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Ask-the-Contractor Teleconference (ACT)

Moderator: J David Bozarth

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Operator: Good morning, my name is (Sherri) and I will be your conference operator today. At this time, I would like to welcome everyone to the Legacy Ask the Contractor teleconference. All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session.

If you would like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you. I would now like to transfer the call over to Mr. J David (inaudible) so that we may begin.

J David: Good morning and welcome. Thank you, (Sherri). I want to thank everyone for taking time out of their busy day to join us today. This is our "Ask the Contractor" teleconference. I am speaking to you from a cold but sunny Chicago and I am here with a number of people who are located at various WPS sites around the Mid-West. My co-host and presenter today is Mr. (Thom) Ryan, speaking to you from WPS home office in Madison, Wisconsin. (Thom) has a room full of people there with him in the conference room. We have also have folks in Bloomington, Minnesota and to the south in Marion, Illinois. We are scheduled to be here with you for 90 minutes this morning.

And this is another in our ongoing series of "Ask the Contractor" teleconferences and today's conference is specifically geared for our legacy providers. These would be providers in the states of Wisconsin, Illinois, Michigan and Minnesota. We had our (J 5) conference yesterday for those in the states of Iowa, Missouri, Kansas and Nebraska. But today is exclusively for legacy.

We want to make mention of two possibilities for accessing today's proceedings after the fact as is usual. We will be posting the audio recording to the WPS website of today's call in approximately one week's time. And then addition we will be posting minutes. These minutes are going to be transcribed by our telephone provider and they will be posted out to the website again in approximately one week's time.

We did have minutes last time, which we did internally. But this time we

turned that process over to the phone provider so they should have a thorough document of what we are discussing here today that you could access at a later time. We also want to make mention of the fact that today's call is being recorded and obviously if we are going to post the recording of it. So if any one has any issue with that it would probably be a good time to disconnect.

We are going to offer several points of presentation items this morning before we actually open it up to Q&A. One of the things you may have noticed in our last posting, or our last advertisement for "Ask the Contractor" teleconferences is we now are providing a link on the information page on the website where you by you could submit a suggestion for an agenda topic. And we did receive some of those, in fact we received several probably a total of – oh, I don't know – 20, 25; and out of those far and away the most frequently suggested topic was that of consultations. What's happening with consultations, what's the update for consultation, what are we supposed to do for 2010, so on and so forth.

Well, number one I do want to make mention of the fact that until day before yesterday we didn't have a lot we could say about this. We were still waiting information and direction from CMS but that was received on Monday of this week and even prior to receiving this we had taken action and tried to be proactive from an educational standpoint in that we have scheduled two teleconferences. We have a teleconference scheduled for January 12th, a Tuesday that is from 9 to 11 in the morning, Central Time, January 12th. And then two days later January 14th, Thursday, in the afternoon 1 to 3, that again is Central Time.

During these teleconferences, we are going to have a presentation of everything that has changed in the way of consultation that we can address and open it up form question and answer period. Both of these calls as indicated have been scheduled for a length of two hours so we are hoping that this will be of service.

Now between now and then we expect to have information posted out to the website. But because as I indicated we just received information that we can publish and we will publish that just as soon as possible, we soon as we can get things written and posted to the website and we expect to have something hopefully as soon as next week.

Now regarding the information that we received, I do want to provide for you an overview of this, this morning. And this is just kind of high-level overview and there will be more specifics forthcoming through our website publications, especially through our teleconferences that we are doing, in January. But one of the things that we want to reference here is change request 6740, six-seven-four-zero. It was though this change

request that CMS made substantial changes to consultation services. Meaning that effective January 1 of 2010, Medicare will no longer recognize consultation codes 99241 through 99255. And that of course is a range of CPT codes and any time we reference CPT we want to acknowledge AMA and their ownership of CPT. So codes 99241 through 99255 no longer recognized for dates of service January 1 and forward. Providers may still use the G codes to represent consultations Telehealth services.

Medicare made payment adjustments to the E&M codes to account for budget neutrality and no longer recognizing the consultation procedure code. This adjustment is made to the global periods for surgery procedure code. Instead a physician called in by another to assist in treating the patient will bill an initial or subsequent care code as appropriate. The procedure code as listed in the CPT book reflects the place of service. This means that of course for multiple providers, there may be multiple providers, to bill an initial code when the patient is in the hospital we have new modifier introducing. It's modifier AI – A as in apple, I as in India – that would be appended to the E&M service billed by the attending physician to separate his or her services from the other physicians who may be in attendance.

Following an initial code any additional services in the hospital be billed at subsequent care, and of course we are talking E&M services here. E&M services other than what were previously designated as consultation. This would work the same way in the office, a provider may bill an initial visit when there has been no face to face contact with the patient including hospital services within the previous three years. If there had been previous contact then an established patient visit would appropriate, would also want to mention the fact that we do recognize the physicians of the same specialty in a group as a same physician because they have access to a common record there.

When Medicare is the secondary payer the same rules apply. The claim amounts and information submitted by the primary care physician should match the claim submitted to Medicare. When billing electronically a provider would tell us the type of Medicare secondary payer situation, the other's insured allowed and other insured's paid amount and code identify the reasons for the primary payer's actions. The billing information must match and when submitting a paper claim you would submit the explanation of benefits from the primary payer.

There is no cross walk from the consultation codes to the E&M codes, very important, no cross walk. Provider should code to what they provide to the patient. The services that are rendered must be identified by a CPT code and that must be supported in the documentation in the file. Claims

submitted with dates of service January 1st of 2010 and after billed with consultation procedure codes will deny as un-processable. So that is our overview and I know that's high level but I think we capitalized the high points of this change and this is significant for many of our offices out there and that many offices bill consultations. This is not a surprise to us that this has come about, we know that there had been discussions and issues pertaining to consultations for some time. So now we know that the dates of service January 1 of next year 2010 and forward you will not be billing the codes in the range 99241 to 99255. Consultation services that are provided up through the end of this year could be still be billed as you had before, remembering that when you bill a consultation you must meet the definition of consultation and have the documentation to support that. But for dates of service January 1 and forward those codes go away.

OK, that's it on consultations. We had a few other questions that were submitted to us and I am going to take a moment here to address some of those. One clinic wrote in and wanted to know what Medicare sees as the difference between standing orders and protocols and how they should be used. Well, rule number one, Medicare doesn't see a difference between standing orders and protocols and second question is can the protocols be used for nursing when seeing patient for urinary tract infections are strapped, if the provider has not seen the patient for that diagnosis. The answer to that would be no. When we are looking at incident two services provided by nurses, we need to make sure that the diagnosis that they are assisting with in that incident two capacities are diagnosis that the doctor has actually treated. And for which there is some documentation.

