Communiqué Part A

Wisconsin Physicians Service Insurance Corporation http://www.wpsmedicare.com

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

May 2009

WPS HEALTH INSURANCE

Items of Importance

HOW YOU MAKE A DIFFERENCE

Have you wondered what WPS Medicare does with your Website Customer Satisfaction ForeSee Results Survey responses? Your feedback is extremely important to WPS Medicare, and your survey responses play a large role in the shaping of the WPS Medicare Website. WPS Medicare staff reviews the results of the survey on a weekly basis, and your feedback directly influences the layout, look and feel, content, and other aspects of the WPS Medicare Website.

Over the last several months, WPS Medicare made the following changes to our Website based upon your feedback:

- Splitting of the J5 MAC Website into separate sites for J5 MAC Part A providers and J5 MAC Part B providers
- Redesign of Contact Information
- New and improved home pages
- Creation of comprehensive "Forms" Web pages
- And so much more!

Be sure to continue to regularly complete the Website Customer Satisfaction survey when you visit the WPS Medicare Website and help WPS Medicare continue to provide a Website that meets your needs.

More information on the Website Customer Satisfaction survey is available at http://www.wpsmedicare.com/sat_survey.pdf.

Claim Submission

BILLING ROUTINE COSTS OF CLINICAL TRIALS
~CMS MLN Matters~

MLN Matters Number: MM6431
Related CR Release Date: April 10, 2009
Related CR Transmittal #: R1710CP

Related Change Request (CR) #: 6431
Effective Date: July 10, 2009
Implementation Date: July 10, 2009

Provider Types Affected

Physicians and non-physician practitioners submitting claims to Medicare Administrative Contractors (MACs) and carriers for clinical trials

Provider Action Needed

This article is based on Change Request (CR) 6431 that alerts providers that they should continue to report the International Classification of Diseases diagnosis code V70.7 (Examination of participant in clinical trial) on clinical trial claims. **It is no longer necessary to make a distinction between a diagnostic and therapeutic clinical trial service on the claim.**

Background

CR 6431 revises the Medicare *Claims Processing Manual*, Chapter 32, Section 69.6 (*Requirements for Billing Routine Costs of Clinical Trails*). The revised manual section is attached to CR 6431. The Centers for Medicare & Medicaid Services (CMS) is clarifying that there no longer remains a need to make a distinction between a diagnostic versus therapeutic clinical trial service on the claim.

If the QV or Q1 modifier is billed and diagnosis code V70.7 is submitted by practitioners as a secondary rather than the primary diagnosis, your Medicare contractor **will not** consider the service as having been furnished to a diagnostic trial volunteer. Instead, they will process the service as a therapeutic clinical trial service.

- Effective for claims processed 90 days after issuance of CR 6431 with dates of service on or after January 1, 2008, claims submitted with either the modifier QV or the modifier Q1 will be returned as unprocessable if the diagnosis code V70.7 is not submitted on the claim.
- Providers will see the following messages from their Medicare contractor with the returned claim:
  - Claims adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication; **and**
  - As least one Remark Code, which may be comprised of either:
    - The Remittance Advice Code (M76, Missing/incomplete/invalid diagnosis or condition) **or**
    - National Council for Prescription Drug Programs Reject Reason Code.

Note: Healthcare Common Procedure Coding System (HCPCS) codes are not reported on inpatient claims. Therefore, the HCPCS modifier requirements (i.e., QV or Q1) as outlined in the outpatient clinical trial section immediately below, are not applicable to inpatient clinical trial claims.

On all outpatient clinical trial claims, providers need to do the following:

- Report condition code 30;
- Report a secondary diagnosis code of V70.7; and
- Identify all lines that contain an investigational item/service with a HCPCS modifier of:
  - QA/QR for dates of service before January 1, 2008; or
  - Q0 for dates of service on or after January 1, 2008.
- Identify all lines that contain a routine service with a HCPCS modifier of:
  - QV for dates of service before January 1, 2008; or
  - Q1 for dates of service on or after January 1, 2008.

Institutional providers should also note that they must not bill outpatient clinical trial services and non-clinical trial services on the same claim for Medicare beneficiaries enrolled in managed care plans.

