MEDICARE PART B

Communiqué

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

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March 2009

CMS CENTERS for MEDICARE & MEDICAID SERVICES

WPS HEALTH INSURANCE

Items of Importance

CREATING A WEBSITE THAT MEETS YOUR NEEDS

WPS values your opinion regarding the WPS Medicare Website and strives to continue to improve the site to meet all of your Medicare needs.

We regularly review input received through the survey administered via the Website by ForeSee Results and encourage all Website visitors to complete the survey that pops up while you are on the WPS Medicare Website (http://www.wpsmedicare.com).

We are hopeful that you can provide additional insight to changes that we can make to the WPS Medicare Website to increase your satisfaction by completing the survey that is accessible by selecting the link below:
http://www.surveymonkey.com/s.aspx?sm=uiSY_2b3CKxNHOby9ZFnA3gQ_3d_3d

We encourage you to complete the survey, and appreciate your valuable time.

DECEASED PHYSICIANS, NON-PHYSICIAN PRACTITIONERS, AND OTHER INDIVIDUALS REPORTED ON MEDICARE ENROLLMENT FORMS

The death of a physician or non-physician practitioner enrolled in the Medicare program must be reported promptly to this office to ensure that the physician or non-physician practitioner's Medicare enrollment record is deactivated on a timely basis and that it reflects the provider's date of death. Group practices to which Medicare benefits are reassigned, and the representatives of physicians and non-physician practitioners in private practice, should contact Wisconsin Physicians Service's Provider Enrollment Department for information regarding the CMS-855 enrollment form and the documentation required to report that a physician or non-physician practitioner has died.

In addition, group practices and organizations are required to submit a CMS-855B change of information to delete other individuals reported on their Medicare enrollment record who have died, such as owners, managing employees, directors, officers, and authorized and delegated officials.

Questions regarding the reporting of the death of a physician, non-physician practitioner, or other individual should be directed to our Provider Enrollment Department:

Wisconsin, Illinois, and Michigan
Wisconsin Physicians Service (WPS)
Medicare Part B
Provider Enrollment Department
P.O. Box 8248
Madison, WI 53708-8248
(877) 908-8476

Minnesota
Wisconsin Physicians Service (WPS)
Medicare Part B
Provider Enrollment Department
Suite 200
Bloomington, MN 55431-1394
(866) 564-0315

ENEWS PROVIDES LATEST ANNOUNCEMENTS

We are pleased to offer the services of WPS Medicare eNews. For those who subscribe, WPS Medicare eNews brings the latest Medicare news to the physicians and suppliers in our jurisdiction. The e-mails announce the posting of:

- Time-sensitive national and local Medicare news
- Local Coverage Decision Policies
- Provider Education and Training events
- *Communiqué* newsletters

WPS Medicare eNews brings the latest Medicare information directly to your e-mail box. If you want the details of a particular announcement, you will be directed to the full page of the WPS Website via a link within the mailing. There is no cost for WPS Medicare eNews, and you may unsubscribe at any time. To subscribe, simply go to http://www.wpsmedicare.com/listserv and enter your e-mail address, click “Submit,” and follow the directions on the page.

HAVE YOU COMPLETED THE WEBSITE SATISFACTION SURVEY LATELY?

Your feedback is extremely important to the provider community, WPS Medicare, and the Centers for Medicare & Medicaid Services (CMS). The survey that pops up while you are on our Website is the Website Customer Satisfaction Survey.

This quick survey, sponsored by CMS and conducted by ForeSee, gauges your satisfaction with the WPS Medicare Website. WPS and CMS review the results of the survey regularly, and your feedback directly influences the layout, look and feel, content, and other aspects of the WPS Medicare Website. We encourage you to complete the survey, and appreciate your valuable time.

For more information on the survey, go to:
http://www.wpsmedicare.com/sat_survey.pdf

IMPORTANT CUSTOMER SERVICE AUTHENTICATION REQUIREMENT CHANGES

Effective April 6, 2009, all Customer Service and Interactive Voice Response (IVR) inquiries require a matching National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and Taxpayer Identification Number (TIN). Note that only the last five digits of the TIN will be required. To allow us to serve you in the timeliest manner, please have all authentication elements ready prior to any calls to the Interactive Voice Response (IVR) or Customer Service.

The new requirement is based on the Centers for Medicare & Medicaid Services (CMS) Change Request (CR) 6139, which was implemented to better safeguard your information.

SUBMITTING AMBULANCE APPEALS ON C-SNAP

Ambulance suppliers with hangars/garages in Illinois, Michigan, Minnesota, or Wisconsin have the ability to submit an appeal through the Centers for Medicare & Medicaid (CMS) Secure Network Access Portal (C-SNAP). All other ambulance suppliers must send appeals to the correct address for the state where the ambulance is hangared/garaged. Recently, Wisconsin Physicians Service (WPS) Medicare has noticed an increase in the submission of C-SNAP appeals for services provided in other states, including Iowa, Kansas, Nebraska, and Missouri. WPS Medicare cannot accept J5 appeal requests submitted through C-SNAP.

If you have submitted a C-SNAP appeal for an ambulance service where the ambulance is hangared/garaged outside Illinois, Michigan, Minnesota, or Wisconsin, you must send the appeal to the appropriate address for the state in which the service was provided. WPS will not be waiving timely filing for J5 redetermination requests which were inappropriately submitted through C-SNAP. To obtain the correct address for a claim processed by WPS Medicare claims in Iowa, Kansas, Nebraska, and Missouri visit the WPS Medicare Website http://www.wpsmedicare.com/mac/business/b_appeals.shtml and use the address for the state the services were provided in.

SUBMITTING APPEALS ON C-SNAP

Providers who submit claims for services performed in Illinois, Michigan, Minnesota, or Wisconsin have the ability to submit an appeal through the Centers for Medicare & Medicaid (CMS) Secure Network Access Portal (C-SNAP). Recently, Wisconsin Physicians Service (WPS) Medicare has noticed an increase in the submission of C-SNAP appeals for services provided in other states, including Iowa, Kansas, Nebraska, and Missouri. WPS Medicare cannot accept J5 appeal requests submitted through C-SNAP.