OK, another question that was submitted has to do with dates of service and places of service for interpretations of diagnostic tests. Diagnostic tests of course can allow for split component, a component for a technical aspect which we, when they are split, they are specifically identified with a modifier TC unless there is a code that identifies that technical component such as is the case with EKG. And then we have the professional component. Well, they don't always take place on the same day or even in the same location.

And the questions that were submitted when along the line of what do we do when they is a split in the days or even in the place of service. And the answer to that and we don't have any changes in this right now. I think these questions were anticipating a change, when we receive a change on this we would publish but for right now we are requesting and it's required that the providers bill to what it is that they are providing and that they hold true to that not only for the date of service but place of service. Meaning that if the technical component happened yesterday and the professional component the interpretation and report is happening today you would bill for that interpretation and report for today's date of service.

You would not match that up to the date of service for the technical component.

The same holds true for the place of service when the place of service for the interpretation and report may in fact be different than that of the technical component. You would bill the place of service as to wherever that place of service was when that interpretation report took place. So hopefully, that answers that question.

We do have some updated information from appeals area. And as I had indicated before we do have a panel of experts on the line today meaning that we have individuals from several key processing areas and different areas within the Medicare programs. So at this time I would like to turn it over for a few minutes to Ms. Lisa Freeze, and Lisa has information pertaining to appeal. Lisa?

Lisa Freeze:

Good morning. Thank you, (J David). And good morning provider community. I just want to hit on a few things this morning. And one of those would be incomplete re-determination request. When we receive a re-determination request on the 227 form, we ask that you put what is needed for us to make the re-determination request, need the date of service, the procedure code. Several are putting on there see attached, they are attaching op notes, chart notes and you give us a procedure code and date of service but you don't exactly say what you want added. So to make it a complete request make sure that you are saying please add diagnosis and give us that code. Or to support the documentation for 22 modifier where you would expect (inaudible) payment for that procedure or if it's a bundled service, give us that information or if you want a modifier add it to a specific code. But we are going to start treating re-determination as enquiries if they are not complete in what you wanting us to do when you as for re-determination.

Also a reminder that un-processable claims do not have re-determination rights when you get a (CL 16) the contractual obligation, it usually gives you that you are missing on your determination, your claim that you submitted and those would need to be resubmitted.

Another topic is when we receive duplicate reviews now if you have not heard about your review we have 60 days to process those reviews. And you can check with our provider contact center but if it's a duplicate review, you will now be contacted by our enquiry department if it's an exact duplicate of the review that we've already done.

Another topic that we have got is just a reminder that there are two levels of appeal. There is the re-determination level which you request through WPS and that is 227 form and just consequently the 233 form which is for

the second level of appeal, reconsideration, it looks almost like 227 so and those cases go to First Coast for the qualified independent contractor for the second level of appeal.

So just to recap what I have got, incomplete re-determinations we are going to treat those as incomplete if you do not tell us exactly what you need done on your re-determinations. Example of that please add diagnosis and give us the code. Tell us if you want to add a modifier and to what code you want that modifier added to. More very specific as to what you would like done in your re-determination. Un-processable claims – determinations do not have appeal right. Those will need to be resubmitted and duplicate reviews will not be treated as enquiries and so watch your forms. Re-determination form first level of appeal is 227 form versus the reconsideration form which is a 233 form and that's your second level of appeal. And those go to qualified independent contractor. Thank you, David.

J David: Thank you much, Lisa. Also want to make mention of the fact that with this un-processable situation we have from our appeals inventory an issue in that offices are trying to request appeals on claims that were returned or rejected un-processable and that is not allowed. An un-processable rejection or return is not an appealable claim. For un-processable they should just be corrected and resubmitted as a new claim. OK, other topic that was suggested that we address today falls into the realm of our provider enrollment area. And to address this and the topic is PECOS, and I think I am correct in this, that is Provider Enrollment Chain of Ownership, I think, but I will be corrected if I am not. But to address this topic, we have from our Bloomington, Minnesota area, Ms. Irene Mitchell. Irene?

Irene Mitchell: Good morning. You were close, David. PECOS is the Provider Enrollment Chain and Organization System. Kind of a cumbersome name, it's a national enrollment system for Medicare providers that was established by the Centers for the Medicare and Medicaid services. By way of background Medicare contractors used to be kind of their own in terms administering the Medicare enrollment process. The Centers for Medicare and Medicaid services issued directives and instructions in that regard but each Medicare contractor had its own administrative process for enrolling Medicare providers that were contractor specific. PECOS evolved after CMS standardized the enrollment process by issuing the CMS 855 enrollment forms that most of you are probably familiar with. That process began in 1996 and has gone through an evolution of its own with numerous revisions to those forms, most recent of which was implemented in September of this year.

In November of 2003 the PECOS national enrollment system was

implemented for the maintenance, enrollment and maintenance of all Medicare providers that's both part A and part B. So it includes individuals and organizations, group practices enrolled with part B contractors as well as providers enrolled through part A of the program, hospitals, skilled nursing facilities, home health agencies, and so forth.

All Medicare contractors participate in the PECOS system and contribute through the data entry process the information that is received on those CMS 855 enrollment forms. When the PECOS system was implemented in 2003, it began with the data entry for providers who were enrolling for the first time and for providers who were submitting changes to their enrollment information. It is still not fully populated six years after implementation. So any providers who enrolled prior to November 2003 and haven't submitted any changes of information during that time and there are quite a few of those are not yet in enrolled though national PECOS enrollment system. The CMS goal is to fully populate PECOS eventually and that will be done through revalidation process.

Until recently PECOS has been relatively transparent to providers. It's been internal to Medicare contractors as they enroll and maintain enrollment information and interact with the PECOS system. Providers have been submitting enrollment forms and getting notification as they always have of the determination on those enrollment applications. But about a year ago CMS implemented the internet based PECOS enrollment system that allows providers to enroll directly online, access their information that's recorded on PECOS, making changes to it. CMS encourages the use of that online access to the PECOS system. It does facilitate the enrollment process and results in processing of applications more quickly than the paper enrollment process.

