

Communiqué

Part A

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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Items of Importance**ARE YOU MISSING YOUR E-NEWS MESSAGES?**

WPS Medicare has been notified that some e-mail service providers are filtering WPS Medicare e-News messages as "junk mail." If you are signed up for WPS Medicare e-News and have not been receiving your weekly messages, please check in your "junk mail" box to see if the messages have been filtered in error.

Still not signed up for e-News? Do so today at <http://www.wpsmedicare.com/listserv>, and get important Medicare news sent straight to your e-mail.

CMS-855 MEDICARE ENROLLMENT APPLICATIONS: 2008 REVISIONS

The Centers for Medicare & Medicaid Services (CMS) revised the CMS-855 Medicare enrollment applications in February 2008. The current versions of the applications are available on the CMS Provider Enrollment Website at <http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage>.

Applications received in our office on and after October 1, 2008 must be submitted on the 2008 versions of the forms. The 2006 versions of the forms will no longer be accepted effective October 1, 2008 and will be returned to the applicant.

IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS

WPS Medicare will close for the following holidays:

<u>Date</u>	<u>Holiday</u>
September 1, 2008	Labor Day
November 27-28, 2008	Thanksgiving

REPORTING OF INFUSIONS AND INJECTIONS

Due to increased inquiries regarding billing, coverage, and documentation of intravenous (IV) infusions and injections in the absence of documented stop times, WPS Medicare Part A felt it was important to state our position regarding the coverage of this service.

Initial IV infusion codes are reported after 15 minutes of infusion. Infusions lasting 15 minutes or less must be billed as an IV push. It is our position that start and stop times of IV drug administration must be clearly documented in order to request Medicare payment for infusion services. In the absence of start and stop time, providers may only request reimbursement at the IV push level. This includes, but is not limited to requests for reimbursement for the following CPT codes:

- 90760** Intravenous infusion, hydration; initial, 31 minutes to 1 hour
- 90761** Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)
- 90765** Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour
- 90766** Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)
- 90767** Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)
- 90768** Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)
- C8957** Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than either hours), requiring use of portable or implantable pump

Claim Submission**CLARIFICATION ON THE CORRECT CONDITION CODE TO REPORT ON PROVIDER ADJUSTMENT REQUESTS TO INDICATE A HEALTH INSURANCE PROSPECTIVE PAYMENT SYSTEM (HIPPS) CODE CHANGE**

~ Revised CMS MLN Matters ~

MLN Matters Number: MM6002 **Revised**
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1565CP

Related Change Request (CR) #: 6002
Effective Date January 1, 2009
Implementation Date: January 5, 2009

Note: This article was revised on July 28, 2008, to reflect that CR 6002 was revised on July 25, 2008. The CR release date, transmittal number, and the Web address for accessing CR 6002 have been changed in this article. All other information remains the same.

Provider Types Affected

Skilled Nursing Facilities (SNF), Swing Bed (SB) providers, Inpatient Rehabilitation Facilities (IRF), and Home Health Agencies (HHA) who bill Medicare fiscal intermediaries (FI) and Medicare Administrative Contractors (A/B MAC) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6002, from which this article is taken, announces that, as of January 1, 2009, you should no longer use the D4 condition code to report HIPPS code changes on SNF adjustment requests, but rather should begin to use Condition Code **D2** – Change in Revenue Codes/HCPCS/HIPPS Rate Codes instead.

Background

Medicare systems have historically required Skilled Nursing Facilities (SNF) and Swing Bed (SB) providers to append condition code D4 to inpatient adjustment requests when a change is made to the original Health Insurance Prospective Payment System (HIPPS) code billed on the claim.

However, because the National Uniform Billing Committee (NUBC) has recently revised the definition for condition code D4, to indicate a change in clinical codes (ICD) for diagnosis and/or procedure codes, CR 6002, from which this article is taken, clarifies the correct condition code to report on adjustment requests when changing a previously processed HIPPS code.

Effective January 1, 2009, you should no longer use the D4 condition code to report HIPPS code changes on SNF adjustment requests, but instead should begin to use Condition Code **D2** – Change in Revenue Codes/HCPCS/HIPPS Rate Codes.

In addition, Medicare systems have been updated to require Inpatient IRFs and HH agencies to also report a condition code D2 on adjustment requests that alter the existing HIPPS code on a previous paid claim, effective January 1, 2009.

You should be aware that your FI or A/B MAC will return adjustment requests when a claim contains a HIPPS code change without a condition code D2.

Additional Information

You can find more information about the correct condition code to report on provider adjustment requests to indicate a health insurance prospective payment system (HIPPS) code change by going to CR 6002, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1565CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

You will find updated *Medicare Claims Processing Manual*, Chapter 6 (SNF Inpatient Part A Billing), Sections 30.5 (Adjustment to Health Insurance Prospective Payment System (HIPPS) Codes Resulting From Long Term Care Resident Assessment Instrument (RAI) Corrections) and 30.5.1 (Adjustment Requests) as an attachment to CR 6002. In addition you might want to refer to Chapter 25, (Completing and Processing the Form CMS-1450 Data Set) at <http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf> on the CMS Website, for further description of the code sets reported on the CMS-1450.

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.

MEDICARE CONTRACTOR ANNUAL UPDATE OF THE INTERNATIONAL CLASSIFICATION OF DISEASES, NINTH REVISION, CLINICAL MODIFICATION (ICD-9-CM) ~ CMS MLN Matters ~

MLN Matters Number: MM6107
Related CR Release Date: July 29, 2008
Related CR Transmittal #: R1566CP

Related Change Request (CR) #: 6107
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DMACs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs)).

Impact on Providers

This article is based on Change Request (CR) 6107 and reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008). You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) Website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage or at the National Center for Health Statistics (NCHS) Website at <http://www.cdc.gov/nchs/icd9.htm> in June of each year.

Background

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 6107 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs)), and for all institutional claims; but is not required for ambulance supplier claims.

Additional Information

The official instruction (CR 6107) issued to your Medicare contractor is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1566CP.pdf> on the CMS Website.

As mentioned, you can find the new, revised, and discontinued ICD-9-CM diagnosis codes at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage on the CMS Website or at the National Center for Health Statistics (NCHS) Website at <http://www.cdc.gov/nchs/icd9.htm> in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for \$25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at

http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage 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.

**REMITTANCE ADVICE REMARK CODE AND CLAIM ADJUSTMENT
REASON CODE UPDATE**
~ CMS MLN Matters ~

MLN Matters Number: MM6109
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1563CP

Related Change Request (CR) #: 6109
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Impact on Providers

CR 6109, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARC) used in electronic and paper remittance advice, and Claim Adjustment Reason Codes (CARC) used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective October 1, 2008.