Additional Information

If you have questions, please contact your Medicare MAC and/or carrier at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Website. The official instruction (CR6431) issued to your Medicare MAC, or carrier is available at http://www.cms.hhs.gov/Transmittals/downloads/R1710CP.pdf on the CMS Website.

MEDICARE CLAIMS PROCESSING MANUAL CLARIFICATIONS FOR SKILLED NURSING FACILITY (SNF) AND THERAPY BILLING

~CMS MLN Matters~

MLN Matters Number: MM6407 | **Related Change Request (CR) #: 6407**
Related CR Release Date: March 27, 2009 | **Effective Date: October 1, 2006**
Related CR Transmittal #: R1706CP | **Implementation Date: April 27, 2009**

Provider Types Affected

Skilled Nursing Facilities and other providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 6407, which includes clarifications to the *Medicare Claims Processing Manual* for Skilled Nursing Facility (SNF) and therapy billing. Be sure billing staff are aware of the clarifications.

Background

Change Request (CR) 6407 provides clarifications and updates to the Medicare Claims Processing Manual, Chapter 5 (Part B Outpatient Rehabilitation Billing), Section 20 (HCPCS Coding Requirements). These clarifications indicate that effective January 1, 2009, the new Current Procedural Terminology (CPT) code 95992 *(Canalith repositioning procedure(s) (eg Epley maneuver, Semont maneuver), per Day)* is bundled under the Medicare Physician Fee Schedule (MPFS).

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our Website at: http://www.wpsmedicare.com

Regardless of whether CPT code 95992 is billed alone or in conjunction with another therapy code, **separate Medicare payment is never made for this code.** If billed alone, this code will be denied. On remittance advice notices for claims so denied, Medicare contractors will use group code CO and claim adjustment reason code 97 ("Payment is included in the allowance for another service/procedure."). Alternatively, reason code B15, which has the same intent, may also be used by your Medicare contractor.

In addition, CR 6407 provides clarifications and updates to the Medicare Claims Processing Manual (Pub 100-04), Chapter 6 (Skilled Nursing Facility (SNF) Inpatient Part A Billing), Section 40 (Special Inpatient Billing Instructions) to indicate that ***both full and partial benefits exhaust claims must be submitted by SNFs monthly.*** For benefits exhaust bills, an SNF must submit a benefits exhaust bill monthly for those patients who continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims:

1. Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim; and
2. Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim.

Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary's applicable benefit period. Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

Note: Part B 22x (SNF inpatient part B) bill types **must be submitted after** the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech-language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (SNF inpatient part B) bill type.

Note: Unlike with benefits exhaust claims, Part B 22x bill types **may be submitted prior** to the submission of bill type 210 (SNF no-payment ***bill type*****)**.

Additional Information

The official instruction (CR 6407) issued to your FI and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/transmittals/downloads/R1706CP.pdf on the Centers for Medicare & Medicaid Services (CMS) Website. If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Website.

Coverage – 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

RETIREMENT OF LCD NOTIFICATION

The following WPS Medicare Part A Local Coverage Determination (LCD) will be retired effective 05/17/2009.

Legacy A (Formerly Mutual of Omaha)	L2415	Non-Invasive Vascular Studies for End Stage Renal Disease (ESRD) Patients	Replaced by new policy

Revised Policies for May 2009

Policy	Title	NCD/LCD	Web	Communiqué Page
L17849	*Upper Intestinal Endoscopy/ Esophagogastroduodenoscopy (EGD)*	LCD	Click here to view	7
MS-004 (L28527)	*Bone Mass Measurement*	LCD	Click here to view	7

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Coverage – Revised Policies

Contractor Name
Wisconsin Physicians Service Insurance Company

Contractor Number
52280

Contractor Type
FI

LCD ID Number
L17849

Revision Effective Date
05/01/09

LCD Title
Upper Intestinal Endoscopy/Esophagogastroduodenoscopy (EGD)

The following ICD -9 codes have been added to our coverage of CPT codes 43231, 43232, 43242, 43259, 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272, and 76975