If you have submitted a C-SNAP appeal for services provided outside Illinois, Michigan, Minnesota, or Wisconsin, you must send the appeal to the appropriate address for the state in which the service was provided. WPS Medicare will not be waiving timely filing for J5 redetermination requests which were inappropriately submitted through C-SNAP. To obtain the correct address for a claim processed by WPS Medicare claims in Iowa, Kansas, Nebraska, and Missouri visit the WPS Medicare Website http://www.wpsmedicare.com/mac/business/b_appeals.shtml and use the address for the state the services were provided in.

WANTED: MEDICARE WEBSITE USERS

Wanted: Medicare Website users
Mission: Provide needed input
How: Via e-mail

If you choose to accept this assignment, please read on.

At WPS Medicare, we strive to make our Website the best resource we can for our Medicare providers. Currently, we are looking at ways to enhance the navigation and search function, so that providers can find what they need as easily as possible. We would like responses from

those who are new to the WPS Medicare Website as well as from those who are experienced in using the site. Please answer any or all of the questions listed below and send your responses to medicareadmin@wpsic.com; please include "Website Input" in the subject line of your e-mail.

Navigation

- What information are you looking for, and what path do you take to find it?
- Do you have suggestions for the organization of the information on our site?

Search

- What search terms do you use (i.e., what words do you enter into the Search field to find your information)?
- What abbreviations do you commonly use when searching?

Please feel free to provide any other comments about the Website not related to those listed above.

Thank you for taking the time to respond. Your feedback ensures that the WPS Medicare Website will continue to be an easy-to-use tool for our entire provider community.

Claim Submission

CLARIFICATION OF DATE OF SERVICE (DOS) OF AMBULANCE SERVICES

~CMS MLN Matters~

MLN Matters Number: MM6372
Related CR Release Date: February 13, 2009
Related CR Transmittal #: R1682CP

Related Change Request (CR) #: 6372
Effective Date: March 13, 2009
Implementation Date: March 13, 2009

Provider Types Affected

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

Impact on Providers

Providers of ambulance services should note the clarifications made by CR 6372, as noted in this article. Specifically, CR6372 clarifies the proper date of service to use on claims, especially in situations where the beneficiary dies.

Background

CR 6372 provides clarification of Centers for Medicare & Medicaid Services' (CMS) policy towards dates of service (DOS) for ambulance services, especially in regard to a beneficiary's date of death.

The clarifications for providers of ambulance services are listed as follows:

- The date of service of an ambulance service is the date that the loaded ambulance vehicle (ground or air) departs the point of pickup, except in cases where the beneficiary is pronounced dead as noted below.
- In the case of a ground transport, if the beneficiary is pronounced dead after the vehicle is dispatched but before the (now deceased) beneficiary is loaded into the vehicle, the DOS is considered to be the date of the ambulance vehicle's dispatch.
- In the case of an air transport, if the beneficiary is pronounced dead after the aircraft takes off to pick up the beneficiary, the DOS is considered to be the date of the ambulance vehicle's takeoff.

Failure to code dates of service correctly in these situations could result in the denial of the claim.

Additional Information

The official instruction, CR 6372, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1682CP.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.

IMPLEMENTATION OF AN AMBULATORY SURGICAL CENTER (ASC) HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) PAYMENT INDICATOR FILE

~CMS MLN Matters~

MLN Matters Number: MM6184
Related CR Release Date: October 17, 2008
Related CR Transmittal #: R1616CP

Related Change Request (CR) #: 6184
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

ASCs submitting claims to Medicare contractors (carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for ASC services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6184 which provides Medicare contractors with instructions for implementing an Ambulatory Surgical Center (ASC) Healthcare Common Procedure Coding System (HCPCS) payment indicator file.

CAUTION – What You Need to Know

CR 6184 provides instructions to your Medicare contractor(s) to modify their systems to accept the new Ambulatory Surgical Center (ASC) Healthcare Common Procedure Coding System (HCPCS) Payment Indicator File and ensure that it properly interfaces with the other ASC files in order to process ASC claims appropriately. This new file will enable your Medicare contactor(s) to enhance the their ability to (1) identify all separately payable and non-separately payable (packaged) services, as well as non-payable services and (2) provide more precise messaging via remittance advice remark codes in the processing and disposition of ASC claims for all HCPCS codes submitted by ASCs.

GO – What You Need to Do

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

Background

As required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 626 of), the Centers for Medicare & Medicaid Services (CMS) implemented a revised Ambulatory Surgical Center (ASC) payment system January 1, 2008.

CMS provided in CR 5680 (Transmittal 1325, August 29, 2007; see related MLN Matters article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5680.pdf on the CMS Website) supporting ASC file record layouts of the ASC facility payment file (ASCFS) and ASC Drug File to interface with the instructions issued to implement the revised ASC payment system. The ASCFS includes rates for all services that are eligible for payment under the revised ASC payment system, except separately paid drugs and biologicals, and the ASC Drug File provides the rates for all drugs and biologicals that are eligible for separate payment under the revised ASC payment system.

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

Using defined "payment indicators" (72 FR 67189-67190; see http://www.gpoaccess.gov/fr/retrieve.html on the Internet), CMS identifies each covered service that is eligible for ASC payment and the payment methodology by which the payment amount is calculated. The payment indicators also indicate which services' costs are packaged into the payment for other services and which surgical procedures are excluded from Medicare payment.

For Calendar Year (CY) 2008, Medicare contractors did not have access to the ASC payment indicators for all services and, therefore, were unable to accurately determine the specific reason for nonpayment in all cases, though the payment decisions made on the claims were correct.

CR 6184 announces that CMS is providing a file of the ASC payment indicators that are assigned to each HCPCS code in order to enhance the ability of Medicare contractors to identify both separately payable and non-separately payable (packaged) services, as well as non-payable services. This information will enable contractors to provide detailed messaging in the processing and disposition of ASC claims for all HCPCS codes submitted by ASCs.

In addition to the ASCFS and ASC Drug File(s), CMS is providing Medicare contractors with a more comprehensive list of HCPCS codes and the payment indicator assigned to each of the codes. Beginning January 1, 2009, Medicare contractors will be able to process ASC claims using the revised ASC HCPCS Code Payment Indicator file and will provide messaging to ASCs and beneficiaries, in part, based on the "messaging " provided in CR 6184. The specific payment indicators are identified in an attachment to CR6184.

Additional Information

The official instruction, CR 6184, issued to your carrier and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1616CP.pdf on the CMS Website. Attachment B of CR6184 contains the list of ASC payment indicators and their respective definitions.