Be sure that your billing staffs are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year and are posted on the Washington Publishing Company (WPC) Website at <http://www.wpc-edi.com/Codes> on the Internet. The tables at the end of this article (right after the “Additional Information” section) summarize the latest changes to these lists, as announced in CR6109.

CMS has also developed a tool to help you search for a specific category of RARC code and that tool is available at <http://www.cmsremarkcodes.info> on the Internet. Note that this Website does not replace the WPC site and, should there be any discrepancies in what is posted at this site and the WPC site, consider the WPC site to be correct.

Additional Information

To see the official instruction (CR 6109) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1563CP.pdf> on the CMS Website.

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS Website.

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI, and/or A/B MAC at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website. The changes that are effective on October 1, 2008 are as follows:

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N433	Resubmit this claim using only your National Provider Identifier (NPI)	Y

Modified Codes

Code	Current Modified Narrative	Last Modified
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.	2/29/08
N175	Missing review organization approval.	2/29/08
N241	Incomplete/invalid review organization approval.	2/29/08
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.	2/29/08

Deactivated Codes

Code	Current Narrative	Last Modified
None		

Health Care Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Effective Date (per WPC Website)
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	1/27/2008
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)	1/27/2008
215	Based on subrogation of a third party settlement	1/27/2008
216	Based on the findings of a review organization	1/27/2008
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)	1/27/2008
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only)	1/27/2008

Code	Current Narrative	Effective Date (per WPC Website)
219	Based on extent of injury (Note: To be used for Workers' Compensation only)	1/27/2008
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only)	1/27/2008
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)	1/27/2008
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/27/2008

Modified Codes

Code	Modified Narrative	Effective Date (per WPC Website)
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	1/27/2008

Deactivated Codes

Code	Current Narrative	Effective Date (per WPC Website)
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/1/2009

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

~ Revised CMS MLN Matters ~

MLN Matters Number: MM6048 **Revised**
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R91NCD

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

Note: This article was revised on July 28, 2008, to reflect changes to CR 6048, which CMS revised on July 25, 2008. The CR release date, transmittal number, and the Web address for accessing CR6048 were revised. All other information remains the same.

Provider Types Affected

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

Impact on Providers

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

Background

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

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

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

Key Points of CR6048

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

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

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

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

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

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

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the NCD manual revision attached to CR6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at section 310.1 of the NCD Manual and chapter 32 and sections 69.6-69.7 (Pub 100-04) of the

Medicare Claims Processing Manual. These manuals are available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Website.

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

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

G0398 Short Descriptor: Home sleep test/type 2 Porta

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

G0399 Short Descriptor: Home sleep test/type 3 Porta

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

G0400 Short Descriptor: Home sleep test/type 4 Porta

Additional Information

To see the official instruction (CR6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC, visit <http://www.cms.hhs.gov/Transmittals/downloads/R91NCD.pdf> on the CMS Website.

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

NEW HEMOPHILIA CLOTTING FACTOR AND HCPCS CODE

~ Revised CMS MLN Matters ~

MLN Matters Number: MM6006 **Revised**
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1564CP

Related Change Request (CR) #: 6006
Effective Date: April 1, 2008
Implementation Date: January 5, 2009

Note: This article was revised on July 28, 2008, to reflect changes made to CR 6006, which CMS revised on July 25, 2008. The CR release date, transmittal number, and the Web address for accessing CR 6006 were revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6006 which announces that Healthcare Common Procedure Coding System (HCPCS) code Q4096 (INJECTION, VON

WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR (NOT OTHERWISE SPECIFIED), PER I.U. VWF:RCO VWF complex, NOS) will be payable for Medicare effective for claims with dates of service on or after April 1, 2008. Appropriate systems changes for editing hemophilia clotting factors **on inpatient claims** will not be made by Medicare's Fiscal Intermediary Shared System (FISS) until January 5, 2009 release. This CR does not impact outpatient hospital claims or on any SNF claims as payment is made under different methodologies. Q4096 is payable in those settings effective April 1, 2008.

Providers need to be aware of the instructions in the rest of this article in order to properly submit inpatient claims with Q4096 for discharges on or after April 1, 2008 through January 5, 2009.

Background

Effective for claims with dates of service on or after April 1, 2008, the new HCPCS code Q4096 listed in the following table will be payable for Medicare.

HCPCS	Short Descriptor	Long Description
Q4096	VWF complex, not Humate-P (NOS)	Injection, Von Willebrand Factor Complex, Human, Ristocetin Cofactor (Not Otherwise Specified), Per I.U. VWF:RCO VWF complex, NOS

This factor (HCPCS code Q4096) is payable on inpatient claims effective April 1, 2008, and appropriate systems changes for editing Q4096 on inpatient claims will be made in the FISS on January 5, 2009.

During the period between April 1, 2008 and January 5, 2009, the following procedures need to be followed for inpatient claims:

- **Hospital providers should submit inpatient claims** to Medicare contractors (FIs and A/B MACs) for inpatient hospital stays during which Alphanate® (for the purposes of treating Von Willebrand disease) was given, **omitting the line item(s) for HCPCS Code Q4096** for dates of discharge on and after April 1, 2008 but prior to January 5, 2009. This includes hospitals paid:
 - Under the inpatient prospective payment system (IPPS), including Indian Health Service (IHS) hospitals,
 - Under the long term care prospective payment system (LTCH PPS),
 - Under the inpatient rehabilitation facility prospective payment system (IRF PPS), and
 - On the basis of reasonable cost (TEFRA hospitals, and critical access hospitals (CAHs)).

This does not apply to claims from inpatient psychiatric facilities (IPFs) paid under IPF PPS; IPFs receive a comorbidity adjustment under IPF PPS based on the presence of a hemophilia diagnosis on the claim. IPFs should refrain from including Q4096 on their inpatient claims.

Note: Medicare contractors will return to provider (RTP) any inpatient claims (Type of Bill (TOB) 11x) containing HCPCS Code Q4096 with discharge dates on and after April 1, 2008 but prior to January 5, 2009.

- Once the provider has received payment for the inpatient claim, the provider should **immediately submit an adjustment request** (TOB = 117), this time **including a line for HCPCS Code Q4096**.
- **Medicare contractors will hold these provider initiated adjustment requests containing HCPCS Code Q4096 with discharge dates between April 1, 2008 and January 5, 2009.**
- **Once the FISS system changes for Q4096 are implemented on January 5, 2009, Medicare contractors will process all held adjustment requests.**

As a reminder, for FY2008, the add-on payment for blood clotting factor administered to hemophilia inpatients is based on average sales price (ASP) plus 6 percent and a furnishing fee. The furnishing fee is updated each calendar year.

Additional Information

The official instruction, CR 6006, issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1564CP.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.