*576.1	Other disorders of biliary tract -cholangitis
*576.5	Other disorders of biliary tract-spasm of sphincter of Oddi
*576.8	Other specified disorders of biliary tract
*782.4	Jaundice , unspecified, not of newborn
*790.4	Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase (LDH)
*790.5	Other non-specific abnormal serum enzyme levels
*793.3	nonspecific abnormal findings on radiological And other examination of biliary tract
*793.4	nonspecific abnormal findings on radiological And other examination of gastrointestinal tract
*794.8	Nonspecific abnormal results of function studies-liver
*997.4	Digestive system complications

Contractor's Policy Number
MS-004

LCD Database Number
L28527

LCD Title
Bone Mass Measurement

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our Website at:
http://www.wpsmedicare.com

Primary Geographic Jurisdiction

Intermediary: Alaska, Alabama, Arizona, Arkansas, California - Entire State, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri - Entire State, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming, District of Columbia, American Samoa, Guam, Northern Mariana Islands, Virgin Islands

Carrier: Wisconsin, Illinois, Michigan, Minnesota

MAC A/B: Iowa, Missouri, Nebraska, Kansas

Revision Effective Date
May 1, 2009

ICD-9 Codes that Support Medical Necessity
Note: ICD-9 codes must be coded to the highest level of specificity.
When 77078, 77079, 77081, 77083, 76977 or G0130 is done as an **initial diagnostic test** that determines a diagnosis of 255.0, 733.00, 733.01, 733.02, 733.03, 733.09 or 733.90, code as a secondary diagnosis the reason for the bone mass density test.
For Use with CPT Codes 77078, 77079, 77080, 77081, 77083, 76977, G0130
*820.00-820.9 Fracture of neck of femur

ICD-9-CM codes 820.00 – 820.9 were added as payable diagnoses for use with CPT codes 77078, 77079, 77080, 77081, 77083, 76977, and G0130 as defined in LCD MS-004.

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http://www.wpsmedicare.com

Electronic Data Interchange (EDI)

INSTRUCTIONS ON UTILIZING ANSI X12 837 INSTITUTIONAL CAS SEGMENTS FOR MEDICARE SECONDARY PAYER (MSP) PART A CLAIMS

~Revised CMS MLN Matters~

MLN Matters Number: MM6275 Revised
Related CR Release Date: December 19, 2008
Related CR Transmittal #: R63MSP

Related Change Request (CR) #: 6275
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Note: On March 27, 2009, the Centers for Medicare & Medicaid Services (CMS) rescinded CR 6275 and replaced it with CR 6426. As a result, this article is replaced by article MM6426, which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6426.pdf on the CMS Website.

INSTRUCTIONS ON UTILIZING 837 INSTITUTIONAL CLAIM ADJUSTMENT SEGMENTS (CAS) FOR MEDICARE SECONDARY PAYER (MSP) PART A CLAIMS (THIS CR RESCINDS AND FULLY REPLACES CR 6275)

~CMS MLN Matters~

MLN Matters Number: MM6426
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R66MSP

Related Change Request (CR) #: 6426
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries

What You Need to Know

CR 6426, from which this article is taken, alerts your Medicare Part A contractors (FIs, MACs, and RHHIs) and their associated systems to the changes they will need to follow when calculating MSP payment amounts from incoming American National Standards Institute (ANSI) ASC X12N 837 4010-A1 claims transactions. It specifically addresses their use of data reported in ANSI ASC X12N 837 institutional CAS segments for MSP Part A Claims.

CR 6426 only affects providers submitting Part A claims. It is important for such providers to code the CAS segments of their claims accurately so that Medicare will make the correct MSP payments. See the Background and Additional Information Sections of this article for further details regarding these changes.

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our Website at: http://www.wpsmedicare.com

Background

The Medicare Secondary Payer (MSP) provisions apply to situations where Medicare is not the beneficiary's primary insurance. Medicare's secondary payment for Part A MSP claims is based on:

- Medicare-covered charges, or the amount the physician (or other supplier) is Obligated to Accept as Payment in Full (OTAF), whichever is lower;
- What Medicare would have paid as the primary payer; and
- The primary payer(s) payment.

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for claim transactions and the implementation guides for each transaction are available at http://www.wpc-edi.com on the Internet.