And more recently, PECOS is becoming the database for the new edits on ordering, referring providers. And that too is resulting in providers becoming more aware of this national enrollment system. For part B claims, those claims that are submitted to WPS the ordering referring edit will work though first by checking enrolled providers in PECOS and then if they are not found the claim system will look to our own enrollment records at WPS. So any provider enrolled in Medicare whether or not they are established in PECOS will be recognized as a valid ordering referring provider assuming they are of the appropriate specialty that is allowed to order and refer.

PECOS becomes more significant however on claims for durable medical equipments, prosthetics, orthotics and supplies that are processed by the demark contractors. For those types of claims the demark contractor is looking only to PECOS enrollment records for validity of ordering referring provider. Those contractors don't have their own local

enrollment records that part B contractors do so with PECOS being the only source of editing for validity of ordering referring providers, it becomes more essential that providers do submit current information that would allow them to be established through the PECOS system, if in fact they do order durable medical equipments prosthetics and orthotics and supplies and have their patients with claims for those kinds of services processed by the demark carriers.

It's important to note that providers who enroll prior to November of 2003 are the only ones that issue for not being enrolled in PECOS. Anyone who enrolled November 2003 or after was enrolled by their Medicare contractor both locally and through the national PECOS system. The implementation of the PECOS actually predated the implementation of national provider identifier and so the initial enrollees in PECOS may not have had their national provider identifier recorded in PECOS. CMS however has populated all of those early PECOS records that lacked NPI information with the appropriate NPI for those individual providers. So it should not be necessary for those providers to submit an enrollment form for purpose of establishing their NPI in the PECOS system. And I think that's all that I was going to say about that (J David).

J David:

OK, well, thank you very much Irene. We appreciate that information and that is helpful for all of our listening in that this is something that would apply to all providers. So thank you.

I had another item here that I had a note on before we open it up for Q&A. And it's just to make the mention of the fact that whenever we need information or additional information to complete the processing of your claim we would typically generate a development letter – we are developing to you for more information and these are usually system generated letters. Those letters will have a fax number on them now and that fax number varies depending upon the state but along with that we are offering a fax cover letter in the forms section of our, on our WPS website.

So you would go out to the Medicare website, look for forms and there you could find Development Fax Cover Letters and they are separated by state and then actually have the picture of the different states there on the cover letters. And use that to get your information to us it's a little faster. Because if you are going to print something out and drop it in the mail you got the mail factor there, but faxing would be faster and we would on that cover letter request some information and you are going to give us like internal control numbers and whatever we are asking for that we can match up with that claim that suspended so that we could go ahead and release that for processing. So that is something that is newer development but faxing for the additional information that you have whenever we are

developing to you for information. So hopefully, that will be helpful.

And with that, I think we have come to the point where we need to open it up for question-and-answer period. We have approximately one hour left in our allotted time and (Jerry) is going to explain to you again how you will get into the queue to post a question. And our goal during this allotted time is to answer as many of these questions live on the call as we possibly can. If for any reason there is not someone on the panel who has an answer to your question or if it's a question that requires a little more research we may ask that you give us your phone number so that we could research whatever the issue may be and get back to you at a later time. So with that (Jerry) I think we are ready to begin.

Operator: Thank you. At this time, I would like to remind everyone in order to ask a question press star one on your telephone keypad. We will pause for just a moment to compound the Q&A roster.

Your first question comes from the line of (Cheryl).

J David: Good morning, (Cheryl).

(Cheryl): Good morning. I had a couple questions on consults. If CMS intends to allow physicians to perform consultations as shared visits, nurse practitioners and PAs when providers begin recording consult choosing initial hospital code, they weren't allowed to do it. But now with the initial hospital care code, they would be allowed to do a shared visit. Is that correct?

J David: I am not sure, (Cheryl), I am understanding your question.

(Becky): OK, David, this is Becky. Hospital visits can be performed as a shared or split visit.

J David: Right.

(Cheryl): So that's OK to do that.

(Becky): Right, but consults cannot.

(Cheryl): But it won't be a consult anymore, it would be initial hospital care, right?

(Becky): Yes.

(Cheryl): So, it's OK to do it as a shared care.

(Becky): Yes, they can be shared or split.

(Cheryl): OK, then my other question is if it doesn't turn out to be what we would normally think as consult but transfer of care, can we still use the initial hospital care code?

(Becky): Yes, any time that you are going to see the patient in the hospital for the first time you are going to bill an initial hospital visit.

(Cheryl): Super, thank you very much. Can I ask one more quick question?

J David: Sure.

(Cheryl): Do you know anything, is Medicaid going to follow suit with the consult?

J David: Well, we don't know, we can't speak on their behalf. We will have to wait and see, it is you know that there is a history in that many of the other payers will follow suit to something that is Medicare regulation just because of the volume of Medicare but we can't say for sure that's going to happen or if it does, when.

(Cheryl): OK, thank you.

J David: You are welcome, and thank you, Becky.

(Becky): You are welcome.

Operator: Your next question comes from the line of (Julie).

J David: Hi, (Julie).

(Julie): Hi there. I do have a question on the same, main specialty with a subspecialty physician.

J David: Yes.

(Julie): So I have internal medicine physician that works out of the internal medicine office, they are going to admit the patient. Once they get the patient into the office, they are going to call our endocrinologist whose main specialty is internal medicine but subspecialty is endocrinology. Because Medicare have them in the same group, my primary physician going to bill a office visit for the initial hospital care with an AI modifier and then my other physician is going to come in but unfortunately he is in the same group because Medicare won't allow us to have additional group.

J David: Right.

(Julie): Now we are going to run into the same thing we are running into now that they are saying, you know we are in a very rural area and our patients come to us. If they have to travel any long distance they try to have appointments with multiple physicians on the same day. So we are running to now that they do see the internal medicine doctor at the clinic and they send them to endocrinologist and endocrinologist then getting rejected that another provider of the same specialty saw the patient on the same day. We are going to run into this with the hospital as well because we are going to lose our chance to call the endocrinologist for consultation. If any hints to how we are going to be able to avoid that problem.

J David: Well, (Julie), you have stated your situation here very clearly. And unfortunately, we don't have anything to offer in a way of a good quick and easy solution to this. It is an issue for you and given the fact that you are correct in that the endocrinology would not separate out in our system as a separate specialty there is going to be that hurdle of same physician same specialty same day.

(Becky): Hey, David, this is Becky I am going to make a comment on this. Because (inaudible) it is definitely going to look as concurrent care and on claim entry that is going to be denied. On this situation what they will need to do is they will need to request re-determination and they will have to provide supporting documentation showing why the two people with the same specialty were treating the patient they are going to have to show that one doctor has a subspecialty of endocrinology and then they are also going to substantiate the fact that the both of the doctors were not treating the patient for the same condition.

