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Medical Directors' Corner**INAPPROPRIATE USE OF MODIFIERS 25 AND 59**

In December of 2005, the Office of the Inspector General (OIG) issued two reports. The first report concerned the use of modifier 25. Medicare payments for medical procedures include payments for certain evaluation and management (E/M) services that are necessary prior to the performance of a procedure. Medicare does not normally allow additional payments for separate E/M services performed by a provider on the same day as a procedure. However, if a provider performs an E/M service on the same day as a procedure that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure, modifier 25 may be attached to the claim to allow additional payment for the separate E/M service. In calendar year 2002, Medicare allowed \$1.96 billion for approximately 29 million claims using modifier 25. The OIG randomly selected 450 claims billed in the calendar year 2002 using modifier 25 for medical review. Thirty-five percent of claims using modifier 25 that Medicare allowed did not meet program requirements. Extrapolating this error rate to the total number of claims paid resulted in \$538 million in improper payments.

The second report concerned the use of modifier 59. The National Correct Coding Initiative (CCI) edits began in January 1996. This initiative was developed to promote correct coding by providers and to prevent Medicare payments for improperly coded services. The CCI edits contain code pairs that generally should not be billed together by a provider for a beneficiary on the same date of service. Under certain circumstances, a provider may bill for two services in a CCI code pair and include a modifier on the claim that would bypass the edit and allow both services to be paid. Modifier 59 is one of these modifiers. Modifier 59 is used to indicate that a provider performed a distinct procedure or service for a beneficiary on the same day as another procedure or service. It may represent a different session, different procedure or surgery, or different anatomical site or organ system, separate incision or excision, or separate injury. OIG selected a random sample of 350 code pairs for services that bypassed CCI edits using modifier 59 in fiscal year 2003. Forty percent of code pairs billed with modifier 59 did not meet program requirements. Extrapolating this error rate to the total number of claims paid resulted in \$59 million in improper payments.

As a result of these findings, The Centers for Medicare & Medicaid services is encouraging all contractors, including carriers and Program Safeguard Contractors (PSCs) to conduct prepayment and postpayment reviews of the use of modifiers 25 and 59.

In another effort to combat fraud and abuse in the Medicare program, the Tax Relief and Health Care Act of 2006 required the expansion of Recovery Audit Contractors (RACs) to all 50 states by 2010. The RACs currently operate as a demonstration project in Florida, New York, and California. The three existing RACs recovered \$303 million in overpayments in 1 ½ years.

With the continued rapidly increasing costs of the Medicare program, improper payments, whether due to fraud or abuse, hurt all Medicare providers and beneficiaries. All contactors are redoubling their efforts to eliminate these improper payments.

- *Kenneth L. Bussan, MD*
Carrier Medical Director - Wisconsin

Items of Importance*** IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS ***

WPS Medicare Provider Customer Service will be closing for brief periods so our Customer Service Representatives may participate in training sessions. Our representatives are eager to learn more in order to serve you better. During the month of April, we will be closed on:

- Thursday, April 12, 2007, 8:00 am to 10:00 am CT
- Thursday, April 26, 2007, 8:00 am to 10:00 am CT

We will also be closed the afternoon of April 6, 2007, in observance of Good Friday.

At these times, the Interactive Voice Response (IVR) and CMS Secure Net Access Pilot (C-SNAP) will continue to be available for your use to check eligibility and claim status. For more information regarding C-SNAP, please call 1-877-476-8116 or visit our Website at <https://medicareinfo.com/apps/cms/home.do>

For more information regarding the IVR, please check out our Website at: <http://www.wpsmedicare.com/provider/pdfs/ivr.pdf>

Alternatively, to use the IVR, call:

Illinois (877) 908-9499 Michigan (877) 567-7201
Minnesota (877) 908-8470 Wisconsin (877) 567-7176

Thank you for your patience and for allowing us this opportunity to serve you better.

2007 MEDICARE PARTICIPATING PHYSICIAN/SUPPLIER DIRECTORY (MEDPARD) NOW AVAILABLE

The new Medicare Part B Participating Physician/Supplier Directory (MEDPARD) for 2007 is now available on the WPS Website at:

http://www.wpsmedicare.com/bene/find_a_doctor.shtml

Please review this site for the most up-to-date information. If you have questions about a specific provider's participation status, please call our Customer Service Center at:

WI: (866) 359-1599
IL: (866) 234-7340
MI: (866) 234-7331
MN: (866) 359-1598

CHANGES COMING TO THE COMPLEX INQUIRY PAGE

In order to serve you better, WPS Medicare is redesigning the Complex Inquiries (found at http://www.wpsmedicare.com/provider/complex_inquiry.shtml) into fact sheets and articles, which will be available on topic-specific pages. The pages will provide “one-stop shopping” for the information you need.

Any bookmarks you have for the Complex Inquiry pages may not work in the future. We will keep you informed of any changes to the page as they occur. For the most up-to-date information about this project and other WPS Medicare information, please sign up for WPS Medicare e-News (Listserv) at <http://www.wpsmedicare.com/listserv>

CHIROPRACTIC DEMONSTRATION ENDS ON MARCH 31, 2007

The Medicare Chiropractic Demonstration, as mandated by Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA,) has been conducted in our state for the last two years and will end on March 31, 2007.

Brandeis University, under contract with CMS to conduct an independent evaluation of the Demonstration, is currently compiling data regarding patient survey responses, service utilization, and provider participation. Additionally, Brandeis is interviewing key players in the Demonstration to obtain their impressions.

An interim report of Brandeis' findings will be sent to Congress in Spring, 2008. The final report is due in late 2009.

INTERACTIVE VOICE RESPONSE (IVR) ENHANCEMENTS EFFECTIVE 03/03/2007

As previously communicated, WPS upgraded the IVR with added features and new security requirements. The new IVR changes took effect on March 3, 2007. Outlined below are the detailed descriptions of the modifications. The new IVR brochure was available for download on March 5, 2007.

http://www.wpsmedicare.com/provider/prov_resources.shtml

Eligibility changes -

- Gender authentication. The IVR no longer authenticates or prompts the caller for the beneficiary's gender.
- Corrected Health Insurance Claim Number (also known as the HICN or Medicare number). The IVR now voices back to the caller the corrected HICN if a previously assigned HICN is used by the caller to obtain eligibility. (The caller also hears the corrected HICN while in the claim status menu option).
- Date of death. The IVR now provides the beneficiary's date of death in the general eligibility section.

- Eligibility details. After general eligibility is played, there is a new option for the caller to request eligibility details. The information listed below is what is heard in the eligibility details section.
- Medicare Secondary Payer (MSP). The MSP type (working aged, liability, etc.) is played to the caller as well as effective and term dates if applicable. Up to two valid records are played.
- Health Maintenance Organization (also known as an HMO or Medicare Advantage Plan). The HMO plan ID is played as well as effective and term dates if applicable. Up to two valid records are played. The HMO name and type (cost versus risk) are played as before. Providers are reminded to submit their claims to the proper payer. Please note that if a beneficiary is enrolled in an HMO, the IVR states that Medicare is primary. It is important that the provider listen to whether the IVR states the HMO is a risk-type HMO or cost-type HMO. If the HMO is a risk-type, providers may only bill the HMO. If the HMO is a cost-type, providers may bill the HMO or WPS as the Medicare Part B Carrier. Please refer to Chapter 1 of Publication 100-04 on the Centers for Medicare and Medicaid Service's (CMS's) website for further details on claim submission (<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>).
- Crossover. The crossover company name is played for up to two valid records. Note that the caller may hear the same name twice; this is due to constraints in programming. Note also, the name is voiced back to the caller using text-to-speech technology and may not be pronounced properly.
- Home Health. The home health information has been moved to the "details" section and plays as before – whether the beneficiary is receiving home health and the date home health was discontinued.

Claim status changes -

- Patient name as an added validation element. The IVR now asks for and verifies the patient's name in the claim status menu option as an added security layer.
- Non-assigned claims. For security reasons, the IVR only provides the following information on non-assigned claims - whether the claim has been received, date it finalized or if it's in process, and whether the claim crossed over.
- Deported and incarcerated beneficiaries. The IVR now checks to see if a beneficiary has either an incarcerated or deported record on CWF. In the extremely rare instance that there is a valid record, the IVR cannot release any claim information for that beneficiary. The IVR will play a message - "I'm sorry, we are unable to provide claim information for this beneficiary." The IVR then refers the caller to a Customer Service Representative (CSR) as CSR's can provide claim information in these situations.
- Corrected HICN. If the caller gives a HICN that has been corrected/changed, the IVR voices back to the caller the corrected number. The IVR uses the corrected number to obtain claim status.

Deductibles changes -

- Gender authentication. The IVR no longer authenticates or prompts the caller for the beneficiary's gender.

Overall menu changes and the "I have a question" prompt -

- Phone numbers, addresses, and the appeal rights message have been moved to a new section called "I have a question." The menu looks as follows.
 1. Eligibility
 2. Claim Status
 3. Provider Summary
 4. Checks
 5. Deductibles
 6. Pricing
 7. I Have a Question
 1. Medicare News (Up to 9 messages determined and maintained by WPS)
 2. Appeal Rights
 3. Phone Numbers
 4. Addresses
- There is a new submenu option within "I have a question" called Medicare News. This plays up to nine informational messages and is controlled and updated by WPS.
- Changed HICNs. In certain situations when a Medicare number has changed, and the IVR is unable to retrieve the new number, the IVR voices a message to tell the caller that the Medicare number has possibly changed and to contact the beneficiary for the new number.

We believe the provider community will benefit from the additional information the IVR now provides. It is our goal to remain committed to enhancing this self-service application while remaining vigilant to beneficiary's security and privacy. Looking to the future, integrating the National Provider Identifier (NPI) into use with the IVR will be the next greatest upcoming modification. Look for future announcements on the looming upgrade.

NATIONAL PROVIDER IDENTIFIER (NPI) FOR A SERVICE FACILITY

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

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

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

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

CMS recently clarified that although you are *not required* to submit a service facility NPI in item 32A, it must be an NPI if you choose to enter a service facility identifier on any Form CMS-1500 submitted on or after May 23, 2007.