This article is to remind you to include CAS segment related group codes, claim adjustment reason codes and associated adjustment amounts on your MSP 837 claims you send to your Medicare contractor. Medicare contractors need these adjustments to properly process your MSP claims and for Medicare to make a correct payment. This includes all adjustments made by the primary payer, which, for example, explains why the claim's billed amount was not fully paid.

The instructions detailed by CR 6426 are necessary to ensure:

- Medicare complies with HIPAA transaction and code set requirements;
- Providers code for the CAS segments claims to reflect any adjustments made by primary payers; and
- MSP claims are properly calculated by Medicare contractors (and their associated shared systems) using payment information derived from the incoming 837 Institutional claim.

Adjustments made by the payer are reported in the CAS segment on the 835 electronic remittance advice (ERA) or on hardcopy remittance advices. Providers must take the CAS segment adjustments (as found on the 835 ERA) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment.

Note: If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer (a.k.a. your contractual obligation), you must identify this amount as Value Code 44 in the 2300 HI Value Information. This amount is also known as the Obligated to accept as payment in full amount (OTAF). Details of the MSP payment provisions may be found in the CMS Medicare Secondary Payer Manual and in the federal regulations at 42 CFR 411.32 and 411.33.

Additional Information

You can find the official instruction (CR6426) issued to your FI, RHHI, or MAC by visiting http://www.cms.hhs.gov/transmittals/downloads/R66MSP.pdf on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Secondary Payer (MSP) Manual,* Chapter 5 (Contractor Prepayment Processing Requirements), Section

40.7.3.2 (Medicare Secondary Payment Part A Claims Determination for Services Received on 837 Institutional Electronic or Hardcopy Claims Format) as an attachment to that CR.

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

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General Information

INITIAL ENROLLMENT ASSIGNMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS), END STAGE RENAL DISEASE (ESRD) FACILITIES, AND RURAL HEALTH CLINICS (RHCS)

~CMS MLN Matters~

MLN Matters Number: MM6207
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R1707CP

Related Change Request (CR) #: 6207
Effective Date: April 27, 2009
Implementation Date: April 27, 200

Provider Types Affected

Federally Qualified Health Centers (FQHCs), End Stage Renal Disease (ESRD) facilities, and Rural Health Clinics (RHCs) that are currently enrolled with a Fiscal Intermediary (FI) or a Medicare Administrative Contractor (MAC), and FQHCs, RHCs, and ESRD facilities that are planning to submit an 855 initial enrollment application.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6207, which describes initial enrollment policy for assignment of FQHCs, ESRD facilities, and RHCs.

CAUTION – What You Need to Know

As FQHCs, ESRD facilities, and RHCs seek to enroll in the Medicare program, they should file their enrollment applications with the legacy FI or MAC that covers the state where they are located. Exceptions to the geographic assignment rule are set forth in MM 5979, which can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5979.pdf on the Centers for Medicare & Medicaid Services (CMS) Website. This represents a shift from legacy-world assignment policy where there existed regional and national FIs for these distinct provider types.

GO – What You Need to Do

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

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 911) amended the Social Security Act (the Act; Title XVIII) to add Section 1874A (Contracts with Medicare Administrative Contractors (MACs)) which replaces the prior Medicare intermediary and carrier contracting authorities formerly found in Sections 1816 and 1842 of the Act. CMS procured the first Part A/B Medicare Administrative Contractor (A/B MAC) in 2006 and continues to award the fifteen A/B MAC contracts. The process of moving workload from legacy contractors to the MACs continues.

The MMA also repealed the provider nomination provision of the Social Security Act and replaced it with the geographic assignment rule. Generally, a provider or supplier will be assigned to the MAC that covers the state where the provider or supplier is located.

Exceptions to the geographic assignment rule are described in MM 5979, which can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5979.pdf on the CMS Website.

In the legacy FI environment, FQHCs, RHCs, and ESRD facilities were concentrated within the workloads of several regional and national FIs.

Most of the providers that were assigned to regional or national FIs represent "out-of-jurisdiction providers" (OJPs). An OJP is defined as a provider that is not currently serviced by the FI or MAC that covers the state where the provider is located. Regional and national Medicare contractors for FQHCs, RHCs, and ESRD facilities will not exist in the MAC environment.

