, we have made the forms on the WPS Medicare Website interactive. Simply open the PDF document, enter your information, and click "Print." All you have to do then is sign the form and mail it in at your convenience.

IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS

WPS Medicare will close for the following holidays:

Date	Holiday
May 26, 2008	Memorial Day
July 4, 2008	Independence Day
September 1, 2008	Labor Day

INTRODUCING THE NEW SYSTEM STATUS FEATURE

WPS Medicare has recently equipped our Website with status functionality. This functionality enables our customers to view system availability by accessing a scroll box, located on every provider homepage, for the various methods of contact that WPS Medicare offers. The benefit of this feature is that it allows providers to determine the most advantageous method of contact to WPS, based on current, real-time availability of systems and telephones. This easy-to-access status feature creates efficiencies for providers and also reduces redundant inquiries coming into our contact center regarding system-related issues.

**WEBSITE CUSTOMER SATISFACTION SURVEY
Your Voice Shapes the WPS Medicare Website**

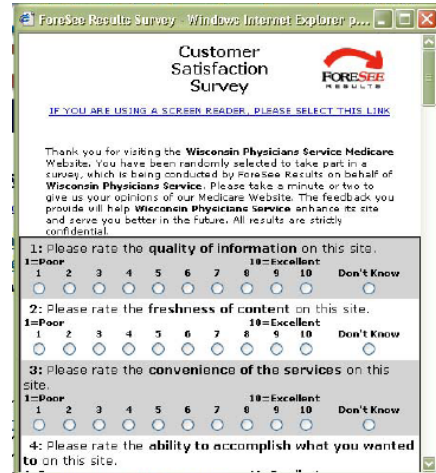
Your feedback is extremely important to the provider community, WPS Medicare, and the Centers for Medicare & Medicaid Services (CMS). Please assist WPS Medicare in ensuring your satisfaction by completing the Customer Satisfaction Survey that pops up when you are on the WPS Medicare (<http://www.wpsmedicare.com>) Website. This quick survey, sponsored by CMS and conducted by ForeSee, gauges your satisfaction with the WPS Medicare Website, and you are strongly encouraged to complete the survey.

WPS Medicare is interested in your feedback on both what you like and what improvements they can make to the wpsmedicare.com Website. Please be specific in your evaluation of the Website - If WPS offers something on the Website that you feel is valuable, be sure to detail the specific tool/Web page/etc. you are referencing. WPS and CMS review the results of the survey regularly, and your feedback directly influences the layout, look and feel, content, and other aspects of the WPS Medicare Website.

The survey is anonymous, and is intended to measure your satisfaction with the <http://www.wpsmedicare.com> Website. Please do not use this survey to evaluate other Websites. When taking the survey, be sure you are evaluating the appropriate section of the wpsmedicare.com Website. The Website Part A Legacy Providers (Formerly Customers of Mutual of Omaha Medicare) is http://www.wpsmedicare.com/part_a

Please note: Once you complete the survey, it will not pop up again until you clear your cookies. However, if in the future you would like to take the survey again to provide additional feedback on the Website, simply clear your cookies (For more information on cookies, go to <http://www.microsoft.com/info/cookies.msp>).

WPS Medicare greatly appreciates your participation and feedback.



Website Customer Satisfaction Survey as it appears on the wpsmedicare.com Website.

Claim Submission

APRIL 2008 INTEGRATED OUTPATIENT CODE EDITOR (I/OCE) SPECIFICATIONS VERSION 9.1 ~CMS MLN Matters~

MLN Matters Number: MM5969

Related Change Request (CR) #: 5969

Related CR Release Date: March 25, 2008

Effective Date: April 1, 2008

Related CR Transmittal #: R1483CP

Implementation Date: April 7, 2008

Provider Types Affected

All providers who submit institutional outpatient claims (including non-OPPS hospitals) to Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5969 and notifies providers that I/OCE Specifications Version 9.1, is effective April 1, 2008. Claims with dates of service prior to July 1, 2007 are routed through the non-integrated versions of the outpatient code editor (OCE) software that coincide with the versions in effect for the date of service on the claim.

Background

This article is based on CR 5969 and informs providers that the I/OCE routes all institutional outpatient claims (including non-outpatient prospective payment system hospital claims) through a single integrated OCE eliminating the need to update, install, and maintain two separate OCE software packages on a quarterly basis. **This integration does not change the current logic that is applied to outpatient bill types that already pass through the outpatient prospective payment system (OPPS) OCE software.** It expands the software usage to include non-OPPS hospitals. The full specifications for the I/OCE as well as detailed lists of the APC (ambulatory payment classifications), HCPCS (health care common procedure coding systems), CPT (Current Procedural Terminology) code changes, additions, and deletions are attached to CR5969. The Web address for accessing CR5969 is in the Additional Information section of this article. Thus, we will not repeat all of those changes in this article. However, the key changes in the Version 9.1 of I/OCE are as follows:

Effective Date	Edit	Description of Change
4/1/08	24	Modify the software to maintain/retain 28 prior quarters (7 years) of programs & codes in each release. Remove older versions with each release. (The earliest version date included in the April 2008 release will be 1/1/01).
4/1/08		Modify appendix D of I/OCE Specifications (attached to CR5969) to exempt codes with SI of "S" and "X" from the conditional bilateral discounting.

Effective Date	Edit	Description of Change
1/1/08		Change HCPCS APC to "0" in the APC/ASC Return Buffer for all PH services on PHP claims.
4/1/02		Add code 29086 to the list of cast procedures (code list for Antigens, splints & Casts)
1/1/08		Modify/correct list of codes identified as partial hospitalization services for PHP claims
1/1/08		Bypass edit 48 for rev code 0637. Assign edit 50 when submitted without a HCPCS code. Apply to OPPS & Non-OPPS claims.
		Make HCPCS/APC/SI changes as specified by CMS
	19, 20, 39, 40	Implement version 14.0 of the NCCI (National Correct Coding Initiative) file, removing all code pairs which include Anesthesia (00100-01999), E&M (92002-92014, 99201-99499), or MH (90804-90911).
1/1/07	22	Add new (genetic testing) modifier (8C) to the valid modifier list.
		Modify description of PHP code lists in appendix C - to include all PH services in list B, and make list A a subset of list B.
01/01/08		Update nuclear medicine/radiopharmaceutical edit requirements.
01/01/08	78	Update procedure/device edit requirements.
01/01/08	71	Remove ASC procedure list - no longer needed to identify claims to be processed as 83X TOB.
		Added explanatory paragraphs, re antigens/splints/casts & CCI editing to the specifications document. Add appendix N, for requested code listings.

Additional Information

For complete details regarding this CR please see the official instruction (CR5969) issued to your Medicare FI, A/B MAC, or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1483CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

To review the Outpatient Code Editor (OCE) Website you may refer to: <http://www.cms.hhs.gov/OutpatientCodeEdit/> on the CMS Website.

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

**APRIL 2008 UPDATE OF THE HOSPITAL OUTPATIENT
PROSPECTIVE PAYMENT SYSTEM (OPPS)****~CMS MLN Matters~****MLN Matters Number:** MM5999**Related Change Request (CR) #:** 5999**Related CR Release Date:** April 8, 2008**Effective Date:** April 1, 2008**Related CR Transmittal #:** R1487CP**Implementation Date:** April 7, 2008**Provider Types Affected**

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

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

This article is based on Change Request (CR) 5999 which describes changes to, and billing instructions for various payment policies implemented in the April 2008 OPSS update.

CAUTION – What You Need to Know

CR 5999 announces that the April 2008 Integrated Code Editor (I/OCE) and OPSS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions. The specific I/OCE updates for April 2008 are in CR5969.