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

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Comprehensive Error Rate Testing (CERT)

COMPREHENSIVE ERROR RATE TESTING (CERT) ALERT – DOCUMENTATION OF TEACHING PHYSICIAN SERVICES

During a recent CERT review, the CERT contractor assessed errors on a teaching physician's claim for inpatient hospital visits performed by a resident because the teaching physician did not document his active role during the inpatient hospital visits.

Per the Centers for Medicare & Medicaid Services (CMS) *Medicare Claims Processing Manual,* Publication 100-04, Chapter 12, Section 100.1.1, where a resident has written notes, the teaching physician's note may reference the resident's note. The teaching physician must document that he/she performed the critical or key portion(s) of the service, and that he/she was directly involved in the management of the patient. For payment, the composite of the teaching physician's entry and the resident's entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

To view Publication 100-04, Chapter 12, including other CMS Teaching Physicians Services instructions, please refer to the following Website address:
http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf

Coverage – General

HEARTSBREATH TEST FOR HEART TRANSPLANT REJECTION
~CMS MLN Matters~

MLN Matters Number: MM6366
Related CR Release Date: February 13, 2009
Related CR Transmittal #: R1683CP and R99NCD

Related Change Request (CR) #: 6366
Effective Date: December 8, 2008
Implementation Date: April 6, 2009

Provider Types Affected

Providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Medicare Administrative Contractors (MACs)) for Heartsbreath testing services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6366 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) determined that the **Heartsbreath Test is not reasonable and necessary** under section 1862(a)(1)(A) of the Social Security Act, **and is non-covered for dates of service on or after December 8, 2008.** See the Background and Additional Information Sections of this article for further details regarding this issue.

Background

On December 8, 2008, CMS issued a decision memorandum in response to a formal request for Menssana Research, Inc., to consider national coverage of the Heartsbreath test as an adjunct to the heart biopsy to detect grade 3 heart transplant rejection in patients who have had a heart transplant within the last year and an endomyocardial biopsy in the prior month. CMS determined that the evidence does not adequately define the technical characteristics of the test nor demonstrate that Heartsbreath testing to predict heart transplant rejection improves health outcomes in Medicare beneficiaries.

Key Points of CR 6366

- Effective for claims with dates of service on and after December 8, 2008, the Heartsbreath test used to predict heart transplant rejection is nationally non-covered. This coverage change to Current Procedural Terminology (CPT) Code 0085T, breath test for heart transplant rejection, will be effective with the April 1, 2009, quarterly update of the Medicare Physician Fee Schedule Database.
- Effective with the April 1, 2009, quarterly update of the Integrated Outpatient Code Editor, CPT code 0085T, breath test for heart transplant rejection, is no longer payable by Medicare.
- When denying claims for CPT code 0085T, Medicare contractors will use:
  - Medicare Summary Notice (MSN) message 16.10: Medicare does not pay for this item or service,
  - Claim Adjustment Reason Code 50: These are non-covered services because this is not deemed a medical necessity by the payer;
  - Claim Adjustment Remark Code MA 51: Missing/Incomplete/Invalid Procedure Code(s); and,

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- N386: This decision was based on an 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, contact your Medicare contractor to request a copy of the NCD.)

- For beneficiaries who choose to have this procedure anyway, providers shall issue an Advance Beneficiary Notice (ABN) indicating that Medicare issued an NCD at section 260.10 of the NCD Manual stating that the Heartsbreath test is not reasonable and necessary for Medicare beneficiaries. Medicare never pays for this test and the beneficiary would be held financially liable. (Beginning March 1, 2009, the ABN-G will no longer be valid and providers must issue the revised ABN (CMS-R-131.)
  - Medicare Contractors will include the Group Code CO (contractor obligation) or PR (provider responsibility) depending on liability.
- For claims already processed with dates of service between December 8, 2008, and April 1, 2009, contractors will not search their files, but may go back and adjust claims that are brought to their attention.

Additional Information

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

The official instruction (CR6366) was issued to your Medicare FI, carrier or MAC via two transmittals. The first conveys the revised claims processing instructions and is available at http://www.cms.hhs.gov/Transmittals/downloads/R1683CP.pdf on the CMS Website. The second transmittal conveys the change to the National Coverage Determinations Manual and that transmittal is at http://www.cms.hhs.gov/Transmittals/downloads/R99NCD.pdf on the CMS Website.

MIST THERAPY® SYSTEM 5.0 WOUND TREATMENT DEVICE

The MIST Therapy® System is a wound care product designed to impact key areas of the wound repair process. Multiple providers have asked Wisconsin Physicians Service (WPS) Medicare if this service is covered using Current Procedural Terminology (CPT) code 0183T. The following is in response to these inquiries:

Ultrasonic Wound Debridement (CPT code 0183T) is a system that uses continuous low frequency ultrasonic energy to atomize a liquid and deliver continuous low frequency ultrasound to the wound bed. WPS Medicare does not consider this cleansing method to be a significantly separately payable coverable service. Therefore, MIST Therapy® (CPT code 0183T) is included in the payment for the Evaluation and Management (E/M) or wound care services.

SHIPBOARD SERVICES BILLED TO THE CARRIER AND SERVICES NOT PROVIDED WITHIN THE UNITED STATES. CHANGE REQUEST (CR) 6327 RESCINDS AND FULLY REPLACES CR 6217

~CMS MLN Matters~

MLN Matters Number: MM6327
Related CR Release Date: February 13, 2009
Related CR Transmittal #: R1677CP and R102BP

Related Change Request (CR) #: 6327
Effective Date: March 13, 2009
Implementation Date: March 13, 2009

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6327 which clarifies payment for shipboard services billed to Medicare contractors and services not provided within the United States.

CAUTION – What You Need to Know

CR 6327 revises the Medicare Claims Processing Manual and the Medicare Benefit Policy Manual to clarify that Medicare contractors will make payment for physician and ambulance services furnished in connection with a covered foreign hospitalization, including emergency physician and ambulance services furnished during the time period immediately preceding the covered foreign hospitalization. **CR 6327 rescinds and fully replaces CR 6217.**

GO – What You Need to Do

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

Background

Medicare law prohibits payment for items and services furnished outside the United States except for certain limited services (see the Social Security Act, Section 1814(f) at http://www.ssa.gov/OP_Home/ssact/title18/1814.htm and Section1862(a)(4) at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the Internet). The law specifies **the following are exceptions to the "foreign" exclusion**:

- Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
  - The emergency arose within the U.S, or
  - The emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay, between Alaska and another State;
- Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual's residence within the U.S. than the nearest U.S. hospital that is adequately equipped and available to treat the individual's condition, whether or not an emergency exists;

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- Physician and ambulance services in connection with a foreign inpatient hospital stay that is covered in accordance with (1) or (2) above.