FQHCs

Most FQHCs are currently within the workload serviced by National Government Services (NGS) Wisconsin. The Jurisdiction 6 MAC will absorb this workload. FQHCs in the NGS workload will be transferred to their destination MACs during the OJP migration. The destination MAC will not always be the geographic MAC.

Indian Health Service (IHS) facilities will be assigned to the Jurisdiction 4 MAC. For purposes of CR6207, "tribal FQHC" means a Medicare FQHC operated by a tribe or tribal organization under the Indian Self-Determination Act (25 USCS 40(b)) or by an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act (25 USCS 13). All other freestanding FQHCs, not meeting that tribal description, will be assigned to the MAC that covers the state where the facility is located.

CMS is implementing the geographic assignment rule for initial enrollment FQHCs now to avoid creating additional OJPs. An initial enrollment for an IHS FQHC will be submitted to the Jurisdiction 4 MAC. A new, non-tribal FQHC will submit its initial CMS-855A application to the FI or MAC that covers the state where the facility is located.

Some classes of FQHCs may present latent challenges for the geographic assignment rule. However, CMS will make accommodations for these providers. For example, if an initial enrollment FQHC satellite is located in the jurisdiction of a MAC other than the audit MAC, then the geographic MAC will service the claims, and the audit MAC will service the cost report.

RHCs and ESRD Facilities

RHCs and many ESRD facilities have been serviced by a limited set of regional FIs in the legacy environment. Those legacy FI workloads will be absorbed by incoming MACs. Out-of-jurisdiction RHCs and ESRD facilities will be transferred to their destination MACs during the OJP migration. An initial enrollment for a RHC or ESRD facility will be submitted to the MAC or FI that serves the state where the RHC or ESRD facility is located.

Note: If the FQHC, RHC or ESRD facility is provider-based, it will be assigned to the FI or MAC that covers the state where the main provider is located.

Misfiled CMS 855-A Applications

If a FQHC, RHC or ESRD facility submits a CMS-855A initial application to an incorrect Medicare contractor, the receiving contractor will mail the application to the appropriate contractor and notify the provider that its application has been sent to the new contractor and that all future questions regarding the application should be directed to the new contractor.

Internet-based PECOS

FQHCs, RHCs, and ESRD facilities will not be able to use Internet-based PECOS for the filing of CMS-855A initial applications, changes of ownership, or changes of information. Only paper forms will be accepted for these transactions.

The following is a table that summarizes the changes of CR 6207:

Facility	New Enrollment Applications
FQHC	FI/MAC covering the state where they are located
RHC	FI/MAC covering the state where they are located
ESRD	FI/MAC covering the state where they are located
IHS FQHC	J4 MAC
Provider-based FQHC	FI/MAC servicing the main provider

Additional Information

The official instruction (CR 6207) issued to your Medicare contractor, regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1707CP.pdf on the CMS Website.

A listing of contractor addresses can be found at http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage 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.

Provider Education

EDUCATION SCHEDULE

Be sure to visit the WPS Medicare Education Schedule at http://www.wpsmedicare.com/part_a/education/seminars.shtml and http://www.wpsmedicare.com/part_a/education/teleconferences.shtml to learn more about the educational events we have scheduled for the upcoming months.

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

- All Part A Provider Seminar
- All Provider Billing & Compliance Seminar
- Outpatient Prospective Payment System (OPPS) Billing Seminar
- Skilled Nursing Facility (SNF) Benefits Exhaust & No Pay Billing Ask-the-Contractor Teleconference (ACT)
- Skilled Nursing Facility (SNF) Billing Seminar
- Skilled Nursing Facility (SNF) Billing & Compliance Seminar

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

ELECTRONIC DATA INTERCHANGE (EDI) ASK-THE-CONTRACTOR TELECONFERENCES (ACTS)

WPS Medicare is pleased to announce the 2009 schedule for our Electronic Data Interchange (EDI) Ask-the-Contractor Teleconference (ACT). The calls will be for Legacy Part A (institutional providers who joined WPS in November 2007) & Part B (IL, MI, WI, and MN), as well as MAC J5 A and B states (IA, KS, MO, and NE). These teleconferences will last one and one-half hours. We encourage providers, billing staff, vendors, and clearinghouses to call with any Medicare EDI questions they deem appropriate.