NOTIFICATION OF RETIRED LOCAL COVERAGE DETERMINATIONS (LCD)

Contractor Name:

Mutual of Omaha Insurance Company (transitioned to Wisconsin Physicians Service)

LCD Database Number(s) and LCD Title:

L2267 Outpatient Occupational Therapy
L2695 Outpatient Physical Therapy
L5731 Speech and Language Pathology

Retirement Effective Date:

July 31, 2008

PROTHROMBIN TIME (PT/INR) MONITORING FOR HOME ANTICOAGULATION MANAGEMENT

~ CMS MLN Matters ~

MLN Matters Number: MM6138
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1562CP and R90NCD

Related Change Request (CR) #: 6138
Effective Date: March 19, 2008
Implementation Date: August 25, 2008

Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs) or Part A/B Medicare Administrative Contractors (A/B MACs)) for home PT and International Normalized Ratio (INR) anticoagulation management monitoring services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 6138, and alerts providers that effective for claims with dates of service on and after March 19, 2008 the Centers for Medicare & Medicaid Services (CMS) revised its National Coverage Determination (NCD) limits and will expand the population eligible for home coverage of PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin. See the *Key Points* section of this article for details.

Background

The prothrombin time (PT) test is an in-vitro test to assess coagulation. PT testing and its normalized correlate, the International Normalized Ratio (INR), are the standard measurements for therapeutic effectiveness of warfarin therapy. Warfarin, Coumadin®, and others, are self-administered, oral anticoagulant, or blood thinner, medications that affect a person's Vitamin K-dependent clotting factors.

Currently, Medicare's national coverage determination (NCD) at 190.11 of the NCD Manual limits coverage of home PT/INR monitoring to anticoagulation management for patients with mechanical heart valves who are on warfarin. The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) (See http://www.cms.hhs.gov/ClinicalLabFeeSched/downloads/410_32.pdf on the CMS Website) and the following requirements must be met:

1. The patient must have been anticoagulated for at least 3 months prior to use of the home INR device;
2. The patient must undergo an educational program on anticoagulation management and the use of the device prior to its use in the home; and
3. Self-testing with the device should not occur more frequently than once a week.

CMS received a formal, complete, written request for reconsideration to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin. CR6138 is a result of that request.

Key Points of CR 6138

Effective for claims with dates of service on and after March 19, 2008, CMS revised its NCD to provide for home coverage of PT/INR monitoring for chronic, oral anticoagulation

management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) and all of the following requirements must be met:

1. The patient must have been anticoagulated for at least 3 months prior to use of the home INR device; and,
2. The patient must undergo a face-to-face educational program on anticoagulation management and must have demonstrated the correct use of the device prior to its use in the home; and,
3. The patient continues to correctly use the device in the context of the management of the anticoagulation therapy following the initiation of home monitoring; and,
4. Self-testing with the device should not occur more frequently than once a week.

NOTE: Applicable HCPCS Codes G0248, G0249, and G0250 will continue to be used for claims processing purposes for PT/INR. With the July 2008 Outpatient Code Editor (OCE) and Medicare Physician Fee Schedule updates, the descriptors of these codes will change to reflect the revised coverage policy.

The following revised descriptors reflect the expanded NCD criteria and are effective for services on or after March 19, 2008 as follows:

- **Long Descriptor G0248:** Demonstration, prior to initial use, of home INR monitoring for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing prior to its use.
- **Short Descriptor G0248:** Demonstrate use home INR mon
- **Long Descriptor G0249:** Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; not occurring more frequently than once a week
- **Short Descriptor G0249:** Provide INR test mater/equipm
- **Long Descriptor G0250:** Physician review, interpretation, and patient management of home INR testing for a patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes face-to-face verification by the physician that the patient uses the device in the context of the management of the anticoagulation therapy following initiation of the home INR monitoring; not occurring more frequently than once a week.
- **Short Descriptor G0250:** MD INR test revie inter mgmt

NOTE: Test materials continue to include 4 tests. Frequency of reporting requirements shall remain the same.

NOTE: Porcine valves are not included in this NCD, so Medicare will not make payment on Home INR Monitoring for patients with porcine valves unless covered by local Medicare contractors.

NOTE: This NCD is distinct from, and makes no changes to, the PT clinical laboratory NCD at section 190.17, of the NCD Manual.

The following are applicable diagnosis codes to be used when submitting claims to Medicare contractors:

- For services furnished on or after March 19, 2008, the applicable ICD-9-CM diagnosis codes for this benefit are:
 - V43.3 (organ or tissue replaced by other means; heart valve);
 - 289.81 (primary hypercoagulable state);
 - 451.0-451.9 (phlebitis & thrombophlebitis);
 - 453.0-453.3 (other venous embolism & thrombosis);
 - 415.11-415.19 (pulmonary embolism & infarction); or
 - 427.31 (atrial fibrillation (established) (paroxysmal))

Medicare contractors will deny claims for PT/INR monitoring services that are not delivered in accordance with CR6138. Denied claims are subject to appeal. When denying such claims, your Medicare carrier, FI or A/B MAC will use the following codes:

- Remittance Advice Remark Code N386, "This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp> on the CMS Website. If you do not have Web access, you may contact the contractor to request a copy of the NCD."
- Claim Adjustment Reason Code 50 will be used: "These are non-covered services because this is not deemed a 'medical necessity' by the payer."

Providers should be aware that your Medicare Contractor will assign liability for the denied charges to you unless documentation of an Advance Beneficiary Notice (ABN) is present on the claim. Also, your contractor will not search for claims but will adjust inappropriately denied claims with dates of service March 19, 2008, through the implementation date of CR6138, that are brought to their attention.

Additional Information

CR6138 was issued in two transmittals, i.e., one for the NCD Manual and one for the Medicare Claims Processing Manual. These transmittals are available at <http://www.cms.hhs.gov/Transmittals/downloads/R90NCD.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R1562CP.pdf>, respectively, on the CMS Website.

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

SCREENING DNA STOOL TEST FOR COLORECTAL CANCER**~ Revised CMS MLN Matters ~**

MLN Matters Number: MM6145 **Revised**
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R93BP and R92NCD

Related Change Request (CR) #: 6145
Effective Date: April 28, 2008
Implementation Date: August 25, 2008

Note: This article was revised on August 11, 2008, to reflect changes made to CR6145. The transmittal number, release date, and Web address for accessing the NCD portion of CR6145 were revised. All other information remains the same.

Provider Types Affected

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

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

This article is based on Change Request (CR) 6145 which announces the Centers for Medicare & Medicaid Services (CMS) decision regarding a request for reconsideration of the current national coverage determination (NCD) for colorectal cancer screening.