GO – What You Need to Do

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

Background

Change Request (CR) 5999 describes changes to, and billing instructions for various payment policies implemented in the April 2008 OPSS update. The April 2008 Integrated Code Editor (I/OCE) and OPSS PRICER will reflect the Healthcare Common Procedure Coding System (HCPCS), Ambulatory Payment Classification (APC), HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in this notification.

April 2008 revisions to I/OCE data files, instructions, and specifications are provided in Change Request (CR) 5969, "April 2008 Integrated Outpatient Code Editor (I/OCE) Specifications Version 9.1". A related MLN Matters article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5969.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. The Key OPSS changes are as follows:

1. Changes to Procedure to Device Edits for April 2008

Procedures to device edits require that when a particular procedural HCPCS code is billed, the claim must also contain an appropriate device code. Failure to pass these edits will result in the claim being returned to the provider. CMS

deleted the procedure to device edits for Current Procedural Terminology (CPT) code 36815, retroactive to their original implementation date of 10/1/2005. The complete list of updated edits can be found under downloads at <http://www.cms.hhs.gov/HospitalOutpatientPPS/> on the CMS Website.

2. Modification of Methodology for Calculation of Hospital Overall Cost-to-Charge Ratio (CCR) for Hospitals that Have Nursing and Paramedical Education Programs

CMS is updating Section 10.11.8 of the Medicare Claims Processing Manual, Chapter 4, to further refine the methodology of the calculation of the hospital overall CCR for hospitals that have nursing and paramedical education programs. Specifically, the instructions for calculating the CCR for cost center 6200 (non-distinct unit observation beds) are being modified. This is a prospective change that is effective April 1, 2008. It is unnecessary to retroactively re-calculate CCRs that are affected by CR 5999.

3. Billing for Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

CMS reminds hospitals that under the OPSS, if commercially available products are being mixed together to facilitate their concurrent administration, the hospital should report the quantity of each product (reported by HCPCS code) used in the care of the patient. Alternatively, if the hospital is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, then the hospital should report an appropriate unlisted drug code (J9999 or J3490). In these situations, CMS reminds hospitals that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399 (Unclassified drug or biological) is for new drugs and biologicals that are approved by FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

a. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective April 1, 2008

In the CY 2008 OPSS final rule, it was stated that payments for separately payable drugs and biologicals based on average sale prices (ASPs) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, we will incorporate changes to the payment rates in the April 2008 release of the OPSS PRICER. The updated payment rates effective April 1, 2008, will be included in the April 2008 update of the OPSS Addendum A and Addendum B, which will be posted on the CMS Web site at the end of March.

b. Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2008

Four drugs have been granted OPPS pass-through status effective April 1, 2008. These drugs, their descriptors and APC assignments are identified in Table 1 below.

Table 1 - Drugs and Biologicals with OPPS Pass-Through Status Effective April 1, 2008

HCPCS Code	Long Descriptor	APC	Status Indicator Effective 4/1/08
C9241	Injection, doripenem, 10 mg	9241	G
C9240	Injection, ixabepilone, 1 mg	9240	G
C9238	Injection, levetiracetam, 10 mg	9238	G
J9226	Histrelin implant (Supprelin La), 50 mg	1142	G

c. New HCPCS Codes for Drugs and Biologicals Effective April 1, 2008

HCPCS codes, their descriptors, OPPS status indicators and APC assignments are listed in Table 2 below.

Table 2 - New HCPCS Codes for Drugs and Biologicals Effective April 1, 2008

HCPCS Code	Long Descriptor	APC	Status Indicator
Q4096	Injection, Von Willebrand factor complex, human, ristocetin cofactor (not otherwise specified), per i.u. VWF:RCO	1213	K
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg	1214	K
Q4098	Injection, iron dextran, 50 mg	1215	K

d. Revised Long and Short HCPCS Code Descriptors for Cardiac Echocardiography Services:

• Cardiac Echocardiography With Contrast

In the January 2008 Update to the OPPS (CR5912, dated January 18, 2008; see related MLN Matters article at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5912.pdf> on the CMS Website), CMS listed eight new C-codes in Table 14 of CR5912 for cardiac echocardiography with contrast services. To ensure appropriate reporting of these services, CMS revised the short and long descriptors for C8921 through C8928, which are reflected in Table 3 below, to appropriately reflect those services that either use contrast or are performed without contrast followed by with contrast. Hospitals are reminded that these codes should be reported for echocardiograms with contrast, and hospitals are advised to report the appropriate units of the HCPCS codes for the contrast agents used in the performance of the echocardiograms. The contrast HCPCS Q-codes associated with these services should be reported separately.

Table 3 - Revised Long and Short HCPCS Code Descriptors for Cardiac Echocardiography Services

HCPCS	Revised Short Descriptor	Revised Long Descriptor
C8921	TTE w or w/o fol w/cont, com	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; complete
C8922	TTE w or w/o fol w/cont, f/u	Transthoracic echocardiography with contrast, or without contrast followed by with contrast; follow-up or limited study
C8923	2D TTE w or w/o fol w/con,co	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d) with or without m-mode recording; complete
C8924	2D TTE w or w/o fol w/con,fu	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, material real-time with image documentation (2d) with or without m-mode recording; follow-up or limited study
C8925	2D TEE w or w/o fol w/con,in	Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, real time with image documentation (2d) (with or without m-mode recording); including probe placement, image acquisition, interpretation and report
C8926	TEE w or w/o fol w/cont,cong	Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
C8927	TEE w or w/o fol w/cont, mon	Transesophageal echocardiography (tee) with contrast, or without contrast followed by with contrast, for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis
C8928	TEE w or w/o fol w/con,stres	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), with or without m-mode recording, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report

- **Cardiac Echocardiography Without Contrast**
Hospitals are reminded to bill for echocardiograms without contrast in accordance with the CPT code descriptors and guidelines associated with the applicable Level I CPT code(s) (93303-93350).

- e. **Recognition of Multiple HCPCS Codes for Drugs**
Prior to January 1, 2008, the OPSS generally recognized only the lowest available administrative dose of a drug if multiple HCPCS codes existed for the drug; for the remainder of the doses, the OPSS assigned a status indicator “B” indicating that another code existed for OPSS purposes. For example, if drug X has 2 HCPCS codes, the first for a 1 ml dose and a second for a 5 ml dose, the OPSS would assign a payable status indicator to the 1 ml dose and status indicator “B” to the 5 ml dose. Hospitals then were required to bill the appropriate number of units for the 1 ml dose in order to receive payment under the OPSS. However, beginning January 1, 2008, the OPSS has recognized each HCPCS code for a Part B drug, regardless of the units identified in the drug descriptor. Hospitals may choose to report multiple HCPCS codes for a single drug, or to continue billing the HCPCS code with the lowest dosage descriptor available.

- f. **Correct Reporting of Drugs and Biologicals When Used As Implantable Devices**
Hospitals are not to bill separately for drug and biological HCPCS codes, with the exception of drugs and biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPSS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using drugs and biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure, report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

- g. **Correct Reporting of Units for Drugs**
Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg but 200 mg of the drug was administered to the patient, the units billed should be 4. Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, bill 10 units, even though only 1 vial was administered. HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