Note: The term "United States" includes the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, American Samoa, and, for purposes of services rendered on a ship, the territorial waters adjoining the land areas of the United States.

The Medicare Claims Process Manual (Chapter 1, Section 10.1.4.7; see http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf on the Centers for Medicare & Medicaid Services (CMS) Website) currently states that:

- Services furnished by a physician or supplier in U.S. territorial waters must be furnished on board vessels of American registry, and
- The physician must be registered with the Coast Guard in order for Medicare to make payment.

However, that manual language is not consistent with Medicare law. Therefore, because Section 10.1.4.7 is not consistent with Medicare law, **CMS is clarifying Section 10.1.4.7 in order to make it consistent with current Medicare law by removing the language that states:**

- The vessels must be of American registry, and
- The physician must be registered with the Coast Guard.

CMS is also clarifying Chapter 1, Sections 10.1.4, and 10.1.4.1 and Chapter 3, Section 110.1 of the Medicare Claims Processing Manual and Chapter 16, Section 60 of the Medicare Benefit Policy Manual to show **that physician and ambulance services furnished in connection with a covered foreign hospitalization are covered**. The term **"and during a period of"** covered foreign hospitalization implies that only physician and ambulance services that are furnished during the period of the covered foreign hospitalization are covered (i.e., the period after the beneficiary has been admitted to the foreign hospital), when, in fact, the emergency physician and ambulance services **are covered** both:

- During the time period immediately before the beneficiary is actually admitted to the foreign hospital, and
- During the covered foreign hospitalization itself.

You can find the revised chapters of two manuals referenced above as attachments to CR 6327.

Additional Information

The official instruction, CR 6327, was issued to your carrier, FI, and MAC via two transmittals. The first modifies the Medicare Claims Processing Manual and is available at http://www.cms.hhs.gov/Transmittals/downloads/R1677CP.pdf and the second modifies the Medicare Benefit Policy Manual and that transmittal is at http://www.cms.hhs.gov/Transmittals/downloads/R102BP.pdf on the CMS Website.

If you have any questions, please contact your carrier, FI, or MAC at their toll-free number, which may be found at

http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS Website.

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

Coverage – Policies

INFORMATION ON WEBSITE

WPS Medicare publishes Local Coverage Determinations (LCDs), National Coverage Provisions (NCPs), and National Coverage Determinations (NCDs), as well as retired LCDs/Local Medical Review Policies (LMRPs) for Medicare Part B, on its Website:
http://www.wpsmedicare.com/part_b/policy/index.shtml

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

Part B Legacy
WPS Medicare Attn: Freedom of Information Act (FOIA) PO Box 8810 Marion, IL 62959

New Policies for March 2009

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
CV-033	*Noninvasive Vascular Testing (N.I.V.T.)*	LCD	Click here to view	16
HONC-010	*Chemotherapy Drugs and their Adjuncts*	LCD	Click here to view	16

Revised Policies for March 2009

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
CV-026	*Transthoracic Echocardiography*	LCD	Click here to view	17
PATH-002	*Pathology – Physician Services*	NCP	Click here to view	17
PHYS-001	*General Coverage for Physicians Services*	NCP	Click here to view	18

Coverage – New Policies

LCD Title
Noninvasive Vascular Testing (N.I.V.T.)

Contractor's Determination Number
CV-033

Effective Date
04/16/2009

This is a new policy. Please read this policy in its entirety at the following Website:
http://www.wpsmedicare.com/part_b/policy/policy_active.shtml

Contractor Number
00951, 00952, 00953, 00954
05101, 05201, 05301, 05401, 05102, 05202, 05392, 05302, 05402

Contractor Type
Carrier
MAC A
MAC B

LCD Title
Chemotherapy Drugs and their Adjuncts

Contractor's Determination Number
HONC-010

Original Determination Effective Date
04/16/09

This is a new LCD. Please read this policy in its entirety on the following Web page:
http://www.wpsmedicare.com/part_b/policy/policy_active.shtml

Coverage – Revised Policies

LCD Policy Revision

Contractor's Policy Number
CV-026

LCD Title
Transthoracic Echocardiography

Primary Geographic Jurisdiction
Wisconsin, Illinois, Michigan, Minnesota

Revision Effective Date
01/01/2009

*93306 *Echocardiography, transthoracic, real-time with image documentation (2D) includes M-mode recording; when performed, complete, with spectral or color doppler echocardiography

New for 2009 CPT code 93306 was inadvertently omitted from CV-026 with the 2009 CPT coding updates.

Subject
Pathology – Physician Services

NCP Number
PATH-002

Billing by a Supplier for the Technical Component (TC) of Surgical Pathology

WPS Medicare updated *PATH-002 Pathology – Physician Services* National Coverage Provision. The Centers for Medicare & Medicaid Services (CMS) Internet Only Manual, Publication 100-04, Chapter 1, and Section 10.1.1.2 provides the documentation for the updated information. The following sentence was removed.

> "Suppliers who choose this billing option must obtain supplier/provider numbers for each carrier service area where the physician is located."

The following sentence was added.

> "*That these services are purchased does not negate the need for appropriate enrollment procedures with the carrier that has jurisdiction over the geographic area where the services were rendered."

The asterisked (*) text indicates changes made since the last publication date. Please refer to the *PATH-002 Pathology – Physician Services* National Coverage Provision in its entirety on the WPS Website:
http://www.wpsmedicare.com/part_b/policy/path002.pdf

Subject
General Coverage for Physicians Services

NCP Number
PHYS-001

Signature Requirements Clarification

Effective Date
September 3, 2007
Implementation Date
April 28, 2008

Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes.