CAUTION – What You Need to Know

CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test; because the Food and Drug Administration (FDA) determines that this test requires pre-market review and approval. A subsequent request for reconsideration will be considered once FDA approval is obtained.

GO – What You Need to Do

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

Background

Congress specifically authorized coverage of certain screening tests under Part B of the Medicare program and made necessary conforming changes in order to ensure that payments are made. As a result, CMS currently covers colorectal cancer screening for average-risk individuals ages 50 years and older using fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema.

Neither the law nor regulations identify screening DNA stool tests as a possible coverage option under the colorectal cancer screening benefit. However, under the Code of Federal Regulations (42 CFR 410.37(a)(1)(v)) at

http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr410_02.html and the Social Security Act (section 1861(pp)(1)(D))

http://www.ssa.gov/OP_Home/ssact/title18/1861.htm on the internet), CMS is allowed to use the NCD process to determine coverage of other types of colorectal cancer screening tests not specifically identified in the law or regulations as it determines to be appropriate, and in consultation with appropriate organizations.

Following a request for reconsideration of the current NCD at Section 210.3 of the Medicare NCD Manual for colorectal cancer screening, CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test, as an alternative to a screening colonoscopy or a screening flexible sigmoidoscopy.

The FDA determined that this test is a medical device that requires pre-market review and approval prior to marketing, which, to date, has not been obtained. In the absence of an FDA determination, CMS believes that there may be unresolved questions regarding the safety and effectiveness of the stool DNA test. Therefore, CMS does not believe that identification of stool DNA mutations is an appropriate colorectal cancer screening test at this time.

Additional Information

The official instruction, CR 6145, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change, is reflected in two transmittals, one for the Medicare Benefit Policy Manual and one for the National Coverage Determinations Manual. These two transmittals are at <http://www.cms.hhs.gov/Transmittals/downloads/R93BP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R92NCD.pdf>, respectively, on the CMS Website.

If you have any questions, please contact your carrier, FI, 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.

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.

<p>Part A Legacy WPS Medicare Medicare Medical Review Attn: Medical Review Supervisor P.O. Box 1602 Omaha, NE 68101</p>
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**CARDIOVASCULAR STRESS TESTING: DRAFT POLICY COMMENTS AND RESPONSE**

- Draft LCD for Cardiovascular Stress Testing (DL2611)
- Final Effective LCD Cardiovascular Stress Testing (DL2611)
- Expected Final Effective Date: 09/30/2008

As an important part of the Medicare Local Coverage Determination (LCD) process, WPS Medicare solicits comments from the provider community and from members of the public, who may be affected by or interested in the purpose of the comment process. The comment process allows for consideration of input from those with expertise and experience on the topic.

WPS Medicare would like to thank the provider community and others who responded to our request for advice and comment. Their comments were helpful in revising the draft policy to its final form. What follows is WPS' Response to Comments that represents a composite of the submitted comments on the Cardiovascular Stress Testing LCD.

- **Comment**

The notification of a new pharmacologic stress agent, Regadenoson (Lexiscan), which received FDA approval and released for use, was received. Regadenoson (Lexiscan) is indicated for radionuclide myocardial perfusion imaging in patient unable to undergo adequate exercise stress.

- **Response**

See Final LCD for incorporation of this agent into the policy, and inclusion of billing and coding information.

- **Comment**
Editorial recommendations were offered by various providers in regard to inclusion of ICD-9-CM codes which would expand utilization for Hypertension diagnoses.

Response

See Final LCD for inclusion of some Hypertensive diagnosis codes, which meet ACC Guidelines.

- **Comment**
Editorial recommendations were offered by providers in regard to inclusion of ICD-9-CM codes relevant for MUGA scans.

Response

The appropriate ICD-9-CM codes are already listed in the LCD, therefore no additional coding changes were required.

MONOCLONAL ANTIBODY THERAPY; IBRITUMOMAB TIUXETAN THERAPEUTIC REGIMEN: DRAFT POLICY COMMENTS AND RESPONSE

- Draft LCD for Monoclonal Antibody Therapy; Ibritumomab Tiuxetan Therapeutic Regimen (DL12324)
- Final Effective LCD Monoclonal Antibody Therapy:Ibritumomab Tiuxetan Therapeutic Regimen (L12324)
- Expected Final Effective Date: 09/30/2008

As an important part of the Medicare Local Coverage Determination (LCD) process, WPS Medicare solicits comments from the provider community and from members of the public, who may be affected by or interested in the purpose of the comment process. The comment process allows for consideration of input from those with expertise and experience on the topic.

WPS Medicare would like to thank the provider community and others who responded to our request for advice and comment. Their comments were helpful in revising the draft policy to its final form. What follows is WPS' Response to Comments that represents a composite of the submitted comments on the Monoclonal Antibody Therapy; Ibritumomab Tiuxetan Therapeutic Regimen LCD.

- **Comment**
Editorial comment received from the American Society of Hematology, after review by a group of physicians who treat patients using this regimen, stating the policy reflects current practice and is appropriate for coverage with no recommended changes.

Response

The LCD is released for final notification with no changes to coverage.

PULMONARY REHABILITATION: DRAFT POLICY COMMENTS AND RESPONSE

- Draft LCD for Pulmonary Rehabilitation (DL5758)
- Final Effective LCD Pulmonary Rehabilitation (L5738)
- Expected Final Effective Date: 09/30/2008

As an important part of the Medicare Local Coverage Determination (LCD) process, WPS Medicare solicits comments from the provider community and from members of the public, who may be affected by or interested in the purpose of the comment process. The comment process allows for consideration of input from those with expertise and experience on the topic.

WPS Medicare would like to thank the provider community and others who responded to our request for advice and comment. Their comments were helpful in revising the draft policy to its final form. What follows is WPS' Response to Comments that represents a composite of the submitted comments on the Pulmonary Rehabilitation LCD.

- **Comment**
Editorial comments received regarding Pulmonary Rehabilitation (PR) as primarily a Respiratory Therapy activity, not a PT/OT function.
Response
We acknowledge the inclusion of PT / OT participation and billing codes for patients in PR, but maintain the position that this is not **primarily** a PT/OT function, as emphasis is on the improvement of the patient's breathing capacity, ability to function in the home and community as well as tolerate exercise, with the focus on the respiratory status rather than PT/OT skilled services.
- **Comment**
Editorial comments were received regarding PR being a physician directed program.
Response
See Final LCD for incorporation of this comment into the policy.
- **Comment**
Editorial comments were received regarding current CMS regulations as it pertains to signatures found in the medical record.
Response
See Final LCD for incorporation of this CMS regulation into the policy.
- **Comment**
Editorial comments were received regarding the need for clarification of "Treatment Notes", as required for documentation of PR services.
Response
See Final LCD for inclusion of and clarification of Treatment Notes information.
- **Comment**
Editorial comments were received regarding a request for inclusion as well as deletion of certain HCPCS/CPT and ICD-9-CM codes.
Response
See Final LCD for inclusion of the codes as requested.