- 4. HCPCS Code G0377**
HCPCS code G0377 (Administration of vaccine for Part D drug) that was in effect for 2007 is discontinued for CY 2008. The April 2008 OCE will implement this change effective January 1, 2008. Hospitals should no longer be reporting this service under OPPS, as this service is covered under the Part D benefit beginning in 2008.
- 5. Use of HCPCS Modifiers**
CMS updated the Medicare Claims Processing Manual, Chapter 4, Section 20.6 to reflect the addition of HCPCS modifiers –FB and –FC effective, January 1, 2007, and January 1, 2008, respectively. CMS added Section 20.6.10, which includes the definition of the modifier -FC (“Partial credit received for replaced device”). This manual revision is attached to CR5999. OPPS hospitals must report the -FC modifier for cases in which the hospital receives a partial credit of 50 percent or more of the cost of a new replacement device under warranty, recall, or field action. The hospital must append the -FC modifier to the procedure code (not the device code) that reports the services provided to replace the device.
- 6. Clarification of HCPCS Code to Revenue Code Reporting**
CMS updated the Medicare Claims Processing Manual, Chapter 4, Section 20.5 to reflect that, generally, CMS does not instruct hospitals on the assignment of HCPCS codes to revenue codes for services provided under OPPS since hospitals’ assignments of costs vary. Where explicit instructions are not provided, providers should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report. Previous language providing guidance on HCPCS code and revenue code billing was deleted.
- 7. Clarification of Manual Instructions Regarding Billing and Payment for Blood and Blood Products under the OPPS**
CMS updated the Medicare Claims Processing Manual, Chapter 4, Section 231 to provide important clarifications regarding billing for blood and blood products. In Section 231.2, CMS specifies that the requirement that the same line item date of service, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on **both** lines, applies to all OPPS providers that transfuse blood. CMS also clarifies that, in order to ensure correct application of the Medicare blood deductible, providers should report charges for whole units of packed red cells using Revenue Code 381 (Packed red cells), and should report charges for whole units of whole blood using Revenue Code 382 (Whole blood). Revenue Codes 381 and 382 should be used only to report charges for packed red cells and whole blood, respectively. The blood coding requirements discussed in Section 231.2 do not apply to blood and blood products carrying only a processing and storage fee; when billing only for blood processing and storage, OPPS providers should follow the coding requirements outlined in Section 231.1. Revenue Code 380 is not a valid revenue code for Medicare billing.

In a revised Section 231.4, Chapter 4 of the Medicare Claims Processing Manual, CMS clarifies that providers should bill split units of packed red cells and whole blood using Revenue Code 389 (Other blood), and should not use Revenue Codes 381 (Packed red cells) or 382 (Whole blood). Providers should bill split units of other blood products using the applicable revenue codes for the blood product type, such as 383 (Plasma) or 384 (Platelets), rather than 389. Reporting revenue codes according to these specifications will ensure the Medicare beneficiary's blood deductible is applied correctly. In revised Section 231.6, CMS provides a chart of blood and blood products indicating whether providers should bill separately for freezing and thawing using the available CPT codes.

In revised Section 231.7 of Chapter 4, CMS specifies that where blood or a blood product is split or irradiated specifically with the intent of transfusion to a beneficiary but is not then used, the hospital may bill for the services of splitting or irradiating the unit of blood but may not bill for the HCPCS code for the blood product that was not transfused. The date of service must be the date on which the decision not to use the blood was made and indicated in the patient's medical record. Where the unit of blood is split or irradiated and stored without specific intention to administer it to a Medicare beneficiary at the time of splitting or irradiation and is not subsequently transfused, there is no service to be reported.

All of the revised sections referenced above are attached to CR5999.

8. Outpatient Partial Hospitalization Program Services

With CR5999, CMS is updating the Medicare Claims Processing Manual, Chapter 4, Sections 260.1 and 260.1.1 to reflect the current policies for Outpatient Partial Hospitalization Program Services. Once again, the revised manual section is attached to CR5999.

9. Coverage Determinations

The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. FIs and Medicare Administrative Contractors determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs determine that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment.

Additional Information

The official instruction, CR 5999, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1487CP.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.

CR 5550 CLARIFICATION - SIGNATURE REQUIREMENTS ~CMS MLN Matters~

MLN Matters Number: MM5971

Related CR Release Date: March 28, 2008

Related CR Transmittal #: R248PI

Related Change Request (CR) #: 5971

Effective Date: September 3, 2007

Implementation Date: April 28, 2008

Provider Types Affected

Physicians and other providers who bill Medicare Contractors (Carriers, Fiscal Intermediaries, Regional Home Health Intermediaries, Part A/B Medicare Administrative Contractors, including Durable Medical Equipment Medicare Administrative Contractors) for care provided to Medicare beneficiaries in hospice.

What You Need to Know

CR 5971, from which this article is taken, clarifies the instructions on signature requirements for the certification of terminal illness for hospice. It provides that Medicare contractors will accept a facsimile of an original written or electronic signature in documenting the certification of terminal illness for hospice.

Make sure that your billing staffs are aware that, to document the certification of terminal illness for hospice, a facsimile of an original written or electronic signature is acceptable

Background

CR 5971, from which this article is taken, clarifies the instructions in *Medicare Program Integrity Manual* Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Subsection 3.4.1.1B (Signature Requirements) that address the signature requirements for the certification of terminal illness for hospice, that were provided in CR 5550 ([Various Medical Review Clarifications](#)).

Subsection 3.4.1.1B of the manual notes that Medicare contractors require a legible identifier for services provided/ordered. It further requires that when this documentation is for medical review purposes, the only acceptable method of documenting the provider signature is by written or an electronic signature. Stamp signatures are not acceptable to sign an order or other medical record documentation for medical review purposes.

CR 5971 provides that there is an exception to this requirement.

It announces that a facsimile of an original written or electronic signature is acceptable for the certification of terminal illness for hospice. Please be sure to note however, that while a signature facsimile is acceptable in this instance; it and **hard copies of a physician's electronic signature** must be present in the patient's medical record.

Additional Information

You can find more information about the signature requirements for the certification of terminal illness for hospice by going to CR 5971, located at <http://www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf> on the CMS Website. You will find updated *Medicare Program Integrity Manual* Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Subsection 3.4.1.1B (Signature Requirements) as an attachment to this CR.

If you have any 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.

**NEW HCPCS CODES FOR THE APRIL 2008 UPDATE
~CMS MLN Matters~**

MLN Matters Number: MM5981	Related Change Request (CR) #: 5981
Related CR Release Date: April 18, 2008	Effective Date: April 1, 2008
Related CR Transmittal #: R1492CP	Implementation Date: April 7, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5981, which instructs Medicare Contractors to implement Healthcare Common Procedure Coding System (HCPCS) code changes effective April 1, 2008. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the Healthcare Common Procedure Coding System (HCPCS) code set on a quarterly basis.

Effective for claims with dates of service on or after April 1, 2008, the following HCPCS codes will no longer be payable for Medicare:

HCPCS Code	Short Description	Long Description
J7602	Albuterol inh non-comp con	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)
J7603	Albuterol inh non-comp u d	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)

HCPCS Code	Short Description	Long Description
J1751	Iron dextran 165 injection	INJECTION, IRON DEXTRAN 165, 50 MG
J1752	Iron dextran 267 injection	INJECTION, IRON DEXTRAN 267, 50 MG

Effective for claims with dates of service on or after April 1, 2008, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description
J7611	Albuterol non-comp con	ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1MG
J7612	Levalbuterol non-comp con	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG
J7613	Albuterol non-comp unit	ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 1MG
J7614	Levalbuterol non-comp unit	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG
Q4096	VWF complex, NOS	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR (NOT OTHERWISE SPECIFIED), PER I.U. VWF:RCO
Q4097	Inj IVIG Privigen 500 mg	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG
Q4098	Inj iron dextran	INJECTION, IRON DEXTRAN, 50MG

HCPCS Code	Short Description	Long Description
Q4099	Formoterol fumarate, inh	FORMORETOL FUMARATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS

Currently, Alphanate® is the only product that should be billed using code Q4096. J7190 should continue to be billed when Alphanate® is furnished for purposes of administering Factor VIII. The blood clotting furnishing fee is payable when payment is allowed for Q4096. When a payment allowance limit for Q4096 is included on the quarterly Part B drug pricing files, the payment allowance limit will include payment for the blood clotting furnishing fee.