J David: Correct. And (Julie) that provision would have been offered to you under the current situation with consultations. Although we realized that you know when you were meeting the definition of the consultation in the current arrangement that would give you an out in some instances, which that of course is not going to be the case for dates of service January 1 and after. Does that make sense to you?

(Julie): It does. The other problem we are having is sometimes when we call the phone review area we are being told that because of the claim rejected as non-processable they cannot be reviewed over the phone and this all going to be have to be reviewed in writing.

J David: Now why would it have rejected as un-processable?

(Julie): Well, because it's rejecting as this provider same specialty, same date of service, cannot get paid. So...

J David: But that shouldn't be an un-processable rejection.

(Julie): So I should point that out to the phone review people when they tell us that?

J David: No, if they are deciding a claim disposition of un-processable that should have been for another reason some other reason something that is critically wrong with the claim. What's rejected and returned to you and not even pulled into our system. But a concurrent care denial would not be the same as an un-processable rejection. So I would look at any that are suspected as un-processable for other reasons as they have been returned. But for these situations of same specialty, same day even with a subspecialty as Becky had indicated these are not going to fly through the system the first time though. The subsequent claims are going to be denied but you would have that option of taking those then to the appeal level, stating the case the fact that this was a physician of a subspecialty and then we will make a consideration based upon the information you provide.

(Julie): It was one of the ladies that was presenting, was with credentialing or pay codes or online, is there a reason that they have denied trying to put some of our physicians into another group or different group.

J David: Well, and Irene correct me if I am wrong on this, it's my understanding that CMS dictates how many specialties we have and the indicators that apply to those specialties. And there just hasn't been the offering of special indicator, special denominator for these subspecialties for some of them.

(Julie): Other question with the AI modifier, I have been on the website, haven't been able to find any documentation on it.

J David: Well, it's not out yet. We just received it day before yesterday. It should be out there next week.

(Julie): Now is it just the initial visit that will get the AI modifier for the attending physician or each time the attending physician saw the patient during that inpatient stay.

Irene Mitchell: It would just be on the initial visit.

(Julie): OK. There was one other question.

Female: Excuse me, there is a subspecialty, there is a specialty on endocrinology it's specialty 46. Is there a reason you have that provider, you don't have them as specialty 46?

(Julie): His primary specialty was internal medicine with subspecialty of endocrinology, that's how he presented it to us. Are you telling me that I can change him to endocrinology as primary specialty?

Female: Working as an endocrinologist, that is what he is doing as primary. I mean, that would be totally up to you and to him. But there is a specialty endocrinology.

(Julie): Wonderful that answers that question. There was one other question about payment cuts starting January.

J David: We don't have any information on that at this time, (Julie).

(Julie): OK. I think we will let somebody else talk.

J David: Real good, thank you.

(Julie): Thank you.

J David: (Jerri), we are ready for our next question please.

Operator: Your next question comes from the line of (Kathy).

J David: Good morning, (Kathy). Hello?

(Kathy): Good morning.

J David: Good morning.

(Kathy): Do you have any information on the 2010 clinical lab fee schedule?

J David: Off the top of my head I don't see remember it came through but that doesn't mean it didn't. Does anybody know from our panel, has that come through yet?

Female: I can't say for sure, but it would be posted onto our website.

J David: Yes, it's usually comes through by now (Kathy). But I don't remember seeing it. But anything something like this comes through we are going to get it out on the website just as soon as possible.

(Thom): (Holly), this is (Thom). (Holly), can you just check and see if may be we got (records) for it? We have someone form our publications department who is available so I am just going to see if maybe if (Holly) will look and

see (inaudible) she has a (records) for it to go up at a certain time or something like that.

Holly: Actually, I was looking as we were talking. We do have the automated multichannel test lab panel pricing out there. And then in addition the (inaudible)...

J David: (Thom), I think I am going to need you to take the call at this point.

(Thom): Your attention please, your attention please, this is security...

(Holly): Excuse me, and then we do link to the CMS website for the actual clinical lab fee schedule. And that information is out there whether or not, it looks like the, I do not see that they have the 2010 files out there yet.

(Thom): OK, thank you, (Holly).

(Holly): So that would be you want to watch the CMS website for that information.

(Thom): So that is the information that (Holly) is looking at. What our website does it link to the CMS website which is what (Holly) is talking about. So make sure you keep an eye on CMS website on that information to be posted. (Kathy), did you have any further questions?

Operator: Your next question comes from the line of Roger.

Roger: Hello.

(Thom): Hi.

Roger: Hi, I had submitted the question online but it didn't get addressed. It had to do with the physician supervision in a clinic setting. And there were several colleagues who had been at a meeting apparently where it was discussed that for direct physician supervision that, that could only be accomplished by physician being physically located on the same floor as the service being provided, the diagnostic testing. And there is a lot of a clinic situations where there are multi-floor clinics where physicians and certain specialties are not in the diagnostic area specifically on the floor. I didn't see anything addressed or specifically noted in writing or in any time of manual or notation relative to the physician location or being present physically on the floor where testing is being provided. Can you comment on that please?

(Thom): Hold on one second.

(Becky): (Thom), I will take that. On direct supervision, are you talking just for lab testing?

Roger: No, this would be something like a cardiac stress test.

(Becky): OK, anytime that direct supervision is required, the physician does have to be in that office suite or that lab. If the office suite is construed to different levels of the building then the physician would have to be on the level where the test is. Because they have to be readily available.

Roger: You don't think that can be accomplished with them one floor above by having access to stairwell. Frankly, you could have a physician closer in location to the testing who is one floor above at the end of stairwell than somebody 150 feet down the hallway at another part of the building.

(Becky): Just on the direct supervision, the guideline states that they have to be in the office suite where the test is being made.

Roger: Which guidelines are you referring to, though? I am not sure I have seen those guidelines where it specifically says on the same floor.

(Becky): No, because it talks about the office suite.

Roger: I guess then we are kind of looking at the interpretation of the office suite.

(Becky): Barb, do you have anything to add? Oh, she is gone. Roger, can I get your phone number?

Roger: Sure, I am at 920-451-7467.

(Becky): I will give you a call and we can discuss this further. But the instruction that we have always been given is that whenever it is an office suite and it's direct supervision of all, the physician does have to be on that floor.

Roger: I have been reading some of the recent stuff that's come out about physician supervision and talking about provider based facilities and hospitals and so forth and just kind of curios where that lies.

(Becky): Are you looking in the IOM for your information is that were you are reading?