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

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

TEMPORARY ADDITION TO THE ADMINISTRATIVE SIMPLIFICATION COMPLIANCE ACT (ASCA) EXCEPTION LIST FOR MEDICARE SECONDARY PAYER (MSP) CLAIMS

~CMS MLN Matters~

MLN Matters Number: MM5488
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R1194CP

Related Change Request (CR) #: 5488
Effective Date: April 9, 2007
Implementation Date: July 1, 2007

Provider Types Affected

Physicians and providers submitting co-payment reimbursement claims to Medicare carriers and Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5488 which informs Medicare carriers and A/B MACs that a temporary waiver to a requirement of the Administrative Simplification Compliance Act (ASCA) is being granted for certain claims as discussed in this article.

CAUTION – What You Need to Know

An exception has been created in CR 5488 that instructs carriers and A/B MACs, who use the Medicare Multi-Carrier System (MCS) for claims processing, to grant a temporary ASCA waiver (until July 1, 2007) for Electronic Media Claim (EMC) MSP claims to allow processing of MSP claims for reimbursement of a beneficiary for co-payment paid to the provider when the primary payer is an employer Managed Care Organization (MCO).

GO – What You Need to Do

Participating Medicare providers must not accept from the beneficiary any co-payment, or coinsurance, upon services rendered when the primary payer is an employer MCO insurance, or any other type of primary insurance. Providers must follow the Medicare Secondary Payer rules and bill Medicare as the secondary payer after the primary payer has made payment. Medicare will inform you on its remittance advice the amount you may collect from the beneficiary. See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Administrative Simplification Compliance Act (ASCA) requires that claims must be submitted to Medicare electronically. CR 5488 instructs MCS contractors (carriers and A/B MACs) to grant a temporary waiver (until July 1, 2007) for Electronic Media Claim (EMC) MSP claims to allow processing of MSP claims for reimbursement of a beneficiary for co-payment paid to the provider when the primary payer is an employer Managed Care Organization (MCO). Therefore, until July 1, 2007, MCS carriers and A/B MACs are instructed to temporarily:

- Allow for co-payment reimbursement claims to be submitted on paper, and
- Send reimbursement directly to the beneficiary.

Additional Information

The official instruction, CR5488, issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1194CP.pdf> on the CMS web site. If you have any questions, please contact your Medicare carrier or A/B MAC at their toll-free number, which may be found on the CMS web site at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

WPS MEDICARE OFFERS NEW EDUCATIONAL TOOL

WPS recently acquired Mediasite, an educational tool that gives you the opportunity to attend a presentation when your schedule allows.

What is Mediasite?

Mediasite is an on-line webinar tool used to record a presentation, including the speaker and the visual aids (such as PowerPoint presentations). The entire presentation is then streamed over the Internet. Mediasite presents several advantages:

- Presentations will be available both live and on-demand (recorded)
- An unlimited number of users can watch a session
- Users do not need to download special software to view a presentation
- Because the entire presentation is on-line, your office will not need to tie up phone lines

What do I need to view a WPS Medicare Mediasite presentation?

- A computer with Internet access and a sound card
- A desire to learn more about Medicare Part B



Mediasite recordings will be marked on our Website with a special icon: Please note that when you click on a Mediasite link, the URL will change from wpsmedicare.com to wps.mediasite.com. You will still be on the WPS Medicare Website.

Want to learn more? View our recording of a Mediasite presentation at http://www.wpsmedicare.com/provider/eye_mediasite.shtml

PQRI Information Available

A new CMS web page dedicated to providing information on the Physician Quality Reporting Initiative (PQRI) is now available.

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by CMS. CMS has titled the statutory program the Physician Quality Reporting Initiative. For more information, visit <http://www.cms.hhs.gov/pqri> on the CMS website.

Claim Submission**CODING CHANGE FOR LUMBAR ARTIFICIAL DISC REPLACEMENT
(LADR)**

~CMS MLN Matters~

MLN Matters Number: MM5462 Revised
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R1164CP

Related Change Request (CR) #: 5462
Effective Date: January 1, 2007
Implementation Date: March 13, 2007

Note: This article was revised on February 1, 2007, to show the correct code of 0163T in the last bullet point on page 2. The article had incorrectly reflected 0263T. All other information remains the same.

Provider Types Affected

All physicians and providers who submit claims to Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs), for LADR.

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

Effective for services on or after January 1, 2007, the CPT codes for billing LADR are changing.

CAUTION – What You Need to Know

No change in Medicare policy results from this coding change. But, be sure billing staff use the correct codes to assure prompt and correct payment of your claims.

GO – What You Need to Do

For services on or after January 1, 2007, use CPT code 22857 in place of CPT Category III code 0091T for LADR. Also, use new CPT Category III code 0163T in place of CPT Category III code 0092T for services on or after January 1, 2007. CPT Category III codes 0091T and 0092T are still appropriate for services on or before December 31, 2006, but are discontinued as of December 31, 2006.

Background

This article is based on Change Request (CR) 5462 and the purpose is to announce a coding change effective January 1, 2007 for LADR. A prior change request (CR) 5057, transmittal 992, issued on June 23, 2006 contains correct codes for services rendered in 2006. However, beginning with services rendered on or after January 1, 2007 there are new coding changes. If you would like to review the MLN article that resulted from CR 5057 click on the following link:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5057.pdf> on the CMS website. Please be aware that the National Coverage Determination (NCD) issued under CR 5057 is not changing, only the codes that should be utilized have changed.

Effective for services performed on or **after January 1, 2007**, carriers will **deny claims**, for Medicare beneficiaries over sixty years of age, submitted with the following Codes:

- **CPT code 22857** for total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, **single interspace**.
- **CPT Category III code 0163T** for total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), lumbar, **each additional interspace**.

Carriers and A/B MACs will continue to follow their normal claims processing criteria for investigational device exemptions (IDEs) for LADR performed with an implant eligible under the IDE criteria.

Carriers will **allow claims** submitted for approved IDEs/clinical trials submitted with:

- **0091T or 0092T** for services performed from May 16, 2006 through December 31, 2006
- **22857 or 0163T** for services performed on or after January 1, 2007 with the modifier QA.

Additional Information

If you have questions, please contact your Medicare A/B MAC or carrier at their toll-free number which may be found at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

For complete details regarding this Change Request (CR) please see the official instruction (CR5462) issued to your Medicare A/B MAC or carrier. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1164CP.pdf> on the CMS web site.

QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI) EDITS, VERSION 13.1, EFFECTIVE APRIL 1, 2007

~CMS MLN Matters~

MLN Matters Number: MM5492
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R1201CP

Related Change Request (CR) #: 5492
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

Physicians who submit claims to Medicare carriers and A/B Medicare Administrative Contractors (A/B MACs).

What You Need to Know

CR 5492, from which this article is taken, gives your carriers and A/B MACs the latest package of Correct Coding Initiative (CCI) edits. These edits (Version 13.1), which include all previous versions and updates from January 1, 1996, will be effective on April 1, 2007.

Background

This article and related Change Request (CR) 5492 provide a reminder for physicians to take note of the latest quarterly Correct Coding Initiative updates. This package of CCI edits, Version 13.1, effective April 1, 2007, will be available via the CMS Data Center (CDC) at the website shown below.

The CMS National Correct Coding Initiative helps promote national correct coding methodologies and helps control improper coding. The policies are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice.

The latest package of CCI edits, Version 13.1, is effective on April 1, 2007. This version will include all previous versions and updates from January 1, 1996 to the present; and will be organized in two tables: 1) Column 1/Column 2 Correct Coding Edits table; and 2) Mutually Exclusive Code (MEC) Edits table.

Additional Information

You can find the official instruction, CR5492, issued to your carrier or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1201CP.pdf> on the CMS website. The CCI and MEC file formats will be maintained in the Medicare Claims Processing Manual (Publication 100-04), Chapter 23, Section 20.9, which can be found at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS web site. You can see the current CCI and Mutually Exclusive Code (MEC) edits at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> on the CMS web site.

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>

REVISIONS TO INCOMPLETE OR INVALID CLAIMS INSTRUCTIONS NECESSARY TO IMPLEMENT THE REVISED HEALTH INSURANCE CLAIM FORM CMS-1500 (VERSION 8/05) ~ CMS MLN Matters ~

MLN Matters Number: MM5391 Revised
Related CR Release Date: February 23, 2007
Related CR Transmittal #: R1187CP

Related Change Request (CR) #: 5391
Effective Date: May 23, 2007
Implementation Date: May 23, 2007

Note: This article was revised on March 20, 2007, to eliminate the words "electronically submitted" from the bullet point at the top of page 3. All other information remains the same.

Provider Types Affected

Physicians and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Regional Carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 5391 which revises the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 1, Section 80.3.2) relating to the handling of incomplete and invalid claims to reflect the changes in reporting items for the National Provider Identifier (NPI) on the revised Form CMS-1500 version 08/05 and updates the

references to remark codes in the instructions and revises the instructions to indicate what is consistent with Health Insurance Portability and Accountability Act (HIPAA) guidelines. Affected providers should assure their billing staff are aware of NPI reporting requirements. These changes apply to claims received on or after May 23, 2007.

Background

The Centers for Medicare & Medicaid Services Form 1500 (CMS-1500; Health Insurance Claim Form) has been revised to accommodate the reporting of the National Provider Identifier (NPI). The revised form is designated as Form CMS-1500 (8/05). The revisions to CMS-1500 include additional items for the reporting of the NPI. The manual revisions also include items that have already been implemented through the Competitive Acquisition of Part B Drugs and Biologicals (CAP) through the following Change Requests (CRs):

- CR4064 at <http://www.cms.hhs.gov/Transmittals/Downloads/R777CP.pdf> and MLN Matters article MM4064 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>
- CR4306 at <http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf>
- CR4309 at <http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf> and MLN Matters article MM4309 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf>
- CR5079 at <http://www.cms.hhs.gov/transmittals/downloads/R1055CP.pdf> and
- CR5259 at <http://www.cms.hhs.gov/transmittals/downloads/R1034CP.pdf>

As a result of the revisions included in the Form CMS-1500 (8/05), the incomplete and invalid claims instructions are being updated to reflect the appropriate items in which the NPI will be reported.