Effective for dates of service on or after April 1, 2008, the requirements under CR 5713 (See the MLN Matters article for CR5713, which is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5713.pdf> on the CMS Website) are being updated by CR 5981 to apply to claims that bill Intravenous Immunoglobulins (IVIG) using Q4097 as follows:

- Effective for dates of service on or after April 1, 2008, Medicare Contractors will:
 - Only pay a claim for preadministration-related services (G0332) associated with IVIG administration if G0332, the drug (IVIG, HCPCS codes: J1566, J1568, J1569, J1561, J1572 and/or Q4097), and the drug administration service are all billed on the same claim for the same date of service;
 - Return institutional claims for G0332 to the provider if J1566, J1568, J1569, J1561, J1572 and/or Q4097 and a drug administration service are not also billed for the same date of service on the same claim;
 - Reject professional claims as unprocessable for G0332 if J1566, J1568, J1569, J1561, J1572 and/or Q4097 and a drug administration service are not billed for the same date of service on the same claim; and
 - Use the appropriate reason/remark messages such as: M67 “Missing other procedure codes” and/or 16 “Claim/service lacks information” which are needed for adjudication when claims are returned/rejected.

Additional Information

The official instruction, CR 5981, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding these changes may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R1492CP.pdf> on the CMS Website.

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.

NPI DROP DEAD DATE MAY 23, 2008**Important Medicare Provider Implementation Dates:**

March 1, 2008 – All providers needed to have the NPI numbers in the primary identifier fields on their claims or the claims would reject. Medicare FFS 837P and CMS-1500 claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to, and rendering provider fields). **Claims with only legacy identifiers in the primary provider fields are being rejected.**

May 23, 2008 – In keeping with the Contingency Guidance issued on April 2, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims and SPR remittance advice. (Note that this date is one day earlier than that mandated by the National Enforcement Policy)

If the claim contains a legacy identifier in any field, it will be rejected.

- This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction.
- CMS will also stop sending legacy identifiers on COB crossover claims at this time.
- Until you submit claims with an NPI only, you will not have a preview of what your experience will be on May 23rd. Now is the time to correct any problems that you may find.
- Medicare urges providers that have successfully paid claims containing NPI and legacy provider identifiers to start testing small batches of production claims with NPI only provider information.
- To test NPI only, send a small batch of production claims now with only the NPI on the claims and follow those claims through to adjudication.

REMEMBER, if you test and your claims are processed successfully, you can approach the May 23rd date with confidence. If you do not, you will most likely face cash flow problems.

To sum this up, no later than May 24, 2008, NPI only is expected in a compliant manner by all covered entities and all contingency plans should be lifted. (Rare exceptions should see Website listed below)

Note: All current and past CMS NPI communications are available on the CMS site at <http://www.cms.hhs.gov/NationalProvidentStand> by clicking "CMS Communications" in the left column.

If you have any questions, please contact the EDI Department: 1-866-734-6656

Coverage – General**LABORATORY COMPETITIVE BIDDING DEMONSTRATION**
~CMS MLN Matters~

MLN Matters Number: MM5359

Related CR Release Date: March 19, 2008

Related CR Transmittal #: R57DEMO

Related Change Request (CR) #: 5359

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

Note: This article was changed on March 20, 2008, to reflect a change that was made to related CR5389 on March 19, 2008. The CR was modified to delete a business requirement instructing carriers and A/B MACs deny claims with dates of service between April 1, 2007 and March 31, 2010 inclusive and with modifier “90” submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA. Since that requirement was deleted, language regarding that denial requirement was deleted from the article. The CR release date, transmittal number and Web address for accessing CR5389 were also changed. All other information remains the same. **However, it is important to note that a more current article, MM5772, is now available regarding this demonstration at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5772.pdf> on the CMS Website. Where there is disagreement between this article and related CR5359 and MM5772 and related CR5772, the information in CR5772 is more current and takes precedence over CR5359.**

Provider Types Affected

Physicians and hospitals (TOB 14X only) who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites.

Background

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

Key Points

This article and Change Request (CR) 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this

article and CR5359 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the zip code of the beneficiary's residence.
- Hospital inpatient testing is covered by Medicare Part A and is therefore **exempt** from the demonstration.
- Physician office laboratory (POL) testing and hospital outpatient testing **are not included in the demonstration, except** where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.
- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

Required Bidders

Laboratory firms with \$100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for "demonstration tests" provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration.

These laboratory firms will be referred to as "required bidders."

Passive Laboratories

Small laboratories or laboratory firms with less than \$100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will **not be required** to bid in the demonstration. These laboratories are considered "passive" laboratories." Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of \$100,000.

Passive laboratory firms exceeding the annual ceiling of \$100,000 by \$25,000 or more will be:

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.
- **Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considered "passive-ESRD" laboratories.** Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration

tests provided to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007 through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

Winners

Both required and non-required bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled “winners.”

Non-Winners

Both required and non-required bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled “non-winners.”

Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Non-winner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, non-winner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

Although non-winner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Demonstration Sites

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's zip code of residence.

CMS will provide the contractors with a list of zip codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Implementation

CR5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

During the first quarter of 2007, CMS will provide Medicare carriers, FIs, and A/B MACs with a national zip code pricing file identifying the zip codes included in the first CBA. Also, in that same timeframe, CMS will provide to the carriers, FIs, and A/B MACs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

Claims submitted by non-winner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code 96 (non-covered charges);
- Remark code M114 (*This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.*); and
- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Medicare will pay claims during the demonstration period submitted by non-demonstration laboratories for beneficiaries residing in the CBA who receive

services outside of those areas (e.g., “snow birds”) according to the laboratory competitive bidding demonstration.

Non-winning laboratories should know that Advance Beneficiary Notices (ABNs) and Notices of Beneficiary Exclusion from Medicare Benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at non-winner laboratories.

Line items for demonstration services and for non-demonstration services may be submitted on the same claim.

A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

Medicare contractors will be prepared to begin processing claims under the laboratory competitive bidding demonstration in the first CBA on April 1, 2007. The tentative start date for the demonstration in the second CBA is April 1, 2008.

Remember that required and non-required bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

Implementation

The implementation date for this instruction is April 2, 2007.

Additional Information

The official instructions issued to your Medicare carrier, FI, or A/B MAC regarding this change can be found at

<http://www.cms.hhs.gov/Transmittals/downloads/R57DEMO.pdf> on the CMS Website.

If you have 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.

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 Part A on its Website:

http://www.wpsmedicare.com/part_a/policy/index.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 Legacy

WPS Medicare
Medicare Medical Review
Attn: Medical Review Supervisor
P.O. Box 1602
Omaha, NE 68101

General Information**ANNOUNCING THE RELEASE OF THE REVISED CMS-855
MEDICARE ENROLLMENT APPLICATIONS
~CMS MLN Matters~**

MLN Matters Number: SE0810
Related CR Release Date: N/A
Related CR Transmittal #: N/A

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

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

The Centers for Medicare & Medicaid Services (CMS) issued revised CMS-855 Medicare enrollment applications in March 2008. With the exception of providers enrolling as a specialty hospital on the CMS-855A, Medicare contractors will continue to accept the 2006 version of the Medicare enrollment application through June 2008.

Providers and suppliers should begin to use the new Medicare enrollment applications immediately. Initially, these applications will be available only from the CMS provider enrollment Website. The link for that CMS Website is listed in the *Additional Information* section of this article.

Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see *Key Points* below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

Key Points

This Special Edition outlines the significant revisions to the Medicare enrollment applications and they are as follows:

Application-Specific Changes for Physicians and Non-Physician Practitioners (CMS-855I)

- Removed the requirement in Section 17 that providers attached their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.

Application-Specific Changes for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)

- Removed the supplier type "Voluntary Health/Charitable Agency" from Section 2A.
- Clarified reporting timeframes throughout the CMS-855B.
- Added additional information about the National Provider Identifier (NPI)-legacy association and expanded the number of NPI – legacy combinations that a provider may enter in Section 4A from one to five.