Roger: That plus some of the federal register information out there.

(Thom): Becky, just FYI, this is (Thom) jumping in here. The interpretation that says the same office floor is not from the IOM. As the (cure) here we have the discretion to further advice when pressed or put into a situation where

we need to adjust or help understand and what they are actually interpreting of the IOM. That is where that same floor comes in. So the interpretation of the same floor is the further clarification of the IOM. The IOM will tell you it needs to be same office suite.

Roger: OK, and I guess what I was looking at was that I wasn't seen that interpretation or something that has been reported to me by a colleague at a verbally at a conference and I didn't see that in writing or any place or on the website.

(Becky): I think the main issue is readily available.

Roger: And that's where we are coming from too, from that perspective of readily available to us. You know looking at physical location could also be one floor above.

Ann: You know readily available also means that the physician or practitioner is readily available they are not in the middle of a procedure on another floor or in the middle of seeing a patient on another floor. Readily available is that's the key term in that situation and so they said you can keep the main office suite as the whole building, I mean we have to define it somewhere.

(Thom): And what we will do is, thank you Ann, that was Ann also from our policy department. We will have someone give you a call back on that and we can discuss it further.

Roger: OK, that would be good. Thanks.

(Thom): Yes, let's go ahead and move to the next call.

Operator: Your next question comes from the line of (Kathy).

(Kathy): Good morning.

(Thom): Morning.

(Kathy): I have a question regarding the purchased services for the lab work. We currently send some labs to one facility to perform for us. That facility is telling us that they are forwarding that lab request onto another facility because they are unable to perform that lab service. So from my understanding from the documentation that I read on CMS' website and WPS is that that the lab we initially send our lab work to is responsible for billing Medicare for those services. This lab is telling us that they are not and they will not bill Medicare for those services. So we need to know how can we get paid for those services. How are we supposed to bill for them? Or who should bill for them?

(Thom): Is there anyone on the panel have an opinion or offering for this one?

J David: Good morning this (J David) (inaudible) again and I apologize. We had a very untimely fire drill here in Chicago, but I am back on the call.

(Thom): Thank you, David. Does anyone on the opinion on the purchase services where a lab is, they are sending it to a certain lab and the lab is forwarding it on, anyone on the panel?

Irene Mitchell: This is Irene in Minnesota. If the caller is from a physician...

(Kathy): We are from a physician clinic, yes, multi-specialty clinic.

Irene Mitchell: ...then you cannot bill for the laboratory services that are not performed at your clinic.

(Kathy): Exactly, my point exactly and I have expressed that to the facility that we send the lab work out to. I have instructed have read that we cannot bill for that service and they are telling me that yes I can with special modifier. And I disagree with them but in the end they are telling me ultimately that they will not bill for it and they cannot.

Irene Mitchell: Well, the general rule is that the provider who performs the clinical lab test has to bill for it. There is an exception for independent clinical laboratories. If an independent clinical lab is unable to perform the test and refers it out to the reference laboratory...

(Kathy): That's exactly what's happening...

Irene Mitchell: Then there are a number of criteria if matched, some of which have to do with the percentage of laboratory services referred out that initial laboratory could bill for the reference laboratory service or alternatively the reference laboratory could bill for the service directly. But those are the only two billing options as I understand them.

Lisa: This is Lisa from the EDI department and I just want to clarify, and I think it was Irene that was speaking. There is a difference between a purchased diagnostic test and a referred laboratory. The diagnostic test would be your anatomical procedure, your diagnostic ultrasounds, x-rays those types of things versus a laboratory procedure which would be, which could fall under referred lab instructions. So those are actually two different types of billing requirements.

Irene Mitchell: Right, and I was referring to clinical laboratory test.

Lisa: Yes, absolutely. I know the caller mentioned the purchased lab from their perspective it's the same type of thing. They are billing for something that they didn't actually perform the complete procedure but those are actually two different billing requirements.

Irene Mitchell: This is referred lab services.

(Kathy): And the third laboratory says that they do not bill Medicare they don't do any third party billing so that's where the issue lies. The third lab that's involved doesn't do any third party billing so therefore they bill back to the laboratory that we sent our services to, that lab in turn is billing us because they say won't bill Medicare for services. So initially we are getting billed for services that we are asking another lab to perform and we cannot bill anybody for those services.

(Thom): We are going to take this offline. It sounds like it's just a bit of a loop there, let's go ahead and get the phone number and we will take it offline.

(Kathy): My phone number is area code 507-389-8589.

(Thom): We will give you call back on that (Kathy) or we will have someone get hold of you.

(Kathy): Thank you.

J David: OK, (Jerri) we are ready for our next question now.

Operator: Your next question comes from the line of (Sue).

J David: Morning, (Sue).

(Sue): Hello, I have two questions.

J David: OK.

(Sue): We are trying to adhere to the rules regarding specimen date of service submission and we have run into a little bit of a glitch because of (hemocoats) and we were wondering if you could comment on that. Let me give you an example. The patient collects three cards and has three different dates of collections, two of which are on Saturday and Sunday. The date that they are received in the office by mail is Tuesday. The computer system that is being used doesn't have open appointments that can be scheduled so that we can create a visit to post those charges against on a week-end. Is it acceptable for us to use the date the specimen was received in the lab in that circumstance?

Male: Yes, as long as, the dates you are saying all three cards came in on Monday, Tuesday; that's an acceptable date to use, yes. Even if the patient actually you are saying collected them on whatever. We are fine with using the date that came in.

(Sue): Great. Second question relates to the consultations again. Any information on whether this ruling from CMS is going to apply to (PMAPS) and Medicare Advantage Plans or is that up to the individual payer that is administering those plans?

J David: Right, we could not speak for those Advantage Plans, (Sue). One of the things that is important for all of our listeners is that when we are speaking here as hosts of this conference call or any of the items that we have from WPS, we are speaking on behalf of historically Medicare and the Advantage Plans are contracted by CMS just as we are contracted. But CMS would work with them and those plans individually to develop whatever those changes are. Now that is true that the guidelines usually parallel each other and the benefits are similar. But again, we cannot speak on their behalf.

(Sue): OK, one more question. In a nursing facility, if a patient is needing to be seen in consultation by somebody from the outside and the consolidated billing rules aside from anything the instruction now would be for the provider that would typically charge the consultation for that visit with the place of service nursing facility we would not bill a nursing facility code?