WPS Medicare is updating *PHYS-001 General Coverage for Physicians Services* National Coverage Provision to reflect the change. The asterisked (*) text indicates changes made since the last publication date. Please refer to the *PHYS-001 General Coverage for Physicians Services* National Coverage Provision in its entirety on the WPS Website:
http://www.wpsmedicare.com/part_b/policy/phys001.pdf

Electronic Data Interchange (EDI)

GET PAID FASTER AND POST PAYMENTS FASTER: SOUND LIKE A GOOD PLAN?

If this sounds like a good idea, there are very easy ways to make this happen. WPS EDI offers the ability to send your Medicare claims electronically. Providers have the option of using Billing Services, Vendors or Clearinghouses, or even Medicare's own FREE software program to send their Medicare claims to WPS Medicare. Did you know that electronically submitted claims get paid faster than paper submitted claims? Please visit the Websites below for more information on claim submission and resources available:
http://www.wpsic.com/edi/get_started.shtml
http://www.wpsic.com/edi/pcacepro32.shtml
http://www.wpsic.com/edi/pdf/medicare_connection.pdf

For more information or if you just need to have general questions answered, please contact helpful WPS EDI staff members at (877) 567-7261.

If you would like to get your Medicare EOB faster, there is an option to receive them electronically. Your electronic remit would be available on our Bulletin Board to download and there is the option of using a vendor or clearinghouse to help with that. Another option is to get set up to download them on your own and use the CMS software product, Medicare Remit Easy Print (MREP), that allows for creating the electronic remit (ERA) into a readable and printable option. As always, feel free to call WPS EDI staff for questions or assistance. More information is available at the Websites listed below:
http://www.wpsic.com/edi/edi_ern_medb.shtml
http://www.wpsic.com/edi/tools.shtml (scroll down to the MREP portion)

Last, but not least, you can have your Medicare funds directly deposited into your bank account, thus getting your actual money much faster than postal mail. It's a very simple process to sign up for Electronic Funds Transfer (EFT). Please contact the EFT staff at 1-866-380-4742 (Option 2 for EDI/EFT) for any questions and assistance. To print out the form and instructions please go to the Website below:
http://www.wpsic.com/edi/pdf/cms588_elec_funds.pdf

Our EDI staff members are always here to help out with any questions you may have. Please don't hesitate to contact us for your Medicare needs.

MEDICARE REMIT EASY PRINT: FEBRUARY 9, 2009 UPDATE

(Code Group revised 1-29)

There is no update to the MREP software (current version 2.5) for the January release; however, the Code Group information has been updated. You can download the Code Group information (11-1-08) from the site listed below. Instructions to Update the Code Group are on page 65 - 67 of the MREP Manual.

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

If you are an electronic biller who does not receive the Electronic Remittance Advice (ERA) and would like to, please download the ERA information sheet at http://www.wpsic.com/edi/pdf/edi_ern_medb.pdf and submit it to our office.

If you already receive the ERA and want to try the MREP software, please download the MREP software at http://www.wpsmedicare.com/part_b/business/mrep.shtml. If you are not an electronic biller and want to receive an ERA to use the MREP software, you will also need to submit an EDI enrollment form. Please label MREP only. You can download this form at http://www.wpsic.com/edi/pdf/medb_enroll.pdf.

For assistance, please contact EDI at (877) 567-7261.

Take advantage of this software. Begin using MREP today!

General Information

CENTRALIZED BILLING PERIOD FOR FLU, PPV

According to the Centers for Medicare & Medicaid Services (CMS), the yearly enrollment period for centralized billing of influenza and Pneumococcal (PPV) immunizations is changed to September 1 through August 31, rather than October 1 through September 30.

When an application for centralized billing from an individual or entity is approved, the approval is limited to the 12-month period from September 1 through the following August 31. The revised period more closely reflects the annual immunization pattern.

It is the responsibility of the centralized biller to reapply to the CMS central office (CO) for approval each year by June 1. TrailBlazer Health Enterprises, which is the carrier selected to process the centralized billing claims, will not process claims for a centralized biller without permission from CMS CO.

Centralized billing is a process in which a provider, who provides mass immunization services for influenza and PPV immunizations, can send all claims to a single carrier for payment regardless of the geographic locality in which the vaccination was administered. (This does not include claims for the Railroad Retirement Board, United Mine Workers, or Indian Health Services. These claims must continue to go to the appropriate processing entity.) This process is only available for claims for the flu and PPV vaccines and their administration. The administration of the vaccinations is reimbursed at the assigned rate based on the Medicare Physician Fee Schedule (MPFS) for the appropriate locality. The vaccines are reimbursed at the assigned rate using the Medicare standard method for reimbursement of drugs and biologicals, which is based on the lower of cost or 95 percent of the Average Wholesale Price (AWP).

Individuals and entities interested in centralized billing must contact the CMS CO, in writing, at the following address by June 1 of the year in which they wish to centrally bill.

Division of Practitioner Claims Processing
Provider Billing and Education Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop C4-12-18
Baltimore, Maryland 21244

By agreeing to participate in the centralized billing program, providers agree to abide by the following criteria.

Criteria for Centralized Billing

1. To qualify for centralized billing, an individual or entity providing mass immunization services for flu and pneumonia must provide these services in at least three payment localities for which there are at least three different carriers processing claims.

2. Individuals and entities providing the vaccine and administration must be properly licensed in the State in which the immunizations are given.

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

3. Centralized billers must agree to accept assignment (i.e., they must agree to accept the amount that Medicare pays for the vaccine and the administration). Since there is no coinsurance or deductible for the flu and PPV benefit, accepting assignment means that Medicare beneficiaries can not be charged for the vaccination, i.e., beneficiaries may not incur any out-of-pocket expense. For example, a drugstore may not charge a Medicare beneficiary $10 for an influenza vaccination and give the beneficiary a coupon for $10 to be used in the drugstore. This practice is unacceptable.

4. The carrier assigned to process the claims for centralized billing is chosen at the discretion of CMS based on such considerations as workload, user-friendly software developed by the contractor for billing claims, and overall performance. The carrier assigned for this year is TrailBlazer Health Enterprises.

5. The payment rates for the administration of the vaccinations will be based on the MPFS for the appropriate year. Payment made through the MPFS is based on geographic locality. Therefore, the payments received may vary based on the geographic locality where the service was performed. Payment will be made at the assigned rate.

6. The payment rates for the vaccines will be determined by the standard method used by Medicare for reimbursement of drugs and biologicals which is based on the lower of cost, or 95 percent of the AWP. Payment will be made based on the assigned rate.