- Removed the requirement in Section 17 that providers attach their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.
- Required that an Independent Diagnostic Testing Facility (IDTF) submit copies of its comprehensive liability insurance policy in Section 17.
- Added a list of the new IDTF standards found in 42 CFR 410.33(g) on a separate page in Attachment 2.
- Added instructions that explain the IDTF liability insurance requirements in 42 CFR 410.33(g)(6) to Attachment 2.

Application-Specific Changes for Institutional Providers (CMS-855A)

- Revised Section 2A2 to include a specific box that specialty hospitals must check when completing the application. Instructions explaining the definition of a “specialty hospital” were also added to the form.
- Clarified the term “primary practice location” in the instructions in Section 4. (The clarification did not change any data elements on the form.)
- Added additional information about the National Provider Identifier (NPI)-legacy association and expanded the number of NPI – legacy combinations that a provider may enter in Section 4A from one to five.
- Removed the data element “Medicare Year-End Cost Report Date” from Section 2.
- Removed the requirement in Section 17 that providers attach their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System

Application-Specific Changes for DMEPOS Suppliers (CMS-855S)

- Added supplier standards 22 – 25 to the list of DMEPOS supplier standards found on page 31.

Additional Information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit <http://www.cms.hhs.gov/MedicareProviderSupEnroll> on the CMS Website.

Special Edition article SE0612 contains helpful information about the Medicare enrollment process. You may review that article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf> on the CMS Website.

NATIONAL PROVIDER IDENTIFIER (NPI) FOR A SERVICE FACILITY

Does the “requirement” to indicate the service facility’s NPI on your Medicare claim submissions confuse you? You are not alone.

Claim form instructions in the Centers for Medicare & Medicaid Services’ (CMS) Internet-Only Manual (IOM), Publication 100-04, Chapter 26, Section 10.4, state the following for item 32A:

Item 32A Form CMS-1500 (08-05) – Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007, and must be reported May 23, 2007, and later.

CMS defines a service facility as a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.

CMS recently clarified that although you are *not required* to submit a service facility NPI in item 32A, it must be an NPI if you choose to enter a service facility identifier on any Form CMS-1500 submitted on or after May 23, 2008.

You can view CMS Publication 100-04 at the following CMS Website address:

<http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>

**WEBSITE FOR ADDITIONS AND DELETIONS OF ZIP CODES
REQUIRING A PLUS FOUR ZIP CODE EXTENSION
~CMS MLN Matters~**

MLN Matters Number: MM5970

Related Change Request (CR) #: 5970

Related CR Release Date: March 21, 2008

Effective Date: April 21, 2008

Related CR Transmittal #: R1480CP

Implementation Date: April 21, 2008

Provider Types Affected

Physicians, providers, and other health care providers submitting claims to Medicare Fiscal Intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs) or Regional Home Health Intermediaries (RHHIs) for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services.

Provider Action Needed

STOP – Impact to You

The ZIP code where services are rendered determines the payment locality for services paid under the MPFS and for anesthesia services. Certain ZIP codes fall into more than one payment locality and require a plus four ZIP code extension to ensure proper payment. (See the MLN Matters article at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5208.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website for further details regarding ZIP code reporting.)

CAUTION – What You Need to Know

The CMS will begin posting additions and deletions to the list of ZIP codes that require a plus four ZIP code extension on their Website. A complete list of all ZIP codes requiring a plus four ZIP code extension will also be posted.

GO – What You Need to Do

Make certain your billing staffs are aware of these resources for checking plus four ZIP code extension requirements.

Key Points of CR5970

- To access a file containing the quarterly additions and deletions to the list of ZIP Codes requiring a plus four extension refer to http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/01_overview.asp on the CMS Website. The file is named “ZIP Code to Carrier Locality” and can be found in the Downloads section of this Web page.
- To access a file containing all ZIP Codes requiring a plus four extension, refer to http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/01_overview.asp on the CMS Website. The file is named “ZIP Codes Requiring +4 Ext” and can be found in the Downloads section of this Web page.
- Upon release of a new quarterly update, the previous quarter’s additions and deletions are incorporated into the file name “ZIP Codes Requiring +4 Ext” file and are not included in the “ZIP Code Changes” file.

Additional Information

To see the official instruction (CR5970) issued to your Medicare FI, carrier, A/B MAC or RHHI refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1480CP.pdf> on the CMS Website.

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

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.

Registration information is available on our Website:

Seminars: http://www.wpsmedicare.com/part_a/education/seminars.shtml

Teleconferences: http://www.wpsmedicare.com/part_a/education/teleconferences.shtml

~SEMINAR SCHEDULE~

Skilled Nursing Facility (SNF) Billing Seminar

Date/Time	Address	Contact Information
05/07/08 9:00am - 4:00 pm	Holiday Inn Issaquah 1801 12th Avenue NW Issaquah, WA 98027 (425) 392-6421	Tanya Hoagland WPS Medicare Omaha 402-351-3975
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:30am - 9am Payment Form must be received before 04/30/08 Cost \$61.00 (includes lunch)		
05/15/08 9:00am - 4:00 pm	Crowne Plaza Concord/Walnut Creek John Glenn Drive Concord, CA 94520 (925) 825-7700	Tanya Hoagland WPS Medicare Omaha 402-351-3975
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:30am - 9am Payment must be received before 05/07/08 Cost \$99.00 (includes lunch)		

Date/Time	Address	Contact Information
05/29/08 9:00am - 4:00 pm	Crowne Plaza Phoenix Airport Hotel 4300 East Washington St. Phoenix, AZ 85034 602-273-7778	Tanya Hoagland WPS Medicare Omaha 402-351-3975
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:30am - 9am Payment must be received before 05/21/08 Cost \$83.00 (includes lunch)		
Date/Time	Address	Contact Information
06/12/08 9:00am - 4:00 pm	Knott's Berry Farm Resort and Hotel 7675 Crescent Ave. Buena Park, CA 90620 (714) 995-1111	Tanya Hoagland WPS Medicare Omaha 402-351-3975
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:30am - 9am Payment must be received before 06/04/08 Cost \$61.00 (includes lunch)		
Date/Time	Address	Contact Information
06/18/08 9:00am - 4:00 pm	Holiday Inn Midtown 2503 S Locust St Grand Island, NE 68801 (308) 384-1330	Aileen Sigler WPS Medicare Omaha 402-351-6419
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:30am - 9am Payment must be received before 06/11/08 Cost \$33.00 (includes breakfast & lunch)		

Date/Time	Address	Contact Information
06/26/08 9:00am - 4:00 pm	Doubletree Hotel 1616 Dodge Street Omaha, NE 68102 (402) 636-4919	Aileen Sigler WPS Medicare Omaha 402-351-6419
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:30am - 9am Payment must be received before 06/18/08 Cost \$70.00 (includes breakfast & lunch)		

Agenda Topics for the Skilled Nursing Facility (SNF) Billing Seminar

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

Skilled Nursing Facility (SNF) Billing/Compliance Seminar

Date/Time	Address	Contact Information
05/21/08 8:30am - 3:30 pm	Holiday Inn French Quarter – Chateau Lemoyne 301 Rue Dauphine – French Quarter New Orleans, LA 70112 (504) 581-1303	Jason Killion WPS Medicare (402) 351-5912
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:00am - 8:30am Payment must be received before 05/14/08 Cost \$67.00 (includes breakfast and lunch)		
Date/Time	Address	Contact Information
06/11/08 8:30am - 3:30 pm	Holiday Inn Select North Dallas 3645 N LBJ Freeway Dallas, TX 75234 (972) 243-3363	Jason Killion WPS Medicare (402) 351-5912
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:00am - 8:30am Payment must be received before 06/04/08 Cost \$67.00 (includes breakfast and lunch)		