CR 5391 instructs Medicare contractors (carriers, DMERCs, DME MACs, and A/B MACs):

- To make all necessary changes to their internal business processes to enable the return of claims as unprocessable that do not report an NPI when required in a provider name segment or another provider identification segment in an electronic or a CMS-1500 (08/05) paper claim. See the Medicare Claims Processing Manual (Pub. 100-04), Chapter One (Sections 80.3.2.1.1 through 80.3.2.1.3) included as an attachment to CR5391, and the Health Care Claim Professional 837 Implementation Guide (<http://www.wpc-edi.com/>) for further information.
- To use the appropriate remittance advice remark codes provided in the Medicare Claims Processing Manual, Chapter One, (Pub. 100-04), Chapter One, Sections 80.3.2.1.1 through 80.3.2.1.3, when returning claims as unprocessable.
- To not search their internal files:
 - To correct a missing or inaccurate NPI on a Form CMS-1500(8/05) or on an electronic claim.
 - To correct missing or inaccurate information required for HIPAA compliance for claims governed by HIPAA.

Additional Information

For complete details, please see the official instruction issued to your Medicare contractor (carrier, DMERC, A/B MAC, or DME MAC) regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1187CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found on the CMS web site at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

Flu Shot Reminder**It's Not Too Late to Give and Get the Flu Shot!**

The peak of flu season typically occurs between late December and March; however, flu season can last until May. **Protect yourself, your patients, and your family and friends by getting and giving the flu shot.** Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a lifetime pneumococcal vaccination. Remember - influenza and pneumococcal vaccination and their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS' website:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf>

Coverage – General

**BILLING FOR MAZE PROCEDURE PERFORMED CONCURRENTLY
WITH OTHER OPERATIVE HEART PROCEDURES**

It is not correct to bill one of the three new (2007) CPT codes (33254, 33255, 33256) for operative tissue ablation and reconstruction of the cardiac atria (MAZE) when performed with other operative cardiac procedures. In this situation, providers should use the NOC code 33999. In Item 19 of the CMS 1500 claim form (or the equivalent field of an electronic claim form), providers should put one of the following descriptions which best describes the 33999 service performed when another operative cardiac procedure was performed:

- 1) 33254 concurrent MAZE
- 2) 33255 concurrent MAZE
- 3) 33256 concurrent MAZE

Please note that you cannot actually bill 33999 AND CPT 33254, CPT 33255, or CPT 33256. The use of CPT 33254, 33255, or 33256 in item 19 is for describing the extent of the MAZE service performed. It is only informational. The choice of code depends on whether the procedure was *limited*, *extensive*, or *extensive with cardiopulmonary bypass*. This coding instruction is effective January 1, 2007.

**CAVERNOUS NERVES ELECTRICAL STIMULATION WITH PENILE
PLETHYSMOGRAPH
~CMS MLN Matters~**

MLN Matters Number: MM5294 Revised
Related CR Release Date: November 24, 2006
Related CR Transmittal #: R61NCD

Related Change Request (CR) #: 5294
Effective Date: August 24, 2006
Implementation Date: January 8, 2007

Note: This article was changed on December 6, 2006 to correct the HCPCS code for the test. The article had incorrectly stated to use HCPCS code 58899 (page 3), but it should have stated HCPCS code 55899. The reference to carriers and FIs was also changed to add a reference to A/B MACs. All other information remains the same.

Provider Types Affected

Physicians and hospitals who bill Medicare fiscal intermediaries (FI) and carriers for performing Cavernous Nerves Electrical Stimulation with Penile Plethysmography in Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

Provider Action Needed

STOP – Impact to You

Effective for claims with dates of service on or after August 24, 2006, Medicare will not pay for performing Cavernous Nerves Electrical Stimulation with Penile Plethysmography in Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

CAUTION – What You Need to Know

CR 5294, from which this article is taken, announces the results of a national coverage determination (NCD) addressing Cavernous Nerves Electrical Stimulation with Penile Plethysmography performed for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures. It states that CMS, after reviewing the evidence, has determined that this test is not reasonable and necessary for Medicare beneficiaries undergoing these procedures.

GO – What You Need to Do

Make sure that your billing staffs are aware of this NCD.

Background

The direct application of electrical stimulation with penile plethysmography (also referred to as cavernosal nerve mapping) may be performed, in nerve-sparing prostatic and colorectal surgical procedures, to assess the integrity and function of the cavernous nerves.

Through either an open or laparoscopic approach, the surgeon can assess the function of the cavernous nerves by stimulating, with an electrical nerve stimulator, the most distal end of the nerve that can be located. A functioning and stimulated nerve will trigger blood flow either into or out of the penis, which can be detected via a penile plethysmography sensor fitted around the penis and connected to a nerve stimulator control unit. If the nerves are intact, cavernous blood flow will cause slight changes in penile girth, which the sensor can detect. The presence (and degree) of a response may be used to provide the surgeon with a more realistic assessment of the chance of the patient regaining potency and assist in choosing appropriate therapy.

Heretofore, local Medicare carriers/FIs had the discretion to cover this test whenever it was determined to be medically necessary for the individual patient, because a national coverage determination (NCD) or national Medicare coverage policy had not been issued. However, on December 9, 2005, a request for review of this test initiated a national coverage analysis.

CR 5294, from which this article is taken, announces the results of this NCD. It provides that CMS has reviewed the evidence and determined that: 1) Cavernous Nerves Electrical Stimulation with Penile Plethysmography is not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures, and 2) this test is noncovered under Medicare (as specified the Medicare National Coverage Manual (100-03, Section 160.26 (Cavernous Nerves Electrical Stimulation with Penile Plethysmography)).

Effective with claims with dates of service on or after August 24, 2006, your FIs and carriers will not pay for these services.

Physicians should use HCPCS code 55899 to bill this for test. Your FIs and carriers will suspend claims containing this code to determine whether this test is the service being billed, and will deny the line item associated with it, using Medicare Summary Notice 21.11 (This test was not covered by Medicare at the time you received it).

You should be aware that your FIs, A/B MACs and carriers will not search for, and adjust, claims for tests that have been paid prior to January 8, 2007, but they will adjust claims brought to their attention. Further, physicians and hospitals should, as appropriate:

1. Issue the appropriate liability notice for Medicare beneficiaries having this test;
2. Include the following language when issuing an Advanced Beneficiary Notice (ABN):
 - **Under “Items or Service” Section:** Cavernous Nerves Electrical Stimulation with Penile Plethysmography.
 - **Under “Because” Section:** As specified in section 160.26 of Medicare NCD Manual, Medicare will not pay for this test as it is not reasonable and necessary for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures. and/or
3. Issue a hospital Issued Notice of Noncoverage (HINN).

If a physician does not issue an ABN, the physician is liable for the service.

Additional Information

You can find more information about payment for Cavernous Nerves Electrical Stimulation with Penile Plethysmography by going to CR5294, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R61NCD.pdf> on the CMS site. You will find revised section 160.26 (Cavernous Nerves Electrical Stimulation with Penile Plethysmography) of the Medicare National Coverage Manual (Publication 100-03) as an attachment to this CR.

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

COVERAGE OF ERYTHROPOIESIS STIMULATING AGENTS (ESAS)

Coverage of Erythropoiesis Stimulating Agents (ESAs) for anemia of cancer will be terminated March 19, 2007 based on new evidence that indicates this may not be safe and effective treatment.

Due to the results of a recent study, the *USPDI* has removed coverage for this condition. There are now new boxed warnings for these drugs.

WPS, like all other Medicare contractors, is bound by the Medicare Benefit Policy Manual (CMS Pub 100 -02). Section 50.4.5 of this national document states:

“If a use is identified as not indicated by CMS or the FDA, or it’s use is specifically identified as not indicated in one or more of the three compendia mentioned or if the carrier determines, based on peer reviewed literature, that a particular use of the drug is not safe and effective, the off-label use is not supported and, therefore, the drug is not covered.”

Similarly, in the Program Integrity Manual (CMS Pub 100-08) the following section indicates that Medicare carriers can restrict coverage without going to a Carrier Advisory Committee (CAC) if

they receive CMS Regional Office approval. Our regional office, has approved this restriction of coverage.

**PIM 13.7.3 - LCDs That Do Not Require a Comment and Notice Period
(Rev. 71, 04-09-04)**

Revised LCD Being Issued for Compelling Reasons - SHALL OBTAIN RO
(for PSCs, the GTL, Co-GTL, and SME) APPROVAL - For example, a highly unsafe procedure/device.

The policy will be changed as follows.

LCD Title

Erythropoiesis Stimulating Proteins
Epoetin alfa (EPO), Darbepoetin alfa (DPA)

Contractor's Determination Number

INJ-023

Indications and Limitations of Coverage and/or Medical Necessity

The following section will be removed

3. Anemia associated with non-myeloid malignancy

The anemia must be due to the non-myeloid malignancy itself, chemotherapy (current or previous) and/or radiotherapy (current or previous). The patient must have documented anemia described as follows:

The patient must have, within the past 30 days, HCT 33 or below or HGB 11 or below, before coverage by WPS Medicare will begin. Where the patient has required a blood or red cell transfusion within the past month, you may use the most recent HCT or HGB before the transfusion.

ICD-9 Codes that Support Medical Necessity

1. EPO or DPA for ESRD on Dialysis

J0886 Injection of EPO, per 1000 units
J0882 Injection darbepoetin alfa, per 1mcg

285.21- anemia in end-stage renal disease.

2. EPO or DPA for indications other than ESRD on dialysis

J0885 Injection of EPO, per 1000 units
J0881 Injection of DPA, per 1 mcg

The crossed out section will be removed.

a. ~~For non-myeloid malignancies or multiple myeloma, code 285.22 - anemia in neoplastic disease plus one of the following: 140.0-204.91, 230.0-238.6, 238.8-239.9, 273.3.~~

a. For Anemia of Chronic disease use ICD-9 code 285.29. No other ICD-9 code is needed.