J David: They would bill an E&M service and again many of those E&M services as we mentioned when we were given the overview of the change pertaining to consultation many of those E&M services do designate a specific place of service. In that there are E&M services for inpatient hospital, for office for home for whatever. So yes, there are visit codes for nursing homes so that would be appropriate code.

(Sue): OK, thank you so much.

J David: You are welcome.

Operator: Your next question comes from the line of (Judy).

(Judy Papki): Actually, we have two quick questions. One is have you heard anything more on whether WPS is going to retrain – retain – the contract as the processor for Medicare in this area or is going to Meridian and the other question is back to the consults where you said the secondary payer, if Medicare is the secondary payer, the codes must be the same. So if we have a primary payer that does not change over to the from a consult code

to the initial visit code will we need to also bill them with the initial visit code?

J David: OK, and your name was (Judy), is that correct?

(Judy Papki): Correct.

J David: OK, (Judy). Let me answer both questions. Number one, we do not any update regarding contracting reform. You do know that there were announcements made early this year and there were follow-up announcements and we have not heard anything since then. All we could do would to advise any of our listeners, any of our participants, any interested parties just to periodically check the CMS website for any updates regarding contractor reform. So again no additional or no updated information at this time. Regarding the second question, it is correct that the services that are billed must be matched. You can't bill one code to one payer and a different code to another payer. The code that comes to us for any of these services for dates of service January 1st and after, have to be an E&M service. They cannot be consultation code in that range that we mentioned the 99241 though 99255. If we receive those the claims are going to be rejected as un-processable. So in a roundabout way, yes, you are going to bill those same, or you are going to have to bill the E&M services whatever it is that accommodates the level of service that you are billing the initial or subsequent be a hospital or at office whatever to the other insurer whoever they may be and then that would be the same code that would be billed to us as a secondary payer.

(Judy Papki): OK, thank you.

J David: You are welcome.

Operator: Your next question comes from the line of (Beth).

J David: Good morning, (Beth).

(Beth): Good morning, just a moment please.

(Grace): Hi, I was just wondering if you could explain the class A findings under foot care, I am a little confused on the definition on that as a non-traumatic amputation of foot and (inaudible) portion. But if the foot is amputated then I don't see how we do foot care on it? Another thing is I would like to know if when would be a situation that we wouldn't have to sue the Q modifiers. Would it be if there is a systemic diagnosis that we use on one of the lists? And another question on that would be if there is a stage you can only do this treatment one in only sixty days? So if you could just kind of explain that foot care coding for me?

J David: Would someone on the panel like to address foot care?

(Barbara Tiller): I guess that would be, my name is (Barbara Tiller) and I would guess that the non, the person who has the amputation, the provider would be billing services to the other foot if they obviously have amputations of both feet, I would have hard time understanding why this would be an issue. There is a new NCD out there right now on the website that everybody who is billing for the (inaudible) code should read in total. It is something that was rewritten with the help of all the podiatrists in all eight states are being serviced today by WPS and the national society and it has three options as far as the Q modifier now. And there is a third selection where we do allow for people who have, do not have class findings to have foot care. And I would suggest that you would need to read that and if you have questions, specific questions about your patients you should be sending it to us. Do you have a specific question because I could talk on foot care for several hours?

(Grace): Yes, it's unclear to me. It states that if we use a specific diagnosis a systemic diagnosis that we wouldn't have to use one of the Q modifiers.

(Barbara Tiller): OK, Medicare does not pay for routine foot care. There is an exception to that. The patient has to have a systemic diagnosis. So if they have systemic diagnosis that means they have one of the conditions. So you have systemic diagnosis or a Q modifier. And when you look at the ICD 9 codes if you have, if you follow those charts, you know that's what you have to follow. Is that what you are looking at? I don't have the policy in front of me, right now.

(Grace): Right, I am looking at that. It's specific to two class B findings or one of the class B and one of the class C. If they just have the systemic diagnosis, I don't see how that's going to fall in to class B or class C. Correct?

(Barbara Tiller): OK, I think you need to ask question about the patient though. Tell me, give me an example of the patient.

(Grace): The patient is having (appearing) of an ulcer; I am sorry (appearing) of callus around an ulcer and has diabetes.

(Barbara Tiller): OK, so that should be quite clear because that would fall into the first category, right?

(Grace): Which category?

(Barbara Tiller): Category one because they have diabetes.

(Grace): OK, so that doesn't fall into one of the classes though. Does it fall into one of the classes?

(Barbara Tiller): I think you need to give us your phone number and we can talk about this.

(Grace): OK, that would be great. It's 630-524-0114.

J David: OK, and your name again please?

(Grace): My name is (Grace).

J David: (Grace), very good, 630-524-0114.

(Grace): Correct.

J David: OK, real good, thank you.

(Grace): That would be great, thank you.

Operator: Your next question comes from the line of (Judy).

J David: Hi, (Judy).

(Judy Papki): Hi this is (Judy) (Papki) from (inaudible) clinic. And one of the callers previously asked if Medicaid was going to follow the consult change for Medicare. And we did the Wisconsin Medical Group Management Association about a week ago with the Wisconsin Medicaid and they are still going to recognize the consult codes. They said if there was any change in that they would send out a forward health update. But at this point they were planning to accept them.

J David: But (Judy), that's for folks who are billing Medicare first that's not going to service any kind of an out.

(Judy Papki): I understand that. I was just answering the question that someone has asked.

J David: We appreciate that, we appreciate that. Now that was specific for Wisconsin.

(Judy Papki): Yes, that was Wisconsin Medicaid.

J David: I don't know if we have anyone on line who in our panel who has heard anything about the other states, but I have not. But there may be similar types of decisions or discussions at least in the other states as to how they are going to approach this. But I think it's important for all of us to then

remember what we are looking at here with these Medicare secondary payer guidelines in that this isn't secondary payer situation but it is the same kind of rule that will hold true as the services billed to the one entity has to be the same as the one billed to the next. And so we do appreciate that information thank you.

(Judy Papki):

Sure, thanks.

Operator:

Your next question comes from (Sylvia).

J David:

Good morning (Sylvia).

(Sylvia):

Hi, good morning. My question goes back to consultation. If the admitting physician uses the modifier AI, my question is if they do not use the modifier AI and then the actual specialty submits the claim without the modifier AI, the initial visit, and then it gets denied as concurrent care, would that be correct?

J David:

Well, it could.

(Sylvia):

OK, we are at the actual initial admitting physician's mercy so that our claims don't get denied and if they get denied then what do we do? Do we then send it for re-determination?