Agenda Topics for the Skilled Nursing Facility (SNF) Billing/Compliance Seminar

- SNF PPS Consolidated Billing
- Billing and Coding; Claims Examples
- SNF Part B & Other Billing Issues
- Therapy Limits & Exceptions
- Medicare Advantage/Hospice Billing

Medicare Secondary Payer Billing/Compliance Seminar

Date/Time	Address	Contact Information
05/21/08 9:00am - 3:00 pm	Krieger's Holiday Inn Convention Center 222 Potomac Boulevard Mt. Vernon, IL 62864 (618) 244-7100	Janet Mateo WPS Medicare Chicago (630) 810-1324 ext 317
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:30am - 9am Payment must be received before 05/14/08 Cost \$32.00 (includes breakfast and lunch)		

Agenda Topics for the Medicare Secondary Billing/Compliance Seminar

- MSP Categories
- MSP Questionnaire/COB Contractor
- MSP Billing Procedures
- Credit Balance Reporting

Clinical Issues and Medicare Overview for Inpatient Rehabilitation Facilities Seminar

Date/Time	Address	Contact Information
05/08/08 9:00am - 3:00 pm	Holiday Inn - Atlanta Airport North 1380 Virginia Avenue Atlanta, GA 30344 (404) 762-8411	John Wrynn WPS Medicare Hartford 860-659-4300 ext 237
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:30am - 9am Payment must be received before 04/30/08 Cost \$60.00 (includes continental breakfast and lunch)		

Agenda Topics for the Clinical Issues and Medicare Overview for Inpatient Rehabilitation Facilities Seminar

- Medicare Overview for Clinicians
- Medical Review/Progressive Corrective Action
- Coverage Criteria and Assessments
- Billing and Payment Provisions
- Documentation Requirements & Common Findings

Medicare Secondary Payer (MSP) Seminar

Date/Time	Address	Contact Information
05/20/08 9:00am - 3:30 pm	Crown Plaza Hotel 390 Forsgate Drive Monroe Township, NJ 08831 (609)655-4775	John Wrynn WPS Medicare John.Wrynn@wpsic.com
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:30am - 9am Payment must be received before 05/14/08 Cost \$60.00 (includes continental breakfast and lunch)		

Agenda Topics for the Medicare Secondary Payer Seminar

- MSP Rules
- MSP Categories and Requirements
- MSP Questionnaire, COB Issues
- MSP Billing and Adjustments
- MSP Credit Balance Reporting Requirements and Common Findings

Outpatient Prospective Payment System (OPPS) Billing Workshop

Date/Time	Address	Contact Information
05/20/08 8:30am - 3:30 pm	Holiday Inn French Quarter - Chateau Lemoyne 301 Rue Dauphine - French Quarter New Orleans, LA 70112 (504) 581-1303	Jason Killion WPS Medicare (402) 351-5912
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register Registration Time 8:00am - 8:30am Payment must be received before 05/14/08 Cost \$67.00 (includes breakfast and lunch)		

Date/Time	Address	Contact Information
06/10/08 8:30am - 3:30 pm	Holiday Inn Select North Dallas 3645 N LBJ Freeway Dallas, TX 75234 (972) 243-3363	Jason Killion WPS Medicare (402) 351-5912
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register		
Registration Time 8:00am - 8:30am Payment must be received before 06/04/08 Cost \$70.00 (includes breakfast and lunch)		
Date/Time	Address	Contact Information
06/25/08 9:00am - 4:00 pm	Stoney Creek Inn 5291 Stoney Creek Ct Johnston, IA 50131 (515) 334-9000	Aileen Sigler WPS Medicare (402) 351-6419
Registration Information		
Please visit the WPS Medicare http://www.wpsmedicare.com/part_a/education/seminars.shtml to register		
Registration Time 8:30am - 9am Payment must be received before 06/18/08 Cost \$61.00 (includes breakfast and lunch)		

Agenda Topics for the Outpatient Prospective Payment System (OPPS) Billing Workshop

- Overview of the Outpatient Prospective Payment System
- Outpatient services treated as inpatient services
- Outpatient observation
- Billing and Payment

For questions about a seminar, please phone the sponsoring Field Office listed for each event.

~TELECONFERENCE SCHEDULE~

Proper Use of Occurrence Span Code 74 Ask-the-Contractor Teleconference (ACT)

May 15, 2008

Teleconference times:

- 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

Registration for this event will end on May 12, 2008.

AGENDA TOPICS:

- Interrupted Stays
- Leave of Absence
- Overlapping Services

Chairperson: Aileen Sigler
Contact Number: (402) 351-6419

To register, please visit the WPS Medicare Website
http://www.wpsmedicare.com/part_a/education/teleconferences.shtml

If you experience difficulties registering via e-mail, please call the contact number.

**Outpatient Therapy Common Findings and Documentation Ask-the-Contractor
Teleconference (ACT)**

May 29, 2008

Teleconference times:

- 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

Registration for this event will end on May 26, 2008.

AGENDA TOPICS:

- Outpatient Therapy Common Findings/Errors
- Review Documentation Requirements
- Discuss how documentation affects payment

Chairperson: Mary Sue Gardner, RN
Contact Number:(402) 351-5207

To register, please visit the WPS Medicare Website
http://www.wpsmedicare.com/part_a/education/teleconferences.shtml

If you experience difficulties registering via e-mail, please call the contact number.

Reimbursement**APRIL 2008 INPATIENT REHABILITATION FACILITY (IRF)
PROSPECTIVE PAYMENT SYSTEM (PPS) PRICER CHANGES
~CMS MLN Matters~**

MLN Matters Number: MM5965
Related CR Release Date: March 14, 2008
Related CR Transmittal #: R1479CP

Related Change Request (CR) #: 5965
Effective Date: April 1, 2008
Implementation Date: April 7, 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**STOP – Impact to You**

This article is based on CR 5965 which instructs Medicare contractors to install the April Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) Pricer.

CAUTION – What You Need to Know

CR 5965 updates the Fiscal Year 2008 (FY08) standard payment conversion factor from \$13,451 to \$13,034, effective for discharges on or after April 1, 2008, and it adds the default Case Mix Group (CMG) of A9999 as a valid CMG to allow “informational only” claims for Medicare Advantage (MA) patients to be processed, effective for discharges on or after October 1, 2006.

GO – What You Need to Do

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

Background

The purpose of Change Request (CR) 5965 is to:

- Update the standard payment conversion factor per the Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Extension Act of 2007 (Section 115), and
- Provide hospitals with a mechanism to submit “informational only” bills to Medicare for Medicare Advantage (MA) patients.

The following background is provided regarding these issues:

Fiscal Year 2008 Standard Payment Conversion Factor (Effective October 1, 2007)

On August 24, 2007, the Centers for Medicare & Medicaid Services (CMS) issued CR 5694 to outline the prospective payment rates applicable for Inpatient Rehabilitation Facilities (IRFs), effective for Fiscal Year (FY) 2008. CR 5694 also instructed the standard system maintainer to install the new IRF Prospective Payment System (PPS) Pricer that contained updated FY 2008 rates, which set the standard payment

conversion factor (also known as the standard Federal rate) at \$13,451. You can review the MLN Matters article related to CR 5694 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5694.pdf> on the CMS Website.

"Informational Only" Billing for Medicare Advantage (MA) Patients (Effective October 1, 2006)

On July 20, 2007, CMS issued CR 5647 to require hospitals to submit "informational only" bills to their Medicare contractor for the MA patients they treat, in order for the days to be eventually captured in the Disproportionate Share Hospital (DSH) (or low income patient (LIP) for IRF) calculations. You can review the MLN Matters article related to CR 5647 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5647.pdf> on the CMS Website.