- b. Use both the anemia code (285.8 or 285.9) and one of the following codes or combination of codes, according to the disease that is being treated:
- i. Chronic renal disease (CRD) (585.1 - 585.9) - Use one of these codes to indicate CRD not yet on dialysis.
 - ii. AZT treatment with AIDS (042, 079.53)
 - *iii. For chemotherapy induced anemia use 995.20 to indicate the anemia is secondary to chemotherapy properly administered to treat neoplastic or other diseases. Also indicate the diagnostic code for the disease being treated.
(Three diagnosis codes will be required when billing for chemotherapy induced anemia: 285.8 or 285.9 to indicate the anemia; 995.20 to indicate the chemotherapy and a third code to indicate the underlying condition.)
 - *iv. For multiple myeloma (203.00)
 - v. Myelodysplastic syndrome (238.72, 238.73, 238.74, 238.75, 284.9, 285.0),
- Chronic myelomonocytic leukemia (CMML)
 - vi. Prophylactic pre-operative use (V07.8) for reduction of allogenic blood transfusions prior to elective hip and knee replacement surgery.

Note: ICD-9 codes must be coded to the highest level of specificity.

INTERSPINOUS PROCESS DECOMPRESSION SYSTEM

WPS Medicare Part B will cover the implantation of an Interspinous Process Decompression System in accordance to the FDA-approved indications. This system will be covered for the treatment of patients aged 50 or older suffering from neurogenic intermittent claudication secondary to a confirmed diagnosis of lumbar stenosis with x-ray, MRI and/or CT evidence of thickened ligamentum flavum, narrowed lateral recess and/or central canal narrowing. This system is indicated for those patients with moderately impaired physical function who experience relief in flexion from their symptoms of leg/buttock/groin pain, with or without back pain, and have undergone a regimen of at least 6 months of nonoperative treatment. This device may be implanted at one or two lumbar levels in patients in whom operative treatment is indicated at no more than two levels. The medical record must document the above requirements. Only FDA-approved systems (e.g. X STOP) will be covered.

Claims for the implantation of these systems should use the CPT codes 0171T, *Insertion of posterior spinous process distraction device, lumbar; single level*, and 0172T, *Insertion of posterior spinous process distraction device, lumbar; each additional level*. These codes became effective 01/01/2007. Place the name of the FDA-approved decompression system in item 19 of the CMS-1500 claim form or its electronic equivalent. The claim must also have both the ICD-9 code for spinal stenosis 724.02 Spinal stenosis, lumbar region and the ICD-9 code for neurogenic intermittent claudication 349.9 Unspecified disorders of the nervous system.

OPEN MEETING ON DRAFT LOCAL COVERAGE DECISIONS (LCD)

In order to assure that development of Local Coverage Decisions (LCD) occurs through a public and open process, WPS, the Medicare Part B Carrier for Wisconsin, Illinois, Michigan, and Minnesota, sponsors open meetings specific to current draft policy. The next Open Policy Meeting will be held Thursday, April 19, 2007, at 1:00 p.m. CST, 2:00 p.m. EST.

WPS Medicare will hold the open meeting to allow the submission of scientific evidence and other information from members of the general public relating to the following draft policies:

INJ-023	Erythropoiesis Stimulating Proteins Epoetin alfa (EPO), Darbepoetin alfa (DPA)
RAD-038	Selective Internal Radiation Therapy (SIRT) for Primary and Secondary Hepatic Malignancy

Comment electronically on the policies listed above using the Draft Local Coverage Decision Comment Board

Interested parties, who wish to make presentations of scientific evidence and other information related to draft local coverage decisions, must submit a written request that includes the following items:

- name, address, telephone number and e-mail address (if applicable)
- name and address of the organization they represent (if applicable)
- name of draft local coverage decision

In addition, two copies of the presentation and any handouts for the meeting must accompany the written request, which will be reviewed by the Medical Director(s). Requests and materials should be forwarded to the lead Carrier Medical Director (CMD) associated with the draft local coverage decision.

All members of the public are invited to offer comment on the draft local coverage decisions via e-mail or in writing to the Medical Directors at the addresses listed below.

Presentations are limited to a maximum of 10 minutes each. The presenter must obtain permission, in writing, for the distribution of any transcription, recording and/or summarization and permission for the copying and/or distribution of any submitted materials. All requests will be acknowledged by either confirming or declining the request to participate in the meeting. Members of the general public are invited.

Dr. Rosenberg is the facilitator for the April 19th meeting.

Wisconsin: WPS
Dr. Bussan
1751 W. Broadway
Madison, WI 53713

Illinois: WPS
Dr. Boren
111 E. Wacker Dr.-Suite 950
Chicago, IL 60601
Large Conference Room

Michigan: WPS
Dr. Rosenberg
23800 Northwestern
Highway - Suite 200
Southfield, MI 48075
Conference Room 228

Minnesota: WPS
8120 Penn Avenue South
Bloomington, MN 55431
Minnesota Room, 2nd Floor

WPS Medicare Tip of the Week

(Published in the 03/05/07 General e-News Listserv)

What is the Centers for Medicare & Medicaid Services (CMS) Online Manual System and where can I access the CMS Internet-only Manuals (IOMs)?

CMS program components, partners, contractors, and State Survey Agencies use the CMS Online Manual System to administer CMS programs. This system offers CMS' day-to-day operating instructions, policies, and procedures based on statutes and regulations, guidelines, models, and directives.

In 2003, CMS transformed their paper-based Program Manuals into a web user-friendly presentation and renamed it the CMS Online Manual System. This system includes the archived paper-based manuals and the current IOMs. You can reference all of the IOMs at the following CMS Website address:

<http://www.cms.hhs.gov/Manuals/IOM/list.asp>

To receive our Tips of the Week, sign up to receive our e-News Listserv at:

<http://www.wpsmedicare.com/listserv>

Coverage – Policies

INFORMATION ON WEBSITE

WPS Medicare publishes Local Coverage Decision (LCDs), National Coverage Provisions (NCPs), and National Coverage Decisions (NCDs), as well as retired LCDs/Local Medical Review Policies (LMRPs) for Medicare Part B on its Website:

http://www.wpsmedicare.com/policies/pol_home.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.

Illinois	Michigan
WPS Medicare Freedom of Information PO Box 4433, Marion, IL 62959	WPS Medicare Freedom of Information PO Box 5533, Marion, IL 62959
Minnesota	Wisconsin
WPS Medicare Freedom of Information 8120 Penn Ave South, Ste. 200, Bloomington, MN 55431	WPS Medicare Freedom of Information PO Box 1787, Madison, WI 53701



Revised Policies for April 2007

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
DERM-004	<i>Mohs' Micrographic Surgery (MMS)</i>	LCD	Click here to view	22
DERM-008	<i>Removal of Benign Skin Lesions</i>	LCD	Click here to view	22
FT-001	<i>Foot Care</i>	NCP	Click here to view	23
GI-008	<i>Colorectal Cancer Screening Benefit</i>	NCD	Click here to view	24
HONC-002	<i>Chemotherapy and Drug Administration</i>	NCP	Click here to view	24
HONC-010	<i>Antineoplastics and their Adjuncts</i>	LCD	Click here to view	25
PHYSMED-009	<i>Physical Medicine and Rehabilitation</i>	LCD	Click here to view	26
PSYCH-015	<i>Health and Behavior Assessment/Intervention</i>	LCD	Click here to view	27

Coverage – Revised Policies

Local Coverage Determination Revision

LCD Title

Mohs' Micrographic Surgery (MMS)

Contractor's Determination Number

DERM-004

Revision Effective Date

04/01/2007

Documentation Requirements

If a skin biopsy is performed on the same day the Mohs' surgery was performed, the physician's documentation should clearly indicate:

- *- There was no prior surgical pathology performed confirming the diagnosis
- The biopsy was performed on a lesion other than the lesion in which the Mohs' surgery was performed or
- If the biopsy is performed on the same lesion in which the Mohs' surgery is performed, the biopsy is performed during an operative session separate from the Mohs' surgery.

~ Companion Article ~

Coding Information

Medicare is aware that a biopsy of the skin lesion for which Mohs' surgery is planned is necessary in order for the physician to determine the exact nature of the lesion(s) to be removed. The National Correct Coding Initiative (CCI) does not permit payment for the biopsy and the Mohs' surgery on the same lesion, in the same operative session, on the same date of service. It is NOT appropriate to report the 59 modifier (distinct procedural service) when the biopsy and Mohs' surgery is performed on the same lesion, in the same operative session, on the same date of service. The -59 modifier should be reported when a biopsy or excision of lesion is performed in situations other than stated above.

- *6. The -59 modifier should be reported when a biopsy/excision is performed with the Mohs' surgery when criteria stated above and in the **Documentation Requirements** of this policy are met.



LCD Title

Removal of Benign Skin Lesions

Contractor's Determination Number

DERM-008

Revision Effective Date

*01/01/2007

The descriptions of CPT code 17000-17004, 17110 and 17111 have been changed with the 2007 HCPCS Update; therefore codes 17110 and 17111 are being added to this policy.

CPT/HCPCS Codes

*17110, *17111

~ Companion Article ~**Article Title**

Removal of Benign Skin Lesions DERM-008: Billing and Coding Guidelines

Article Effective Date

*01/01/2007

Coding Information

- *1. List the appropriate procedure code for the service performed, include any necessary modifiers (See *CPT 2007*). Medicare Global Surgery and CCI rules apply to benign lesion removals.
- *7. When billing the destruction of multiple premalignant lesions use CPT 17000 with a “1” in the unit box (e.g. “0010”) and 17003 with the number of additional lesions destroyed (up to 13 lesions) in the unit box (e.g. “0130”). If 15 or more lesions are destroyed use CPT code 17004 with a “1” in the unit box. 17000 and 17003 are included in 17004, and may not be reported in addition to 17000 and 17003.
- *8. When billing the destruction of multiple other benign lesions use CPT 17110 or 17111 with a “1” in the unit box (e.g. “0010”). 17111 is included in 17110, and these codes may not be reported together.