7. Centralized billers must submit their claims on roster bills in an Electronic Media Claims standard format using the HIPAA ANSI X12N 837 (version 4010). Paper claims will not be accepted.

8. Centralized billers must obtain certain information for each beneficiary including name, health insurance number, date of birth, sex, and signature. TrailBlazer must be contacted prior to the season for exact requirements. The responsibility lies with the centralized biller to submit correct beneficiary Medicare information (including the beneficiary's Medicare Health Insurance Claim Number) as the carrier will not be able to process incomplete or incorrect claims.

9. Centralized billers must obtain an address for each beneficiary so that an Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) can be sent to the beneficiary by the carrier. Beneficiaries are sometimes confused when they receive an EOMB or MSN from a carrier other than the carrier that normally processes their claims, which results in unnecessary beneficiary inquiries to the Medicare carrier. Therefore, centralized billers must provide every beneficiary receiving an influenza or PPV vaccination with the name of the processing carrier. This notification must be in writing, in the form of a brochure or handout, and must be provided to each beneficiary at the time he or she receives the vaccination.

10. Centralized billers must retain roster bills with beneficiary signatures at their permanent location for a time period consistent with Medicare regulations. TrailBlazer can provide this information.

11. Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from TrailBlazer. This can

be done by completing Form CMS-855 (Provider Enrollment Application), which can be obtained from TrailBlazer.

12. If an individual or entity's request for centralized billing is approved, the approval is limited to the 12-month period from September 1 through August 31 of the following year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year by June 1. TrailBlazer will not process claims for any centralized biller without permission from CMS CO.

13. Each year the centralized biller must contact TrailBlazer to verify understanding of the coverage policy for the administration of the PPV vaccine, and for a copy of the warning language that is required on the roster bill.

14. The centralized biller will be responsible for providing the beneficiary with a record of the PPV vaccination.

The information requested in items 1 through 6 below must be included with the individual or entity's annual request to participate in centralized billing:

1. Estimates for the number of beneficiaries who will receive influenza virus vaccinations;
2. Estimates for the number of beneficiaries who will receive PPV vaccinations;
3. The approximate dates for when the vaccinations will be given;
4. A list of the states in which flu and PPV clinics will be held;
5. The type of services generally provided by the corporation (e.g., ambulance, home health, or visiting nurse); and
6. Whether the nurses who will administer the flu and PPV vaccinations are employees of the corporation or will be hired by the corporation specifically for the purpose of administering flu and PPV vaccinations.

For additional information, please visit the CMS Website at
http://www.cms.hhs.gov/AdultImmunizations/02_Providerresources.asp

CHANGE IN THE AMOUNT IN CONTROVERSY REQUIREMENT FOR ADMINISTRATIVE LAW JUDGE HEARINGS AND FEDERAL DISTRICT COURT APPEALS

~CMS MLN Matters~

MLN Matters Number: MM6295
Related CR Release Date: January 30, 2009
Related CR Transmittal #: R1676CP

Related Change Request (CR) #: 6295
Effective Date: May 4, 2009
Implementation Date: May 4, 2009

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 6295, which notifies Medicare contractors of the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2009.

The amount remaining in controversy requirement for **ALJ hearing requests** made before January 1, 2009, is $120. The amount remaining in controversy requirement for requests made on or after January 1, 2009, is $120.

For **Federal District Court r**eview, the amount remaining in controversy goes from $1,180 for requests **on or after January 1, 2008**, to $1,220 for requests **on or after January 1, 2009.**

Background

The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). CR 6295 modifies the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 29, Section 330.1 and Section 345.1) to update the AIC required for an ALJ hearing or judicial court review.

Additional Information

The official instruction (CR6295) issued to your Medicare Carrier, A/B MAC, DME MAC, FI, and/or RHHI is available at http://www.cms.hhs.gov/Transmittals/downloads/R1676CP.pdf on the CMS Website.

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

IMPLEMENTATION OF NEW PROVIDER AUTHENTICATION REQUIREMENTS FOR MEDICARE CONTRACTOR PROVIDER TELEPHONE AND WRITTEN INQUIRIES

~CMS MLN Matters~

MLN Matters Number: MM6139 Revised
Related CR Release Date: February 10, 2009
Related CR Transmittal #: R23COM

Related Change Request (CR) #: 6139
Effective Date: April 6, 2009
Implementation Date: April 6, 2009 for providers

Note: This article was revised on February 11, 2009, to reflect the revised CR 6139, which CMS re-issued on February 10, 2009. The effective and implementation dates for providers have been changed to April 6, 2009. Also, the CR release date, transmittal number, and the Web address of the CR have been changed. All other information remains the same.

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

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

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 April 6, 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,
  3) Health Insurance Claim Number (HICN), and
  4) Either date of birth (eligibility, next eligible date, 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, the 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.

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

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/R23COM.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.

NEW...IMPROVED....STREAMLINED...WPS MEDICARE (PART B) APPEALS REDETERMINATION FORM

To ensure your appeal has all the required information when submitted, we highly recommend you begin using the NEW WPS Medicare Part B Redetermination Request Form today. Completing the form aids in the efficient processing of the request.

WPS Medicare will continue to process complete Redetermination requests, whether you use the CMS form 20027 or the WPS form. If you choose to request a redetermination WITHOUT a form, the following information MUST be included:

- Beneficiary name
- Medicare Health Insurance Claim Number (HICN)
- Date(s) of service for which initial determination was issued
- Which item(s), if any, and/or service(s) are at issue in the appeal
- Name and signature of the party or representative of the party
- Reason(s) you disagree with the initial claim(s) determination

Incomplete or missing information will delay or dismiss your redetermination.

The new WPS Medicare Redetermination Form is available on the WPS Medicare Website: http://www.wpsmedicare.com/part_b/business/appeal_forms.shtml

PHYSICIAN SIGNATURE REQUIREMENTS FOR DIAGNOSTIC TESTS

~CMS MLN Matters~

MLN Matters Number: MM6100 Revised
Related CR Release Date: August 29, 2008
Related CR Transmittal #: R94BP

Related Change Request (CR) #: 6100
Effective Date: January 1, 2003
Implementation Date: September 30, 2008

Note: This article was revised on February 6, 2009, to remove a parenthetical statement from the first paragraph of page 2 of this article. All other information remains the same.