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

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

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

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

Please Note: No Registration is Necessary

EDI Ask-the-Contractor Teleconference

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

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

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

Reimbursement

HOSPICE CAP CALCULATIONS LETTERS AND ADMINISTRATIVE APPEALS

~CMS MLN Matters~

MLN Matters Number: MM6400
Related CR Release Date: April 3, 2009
Related CR Transmittal #: R1708CP

Related Change Request (CR) #: 6400
Effective Date: July 1, 2009
Implementation Date: July 6, 2009

Provider Types Affected

Hospice providers submitting claims to Medicare contractors (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) 6400 which requires Medicare contractors to send each of their providers a letter which serves as a determination of program reimbursement, regardless of whether or not they have exceeded a cap. The letter you receive will include the inpatient and aggregate cap calculation results. Additionally, it will include appeals language in every determination of program reimbursement letter. If you have exceeded the cap, the letter will include a demand for repayment.

Background

The law governing payment for hospice care subjects hospice payments to two statutory caps:

- A cap on payments for inpatient days, described in Section 1861(dd)(2)(A)(iii) of the Social Security Act and
- An aggregate cap on total payments, described in Section 1814(i)(2)(A)-(C).

These statutory caps limit total hospice payments during a cap year. Payments in excess of either cap must be refunded. Currently, after the end of the cap year, the applicable contractor (RHHI, FI, or A/B MAC) computes both cap amounts, and determines the amount of program reimbursement for each hospice provider they serve.

Important Information:

The latest hospice cap amount for the cap year ending October 31, 2008 is $22,386.15. The hospice cap is discussed further in the Medicare Claims Processing Manual (Chapter 11 - Processing Hospice Claims, Section 80.2) which is available at http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf on the Centers for Medicare & Medicaid Services Website. Your contractor (RHHI, FI, or AB MAC) will issue a letter to notify you of the results of the contractor's cap calculations and to serve as your determination of program reimbursement. If there is a cap overpayment, there will be an accompanying demand for repayment.

Administrative Appeals:

As indicated in section 418.311 of 42 CFR, if you believe that your payments have not been properly determined, you may request a review from the applicable contractor if the

amount in controversy is $1,000 or more, but less than $10,000, or from the Provider Reimbursement Review Board (PRRB) if the amount in controversy is $10,000 or more. Appeal requests must be in writing and be filed within 180 days from the date of the determination. Your appeal rights are discussed further in the Medicare Claims Processing Manual (Chapter 11 - Processing Hospice Claims, Section 80.3), which is attached to CR 6400.

Additional Information

The official instruction, CR 6400, issued to your RHHI, FI or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1708CP.pdf on the CMS Website.

If you have any questions, please contact your RHHI, 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.

IMPLEMENTATION OF CAPITAL TO INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) INDIRECT MEDICAL EDUCATION (IME) AND LONG TERM CARE HOSPITAL (LTCH) PROVISIONS FROM THE AMERICAN RECOVERY AND REINVESTMENT ACT (ARRA) OF 2009

~CMS MLN Matters~

MLN Matters Number: MM6444
Related CR Release Date: March 27, 2009
Related CR Transmittal #: R466OTN

Related Change Request (CR) #: 6444
Effective Date: February 17, 2009
Implementation Date: April 6, 2009

Provider Types Affected

Inpatient Acute Care Hospitals and LTCHs that bill Medicare fiscal intermediaries (FIs) or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article discusses provisions of the ARRA that impact capital IPPS payments to hospitals for indirect medical education (IME) and changes to certain LTCH Prospective Payment System (PPS) payment policies. Please note that FIs and MACs will reprocess any claims with discharge dates on or after October 1, 2008, that were previously processed with an incorrect payment amount for IME and/or short-stay outlier claims of LTCHs with a teaching program. **You need take no action to initiate the reprocessing of the claims.** You should notify your billing office staff that adjustments to payments will be made within six months of Pricer software installation at your contractor. That installation is scheduled to occur on or before April 6, 2009.

Background

The ARRA was signed into law on February 17, 2009. Change Request (CR) 6444 provides a summary of the legislation as well as implementation instructions on certain provisions that affect the Medicare Fee-for-Service program.