Standard Payment Conversion Factor Update

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (Section 115) amended the Social Security Act (Section 1886(j)(3)(C)) to apply a 0.0 percent increase to payment rates for IRFs for part of FY 2008. You can find Section 1886(j)(3)(C) of the Social Security Act at http://www.ssa.gov/OP_Home/ssact/title18/1886.htm on the internet.

Note that the new rates will become effective for discharges occurring on or after April 1, 2008, and will apply to the last two quarters of FY 2008 (from April 1, 2008 through September 30, 2008).

Payment rates for the first two quarters of FY 2008 (from October 1, 2007 through March 31, 2008) will continue to be based on the 3.2 percent market basket increase that was implemented in the FY 2008 IRF PPS final rule (72 FR 44284). You can review 72 FR 44284 at

<http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3789.pdf> on the internet.

Effective April 1, 2008, the new IRF standard payment conversion factor will be \$13,034.

Applying this new standard payment conversion factor to the case-mix group relative weights published in the FY 2008 IRF PPS final rule (72 FR 44284, 44293 through 44297) results in the new IRF payment rates listed at:

http://www.cms.hhs.gov/InpatientRehabFacPPS/07_DataFiles.asp#TopOfPage on the CMS Website. You can review 72 FR 44284 and 72 FR 44293 through 44297 at <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-3789.pdf> on the internet.

"Informational Only" Billing for MA Patients

For IRF "informational only" claims (Type of Bill 111 with a condition code 04) for MA patients with discharges on or after October 1, 2006, CMS is instructing IRFs to submit a default Case Mix Group (CMG) code of A9999.

Note: Prior to the implementation of this CR 5965, CMS has been instructing IRFs, on a case-by-case basis, to use any CMG until a default Health Insurance Prospective Payment System (HIPPS) code could be considered a valid CMG in the IRF Pricer software.

In summary, CR 5965 instructs your Medicare contractor to:

- Update the FY 08 standard payment conversion factor from \$13,451 to \$13,034, effective for discharges on or after April 1, 2008; and
- Add the default CMG of A9999 as a valid CMG to allow “informational only” claims for MA patients to be processed, effective for discharges on or after October 1, 2006.

In addition, CR 5965 instructs your Medicare contractor to install and pay IRF claims with the April 2008 IRF PPS Pricer.

Additional Information

The official instruction, CR 5965, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1479CP.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.

APRIL 2008 QUARTERLY AVERAGE SALES PRICE (ASP) MEDICARE PART B DRUG PRICING FILES AND REVISIONS TO PRIOR QUARTERLY PRICING FILES

~CMS MLN Matters~

MLN Matters Number: MM5982
Related CR Release Date: March 26, 2008
Related CR Transmittal #: R1484CP

Related Change Request (CR) #: 5982
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 5982, from which this article is taken, instructs Medicare contractors to download and implement the April 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised January 2008, January 2007, April 2007, July 2007, October 2007, and October 2006 files.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs has been performed by the local contractor.

Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), are paid based on the ASP methodology.

The ASP methodology is based on quarterly data that drug manufacturers submit to the Centers for Medicare & Medicaid Services (CMS), which CMS then provides (quarterly) to Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” have been operationalized in the context of payment under section 1847A.

For the purpose of identifying “single source drugs” and “biological products” subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

- The FDA approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.
- As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of “not otherwise classified, (NOC)” HCPCS codes.

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities); and
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPPS.

Beginning January 1, 2008, under the OPSS, payment allowance limits for specified covered outpatient drugs are paid based on 105 percent of the ASP. Drugs and biologicals with pass-through status under the OPSS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPSS at the amount specified for the Ambulatory Payment Class (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits will not be updated in 2008.** The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPSS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in Pub. 100-04, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. **For 2008, the blood clotting furnishing factor of \$0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.**
- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by

the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.

- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after March 18, 2008, the April 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after March 18, 2008, the April 2008 ASP NOC files will be available for retrieval from the CMS ASP Webpage along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

The payment files will be applied to claims processed or reprocessed on or after the implementation date of CR5982 for the dates of service noted in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008
October 2007 ASP and ASP NOC files	October 1, 2007, through December 31, 2007
July 2007 ASP and ASP NOC files	July 1, 2007, through September 30, 2007
April 2007 ASP and ASP NOC files	April 1, 2007, through June 30, 2007
January 2007 ASP and ASP NOC files	January 1, 2007, through March 31, 2007
October 2006 ASP and ASP NOC files	October 1, 2006, through December 31, 2006

NOTE: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug

in that specific category. The local Medicare contractor processing the claim makes these determinations.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

To see the official instruction (CR5982) issued to your Medicare contractor visit <http://www.cms.hhs.gov/Transmittals/downloads/R1484CP.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.

**APRIL UPDATE TO THE 2008 MEDICARE PHYSICIAN FEE
SCHEDULE DATABASE (MPFSDB)
~CMS MLN Matters~**

MLN Matters Number: MM5980

Related CR Release Date: March 21, 2008

Related CR Transmittal #: R1482CP

Related Change Request (CR) #: 5980

Effective Date: January 1, 2008

Implementation Date: April 7, 2008

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 5980 which amends payment files previously issued to Medicare contractors based upon the 2008 Medicare Physician Fee Schedule Final Rule. CR 5980 also includes new/revised codes for the Physician Quality Reporting Initiative (PQRI).

Background

Attachment 1 of CR 5980 contains changes included in the April Update to the 2008 MPFSDB, and CR5980 can be reviewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1482CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. Specific changes are detailed in Attachment 1 of CR 5980 and are summarized as follows:

CPT/HCPCS code revisions

A number of CPT/HCPCS codes have been modified to reflect revised bilateral indicators, Relative Value Unit (RVU) revisions, or procedure status changes retroactive to January 1, 2008.

Reinstated “J” Codes

A number of “J” Codes (J7611 through J7614) are reinstated with a status indicator of “E” and the reinstated codes are effective for dates of service on or after April 1, 2008. Descriptors and payment indicators for the reinstated codes are in attachment 1 of CR5980.

New “Q” Codes

There are several new “Q” codes (Q4096 through Q4098) with a status indicator of “E” and which are effective for dates of service on or after April 1, 2008. The codes with their descriptors are in the following table:

Code	Long Descriptor	Short Descriptor
Q4096	Injection, Von Willebrand Factor Complex, Human, Ristocetin Cofactor (Not Otherwise Specified), Per I.U. VWF:RCO	VWF complex, not Humate-P
Q4097	Injection, Immune Globulin (Privigen), Intravenous, Non-Lyophilized (E.G., Liquid), 500 mg	Inj IVIG Privigen 500 mg
Q4098	Injection, Iron Dextran, 50 mg	Inj iron dextran
Q4099	Formoterol fumarate, inhalation solution, FDA approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms	Formoterol fumarate, inh

New Category II Codes for PQRI

There are new Category II codes for the PQRI for dates of service on or after April 1, 2008. These new codes and their descriptors are in the following table:

Code	Long Descriptor	Short Descriptor
0525F	Initial visit for episode	Initial visit for episode
0526F	Subsequent visit for episode	Subs visit for episode