TRANSESOPHAGEAL ECHOCARDIOGRAPHY (TEE) INCLUDING INTRAOPERATIVE: DRAFT POLICY COMMENTS AND RESPONSE

- Draft LCD for Transesophageal Echocardiography (TEE) including Intraoperative
- Final Effective LCD Transesophageal Echocardiography (TEE) including Intraoperative (DL28215)
- Expected Final Effective Date: 09/15/2008

As an important part of the Medicare Local Coverage Determination (LCD) process, WPS Medicare solicits comments from the provider community and from members of the public, who may be affected by or interested in the purpose of the comment process. The comment process allows for consideration of input from those with expertise and experience on the topic.

WPS Medicare would like to thank the provider community and others who responded to our request for advice and comment. Their comments were helpful in revising the draft policy to its final form. What follows is WPS' Response to Comments that represents a composite of the submitted comments on the Transesophageal Echocardiography (TEE) including Intraoperative.

- **Comment**

Comments were received from the American Society of Anesthesiologists regarding expansion of the use of TEE in the intraoperative period for patients undergoing cardiac surgery.

- **Response**

See Final LCD for incorporation of the comments and clarification of the use of TEE in post-cardiac surgery.

- **Comment**

ASA offered comments to insure that wording which states which conditions constitute medical necessity are noted as individual options rather than all-encompassing statements.

- **Response**

See Final LCD for incorporation of the comments and statement that does not limit medical necessity.

- **Comment**

A request for inclusion on 3-D Radiographic codes under the CPT/HCPCS section was reviewed.

- **Response**

Although 3-D rendering codes do apply to echocardiography, the decision was made to include these codes in a future LCD on 3-D rendering which will apply to all types of imaging modalities.

TRANSTHORACIC ECHOCARDIOGRAPHY (TTE): DRAFT POLICY COMMENTS AND RESPONSE

- Draft LCD for Transthoracic Echocardiography (TTE) (DL28168)
- Final Effective LCD Transthoracic Echocardiography (TTE) (L28168)
- Expected Final Effective Date: 09/08/2008

As an important part of the Medicare Local Coverage Determination (LCD) process, WPS Medicare solicits comments from the provider community and from members of the public, who may be affected by or interested in the purpose of the comment process. The comment process allows for consideration of input from those with expertise and experience on the topic.

We would like to thank the provider community and others who responded to our request for advice and comment. Their comments were helpful in revising the draft policy to its final form. What follows is WPS' Response to Comments that represents a composite of the submitted comments on the Transthoracic Echocardiography (TTE) LCD.

No comments were received during the open comment period. The LCD is released for final notification with no changes to coverage.

WOUND CARE: DRAFT POLICY COMMENTS AND RESPONSE

- Draft LCD for *Wound Care (DL15700)
- Final Effective LCD *Wound Care (L15700)
- Expected Final Effective Date: 09/30/2008

As an important part of the Medicare Local Coverage Determination (LCD) process, WPS Medicare solicits comments from the provider community and from members of the public, who may be affected by or interested in the purpose of the comment process. The comment process allows for consideration of input from those with expertise and experience on the topic.

WPS Medicare would like to thank the provider community and others who responded to our request for advice and comment. Their comments were helpful in revising the draft policy to its final form. What follows is WPS' Response to Comments that represents a composite of the submitted comments on the Wound Care LCD.

- **Comment**
Editorial recommendations were offered by various commenter's regarding clarification of surgical versus sharp, as well as conservative debridement.
Response
See Final LCD for incorporation of those comments.

- **Comment**
Editorial comments were offered regarding clarification of expectations of ongoing improvement with wound care.
Response
See Final LCD for incorporation of those comments.

- Comment**
Editorial comments were offered regarding generalization of therapy disciplines potentially involved in wound care.

Response
See Final LCD for incorporation of those comments.
- Comment**
Editorial comments were offered regarding inclusion of professional debridement codes, as well as additional ICD-9-CM codes.

Response
See Final LCD for inclusion of those codes.



Revised Policies for September 2008

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
DL23363	<i>Erythropoiesis Stimulating Agents*</i>	LCD	Click here to view	26

Coverage – Revised Policies**Local Coverage Determination (LCD) Title**

Erythropoiesis Stimulating Agents*

LCD ID Number

DL23363

Contractor Name

Mutual of Omaha Insurance Company (Transitioned to Wisconsin Physicians Service)

Comment Period End Date

07/27/2008

Start Date of Notice Period

08/07/2008

Revision Effective Date

09/22/2008

This is a revision of the Legacy Part A policy. The revision includes Coding and Billing Guidelines Attachment, as well as a Comment and Response LCD Document attachment. You may access this revised policy at the following Website:

http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=27433&lcd_version=5&show=all

General Information**IMPLEMENTATION OF NEW PROVIDER AUTHENTICATION
REQUIREMENTS FOR MEDICARE CONTRACTOR INTERACTIVE
VOICE RESPONSE (IVR) SYSTEMS**

~ Revised CMS MLN Matters ~

MLN Matters Number: MM6139 **Revised**
Related CR Release Date: August 8, 2008
Related CR Transmittal #: R22COM

Related Change Request (CR) #: 6139
Effective Date: March 1, 2009
Implementation Date: January 5, 2009

Note: This article was revised on August 13, 2008, to change the title to more accurately reflect the Change Request requirements. Additionally, changes were made to further clarify the authentication requirements. In particular, the note on page 2 was changed to show that you will only be allowed three attempts to correctly provide your NPI, PTAN, **AND** last 5-digits of your TIN.

Provider Types Affected

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

What You Need to Know

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

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

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

Background

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

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last 5-digits of the provider's

TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last 5-digits of the TIN are correct and belong to you before providing the information you request.

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

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

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

- **Authentication of Providers with No NPI**

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

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

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

- **Beneficiary Authentication**

Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication: 1) last name, 2) first name or initial, Health Insurance Claim Number (HICN), 3) and either date of birth (eligibility, next eligible date), and 4) Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim) **or** date of service (claim status, CMN/DIF (post-claim.)).

- **Written Inquiries**

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

The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider

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

- **Overlapping Claims**

When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last 5-digits of the TIN, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional Information

You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at <http://www.cms.hhs.gov/Transmittals/downloads/R22COM.pdf> on the CMS Website.