**National Coverage Provision Revision****Subject**

Foot Care

NCP Number

FT-001

Effective Date

*04/01/2007

Coding Information

I. Explanations

***The services of a non-physician practitioner (PA, NP, CNS), acting within their scope of practice, may be covered under Part B when these services are performed under the appropriate level of physician supervision and/or in collaboration with a doctor of medicine or osteopathy (MD or DO). A podiatrist may not supervise or collaborate with a**

non-physician practitioner for their services, as the podiatrist does not meet the definition of a physician stated in SSA §§1861(r)(1); (s)(2)(K)(i)(ii).



Subject:

Colorectal Cancer Screening Benefit

Subject Number:

GI-008

Effective Date:

01/01/2007

Implementation Date:

07/02/2007

*8. *Deductible and Coinsurance:*

There is no deductible and no coinsurance or copayment for the fecal occult blood tests (G0107 and G0328).

Prior to January 1, 2007, deductible and coinsurance applied to codes (G0104, G0105, G0106, G0120 and G0121). Beginning with services provided on or after January 1, 2007, Section 5113 of the Deficit Reduction Act of 2005 waives the requirement of the annual Part B deductible for these services. Coinsurance still applies.

Effective January 1, 2007, a 25 percent coinsurance applies for all colorectal cancer screening colonoscopies (G0105 and G0121) performed in Ambulatory Surgical Centers (ASCs) and non-OPPS hospital outpatient departments. The 25 percent coinsurance is currently being applied in the Outpatient Prospective Payment System (OPPS) PRICER for OPPS hospitals. However, it is not currently being applied to ASCs or non-OPPS hospitals.

A 25 percent coinsurance also applies for colorectal cancer screening sigmoidoscopies (G0104) performed in non-OPPS hospitals effective for services performed on or after January 1, 2007.



Subject Title

Chemotherapy and Drug Administration

Subject Number

HONC-002

CPT/HCPCS Codes

	Therapeutic, prophylaxis or diagnostic injection;
90772	subcutaneous or intra-muscular
	Chemotherapy administration, subcutaneous or intra-muscular;
96401	non-hormonal anti-neoplastic

The following question and response has been added to this document:

*7. **Example:** Which administration code (90772 or 96401) should be used when billing for the administration of EPO™, Neulasta™ and Leukine™?

Response: EPO™, Neulasta™ and Leukine™ are not chemotherapy agents. They should be billed with the 90772-Therapeutic, prophylaxis or diagnostic, subcutaneous or intra-muscular injection code. It is not appropriate to bill these with CPT code 96401.

CPT 96401 is for the administration of antineoplastic chemotherapeutic agents and biologic response modifiers. Traditional antineoplastic chemotherapy agents and the newer biologic response modifiers have a higher patient risk, requiring special knowledge for use and requires longer patient monitoring.



LCD Title

Antineoplastics and their Adjuncts

Contractor's Determination Number

HONC-010

Revision Effective Date:

04/01/2007

Indications and Limitations:

The following updates have been made to this policy.

Section C:

We have expanded coverage for Paclitaxel protein-bound particles (Abraxane™) to include its use as monotherapy for the first-line treatment of metastatic breast cancer.

We have **removed** the following information from the LCD: Indicated for the treatment of breast cancer after failure of combination chemotherapy for metastatic disease or relapse within 6 months of adjuvant chemotherapy. Prior therapy should have included an anthracycline unless clinically contraindicated.

34. Paclitaxel protein-bound particles, 1 mg (Abraxane™) (J9264)

Breast

174.0-175.9

Paclitaxel protein bound particles is covered for the treatment of metastatic breast cancer.

Section D:

EGFR Expression is no longer required for the treatment of Panitumumab (Vectibix) and has been removed.

3. Panitumumab (Vectibix) (J9999) effective 09/27/06

Colorectal cancer

153.0-154.8

Panitumumab (Vectibix™) is indicated for the treatment of metastatic colorectal carcinoma with disease progression on or following fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens.

**Local Coverage Determination (LCD) Revision****LCD Title**

Physical Medicine and Rehabilitation

Contractor's Determination Number

PHYSMED-009

Revision Effective Date

*04/01/2007

ICD-9 Codes that Support Medical Necessity

Effective for services performed on or after 04/01/2007, ICD-9 code 457.1-Other Lymphedema is added to the diagnosis code lists for CPT codes 97110, 97124, 97140, and 97530.

~ Companion Article ~**Article Title**

Physical Medicine Rehabilitation Procedures and Modalities – PHYSMED-009: Billing and Coding Guidelines

Article Effective Date

10/24/2006

Denial Summary

In the following section the ICD-9 code range was listed as 880.00-887.79 is corrected to 880.00-

887.7

- *15 *Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services announce a NCD stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy, is non-covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries. Contractors shall deny claims with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) if the claim contains any of the following ICD-9 codes:*

250.60-250.63, 354.4, 354.5, 354.9, 355.1-355.4, 355.6-355.9, 356.0, 356.2-356.4, 356.8-356.9, 357.0-357.7, 674.10, 674.12, 674.14, 674.20, 674.22, 674.24, 707.00-707.07, 707.09-707.15, 707.19, 870.0-879.9, *880.00-887.7, 890.0-897.7, 998.31-998.32



Contractor’s Policy Number

PSYCH-015

LCD Title:

Health and Behavior Assessment/Intervention

Revision Effective Date:

Claims submitted on or after 5/16/2007

96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
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Local Coverage Determination (LCD) PSYCH-015 contains a utilization parameter stating, "**The initial service (CPT code 96150) is limited to one visit (maximum of one hour/four 15-minute services) regardless of the number of sessions it takes to complete the initial assessment.**"

A review of claims submitted between 07/01/2006 and 12/31/2006 showed that providers are submitting more than four services. Therefore, effective for claims submitted on and after 5/16/2007, when more than four CPT codes 96150 are submitted by a provider/group the additional services will be denied:

151: Payment adjusted because the payer deems the information submitted does not support this many services.

N115: This decision was based on a Local Medical Review Policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd> or if you do not have Web access, you may contact the contractor to request a copy of the LMRP/LCD.

If a redetermination is requested, documentation showing the medical necessity of the additional time must be submitted.

Electronic Data Interchange (EDI)**NATIONAL PROVIDER IDENTIFIER (NPI) READINESS – CRUCIAL TO PROVIDERS**

NPI is almost here – the requirement that only NPI numbers be used for Medicare claims processing. Have you taken all the steps you should to make sure there is no interruption in your cash flow? Here are some examples of actions you should take.

Make sure you have applied for your NPI number. Don't be caught without an NPI when the deadline arrives. Obtain your NPI by going on-line to: <https://NPPES.cms.hhs.gov/NPPES/Welcome.do> or calling them at 800-465-3203. Be sure to enter all of your Medicare legacy numbers to the NPPES Website to avoid further problems later.

Begin using your NPI number on your electronic claims transmissions. We recommend you still use your Medicare legacy numbers in conjunction with the NPI, but give yourself plenty of time to make sure your NPI is correctly billed. Don't wait until the last minute then find you need programming changes. This could adversely affect your cash flow.

Don't forget to put your NPI number on any forms you submit to the EDI area – NPI is a condition for EDI Enrollment. Make sure you use the NPI number that corresponds with your provider number.

Check your electronic Medicare reports when you use the NPI number on your transmissions. Make sure your NPI is not receiving edits indicating that your number is not on the NPI Crosswalk. See our March 2007 *Communiqué* for steps to take if you are receiving these informational edits. One hint to avoid these edits is to be sure to add your Medicare legacy numbers on the NPPES Website.

Medicare is attempting at all times to keep you educated and informed regarding NPI numbers and other Medicare billing issues. We don't want to see your cash flow interrupted. If you have any questions, please contact the EDI Hotline for IL/MI/WI (877) 567-7261. For Minnesota, please contact (952) 885-2882, (952) 885-2881 or (952) 885-2811

PC-ACE PRO32 SOFTWARE FOR AMBULANCE BILLING

Per CMS Change Request (CR) 5390, effective April 2, 2007, Form CMS-1491 will no longer be a valid format for submitting claims. As of April 2, 2007, suppliers are no longer permitted to submit paper claims on the CMS-1491 form. To read more about this CR, please see the CMS MLN Matters Article at the following Website
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5390.pdf>

WPS Medicare has a HIPAA-compliant software product available for all types of Medicare billing called PC-ACE Pro32. This software may be used for specialty billing, such as ambulance as well as regular office visits.

This software will allow you to submit your Medicare claims electronically. The newest version of PC-ACE Pro32 also allows for your new NPI number.

SOFTWARE COST

PC-ACE Pro32 is free to use for Medicare billers. WPS will provide:

- * Telephone support by WPS Electronic Data Services staff
- * User Manual updates
- * Periodic software updates

PC-ACE Pro32 software can now be downloaded from our Website.

If you are interested in using PC-ACE Pro32, download the PC-ACE request form from: <http://www.wpsic.com/edi/pdf/medbpcace.pdf> or call the EDI Hotline at the numbers below.

If you are currently using the PC-ACE Pro32 billing software, you can now download the most current upgrade at: http://www.wpsic.com/edi/pcacepro32_p.shtml

EDI Hotline for IL, MI and WI: 877-567-7261, or for MN: 952-885-2811, 952-885-2881 or 952-885-2882.

WPS Medicare Tip of the Week

(Published in the 02/26/07 General e-News Listserv)

Do you still have questions on the National Provider Identifier (NPI)? Would you like help answering the questions?

Attend the monthly NPI question and answer teleconferences hosted by WPS Medicare. The teleconference is opened with a short update presentation, followed by approximately 1 hour 15 minutes of providers' questions being answered. For dates and times, visit the following Website:

http://www.wpsmedicare.com/provider/proved_seminar.shtml

To receive our Tips of the Week, sign up to receive our e-News Listserv at:
<http://www.wpsmedicare.com/listserv>

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 C4-10-08
 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.

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 either the National Standard Format (NSF) or American National Standards Institute (ANSI) X12N 837 (version 3051) format (or the HIPAA ANSI X12N 837 (version 4010) when required). 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.