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors (A/B MAC)) for diagnostic laboratory services provided to Medicare beneficiaries.

What You Need to Know

CR 6100, from which this article is taken, updates the *Medicare Benefit Policy Manual,* Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests) Subsection 80.6.1 (Definitions); to incorporate language previously contained in Section 15021 of the *Medicare Carriers Manual*, but inadvertently omitted when the *Medicare Benefit Policy Manual* was published.

Specifically, it notes that a physician's signature is not required on orders for clinical diagnostic tests that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.
Make sure that your office, billing, and/or laboratory staffs are aware of this updated guidance regarding the signature requirement for diagnostic tests.

Additional Information

You can find more information about physician signature requirements for diagnostic tests by going to CR 6100, located at http://www.cms.hhs.gov/Transmittals/downloads/R94BP.pdf on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Benefit Policy Manual,* Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests), Subsection 80.6.1 (Definitions) as an attachment to CR6100.

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.

Provider Education

EDUCATION SCHEDULE

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

Some of the educational events WPS Medicare is hosting include the following:
- Ask-the-Contractor Teleconference (ACT)
- Basic Principles of Medicare Seminars
- Chiropractic Care Seminars

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

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

WPS Medicare is pleased to announce the 2009 schedule for our Electronic Data Interchange (EDI) Ask-the-Contractor Teleconference (ACT). The calls will be for Legacy Part A (institutional providers who joined WPS in November 2007) & Part B (IL, MI, WI, & MN) as well as MAC J5 A and B states (IA, KS, MO & NE).

We have scheduled our EDI ACT for 2009. These teleconferences will last one and one half hours. We encourage providers, billing staff, vendors and clearinghouses to call with any Medicare EDI questions they deem appropriate.

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

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

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

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

Please Note: No Registration is Necessary

EDI Ask the Contractor Teleconference

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

Date	Time	Dial In	ID
March 12, 2009	1 pm CST	800-305-2862	70745451
May 14, 2009	1 pm CST	800-305-2862	70745640
July 9, 2009	1 pm CST	800-305-2862	70745908
September 10, 2009	1 pm CST	800-305-2862	70746156
November 12, 2009	1 pm CST	800-305-2862	70746399

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

SELF-SERVICE (ARTICLE 6) – MEDICARE REMIT EASY PRINT (MREP) SOFTWARE

This is the sixth in a series of articles about Self-Service Technology. The article today will focus on the free Medicare Remit Easy Print (MREP) Software.

The Centers for Medicare & Medicaid Services (CMS) has developed software called Medicare Remit Easy Print (MREP) that enables physicians and suppliers to view and print Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 835s from their own computers. Remittance advices printed from the MREP software are similar to the current Standard Paper Remittance Advice (SPR) format.

This software offers important capabilities that allow physicians and suppliers to:

- View, search, and print remittance information
- Print and export reports containing remittance information

The MREP software also allows physicians and suppliers to run several useful reports.

- Adjusted Service Lines Report: Shows claims within a single remittance that have a claim status 22 (reversed claim).
- Denied Service Lines Report: Shows only claim service lines that have an allowed amount of zero *and* are associated with a claim that does not have a claim status 22 (reversed claim).
- Deductible/Coinsurance Service Lines Reports: Shows claim service lines that have a deductible and/or a coinsurance amount.
- Coordination of Benefits (COB)/Non-COB Claims Reports: Shows claims by their COB status. Providers may view all claims that were crossed over, or all those that were not crossed over.

- Other Adjustments Report: Shows claims that had some type of adjustment, including claims that have late filing and interest charges and remittances that have withholding or a forwarding balance.

Prints Information for Use by Other Payers
The MREP software gives physicians and suppliers the ability to print remittance information for individual or multiple selected claims. This allows them to forward only those claims that are needed by other payers for secondary/tertiary payment. Physicians and suppliers may view and/or print as many or as few claims as needed.

Easy to Navigate and View Remittance Information
The MREP software presents remittance information that is organized and easy to view. The MREP software provides separate tabs that include the following information:

- A list of claims
- Details for individually selected claims
- Summary information
- Glossary information containing Claim Adjustment Reason Codes, Remittance Advice Remark Codes, and their definitions
- A data view that allows physicians and suppliers to look at the various loops and segments containing data in the HIPAA 835
- A search function to find claims containing specific information

Allows Quick and Easy Access to Claim Information
The MREP software features a search function that allows physicians and suppliers to find a claim (or multiple claims) based on customized search criteria. Physicians and suppliers may search by names, numbers, and even portions of information, such as:

- Adjusted Lines
- Beneficiary Account Number
- Beneficiary Last Name
- COB/Non-COB Claims
- Deductible/Coinsurance Lines
- Denied Lines
- Health Insurance Claim Number (HICN)
- Internal Control Number (ICN)
- National Drug Code (NDC)
- Other Adjustments
- Procedure Code
- Rendering Provider Number
- Service Date

Caution
Providers using clearinghouses or vendors that alter the HIPAA 835 report before sending to your office may not be able to use the MREP software.

For more information, visit http://www.cms.hhs.gov/ElectronicBillingEDITrans/ on the CMS Website.

SELF-SERVICE (ARTICLE 7) – INTERACTIVE VOICE RESPONSE (IVR) SYSTEM

This is the seventh in a series of articles about Self Service Technology. The article today will focus on the Interactive Voice Response (IVR) System.

How to reach the IVR:
IL – (877) 908-9499
MI – (877) 567-7201
MN – (877) 908-8470
WI – (877) 567-7176

The IVR offers the provider community quick and easy access to Medicare-related information 24 hours a day. By simply calling the toll-free telephone number listed above, you will have the ability to access Medicare claims information and patient eligibility.

You can access the IVR by either speaking the required information or entering it using your telephone number pad. For complete instructions and helpful hints on using the IVR visit: http://www.wpsmedicare.com/part_b/selfservice/ivr.pdf

What's available on the IVR?

Touch-tone Option	Vocal Option
1	Eligibility
2	Claim Status
3	Provider Summary
4	Checks
5	Deductibles
6	Pricing
7	Questions

When is the IVR available?

The IVR is available 24 hours a day, 7 days a week. However, the standard hours of operation when all IVR functions are available

Monday – Friday 6:00 am – 6:00 pm CT*
Saturday 7:00 am – 12:00 pm CT*

*Please note that the functions which require a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN) to be entered, such as eligibility and claim status, have limited hours due to system availability. The hours vary by state and option.