J David:

Well, that would be the appropriate next step. But one of the things (Sylvia) that we are going to work very hard to do here is to make sure everyone is educated as to what the changes are and how they can comply with the changes so that nobody is left short here. We do have these teleconferences scheduled as we indicated and the we will be publishing the information to the website about this as well.

(Sylvia):

OK, OK. My next question is I think it's answered, but I want to just reaffirm it that the other insurance carriers for the time being are still going to be using the consultation code?

J David:

(Sylvia), again we cannot speak on any other payer, other than Medicare. We cannot speak on their behalf. You know some may, some may not, we don't know. But what we are saying is if any service comes to Medicare billed in the range of codes 99241 through 99255 for a date of service January 1 and after, it will be rejected as un-processable.

(Sylvia):

OK, OK, come back to my first question then. If our claim is denied as concurrent care then what steps should we take to get our claim?

J David:

Well, an appeal would be appropriate, you could request the re-determination. And state your case as to what went on here. But again it's

the attending physician who would append the AI modifier to his or her claim.

(Sylvia): OK, thank you.

J David: You are welcome.

(Sylvia): OK, bye bye.

J David: Bye.

Operator: Your next question comes from the line of (Elizabeth).

J David: Good morning, (Elizabeth).

(Elizabeth): Hi. I too am also interested in the outcome of your conversation with Roger regarding the definition of office suite. This has come up too regarding different floors. Is that considered an office suite, so hopefully clarification on this will be published on your website. Can I look forward to seeing that?

J David: OK, and I am sorry that discussion was the one that took place when I was off of the call. But yes, there is no reason we can't further look into the incident to provision but my understanding is that office suite does imply the same floor. (Inaudible) incidence to policy.

(Elizabeth): Right, you know, regarding if it's a same floor or if the physician is, can be accessed quickly, that's the purpose of this whole conversation. So I would need clarification on that too.

J David: OK.

Male: Hold on second, (Dr. Busson) has something that he would like to add.

J David: Yes, thank you.

(Busson): Yes, this is (Dr. Busson) neither CMS nor WPS has ever given a definition of office suite and the reason that we have not done this is because the configuration of all these clinics is different. So there would literally be no end to the various combination of things that you can question whether this is a suite or not. Again, the important thing is the physician immediately available so generally what we would like to do is talk to the individual person off line and see how their suite is configured and kind of go from there. But it's just impossible to make a definition of office suite without knowing a particular circumstance. So maybe you could get one your staff the phone number and we could get back to you then.

(Elizabeth): Well, your recommendation would be if this does come up to either send a letter to WPS or call and specifically talk regarding your situation.

(Busson): Yes, that's preferable.

(Elizabeth): OK, thank you. I have one more question of course regarding the consultation codes. As stated there is no cross walk for these codes and my concern is the initial hospital visit. As we all know there are only three levels and the first one is the detailed exam and history and medical decision making. But what if you have a low level inpatient consultation, expanded problem focused, what code would you submit, would you submit a subsequent hospital visit in place of the initial, because it doesn't meet the criteria for the initial?

J David: Well, in choosing initial and subsequent the guideline is whether or not there has been face to face contact with that person with that patient. Doctor to patient face to face contact within the previous three years.

Male: David, I think it would, just in the Madison area where I am at sitting with (Dr. Busson) and the policy staff, we believe it will be an NLC code. Another word (inaudible) code.

(Elizabeth): Why would that be? If it meets the criteria for expanded problem focus exam, may be low medical decision making, an expanded problem focus history, all this meets the criteria for the subsequent hospital visit. Why would we have to submit an unlisted code and then go through the hassle of submitting documentation?

Male: What is the initial visit, what you are subsequent to?

(Elizabeth): I am sorry?

Male: A subsequent code has to be subsequent to something. What are you subsequent to? Where was the initial visit?

(Elizabeth): Unfortunately, per CMS there is none that meets that criterion.

Male: Then you got to have the NLC code to bill that initial visit.

(Elizabeth): So WPS wants all these NLCs and then we have to submit the documentation.

Male: I apologize, but yes that is what would happen. Because you can't have the subsequent code billed without an initial visit. That's the way it's setup. That's why it's called subsequent. I mean, you can go back to CMS

if you feel that's not something they didn't think about or (inaudible) that's fine. But at this point as your carrier what we are advising you would be an NLC.

(Elizabeth): What if CMS has addressed this issue?

Male: No, not that we have seen it directly.

(Elizabeth): So CMS has not suggested to bill NLC on this. I was at the AMA symposium here in Chicago and we had three medical directors there and they didn't feel that having all these codes submitted as unlisted would be appropriate.

Male: What CMS has addressed is still the fact that you need to have an initial visit. You need to have an initial visit there is no way around that. So we can't get you an initial visit if it doesn't meet the criteria of initial visit, so you got to do the NLC there is no other way to get that initial visit on file.

(Elizabeth): Well, what I am saying is the subsequent could be in place of an initial.

Male: What are you subsequently billing to?

(Elizabeth): I know it's not a perfect situation but this has caught everybody off-guard and we are. I know you are going to give a conference call on January 12th, but you know in the mean time those two weeks we are trying to make some determination on how to bill appropriately and so you are suggesting we have to bill unlisted and submit this documentation.

Female: (Elizabeth)?

(Elizabeth): Yes.

Female: In the ILM, the CMS does state that any time that you are not meeting all the criteria as particular procedure code...

(Elizabeth): I realized that, but I figured this situation since this was done very quickly perhaps that criterion would be dropped or amended.

Female: We have not heard that there is any intention of doing that.

(Elizabeth): All right, thank you.

Female: You are welcome.

J David: Thank you.

Operator: Your next question comes from the line of (Vera).

J David: Good morning, (Vera).

(Vera): Hello, good morning, I have two questions. Several of our physicians' clients have been told by the hospitals at seminars that if they are not in the PECOS system by January 1, 2010 that all of their claims will deny, and we have several clients that have been part of the Medicare program for years and years and may or may not be in the PECOS system. Now I know this was addressed a little earlier, did they misinterpret what was said, is this just for DME?

J David: Irene, would you like to take that question?

Irene Mitchell: Yes, the new editing claims pertain to services that require an ordering physician or referring physician. It has nothing at all to do with services that are performed by the billing physician, so for part B claims pertains largely to diagnostic tests such as X-rays and EKGs, and then the other big category that requires an ordering physician is the DME orthotic and supply prosthetic codes. So for the claims that come, part B claims that come to WPS, PECOS isn't really an issue because we will be checking and editing for the ordering referring physician but will be looking not only whether or not they are represented in PECOS but also whether we have a WPS enrollment record for them. So even if they enrolled prior to November of 2003 and they reside solely on WPS' record without having been established in PECOS that will not be an issue. In terms of the ordering referring editing on those part B claims PECOS becomes an issue with the durable medical equipment prosthetics and orthotics supply claims.