CHANGE TO MEDICARE REFUND PROCEDURE

When returning money to Wisconsin Physicians Service (WPS) Medicare in response to receipt of a refund request letter, please attach your check/payment to the demand letter and return it to the appropriate Post Office Box listed below. In an effort to control costs, WPS Medicare demand letter mailings will no longer include a return-address envelope. WPS Medicare already implemented this cost-saving measure in Minnesota and will now extend this procedure to include those demand letters sent to providers in Wisconsin, Illinois, and Michigan.

For the following respective states, please send your WPS Medicare refunds to:

Wisconsin
P.O. Box 6611
Marion, IL 62959

Illinois
P.O. Box 999
Marion, IL 62959

Michigan
P.O. Box 5511
Marion, IL 62959

For Minnesota, please continue to send your WPS Medicare refunds to:

Minnesota
P.O. Box 7711
Marion, IL 62959

**CHANGES TO THE LABORATORY NATIONAL COVERAGE
DETERMINATION (NCD) EDIT SOFTWARE FOR APRIL 2007**
~CMS MLN Matters~

MLN Matters Number: MM5514
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R1200CP

Related Change Request (CR) #: 5514
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

Provider Action Needed

This article and related Change Request (CR) 5514 announces the changes that will be included in the April, 2007 release of the edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). You may want to assure your billing staff is aware of these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Subsequently, the Centers for Medicare & Medicaid Services (CMS) contracted for nationally uniform software to be developed and incorporated into its claims processing systems so that laboratory claims subject to one of the 23 NCDs can be processed uniformly throughout the nation effective April 1, 2003. The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the Medicare Claims Processing Manual (Publication 100-04), Chapter 16, Section 120.2., available at <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf> on the CMS website.)

These updating changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs, and biannual updates of the ICD-9-CM codes. In addition, many of the listed changes may correct Current Procedural Terminology (CPT) codes to reflect the current CPT update.

CR5514 informs your Medicare carrier, FI, or A/B MAC about changes to the laboratory edit module and changes in laboratory NCD code lists effective for services furnished on or after April 1, 2007.

Key Point of CR5514

Effective for dates of service on or after April 1, 2007:

- The **new HCPCS code G0394** for Blood occult test (e.g., guaiac), feces, for single determination for colorectal neoplasm (i.e., patient was provided three cards or single

triple card for consecutive collection) is added to the list of HCPCS codes for the Fecal Occult Blood Test NCD (190.34).

Additional Information

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

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

To see the official instruction (CR5514) issued to your Medicare carrier, FI, or A/B MAC, go to <http://www.cms.hhs.gov/Transmittals/downloads/R1200CP.pdf> on the CMS website.

DIFFERENTIATING MASS ADJUSTMENTS FROM OTHER TYPES OF ADJUSTMENTS AND CLAIMS FOR CROSSOVER PURPOSES AND REVISING THE DETAILED ERROR REPORT SPECIAL PROVIDER NOTIFICATION LETTERS

~CMS MLN Matters~

MLN Matters Number: MM5472
Related CR Release Date: February 28, 2007
Related CR Transmittal #: R1189CP

Related Change Request (CR) #: 5472
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Note: This article was revised on March 1, 2007, to reflect changes made to CR5472, which CMS revised on February 28, 2007. The CR transmittal number, release date, and Web address for accessing CR5472 have been revised. All other information remains the same.

Provider Types Affected

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

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

This article is based on Change Request (CR) 5472 which implements changes to Medicare contractor systems so that their claim transmissions to the Coordination of Benefits Contractor (COBC) for mass adjustments and other kinds of adjustments may be differentiated from all other types of claims sent for crossover.

CAUTION – What You Need to Know

This will be accomplished through modifications to the 837 COB flat files and National Council for Prescription Drug Programs (NCPDP) Part B drug claim files, all of which are transmitted to the COBC on a daily basis.

Through CR5472, Medicare contractors' systems will be modified so that the COBC Detailed Error Report information that is printed on the outgoing special provider notification letters/report that you receive when claims will not be crossed over due to claim data errors

will be modified to also include the error/trading partner rejection code and accompanying description. These changes to the special provider letters should enable your billing service to determine why claims that were previously selected by Medicare for crossover were not actually crossed over.

Without these changes, CMS would be unable to isolate mass adjustment claims as part of the national COBA crossover process. This change corrects a problem that the Centers for Medicare & Medicaid Services (CMS) encountered as part of its implementation of the Deficit Reduction Act (DRA). Also, providers would continue to be unaware of the specific reasons as to why their patients' claims were not crossed over.

GO – What You Need to Do

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

Background

All Medicare contractors currently send processed claims, for which Medicare systems show the beneficiary has other insurance to the COBC for crossover under the national Coordination of Benefits Agreement (COBA) program.

The Centers for Medicare & Medicaid Services (CMS) requires a method whereby its Coordination of Benefits Contractor (COBC) can differentiate among the various categories of adjustment crossover claims including:

- Mass adjustments - Medicare physician fee schedule (MPFS),
- Mass adjustments - other, and
- All other adjustments.

Having the ability to differentiate among the various categories of adjustment crossover claims will enable CMS (and the COBC) to better address the kinds of contingencies that arise with the passage of legislation such as the Deficit Reduction Act, which mandate changes for Medicare that can affect claims already processed.

CR5472 instructs that the COBC Detailed Error Report process be modified to ensure that the contractor-generated special provider letters which are created and sent in accordance with CR 3709 contain the specific Claredi rejection code returned for the claim along with its description. (See the MLN Matters article at <http://www.cms.hhs.gov/mlnMattersArticles/downloads/MM3709.pdf> for information on CR3709.)

Providers may wish to contact their billing agent/vendor to obtain a better understanding of these error codes and accompanying descriptions, which, in turn, explains why their patients' claims were not crossed over successfully. In addition, providers should notify their billing agent/vendor when they receive special provider letters or reports stating why their patients' claims were not crossed over.

Additional Information

The official instruction, CR5472, issued to your carrier, FI, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1189CP.pdf> on the CMS website. Attached to CR5472, you will find the new chapter of the Medicare Claims Processing

Manual explaining in detail the new special mass adjustment process for COB. In addition, you will also find revised chapters for other portions of that manual, which discuss the COB process.

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

INPATIENT, OUTPATIENT, OFFICE: WHERE IN THE WORLD IS MY PATIENT?

Editor's Note: *This article was originally published in the June 2005 Communiqué. We are republishing the article in response to recent inquiries on this topic.*

Choosing the correct place of service (POS) can be confusing when the patient is physically located at the hospital. The hospital can classify a patient in many different ways. The hospital can classify the patient as inpatient, outpatient, emergency room patient, or observation care patient. These classifications make a difference in the E&M services a physician may bill. Medicare only has two classifications – inpatient and outpatient.

There are special rules concerning patients registered with the hospital with either of the classifications listed above. There are three POS codes used when the patient is registered with the hospital. Discuss with the hospital the specific classification. Those POS codes are:

- 21 Inpatient Hospital
- 22 Outpatient Hospital – This would include Observation Care
- 23 Emergency Room

Physicians should bill professional services separately to Medicare Part B through the Part B contractor. Physician Professional services include the E&M service to treat the patient, the professional component of x-rays, cardiology services, etc. The physician or non-physician practitioner provides these services directly. Non-physician practitioners include nurse practitioners, clinical nurse specialists and physician assistants.

Medicare Part B cannot pay services as “incident to” when provided to a hospital inpatient or outpatient. The hospital includes the services of auxiliary personnel in the charges to Medicare Part A.

The hospital will bill technical services to Medicare Part A through the Fiscal Intermediary for Medicare payment. This is true whether hospital-employed personnel or other entities provide the service. Services provided by entities that lease space from the hospital to provide technical services would need to make arrangements with the hospital to receive payment. The hospital includes the technical service in their claim.

Example 1:

General Hospital admits the patient to the emergency room. Dr. Smith provides an E&M service and orders a chest x-ray. The patient is taken to space leased by ABC Radiology Services to have the chest x-ray performed. The technician performs the chest x-ray and Dr. Brown interprets and provides a written report on the chest x-ray. The charges for these services would be as follows:

- Dr. Smith bills the E&M service under his/her provider number to Medicare Part B.
- He/She uses POS 23 for the E&M service.
- General Hospital bills the Fiscal Intermediary for the technical portion of the chest x-ray.
- ABC Radiology Services and General Hospital make arrangements for ABC Radiology to receive payment. (The charge for the technical portion of the chest x-ray cannot be billed to Medicare Part B even if the radiology service and the hospital do not have a written agreement.)
- Dr. Brown bills Medicare Part B for the professional component of the chest x-ray using POS 23.

Example 2:

General Hospital admits the patient as an inpatient. The staff takes the patient across the hallway to Dr. Jones for a consultation and cardiology service. Dr. Jones' staff provides the technical portion of the cardiology service. Dr. Jones interprets the service and provides a written report.

- Dr. Jones bills the consultation with POS 21.
- General Hospital includes the technical portion of the cardiology service in the bill submitted to the Fiscal Intermediary.
- There should be a written agreement.
- Dr. Jones bills the professional component of the cardiology service to Medicare Part B with POS 21.

Example 3:

General Hospital admits the patient in the outpatient or observation unit. Dr. Smith's nurse accompanies Dr. Smith to treat the patient. The nurse provides a blood pressure check, weight check and provides a B-12 injection. Dr. Smith and his nurse do not provide other services.

- Dr. Smith cannot charge separately for these services. He/she did not provide an E&M service.
- The nurse provided the service.
- The hospital includes nursing services in the charges to the Fiscal Intermediary.
- Services provided as "incident to" are included in the hospital charges.

Example 4:

Dr. Smith sees the patient in the office. He/She determines the patient needs to be admitted to the hospital. Dr. Smith sends the patient to the hospital and the patient is admitted. Dr. Smith then goes to the hospital to perform the Initial Hospital Visit.

- Dr. Smith should not bill an office visit code.
- Dr. Smith includes the E&M services provided in the office to determine the procedure code to bill for the initial hospital visit.
- Dr. Smith can look at the prolonged care codes information to determine if the use of these codes is appropriate.