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

TRANSITION OF RESPONSIBILITY FOR MEDICAL REVIEW FROM QUALITY IMPROVEMENT ORGANIZATIONS (QIOS)

~ Revised CMS MLN Matters ~

MLN Matters Number: MM5849 **Revised**

Related CR Release Date: August 7, 2008

Related CR Transmittal #: R264PI and R1571CP

Related Change Request (CR) #: 5849

Effective Date: August 1, 2008

Implementation Date: No later than August 15, 2008

Note: This article was changed on August 19, 2008, to correct the effective date, which should have been stated as August 1, 2008, NOT April 1, 2008. All other information remains unchanged.

Provider Types Affected

Hospitals paid under the Inpatient Prospective Payment System (IPPS) and long-term care hospitals (LTCH).

What You Need to Know

CMS has shifted the majority of utilization review of inpatient hospital claims (including acute inpatient prospective payment system (IPPS) hospital and long-term care hospital (LTCH) claims) from the Quality Improvement Organizations (QIOs) to Medicare Fiscal Intermediaries (FIs) and Part A and B Medicare Administrative Contractors (A/B MACs). FIs and MACs will begin performing reviews on IPPS hospital and LTCH claims for improper

payment reduction purposes in August 2008. FIs and MACs will be allowed to review claims submitted January 1, 2008 forward.

Responsibility for IPPS hospital and LTCH error rate measurement has been shifted from the QIOs to the Comprehensive Error Rate Testing (CERT) contractor. The CERT contractor began reviewing acute care hospital claims for improper payment measurement beginning April 1, 2008.

Background

This article is based on Change Request (CR) 5849. CR5849 makes modifications to the Medicare Program Integrity Manual. The key points are:

- FIs or MACs may still make referrals to the QIO for quality of care issues of claims when their review of outpatient claims or inpatient claims data reveal a problem provider.
- FIs and MACs will perform most utilization reviews, for improper payment reduction purposes, of acute care inpatient hospital claims, and the CERT contractor will measure the inpatient hospital paid claims error rate.
- QIOs will no longer conduct the HPMP program and will instead focus their efforts on quality improvement, continuing to perform quality reviews, expedited determinations, and certain utilization reviews, such as provider-requested higher-weighted Diagnosis Related Group (DRG) reviews and referrals.

Additional Information

The official instruction (CR5849) was issued to your Medicare FI or A/B MAC in two transmittals, one related to the Medicare Program Integrity Manual and one for the Medicare Claims Processing Manual. These transmittals are available at <http://www.cms.hhs.gov/Transmittals/downloads/R264PI.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R1571CP.pdf>, respectively, on the CMS Website.

CMS has posted a Fact Sheet and Power Point Slides to the CMS Website. These documents can be found at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/InpatientReviewFactSheet.pdf> and http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/Inpatient_Hospital_Review_Transition.zip on the CMS Website.

Provider Education**ANSWERS TO FREQUENTLY ASKED QUESTIONS ABOUT BILLING AND COVERAGE**

The following are Frequently Asked Questions (FAQs), along with their answers, to questions asked during the third quarter of Fiscal Year (FY) 2008 regarding billing and coverage. More FAQs are available on our Website at

http://www.wpsmedicare.com/part_a/selfservice/faqs.shtml.

Telephone Inquiry FAQs

Q: I have a claim that rejected for reason code U5235, stating that it was overlapping the service dates for a Hospice claim and the claims contain the same diagnosis. How can I get reimbursed for the services given?

A: If the diagnosis is hospice related and the beneficiary is enrolled in hospice, then Hospice would be responsible to reimburse the claim.

Q: Several claims that previously processed through the system were cancelled by the Common Working File (CWF) because of an incorrect discharge status. We realize now that the patient went to a Home Health Agency within three days of discharge and should have appended a discharge status of 06. Can we resubmit a new claim with the correct discharge status?

A: Yes, providers can resubmit a new claim with the correct discharge status.

Q: We submitted a claim that rejected for reason code U538H, stating that these charges were overlapping an incarceration period. We contacted the beneficiary and verified that the beneficiary was not incarcerated at the time of service. How do we get this corrected?

A: If the dates of incarceration (INCR) on the CWF are incorrect, you will have to contact the State Department of Corrections to verify the actual dates. If the information is not updated on the CWF, then you will need to contact the CMS Regional Office (RO) in their region.

Q: I billed an inpatient claim, which is now editing with reason code 15202 stating that the accommodation days are greater than the covered days. How can I correct this claim?

A: Your covered days must match the accommodation days shown with revenue codes 10X-21X. To correct your claim in Direct Data Entry (DDE) Claims Correction, change the sum of the covered units associated with the accommodation days (Page 2) to equal the covered days (Page 1). Providers that do not have DDE can contact our Corrections line.

Q: All of my claims are hitting reason code WW404, stating that this is a temporary edit to suspend all claims. Is there anything that I need to do to get these claims to process?

A: No, there is no provider action needed. Status location WW404 is a temporary quarterly release hold. WPS Medicare will release these claims once the release is implemented.

Q: I submitted a Medicare Secondary Payer (MSP) claim. The claim was returned to me for reason code 77745, stating that Medicare is primary. How can I correct my claim?

A: If Medicare is the primary payer and a primary payment was received from another insurance, refund the payment and then resubmit the claim as Medicare Primary. If a primary payment was not received from another insurance but a denial was received, please remove all other insurance information from the claim and resubmit the claim as Medicare Primary. If Medicare is not the primary payer, please contact the Coordination of Benefits Contractor (COBC) at 1-800-999-1118 to have the primary insurance information added to the patient's MSP record. When the CWF is updated, resubmit the patient's Medicare Secondary claim.

Q: We have several claims that denied (DB9997) for reason code 32153, stating that the claims overlaps a period of time that the operating physician was sanctioned by the Office of the Inspector General (OIG). The physician was not sanctioned at this time. How do I get these claims to pay?

A: At this time, we are aware of the issue and no provider action is needed. The Fiscal Intermediary will correct the claims.

Q: Several claims that I submitted are editing with reason code 30022, stating that it is for intermediary use only, no provider action needed. Is there anything I need to do to get these claims to process?

A: No, providers do not need to take any action on these claims when they are editing for reason code 30022.

Q: I submitted an MSP claim without an appropriate value code. The claim is now editing for reason code 31102 stating that the primary payer code on the claim is "C" and is missing or has an incorrect occurrence code or value code. How do I correct my claim?

A: Providers must add the MSP value code with no amount listed and ensure that Occurrence code 01, 02, 03, 04, or 24 is present and F9 (store) the claim.

Q: We have had several claims error out for reason code W7062 because procedure code 90780 is not recognized by the Outpatient Prospective Payment System (OPPS). What steps should I take to determine the correct code?

A: Procedure code 90780 is no longer recognized by OPPS; an alternate code for the same service may be available. You will need to correct the code and re-submit the claim to Medicare.