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our Website at: http://www.wpsmedicare.com

The first key point of the legislation affects capital IPPS IME payments for fiscal year (FY) 2009. Beginning in FY 2009, hospitals were to receive 50 percent of the capital IME adjustment provided under the current formula. Section 4301(b)(1) of the ARRA removes the 50 percent adjustment that applied for FY 2009 and gives teaching hospitals the full capital IME amount for discharges occurring on or after October 1, 2008, through September 30, 2009. The AARA also explicitly specifies that the elimination of the capital IME adjustment in FY 2010 and subsequent years is not to be affected. Therefore, beginning in FY 2010 and after, under current law, hospitals will no longer receive a teaching adjustment under the capital IPPS. This provision also affects LTCH PPS payments as part of the Short Stay Outlier (SSO) calculation. The revision to the capital IPPS IME adjustment for FY 2009 provided for by section 4301(b)(1) of the ARRA also affects the payments for some SSO cases from LTCHs with teaching programs since the calculation of the “IPPS comparable amount” component of the SSO “blend” option must also be revised to reflect the change to the capital IME adjustment for FY 2009 provided for in the ARRA. In the same way as with the SSO calculation, changes to the capital IME payments specified by the ARRA of 2009 affect LTCH PPS payments governed by the “25 percent” threshold payment adjustments. Under these policies, those cases in excess of the applicable thresholds are paid an amount based on an amount **equivalent** to what would be paid under the IPPS. Therefore, the revision to the capital IPPS IME adjustment for FY 2009 provided for in section 4301(b) would apply to those LTCHs with teaching programs.

A second key point of the legislation affects LTCHs. The Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 placed a moratorium on new LTCHs or new LTCH satellites and expansions in the number of beds in existing LTCHs, effective December 29, 2007. MMSEA allowed for limited exceptions to the moratorium. The ARRA makes one additional exception to the moratorium that will allow existing LTCHs to expand the number of beds in the LTCH or its satellite if the hospital obtained a certificate of need for an increase in beds in a State for which such certificate of need is required that was issued on or after April 1, 2005, and before December 29, 2007.

A third key point of the legislation also affects LTCHs. As noted above, CMS regulations create special payment provisions for LTCHs or LTCH satellites that receive more than 25 percent of their admissions from a single referral source. The ARRA amended the MMSEA changes to the 25 percent threshold policy by adding another category of LTCHs that would be subject to the 3-year delay in application of the 25 percent payment provision, i.e., LTCHs or LTCH satellites that were co-located with provider-based locations of an IPPS hospital that did not deliver services payable under the IPPS at those campuses where the LTCHs or LTCH satellites were located. The ARRA also extended the increase in percentages under the 25 percent threshold policy to include “grandfathered” LTCH satellites, i.e., those in existence prior to October 1, 1999 and changed the implementation date of all changes to the 25 percent threshold payment adjustment from the date of enactment of the MMSEA (December 29, 2007), to either July 1, 2007 or October 1, 2007, as appropriate for the specific provision.

Additional Information

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

The official instruction (CR6444) issued to your Medicare MAC and/or FI is available at http://www.cms.hhs.gov/Transmittals/downloads/R466OTN.pdf on the CMS Website.

INCORPORATION OF PHYSICIAN FEE SCHEDULE REGULATORY CHANGES INTO CHAPTER 10 OF THE PROGRAM INTEGRITY MANUAL (PIM)

~Revised CMS MLN Matters~

MLN Matters Number: MM6310 Revised
Related CR Release Date: April 15, 2009
Related CR Transmittal #: R289PI
Related Change Request (CR) #: 6310
Effective Date: January 1, 2009
Implementation Date: April 1, 2009

Note: This article was revised on April 16, 2009, to reflect a revision made to CR 6310. Specifically, the Centers for Medicare & Medicaid Services modified two requirements of CR6310. The specific change in this article is in the last bullet point under "Timeframes for reporting changes of information" on page 3. That bullet point was changed to show that an overpayment may be assessed. Previously, it stated an overpayment will be assessed. The CR release date, transmittal number, and the Web address for accessing the CR have also been revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

All Medicare physicians, providers, and suppliers, as well as those who are considering applying to participate in the program should be aware of the new rule and of upcoming changes to the Medicare enrollment process.