MEDICALLY UNLIKELY EDITS (MUES)

~CMS MLN Matters~

MLN Matters Number: MM5495
 Related CR Release Date: March 9, 2007
 Related CR Transmittal #: R1202CP

Related Change Request (CR) #: 5495
 Effective Date: April 1, 2007
 Implementation Date: April 2, 2007

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative contractors (DME/MACs), and/or regional home health intermediaries (RHHIs)).

Background

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as MUEs. The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs.

- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- For carrier claims, the MUEs will automatically deny or suspend claim line items containing units of service billed in excess of the MUE criteria and for FI claims, the MUEs will Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

Key Points

- CR5495 announces the upcoming release of the next version of the MUEs, which is version 1.1.
- CR5495 states that Medicare carriers and A/B MACs will deny the entire claim line from non-institutional providers with units of service that exceed MUE criteria and pay the other services on the claims.
- FIs and A/B MACs will RTP claims from institutional providers with units of service that exceed MUE criteria.
- An appeal process will not be allowed for RTP'ed claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the National Correct Coding Contractor.
- Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"), and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5495) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to

<http://www.cms.hhs.gov/Transmittals/downloads/R1202CP.pdf> on the CMS website.

If you have questions, please contact your Medicare carrier, FI, DME MAC, RHHI, 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.

PART C PLAN TYPE DESCRIPTION DISPLAY ON MEDICARE'S COMMON WORKING FILE (CWF)

~CMS MLN Matters~

MLN Matters Number: MM5349 Revised
Related CR Release Date: February 2, 2007
Related CR Transmittal #: R1175CP

Related Change Request (CR) #: 5349
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Note: This article was revised on March 8, 2007, to reflect that the plan directory will be posted on the CMS website in mid-March of 2007. Originally, the article stated the directory would be posted as of March 1, 2007. All other information in the article remains the same.

Provider Types Affected

Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through CWF eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).

Provider Action Needed

Be aware of the expanded list of MA Plan Type Descriptions that are being displayed by Medicare's CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in Private Fee-For-Service (PFFS) plans.

A plan directory, which will be quite descriptive, will soon be published that contains the list of all active Medicare contracts and their corresponding plan type. The directory will be in a table format and will be posted at the following URL in mid-March of 2007:

http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage

Background

When you query Medicare regarding a beneficiary's entitlement and eligibility, Medicare's CWF system responds with information on the Medicare managed care contract number in which a beneficiary is enrolled, including the plan type description associated with the contract. Currently, CWF largely displays the label "HMO" for these contracts. In many cases, the "HMO" label is incorrect since the list of possible plan type values has grown far larger since the creation of the Medicare Advantage program.

For example, under the MA Part C program, Medicare beneficiaries can enroll in Private Fee-for-Service (PFFS) plans. PFFS plans are very different from the more traditional MA HMO type plan.

PFFS PLANS

PFFS plans generally have no plan specific provider network. Enrollees in a PFFS plan can obtain plan covered health care services from any Medicare FFS enrolled provider in the U.S. who is willing to furnish services to a PFFS plan beneficiary. It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan.

In most cases, a PFFS enrollee will inform a provider before obtaining a service that they are enrolled in a PFFS plan. In addition, the PFFS enrollee will have an enrollment card provided by the PFFS plan identifying them as enrollees in a PFFS plan. The card will specify a phone number and/or a web address where the provider can obtain the PFFS plan's terms and conditions of participation.

At a minimum, the terms and conditions will specify:

- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures, including
 - The amount the provider is permitted to collect from the enrollee; and
 - Whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers in the U.S. from whom its enrollees seek health care services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a web site and also make them available upon written or phoned request.

To be paid by a PFFS organization, the provider must send their bill to the address (or electronic address) provided in the PFFS plan's terms and conditions of participation.

For more detailed information on PFFS plans as they relate to providers, see the "Provider Q&A" Downloadable document on <http://www.cms.hhs.gov/PrivateFeeForServicePlans/>

Additional Information

If you have questions regarding the plan of a specific Medicare MA enrolled patient, you may wish to contact that plan.

To view the official instruction (CR5349) issued to your Medicare FI, carrier, MAC, DMERC or RHHI, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1175CP.pdf> on the CMS website.

To review a related article that explains Medicare's Common Working File (CWF) Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5118.pdf> on the CMS website.

PROGRAM OVERVIEW: 2007 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) ~CMS MLN Matters~

MLN Matters Number: MM5558
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R265OTN

Related Change Request (CR) #: 5558
Effective Date: March 2, 2007
Implementation Date: N/A

Provider Types Affected

Physicians, practitioners, and therapists (as defined in the “Eligible Professionals” section on page 2 of this article) submitting claims to Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 5558 which provides overview-level information on the Physician Quality Reporting Initiative (PQRI). The Centers for Medicare & Medicaid Services (CMS) encourages all physicians to be familiar with the PQRI, its importance, and benefits.

Background

CMS is developing and implementing pay for performance to encourage quality improvement and avoidance of unnecessary costs in the care of Medicare beneficiaries. Physician services comprise a significant component of the larger CMS value-based purchasing enterprise initiative that also includes hospitals, nursing homes, home health agencies, and dialysis facilities.

Introduction to the 2007 Physician Quality Reporting Initiative (PQRI)

On December 20, 2006, President Bush signed the Tax Relief and Health Care Act of 2006 (TRHCA). Division B, Title I, Section 101 of the TRHCA authorizes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals, who choose to participate and successfully report on a designated set of quality measures for services paid under the Medicare Physician Fee Schedule and provided between July 1 and December 31, 2007, may earn a bonus payment of 1.5% of their charges during that period, subject to a cap. CMS has titled the statutory program the 2007 Physician Quality Reporting Initiative (PQRI).

The purpose of this document is to give a high-level overview of CMS’ approach to 2007 PQRI implementation, as directed by the statute. Detailed program instructions, educational materials, and supportive tools will be posted as they become available on the CMS PQRI website at: <http://cms.hhs.gov/PQRI>. This overview of the 2007 PQRI will address: (1) eligible professionals, (2) quality measures, (3) form and manner of reporting, (4) determination of successful reporting, (5) bonus payment, (6) validation, (7) appeals, (8) confidential feedback reports, (9) transition from the 2006 Physician Voluntary Reporting Program (PVRP), and (10) 2008 considerations.

Eligible Professionals

TRHCA Section 101 defines “eligible professional” as the following:

1. Medicare physician, as defined in Social Security Act (SSA) section 1861(r):
 - Doctor of Medicine
 - Doctor of Osteopathy

- Doctor of Podiatric Medicine
 - Doctor of Optometry
 - Doctor of Oral Surgery
 - Doctor of Dental Medicine
 - Chiropractor
2. Practitioners described in SSA section 1842(b)(18)(C):
- Physician Assistant
 - Nurse Practitioner
 - Clinical Nurse Specialist
 - Certified Registered Nurse Anesthetist
 - Certified Nurse Midwife
 - Clinical Social Worker
 - Clinical Psychologist
 - Registered Dietician
 - Nutrition Professional
3. Therapists:
- Physical Therapist
 - Occupational Therapist
 - Qualified Speech-Language Pathologist

All Medicare-enrolled professionals in these categories are eligible to participate in the 2007 PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims.

Quality Measures for Reporting

For 2007, TRHCA section 101 specifies that the quality measures for the PQRI shall be the “2007 physician quality measures under the Physician Voluntary Reporting Program as published on the public website of the Centers for Medicare & Medicaid Services as of the date of enactment of this subsection, except as may be changed ... based on the results of a consensus-based process in January 2007” This provision refers to the list of 66 Physician Voluntary Reporting Program (PVRP) measures that CMS had posted on its website on December 5, 2006 (see Transition from 2006 PVRP section below). The list referred to in the statute was expanded based on actions approved at the January 22, 2007 AQA Alliance consensus process. The result is a final 2007 PQRI Quality Measures List, which is available at www.cms.hhs.gov/PQRI, as a download from the Measures/Codes webpage.

In addition, the statute allows modifications or refinements, such as code additions, corrections, or revisions, to the detailed specifications for the measures included in the final 2007 PQRI Measures List until the beginning of the reporting period. The final 2007 PQRI Quality Measure Specifications will be available on the CMS PQRI website well in advance of the July 1, 2007 start date for the reporting period. The detailed specifications for each measure describe: (1) when that measure is reportable and (2) which quality-data code to report.

Prior to the July 1, 2007 start date, eligible professionals who plan to participate in the 2007 PQRI should familiarize themselves and their office staff with the PQRI Quality Measures List and the specifications for each measure that applies to their patient populations.

Form and Manner of Reporting

TRHCA section 101 allows CMS to specify the form and manner of reporting. For 2007, CMS will be building on the claims-based quality reporting system implemented for the 2006 Physician Voluntary Reporting Program (PVRP), which ended December 31, 2006 (see Transition from 2006 PVRP section below). Participating eligible professionals whose Medicare patients fit the specifications of the 2007 PQRI quality measures will report the corresponding appropriate CPT Category II codes or G-codes (where CPT Category II codes are not yet available) on their claims. CPT Category II codes and G-codes are Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P. Importantly, there is no need to enroll or register to begin claims-based reporting for 2007 PQRI.

The applicable CPT Category II code or G-code quality data must be reported on the same claim as the patient diagnosis and service to which the quality-data code applies. The analysis algorithms that determine successful reporting match the quality-data codes to the diagnosis, service, and procedure codes on the claim. Thus, quality-data codes that are not submitted on the same claim as the applicable patient diagnosis, service, and procedure codes will not count toward successful reporting or for calculation of a potential bonus payment.

Determination of Successful Reporting

The statutory description of satisfactory reporting depends on how many quality measures are applicable to the services furnished by the eligible professional during the entire reporting period of July 1-December 31, 2007. If there are no more than three quality measures applicable to the services provided by the eligible professional, then each measure must be reported for at least 80% of the cases in which the measure was reportable. If there are four or more quality measures applicable to the services provided by the eligible professional, then at least three measures, selected by the eligible professional, must be reported for at least 80% of the cases in which each measure was reportable.

The analysis of whether an eligible professional has successfully reported is expected to be performed at the individual eligible professional level using the individual-level National Provider Identifier (NPI). The eligible professional's individual NPI must be listed along with the HCPCS codes for services, procedures, and quality data on the claim. Thus, to participate in the 2007 PQRI, eligible professionals must have their individual-level NPIs and must consistently use their individual NPIs to correctly identify their services, procedures, and quality-data codes for an accurate determination of satisfactory reporting.