Code	Long Descriptor	Short Descriptor
1130F	Back pain and function assessed, including all of the following: Pain assessment AND functional status AND patient history, including notation of presence or absence of “red flags” (warning signs) AND assessment of prior treatment and response, AND employment status	Bk pain + fxn assessed
1134F	Episode of back pain lasting six weeks or less	Epsd bk pain for =< 6 wks
1135F	Episode of back pain lasting longer than six weeks	Epsd bk pain for > 6 wks
1136F	Episode of back pain lasting 12 weeks or less	Epsd bk pain for <= 12 wks
1137F	Episode of back pain lasting longer than 12 weeks	Epsd bk pain for > 12 wks
2040F	Physical examination on the date of the initial visit for low back pain performed, in accordance with specifications	Bk pn xm on init visit date
2044F	Documentation of mental health assessment prior to intervention (back surgery or epidural steroid injection) or for back pain episode lasting longer than six weeks	Doc mntl tst b/4 bk trxmnt
3330F	Imaging study ordered	Imaging study ordered (bkp)
3331F	Imaging study not ordered	Bk imaging tst not ordered
3340F	Mammogram assessment category of “incomplete: need additional imaging evaluation”, documented	Mammo assess inc xray docd
3341F	Mammogram assessment category of “negative”, documented	Mammo assess negative docd
3342F	Mammogram assessment category of “benign”, documented	Mammo assess bengn docd
3343F	Mammogram assessment category of “probably benign”, documented	Mammo probably bengn docd
3344F	Mammogram assessment category of “suspicious”, documented	Mammo assess susp docd
3345F	Mammogram assessment category of “highly suggestive of malignancy”, documented	Mammo assess hghlymalig doc
3350F	Mammogram assessment category of “known biopsy proven malignancy”, documented	Mammo bx proven malig docd
4240F	Instruction in therapeutic exercise with follow-up by the physician provided to patients during episode of back pain lasting longer than 12 weeks	Instr xrcz 4bk pn >12 weeks
4242F	Counseling for supervised exercise program provided to patients during episode of back pain lasting longer than 12 weeks	Sprvsd xrcz bk pn >12 weeks
4245F	Patient counseled during the initial visit to maintain or resume normal activities	Pt instr nrml lifest

Code	Long Descriptor	Short Descriptor
4248F	Patient counseled during the initial visit for an episode of back pain against bed rest lasting 4 days or longer	Pt instr–no bd rest>= 4 days
4250F	Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 30 minutes immediately after anesthesia end time	Wrmng 4 surg - normothermia
5060F	Findings from diagnostic mammogram communicated to practice managing patient's on-going care within 3 business days of exam interpretation	Fndngs mammo 2pt w/in 3 days
5062F	Findings from diagnostic mammogram communicated to the patient within 5 days of exam interpretation	Doc f2fmammo fndng in 3 days
6040F	Use of appropriate radiation dose reduction devices OR manual techniques for appropriate moderation of exposure, documented	Appro rad ds dvcs techs docd
6045F	Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented	Radxps in end rpt4fluro pxd
7020F	Mammogram assessment category [eg, Mammography Quality Standards Act (MQSA), Breast Imaging Reporting and Data System (BI-RADS®), or FDA approved equivalent categories] entered into an internal database to allow for analysis of abnormal interpretation (recall) rate	Mammo assess cat in dbase
7025F	Patient information entered into a reminder system with a target due date for the next mammogram	Pt Infosys alarm 4 nxt mammo

Revised Descriptors for PQRI Codes

Attachment 1 of CR5980 also contains a list of editorial changes to the short and/or long descriptors for a number of PQRI codes.

Additional Information

The official instruction, CR 5980, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1482CP.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 - IMPLEMENTATION OF SECTION 113 MEDICARE, MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (MMSCHIP) LEGISLATION

~CMS MLN Matters~

MLN Matters Number: MM5987

Related Change Request (CR) #: 5987

Related CR Release Date: April 11, 2008

Effective Date: April 1, 2008

Related CR Transmittal #: R331OTN

Implementation Date: May 12, 2008

Provider Types Affected

Clinical laboratories billing Medicare contractors (carriers, fiscal intermediaries, or Part A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 5987 which alerts clinical laboratories that, effective for tests furnished on or after April 1, 2008, the MMSCHIP Extension Act of 2007 sets payment for code 83037 and 83037QW (Hemoglobin; glycosylated (A1c) by device) by crosswalking it to be the same as 83036 (glycosylated (A1c)). Make certain your billing staffs are aware of this change.

Background

The MMSCHIP Extension Act of 2007 passed in December 2007 and included Section 113. Section 113 of the legislation set the price for any diagnostic test for HbA1C that is labeled by the Food and Drug Administration (FDA) for home use equal to the payment rate for a glycosylated hemoglobin test (identified as of October 1, 2007, by Healthcare Common Procedure Coding System (HCPCS) code 83036 (and any succeeding codes)). **The legislation is effective for tests furnished on or after April 1, 2008.**

- For Calendar Year (CY) 2006, the Current Procedural Terminology (CPT) established new code 83037 Hemoglobin; glycosylated (A1C) by device cleared by the FDA for home use. CPT code 83036, glycosylated (A1c), already existed and was priced at \$13.56 on the clinical laboratory fee schedule.
- For calendar year 2006, CMS determined that code 83037 should be paid via carrier gap filling.
- For calendar year 2007, CMS set the payment for code 83037 by crosswalking it to code 82985 (Glycosylated protein).
- For tests furnished on or after April 1, 2008, the payment for 83037 or 83037QW will be the same as the payment on the clinical laboratory fee schedule for 83036.

Your Medicare contractor will adjust claims for services on or after April 1, 2008, processed prior to implementation of this change if you bring such claims to the contractor's attention.

Additional Information

To see the official instruction (CR5987) issued to your Medicare contractor visit <http://www.cms.hhs.gov/Transmittals/downloads/R331OTN.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.

EXTENSION OF REASONABLE COST PAYMENT FOR CLINICAL LABORATORY TESTS FURNISHED BY HOSPITALS WITH FEWER THAN 50 BEDS IN QUALIFIED RURAL AREAS

~CMS MLN Matters~

MLN Matters Number: MM5961

Related CR Release Date: April 4, 2008

Related CR Transmittal #: R3300TN

Related Change Request (CR) #: 5961

Effective Date: Cost report periods beginning July 1, 2007 through June 30, 2008

Implementation Date: July 7, 2008

Provider Types Affected

Hospitals with fewer than 50 beds in qualified rural areas submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs)) for outpatient clinical laboratory tests provided to Medicare beneficiaries

Impact on Providers

This article is based on Change Request (CR) 5961 which instructs that payment for outpatient clinical laboratory tests to hospitals (with fewer than 50 beds in qualified rural areas) will be made on a reasonable cost basis for cost reporting periods beginning on or after July 1, 2004 through June 30, 2008. Currently Section 107 of the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Extension Act of 2007 extends reasonable cost payment for clinical laboratory tests performed by hospitals with fewer than 50 beds in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2004 through June 30, 2008. Thus, this can apply to services performed as late as June 30, 2009, depending upon the provider's cost reporting period.

- Providers should note that Medicare contractors will adjust any claims that were not previously paid according to reasonable cost, but should have been paid as such, per section 107 of the Medicare, Medicaid and SCHIP Extension Act of 2007.
- Beneficiaries are not liable for any deductible, coinsurance, or any other cost-sharing amount.

Background

A provision in Section 416 of the Medicare Modernization Act (MMA) of 2003 provided for payment on a reasonable cost basis for outpatient clinical laboratory tests to hospitals with fewer than 50 beds in qualified rural areas for cost reporting periods beginning during the 2-year period beginning on July 1, 2004. At that time the Centers for Medicare & Medicaid Services (CMS) issued CR 3301 on February 13, 2004, to implement procedures to provide for such payment.

Based on Section 105 of the Tax Relief and Health Care Act (TRHCA) of 2006, CMS issued CR 5493, on February 2, 2007, to extend the 2-year provision outlined within CR 3301 for an additional cost-reporting year. Because CR 5493 was implemented beyond the original sun-setting date outlined in CR 3301, Medicare contractors were instructed to adjust any claims for laboratory services that should have received reasonable cost payment under TRHCA. You may review the MLN Matters article related to CR5493 at <http://www.cms.hhs.gov/MLNMattersArticles/Downloads/mm5493.pdf> on the CMS Website.

Additional Information

To see the official instruction (CR5961) issued to your Medicare FI or A/B MAC, refer to <http://www.cms.hhs.gov/Transmittals/downloads/R3300TN.pdf> on the CMS Website.

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

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