Remember: Customer Service Representatives are prohibited from giving you information that can be obtained using IVR. However, they will assist you with more complex inquiries.

SELF-SERVICE (ARTICLE 8) – COMPUTER-BASED TRAININGS (CBTS)

This is the eighth in a series of articles about Self-Service Technology. The article today will focus on Computer-Based Trainings (CBTs).

CBTs are self-study courses designed to increase knowledge of the Medicare program. The Centers for Medicare & Medicaid Services (CMS) and Wisconsin Physicians Service (WPS) Medicare have developed CBTs for providers' use.

WPS Medicare CBTs are located on our Website at:
http://www.wpsmedicare.com/part_b/education/cbt.shtml

The CBTs consist of two different formats.

1. Recorded audiovisual presentations have a speaker presenting material. The information is also available in written format for people unable to view the audio-visual format by selecting "read the script."
2. Slideshow format allows the user to move through the presentation at his/her own pace. This format does not contain audio and is read-only.

CMS CBTs consist of the slideshow format only and are located at:
http://cms.meridianksi.com/kc/ilc/course_info_enroll_lnkfrm_f1.asp?lgnfrm=wbt&table=crs&function=course_info_enroll&strBuildingID=5&strFunctionID=37&strFunctionPath=37&strFrom=Search&topic=All&keywords.

CBTs are available for a wide variety of topics and are ideal for staff that is new to Medicare. We encourage you to take control of your Medicare education by using the Computer-Based Trainings (CBTs) today!

Reimbursement

PAYMENT FOR REPAIR, MAINTENANCE AND SERVICING OF OXYGEN EQUIPMENT AS A RESULT OF THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT (MIPPA) OF 2008

~CMS MLN Matters~

MLN Matters Number: MM6296
Related CR Release Date: February 13, 2009
Related CR Transmittal #: R443OTN

Related Change Request (CR) #: 6296
Effective Date: April 1, 2009
Implementation Date: April 6, 2009

Provider Types Affected

Providers and suppliers submitting claims to Medicare DME Medicare Administrative Contractors (DME MACs), and/or Regional Home Health Intermediaries (RHHIs)) for repair, maintenance and servicing of oxygen equipment provided to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 6296 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is providing instructions regarding repair, maintenance, and servicing of oxygen equipment resulting from implementation of Section 144(b) of the MIPPA. The 36-month cap noted in MIPPA applies to stationary and portable oxygen equipment furnished on or after January 1, 2006. **Therefore, the 36-month cap may end as early as January 1, 2009, for beneficiaries using oxygen equipment on a continuous basis since January 1, 2006.**

CMS has determined that, for services furnished during calendar year 2009, it is reasonable and necessary to make payment for periodic, in-home visits by suppliers to inspect certain oxygen equipment and provide general maintenance and servicing after the 36-month rental cap. These payments only apply to equipment falling under HCPCS codes E1390, E1391, E1392, and K0738, and only when the supplier physically makes an in-home visit to inspect the equipment and provide any necessary maintenance and servicing. Payment may be made every 6 months, beginning 6 months after the 36-month rental cap (as early as July 1, 2009, in some cases), and the allowed payment amount for each visit is equal to the 2009 fee for code E1340 (K0739 for dates of service on or after April 1, 2009) multiplied by 2, for the state in which the in-home visit takes place.

Suppliers should use the HCPCS code for the equipment E1390, E1391, E1392, and/or K0738 along with the MS modifier in order to bill and receive payment for these maintenance and servicing visits. For example, if the supplier visits a beneficiary's home in Pennsylvania to perform the general maintenance and servicing on a portable concentrator, the supplier would enter E1392MS on the claim and the allowed payment amount would be equal to the lesser of the supplier's actual charge or two units of the allowed payment amount for K0739 in Pennsylvania. If the supplier visits the beneficiary's home to provide the periodic maintenance and servicing for a stationary concentrator (E1390 or E1391) and a transfilling unit (K0738), payment can be made for maintenance and servicing of both units (E1390MS or E1391MS, and K0738MS). If the supplier visits the beneficiary's home to provide the periodic maintenance and servicing for a portable concentrator (E1392),

payment can only be made for maintenance and servicing of the one unit/HCPCS code (E1392MS).

CMS will issue further instructions in the future regarding continuation of these payments for dates of service on or after January 1, 2010.

Background

Section 144(b) of MIPPA repeals the transfer of ownership provision established by the Deficit Reduction Act (DRA) of 2005 for oxygen equipment and establishes new payment rules and supplier responsibilities after the 36-month payment cap. Initial instructions related to implementation of these changes were issued as part of the January 2009 Durable Medical Equipment Prosthetics Orthotics & Supplies (DMEPOS) Fee Schedule Update, CR 6297. The MLN Matters article related to CR6297 may be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6297.pdf on the CMS Website.

Key Points in CR6296

- To distinguish between the repair or nonroutine service of beneficiary-owned DME and oxygen equipment, two new "K" codes are effective for claims with dates of service on or after April 1, 2009. Those "K" codes are:
  - K0739 – Repair or Nonroutine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes
  - K0740 – Repair or Nonroutine Service for Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes

- The new non-covered code K0740 should be used by suppliers to indicate the labor associated with the repair of stationary or portable oxygen equipment.

- The existing E1340 HCPCS code is invalid for Medicare claims, effective April 1, 2009. The revised 2009 labor payment rates, provided in CR 6297, map directly to the new K0739 code and will be used to pay claims for code K0739 with dates of service on or after April 1, 2009.

- **Note that the two new codes are not yet final and should not be used until effective on April 1, 2009.**

- DME MACs and RHHIs:
  - Deny claims with dates of service on or after April 1, 2009 for HCPCS code K0740.
  - Will deny claims with dates of service on or after January 1, 2009, for claims received on or after April 6, 2009, for replacement parts billed using a HCPCS code and the "RB" modifier when the part is replaced in conjunction with the repair of oxygen equipment identified by HCPCS codes E0424, E0431, E0434, E0439, E1390, E1391, E1392, E1405, E1406, or K0738.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR 6296) issued to your Medicare DME MAC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R443OTN.pdf on the CMS Website.

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

If you have questions, please contact your DME MAC and RHHI 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

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