Written Correspondence FAQs

Q: Who do we contact to obtain our Electronic Remittance Advice (ERA) if it was not received?

A: Providers that receive ERAs have up to 30 days from the original ERA date to contact the Medicare Systems Area and request a duplicate electronic copy of their ERA. You must fax all requests to 402-351-6188 on your company letterhead to our Electronic Data Interchange (EDI) Department.

If the ERA is over 30 days old, we will not be able to provide an electronic copy. Instead, providers on ERA will have to mail or fax a request for a paper copy of their ERA to the following address or fax number:

WPS Insurance Company
Medicare Administration
PO Box 1602
Omaha, NE 68101
FAX (402) 351-8047

For more information, visit our Website at the following address:

http://www.wpsmedicare.com/part_a/selfservice/dup_advice.shtml

Q: If a patient in our Skilled Nursing Facility (SNF) drops to a non-skilled level of care, we are required submit a No-Pay claim. Do we have to continue to bill a No-Pay claim when the patient discharges to the hospital?

A: Yes, this claim can be billed either monthly if a denial is needed or when the patient discharges, whether that would be to home or to a non-certified bed.

Q: We have a claim that denied for timely filing. What documentation is accepted as proof of timely filing?

A: Medicare will consider claims as received for timely processing based on the date of receipt. Improperly completed claims that are returned are considered received for timely processing purposes when received again, properly completed. Documentation showing that the claim was previously submitted and in our system is needed (i.e., screen print of system, 201 report). Exception rules on when an extension is allowed to the time limit can be found in the CMS Internet-Only Manual (IOM) Pub. 100-4, *Medicare Claims Processing Manual*, Chapter 1, Sections 70.7 - 70.7.1. The following instructions detail how to access Pub. 100-4 on the CMS Website:

- Go to <http://www.cms.hhs.gov/>
- Click on "Regulations and Guidance"
- Under "Guidance" click on "Manuals"
- Under "Manuals" on the left side, click on "Internet Online Manuals"
- Click on 100-4 *Medicare Claims Processing Manual*
- Click on Chapter 1
- Click on section 70.7 & 70.7.1

Q: I billed a SNF claim with the wrong patient assessment indicator. Would I need to appeal the claim to have the indicator changed?

A: You do not need to file an appeal. Providers should send in an adjustment bill with the correct assessment indicator.

Q: Does an outpatient hospital department need certification to provide digital mammographies?

A: Effective October 1, 1994, all facilities providing screening and diagnostic mammography services (except VA facilities) must have a certificate issued by the Food and Drug Administration (FDA) to continue to operate.

For more information, please refer to the CMS Internet-Only Manual (IOM) Pub. 100-4, *Medicare Claims Processing Manual*, Chapter 18, Section 20.1. The following information details how to access Pub. 100-4 on the CMS Website:

- Go to <http://www.cms.hhs.gov/>
- Click on "Regulations and Guidance"
- Under "Guidance" click on "Manuals"
- Under "Manuals" on the left side, click on "Internet Online Manuals"
- Click on 100-4 *Medicare Claims Processing Manual*
- Click on Chapter 18
- Click on section 20.1

Q: The Common Working File (CWF) is showing a Date of Death for patient that is still living. How can we get this corrected?

A: The representative for the beneficiary must contact the Social Security Administration (SSA) to have this corrected, as the Fiscal Intermediary cannot correct these cases.

Q: I submitted a claim with the wrong admission type. The claim is now inactivated (IB9997) with reason code 11701 stating that correct type of admission is required. How can I correct this claim?

A: Claims that have been inactivated cannot be corrected. Providers would need to send in a new claim with the correct admission type.

Q: I submitted an outpatient claim with procedure code 97039. It is now editing with reason code 36602, stating that this procedure code is either not a billable code and/or is being held until a price is obtained from the carrier. Is there anything I need to do to correct this claim?

A: If claims are returned to providers for reason code 36602, providers will need to verify that procedure code 97039 is valid and seek documentation. Once the provider has located the documentation and it is determined that the code is valid, please contact Medicare Customer Service for assistance to get this corrected.

Q: What is the difference between the GZ and GY modifiers?

A: Modifier GZ is used when you think a service will be denied because it does not meet Medicare program standards for medically necessary care and you did not obtain a signed Advance Beneficiary Notice (ABN) from the beneficiary. Claims will deny provider liable.

Modifier GY is used when an item or service is statutorily excluded or does not meet the definition of any Medicare benefit. The provider should show non-covered charges on a payable claim. Claims will deny Beneficiary liable.

For more information, please see Change Request (CR) 3416. Please follow the directions below to access CR 3416 on the CMS Website.

- Go to <http://www.cms.hhs.gov/>
- Click on “Regulations and Guidance”
- Under “Guidance” click on “Transmittals”
- Under Transmittals Overview on the Left side, click on “2004 Transmittals”
- Select CR 3416

Q: Where can I find information on billing a non-covered observation claim?

A: The hospital should submit a claim with the GY modifier on the line item next to the procedure codes for non-covered services.

For more information, visit our Computer-Based Training (CBT) Web page at http://www.wpsmedicare.com/part_a/education/cbt.shtml for a tutorial on “Observation Services.”

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.

Coming up, we will host events such as:

- All Provider Billing/Compliance Seminar
- Medicare Secondary Payer Billing/Compliance Seminar
- Skilled Nursing Facility (SNF) Billing Seminar
- Inpatient Rehabilitation Facility (IRF) Clinical Workshop
- Critical Access Hospital (CAH) Billing Workshop
- Hospital Notices of Non-Coverage Ask-the-Contractor Teleconference (ACT)
- Questionable Covered Procedure LCDS of Blepharoplasty and Reduction Mammoplasty Ask-the-Contractor Teleconference (ACT)

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

Reimbursement**FISCAL YEAR (FY) 2006 SUPPLEMENTAL SECURITY INCOME (SSI)
DATA**

~ CMS MLN Matters ~

MLN Matters Number: MM6126
Related CR Release Date: August 8, 2008
Related CR Transmittal #: R363OTN

Related Change Request (CR) #: 6126
Effective Date: May 5, 2008
Implementation Date: September 8, 2008

Provider Types Affected

Hospitals submitting cost reports to a Medicare Administrative Contractor (A/B MAC) or fiscal intermediary (FI).

Impact on Providers

This article is based on Change Request (CR) 6126, which states that, **as of May 5, 2008, hospitals (this includes acute care hospitals paid under the inpatient prospective payment system and inpatient rehabilitation facilities (IRF))** may elect to use either its FY 2005 or FY 2006 SSI ratio from the files published on the Centers for Medicare & Medicaid Services (CMS) Website to file its cost report that would otherwise be submitted with the FY 2006 SSI ratio.