Background

Change Request (CR) 6310 implements regulatory changes found in the CY 2009 Medicare Physician Fee Schedule final rule with comment (CMS-1403-FC). Significant changes are summarized below.

Effective date of Medicare billing for physicians, certain non-physician practitioners, and Physician and Non-Physician Practitioner Organizations

- Carriers and Part A and Part B Medicare Administrative Contractors (A/B MACs) will establish the effective date of Medicare billing privileges (see 42 CFR 424.520(d)) for physicians, non-physician practitioners, and physician or non-physician practitioner organizations. Physicians, non-physician practitioners and physician and non-physician practitioner organizations will no longer be allowed to establish retrospective Medicare effective billing dates.
- Carriers and A/B MACs will establish an effective date of Medicare billing privileges for the following individuals and organizations: physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered

dietitians or nutrition professionals; and physician and non-physician practitioner organizations (e.g., clinics/group practices).

- The effective date of Medicare billing privileges for the individuals and organizations identified above is the later of the date of filing or the date they first began furnishing services at a new practice location. Note: The date of filing for Internet-based Provider Enrollment, Chain and Ownership System (PECOS) applications for these individuals and organizations is the date that the contractor received an electronic version of the enrollment application and a signed certification statement that were both processed to completion.
- The individuals and organizations identified above may, however, retrospectively bill for services when:
  - The supplier has met all program requirements, including state licensure requirements, **and**
  - The services were provided at the enrolled practice location for up to-
    - 30 days prior to their effective date if circumstances precluded enrollment in advance of providing services to Medicare beneficiaries, or
    - 90 days prior to their effective date if a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§5121-5206 (Stafford Act) precluded enrollment in advance of providing services to Medicare beneficiaries.

Timeframes for reporting changes of information

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives; clinical social workers; clinical psychologists; registered dietitians or nutrition professionals; and organizations (e.g., group practices) consisting of any of the categories of individuals identified in this paragraph; the following changes must be reported within 30 days:
  - A change of ownership;
  - A final adverse action; or
  - A change in practice location.
- If an individual or organization identified above does not comply with the reporting requirements relating to, respectively, final adverse actions and practice location changes, the supplier may be assessed an overpayment back to the date of the final adverse action or change in practice location.

Application rejections and denials for physician and certain non-physician practitioner applications

- Carriers and A/B MACs will deny, rather than reject, incomplete applications submitted by physicians, non-physician practitioners, and physician or non-physician practitioner organizations.
- This change will allow the individuals and organizations identified above to preserve their effective date of filing by submitting a corrective action plan or an appeal and submitting the missing information/documentation to allow the carrier or A/B MAC to adjudicate the enrollment application to completion.

Revocation effective dates

- A revocation based on a: (1) Federal exclusion or debarment, (2) felony conviction, (3) license suspension or revocation, or (4) determination that the provider or supplier is no longer operational, is effective with the date of the exclusion,

debarment, felony conviction, license suspension or revocation, or the date that the Centers for Medicare & Medicaid Services (CMS) or its contractor determined that the provider or supplier is no longer operational.

- Any physician, physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, registered dietitian or nutrition professional, organization (e.g., clinic/group practices) consisting of the individuals previously identified, or IDTF who/that is revoked from the Medicare program must, within 60 calendar of the effective date of the revocation, submit all claims for items and services furnished.

Requirements for maintaining ordering and referring documentation

- Carriers or A/B MACs may revoke the billing privileges of any provider or supplier that fails to comply with Medicare's ordering and referring documentation requirements as specified in 42 CFR 424.5216 (f).
- Such revocation is also possible in cases where the physician or non-physician practitioner fails to maintain written ordering and referring documentation for seven (7) years from the date of service.
- Off-site or electronic storage of the ordering and referring documentation described in 42 CFR §424.516(f) is not precluded, as long as these records are readily accessible and retrievable.

Other changes

- Final adverse action is defined.

Additional Information

The official instruction (CR 6310) issued to your carrier, FI, and A/B MAC, regarding this change may be viewed at http://www.cms.hhs.gov/transmittals/downloads/R289PI.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.

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