(Thom): I just want to add – this is (Thom) – we have also heard that from other different groups and that is what they have done – taken and generalized it across the board you are correct, it's going to affect everything, everything from (auditing and ordering). And so some of those generalizations were much bigger than what is the reality of the situation.

Irene Mitchell: And the other thing I should mention is that phase 2 of this editing process where claims for services that don't meet the ordering referring requirements will begin to be rejected has been delayed until April 5th. It's not happening in January as has originally been scheduled.

(Vera): OK, thank you very much. I have one more question. Also some of our physicians have been getting letters from other organizations that are indicating that they have to, that CMS is requiring training for anyone who bills for Medicare part C or part E programs. And is there any where that I can get clarification on what the training requirements for Medicare part C

is? Our physicians do see Medicare Advantage patients and they have been submitting these letters from the other organizations such as WellCare to us and asking do they really have to attend these trainings or not.

J David: (Vera), again, we would not be able speak on behalf of the other plans. We of course are representing part B, historical part B exclusively here today but I am not aware of these types of requirements, but by no means that they are not happening. Does anyone on the panel have any knowledge of this?

(Thom): David, this is (Thom). I have actually seen the letters and they are coming from the part C individual plans – are different requirements that they have to meet. Really has nothing to do with us, the best advice we can give is to contact your plan and discuss with them. If you have further questions, you could go to CMS and ask questions from them. But as a traditional fee for service Medicare we are unable to comment.

(Vera): OK. I will see if I can contact someone at CMS. Thanks again.

J David: You are welcome. Thank you.

Operator: your next question comes from the line of (Melissa).

J David: Good morning (Melissa).

(Melissa): Good morning. On November 25th, the AMA sent a letter to CMS requesting to delay the implementation of their policy of no longer recognizing the consults, are you aware of this letter?

J David: No.

(Melissa): OK, that was my question.

J David: OK, we received pricing information on files back several weeks ago, which was when we saw that we were not going to be able to pay consultations in the New Year. We were then awaiting further instruction and information from CMS regarding this and that's what I had referenced earlier that just came though on Monday of this week. So that's what we have right now. And this is kind of new to all of us and everyone has a lot of questions about it. We are going to be digesting this and asking our own questions and getting clarification publishing and then also conducting these two teleconferences in January and hopefully hear during the next few days and few weeks we will have all of the information we need to provide more complete answers on this subject. But we were not aware of

what was happening behind the scenes regarding AMA or anyone else with letters and request.

(Melissa): Thank you.

J David: You are welcome. (Jerri), I think we have time for one last question this morning.

Operator: Your last question comes from the line of (Casey).

J David: Good morning, (Casey).

(Casey): Good morning. I have question about one of your physical medicine LCDs - specifically the PHYSMED-009. I was informed that the PHYSMED-009 was pulled from publication and was later expired around the middle of the year September-October, and I am showing that you do have a new PHYSMED-009 that's coming out but it's not effective until January 15th of 2010. I am wondering what policy is in effect right now and how I can get a hold of that.

J David: Would someone from our policy staff would like to address that question?

(Barbara Tiller): This is (Barbara Tiller). What is in effect is the carrier manual and basically both the old policy and the new policy are directly from the carrier manual. So what is in effect is the old policy, although it was taken off of the web, nothing has changed between the two. The formatting has changed but nothing has changed.

(Casey): OK, if the old policy is still in effect why isn't it published?

(Barbara Tiller): It was a formatting issue when we submitted it to CMS there was some formatting issues and we had some problems are we were unable to publish it.

(Casey): OK, I guess the only concern that I have is, I am receiving denials based on, I mean my denial specifically state that this is based on LMRP LCD and I can't access that information. Because the only thing I have access to on your website is the policy that is not effective. I need to know where I can go to get whatever is effective right now. If your old policy isn't published, you are stating it's still in effect but it's not published, I can't get to it. Is there any way you can send me a paper copy of it?

(Barbara Tiller): Could I have your phone number?

(Casey): Sure, it's 616-459-7101 extension 415.

J David: Very good, thank you.

(Casey): Thanks.

J David: OK, with that, we have come to the end of yet another in our ongoing series of “Ask the Contractor” teleconferences. We want to thank everyone for taking time out of their busy day to join us here today. We have some closing comments that we want to make. Number one we do have our dates posted or I am sorry our dates scheduled for the entire series of ACTs for the rest of the fiscal year. For legacy, which was what today’s call was, our next date would be March 17th and after that we jump to June 16th and then September 15th. We will post these to the website each time a few weeks prior to the call and then we are going to maintain throughout this fiscal year this link whereby you could submit suggest the topic. If the questions or suggestions could have some specifics to them, not claim specific, but more specific example that would also be helpful.

But all of these calls for legacy take place on Wednesday, same time slot in a 9 to 10:30 AM slot Central Time. So again, March 17th, June 16th and September 15th. In addition we want to encourage everyone to pay close attention to listserv messaging and updates to the website especially during these next few weeks. I mean, it’s always important to pay attention to the publications that you receive and the notices that you receive from Medicare but especially at this time of the year when we are right on the cusp of the number of changes here and information that should still be forthcoming regarding pricing, regarding fees, regarding changes for the new year, regarding clarifications, it’s a very active time for Medicare and many other things as well. But we want all of you to be as informed as you can be.

And with that, for those of you haven’t signed up for listserv messaging, we very much want to encourage you to do so. You can go to the WPS website and you will see a provision for this in the upper right hand corner where you can give us your email address and we can keep you informed by sending you weekly notifications very important. In addition we do want to stress that we understand this consultation situation is frustrating and it’s new and there are some unanswered questions and we are working on it. We will be in communication with CMS regarding this. Watch for additional publications, again, dates of the scheduled teleconferences are January 12th that’s a Tuesday 9 to 11 and January 14th a Thursday 1 to 3. And we hope all of you who are interested in topic will join us at that time.

So on behalf of myself, (J David Bozart) and my co-presenter and co-lead (Thom) Ryan and all of our panel members from all of the locations at

WPS and WPS Medicare, we wish each and every one of you a happy holiday time, healthy and happy New Year. Take care and we will be talking to you again soon. Bye now.

Operator: And this concludes today's conference call and you may now disconnect.

END