Key Points

- Until the FY 2007 SSI ratios are published, a hospital, as defined above, may elect to use either its FY 2005 or FY 2006 SSI ratio from the files published on the CMS Website to file its cost report that would otherwise be submitted with the FY 2006 SSI ratio.
- Until the FY 2007 SSI ratios are published, if a hospital (as defined above) submitted its cost report using the FY 2006 ratio but would like to use the published FY 2005 SSI ratio instead, the hospital should submit a written request, signed by an official of the hospital, to its FI or MAC. After receiving such a written request, the FI/MAC shall issue (or reissue to the extent a tentative settlement has already been issued) a tentative settlement using the selected FY SSI ratio.

Background

A hospital may elect to use either its FY 2005 or FY 2006 SSI ratio from the files published on the CMS Website to file its cost report that would otherwise be submitted with the FY 2006 SSI ratio. Once the FY 2007 SSI ratios are published on the CMS Website, hospitals will no longer have the option of submitting cost reports using the published FY 2005 or FY 2006 SSI ratio.

If a hospital has already submitted its cost report using the FY 2006 SSI ratio but would like to use the published FY 2005 SSI ratio instead, the hospital should submit its written request, signed by an official of the hospital, to its Fiscal Intermediary (FI) or Medicare Administrative Contractor (MAC). After receiving such a written request, the FI/MAC will issue (or re-issue, to the extent a tentative settlement has already been issued) a tentative settlement using the selected FY SSI ratio.

Additional Information

For complete details regarding this CR please see the official instruction (CR6126) issued to your Medicare FI or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R363OTN.pdf> on the CMS Website.

CMS has published IRF SSI ratios in the “Downloads” section of http://www.cms.hhs.gov/InpatientRehabFacPPS/05_SSIData.asp#TopOfPage on the CMS Website. Other SSI ratios are published in the “Downloads” section of http://www.cms.hhs.gov/AcuteInpatientPPS/05_dsh.asp#TopOfPage on the CMS site.

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.

**REQUIREMENT TO EDUCATE PROVIDERS REGARDING CENTERS
FOR MEDICARE & MEDICAID SERVICES (CMS) USE OF MEDICARE
COST REPORT DATA**
~ CMS MLN Matters ~

MLN Matters Number: MM6132
Related CR Release Date: August 1, 2008
Related CR Transmittal #: R362OTN

Related Change Request (CR) #: 6132
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

Providers required to submit cost reports to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

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

This article is based on Change Request (CR) 6132, which requires Medicare contractors to educate Medicare providers regarding the specific way that the Centers for Medicare & Medicaid Services (CMS) uses Medicare Cost Report (MCR) data. Medicare providers are statutorily required to submit cost reports annually.

CAUTION – What You Need to Know

MCR data play a central role in the development of the input price indexes (market baskets) used to update PPS payments. Similarly, they are essential in evaluating Medicare payment adequacy. It is crucial that Medicare providers fill out these reports with complete and valid data.

GO – What You Need to Do

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

Background

Most Medicare providers are statutorily required to submit annual Medicare Cost Reports (MCRs). The rules governing the submission of MCRs are set forth in the Code of Federal Regulations (CFR) (42 CFR 413.20(b) and 413.24(f)), which require providers to submit cost reports annually, with the reporting period based on the provider's accounting year. Additionally, under 42 CFR 412.52, all hospitals participating in the Prospective Payment System (PPS) must meet cost reporting requirements set forth in 42 CFR 413.20 and 413.24. See http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr413_04.html on the Internet.

In reviewing the MCR data submitted by providers, CMS has found that many are failing to completely fill out their MCR with valid data likely due to the misconception that the data submitted on the MCR do not impact their payments.

To correct that misconception and to educate Medicare providers, CR 6132 is intended to provide information regarding how CMS uses the MCR data to update future PPS payments. It is crucial that Medicare providers know how CMS uses the MCR data and understand the importance of filling out these reports with complete and valid data.

The MCRs play a central role in CMS' development of the input price indexes (or market baskets) used to update PPS payments. Similarly, MCR data are essential in evaluating Medicare payment adequacy in aggregate and for subclasses of providers. Following are key uses of the MCR data:

- MCR data are used to develop the major cost weights that are used in the market baskets. Market baskets are used by CMS to annually update payments for the various providers paid via a PPS. They are designed to measure the input price inflation that providers face in the provision of the medical care services they deliver.
- MCR data are also used to determine the labor-related share of a given market basket, that is, the proportion of costs that are related to, influenced by, or vary with the local labor markets. The labor-related share is used in conjunction with the area wage index to determine the geographic adjustment to Medicare payments. This adjustment can vary widely, thus individual hospitals' payment levels can be very sensitive to the changes, and errors, in measuring the labor-related share. For more information on Medicare's Market Baskets, visit http://www.cms.hhs.gov/MedicareProgramRatesStats/04_MarketBasketData.asp on the CMS Website.
- CMS, as well as the Medicare Payment Advisory Commission (MedPAC), rely heavily on complete, valid, and up-to-date MCR data to evaluate the adequacy of PPS payments, i.e., determining whether Medicare is paying its "fair share" to providers' in aggregate and in a variety of subclasses (urban/rural, hospital-based/freestanding, etc.). In addition, periodically, CMS is approached by Congress or other payment rate stakeholders and asked to evaluate revenues and costs for specific providers and compare and contrast those estimates to those of their peers in the immediate market area. Having complete and valid data is essential to address such inquiries.
- Policymakers and program administrators, as stewards of the public trust, require the ability to validly quantify whether Medicare is paying a fair amount for the health services it purchases for its beneficiaries. The information submitted on the MCRs represents the

only nationally-available data on which these statutorily-required payment updates in aggregate and by subclass can be appropriately based.

To carry out the tasks described above, CMS typically uses cost data from Worksheets A, B, D, and G of the cost report, provider characteristics and salary data from the S worksheets, and payment data from Worksheet E and other cost report worksheets (the location of which varies by provider-type). Be sure to be thorough and accurate in completing these worksheets.

Additional Information

The official instruction, CR 6132, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R362OTN.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.

WPS MEDICARE PROVIDER SERVICES

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

Part A Legacy	
Southeast Region WPS Insurance Company Medicare Administration P.O. Box 1602 Omaha, Nebraska 68101 866-580-5981	Central Region WPS Insurance Company Medicare Administration P.O. Box 1602 Omaha, Nebraska 68101 866-580-5984
West Region WPS Insurance Company Medicare Administration P.O. Box 1602 Omaha, Nebraska 68101 866-580-5987	Northeast Region WPS Insurance Company Medicare Administration P.O. Box 1602 Omaha, Nebraska 68101 866-580-5945

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