Eligible professionals select the quality measures that are applicable to their practices. If an eligible professional submits data for a quality measure, then that measure is presumed to be applicable for the purposes of determining satisfactory reporting. CMS recommends that eligible professionals report on every quality measure that is applicable to their patient populations to: (1) increase the likelihood that they will reach the 80% satisfactory reporting requirement for the requisite number of measures and (2) increase the likelihood that they will not be affected by the bonus payment cap.

As detailed instructions, education, and tools to support successful claims-based reporting become available, they will be posted on the CMS PQRI website at <http://www.cms.hhs.gov/PQRI>

Payment for Reporting

Participating eligible professionals who successfully report as prescribed by TRHCA section 101 may earn a 1.5% bonus, subject to cap. The potential 1.5% bonus will be based on allowed charges for covered professional services: (1) furnished during the reporting period of July 1 through December 31, 2007, (2) received into the CMS National Claims History (NCH) file by February 29, 2008, and (3) paid under the Medicare Physician Fee Schedule. Because claims processing times may vary by time of the year and Medicare Carrier/Medicare Administrative Contractor (MAC), participating eligible professionals should submit claims from the end of 2007 promptly, so that those claims will reach the NCH file by February 29, 2008. Bonuses will be paid as a lump sum in mid-2008. There is no beneficiary co-payment or notice to the beneficiary regarding the bonus payments.

The bonus will apply to allowed charges for all covered professional services, not just those charges associated with reported quality measures. The term “allowed charges” refers to total charges, including the beneficiary deductible and copayment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Note that the amounts billed above the physician fee schedule amounts for assigned and non-assigned claims will not apply to the bonus. The statute defines PQRI covered services as those paid under the Physician Fee Schedule only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology. Other Part B services and items that may be billed by eligible professionals but are not paid under the Physician Fee Schedule, such as clinical laboratory services, pharmaceuticals billed by physicians, and Rural Health Center/Federally Qualified Health Center services, do not apply to the bonus.

A payment cap that would reduce the potential bonus below 1.5% of allowed charges may apply in situations where an eligible professional reports relatively few instances of quality measure data. Eligible professionals’ caps are calculated by multiplying: (1) their total instances of reporting quality data for all measures (not limited only to measures meeting the 80% threshold), by (2) a constant of 300%, and by (3) the national average per measure payment amount.

The national average per measure payment amount is one value for all measures and all participants that is calculated by dividing: (1) the total amount of allowed charges under the Physician Fee Schedule for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program by (2) the total number of instances for which data were reported by all participants in the program for all measures during the reporting period. (Note that the national average per measure payment amount calculation only takes into account the charges on claims for which quality measures were reported, whereas the individual bonus calculation takes into account charges for all services furnished during the reporting period.) Thus, while the purpose of the cap is clear, it is not possible to determine the impact of the cap until the national average per measure payment amount can be calculated after the end of the reporting period.

TRHCA section 101 specifies that for 2007, CMS must use the Taxpayer Identification Number (TIN) as the billing unit, so any bonuses earned will be paid to the TIN holder of record. Though the analysis of satisfactory reporting will be performed at the individual eligible professional level using individual-level NPI data (as discussed above in the Form and Manner of Reporting section), bonuses will be paid to the holder of the TIN, aggregating

individual bonuses for groups that bill under one TIN. For eligible professionals who submit claims under multiple TINs, CMS plans to group claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the bonus payment under more than one TIN will receive a separate bonus payment associated with each TIN.

In situations where eligible professionals who are employees or contractors have assigned their payments to their employers or facilities, the statute specifies that any bonus payment earned will be paid to the employers or facilities.

Validation

TRHCA section 101 requires CMS to validate, using sampling or other means, whether quality measures applicable to the services furnished by a participating eligible professional have been reported. CMS plans to focus on situations where eligible professionals have successfully reported fewer than three quality measures. If CMS finds that eligible professionals who have reported fewer than three quality measures have not reported additional measures that are also applicable to the services they furnished during the reporting period, then CMS cannot pay those eligible professionals the bonus incentive payment.

Appeals

The statute specifically states that there shall be no administrative or judicial review of the determination of: (1) quality measures applicable to services furnished by eligible professionals, (2) satisfactory reporting, (3) the payment limitation or cap, or (4) the bonus incentive payment. However, CMS will establish a process for eligible professionals to inquire about these matters.

Confidential Feedback Reports

CMS will provide confidential feedback reports to participating eligible professionals at or near the time that the lump sum bonus payments are made in mid-2008. There will be no interim feedback during 2007. Quality data reported under the 2007 PQRI will not be publicly reported.

Access to confidential feedback reports may require eligible professionals to complete an identity-verification process to obtain a login identification and password for a secure interface. However, this process is not required to participate in the 2007 PQRI or to receive a bonus payment.

Transition from the 2006 Physician Voluntary Reporting Program (PVRP) The 2007 PQRI will build on and replace the 2006 Physician Voluntary Reporting Program (PVRP), which was implemented as the first step toward pay for performance for physician services. For services provided to Medicare beneficiaries from January 1 through December 31, 2006, physicians were able to voluntarily report to CMS a starter set of 16 evidence-based performance measures that captured quality of care data. The data were collected via claims using CPT Category II codes and G-codes where CPT codes were not yet available. In December 2006, CMS provided confidential feedback reports containing reporting and performance rates to the physicians who had submitted performance data during the second calendar quarter of 2006. Though PVRP ended December 31, 2006, feedback reports for services provided during the third and fourth calendar quarters of 2006 will be made available during 2007.

2008 Considerations

For 2008, quality measures for eligible professionals must be proposed and finalized through rulemaking. According to the statute, the measures shall: (1) have been adopted or endorsed by a consensus organization, such as the AQA Alliance or National Quality Forum (NQF), (2) include measures that have been submitted by a physician specialty, (3) be identified by CMS as having used a consensus-based process for development, and (4) include structural measures, such as the use of electronic health records and electronic prescribing technology. The proposed 2008 quality measures set must be published by August 15, 2007 and finalized by November 15, 2007.

Though the short lead time for implementation of the 2007 PQRI will not allow CMS to offer registry-based or electronic health record-based reporting for 2007, CMS is exploring the use of these reporting mechanisms for 2008. CMS has already begun a series of meetings with representatives of physicians, medical boards, group practices, and therapists to discuss how CMS can promote the use of standardized specifications for centralized, electronic reporting.

Additional Information

Additional information is available on the CMS PQRI website at:

<http://www.cms.hhs.gov/PQRI> or by contacting your Medicare Carrier/MAC at their toll-free number, which may be found on the CMS website at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

QUARTERLY PROVIDER UPDATE

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare, including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at:

<http://www.cms.hhs.gov/QuarterlyProviderUpdates/>

We encourage you to bookmark this Website and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update listserv (electronic mailing list) at:

<http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1>

Program Safeguards

SANCTIONED AND REINSTATED PROVIDERS

The Medicare & Medicaid Patient and Program Protection Act provides the Department of Health and Human Services (DHHS) with the authority to exclude health care providers, individuals, and businesses from receiving Medicare payment for services otherwise payable. This sanction practice represents the full range of administrative remedies and actions available to deal with questionable, improper, or abusive practices of providers under the Medicare program.

When an exclusion is imposed, no payment is made after the date of the exclusion to anyone for any item or service (other than emergency items or services not provided in a hospital emergency room) furnished, ordered or prescribed by an excluded party. This is based upon Sections 1128 and 1156 of the Social Security Act.

Medicare must deny any service submitted, ordered, or prescribed by a sanctioned provider. The beneficiary is not liable for any service denied due to the provider's sanctioned status. If claims are submitted by a sanctioned provider for items or services furnished under the Medicare program after the date of the sanction, the provider is liable for criminal prosecution as well as additional civil penalties.

WPS will not issue payments for services performed, ordered, or referred by these providers after the indicated dates. All providers are excluded as of February 20, 2007, unless otherwise indicated after their name.

In addition to the following, current listings of sanctioned providers are available on the DHHS Office Inspector General Website at: <http://oig.hhs.gov/fraud/exclusions.html>

Illinois Sanctioned Providers

Name/Specialty/Address/Date of Birth
Lesia Reaves Owner-Operator PO Box 5000, NUM 20703-076 Greenville, IL 62246 09/13/1969

Name/Specialty/Address/Date of Birth
Richard Frank Schulz Nurse/Nurses Aide 6300 Eagle Ridge Rd. Gurnee, IL 60031 07/09/1950

Illinois Reinstated Providers

Name/Specialty/Address/Date of Birth
Ruth Kraft, R.N. Registered Nurse 23411 Summerfield 55H Aliso Viego, CA 92656 10/10/1970 WITHDRAWN: 01/20/1999

Name/Specialty/Address/Date of Birth
Thomas A. Maibenco, M.D. General Practice 224 Eagle ridge Condos O'Fallon, IL 62269 09/15/1959 REINSTATED: 01/24/2007

Minnesota Reinstated Providers**Name/Specialty/Address/Date of Birth**

Jeffery C. Morgan, M.D.
General Practice
10655 57th Ave. N.
Plymouth, MN 55442
03/29/1951

REINSTATED: 01/23/2007

WPS Medicare Tip of the Week

(Published in the 03/19/07 General e-News Listserv)

Is there any prohibition against writing-off the beneficiary coinsurance when he/she does not have a Medicare supplement plan and cannot afford the coinsurance?

A provider, practitioner, or supplier may not routinely waive Medicare deductibles or co-payments. One important exception to the prohibition against waiving co-payments and deductibles is that providers, practitioners, or suppliers may forgive the co-payment in consideration of a particular patient's financial hardship. Any exception must address the special needs of a particular patient.

For additional information, please refer to the article entitled "Fraud and Abuse," located on our Website at the following address: http://www.wpsmedicare.com/provider/fraud_abuse.shtml

To receive our Tips of the Week, sign up to receive our e-News Listserv at:
<http://www.wpsmedicare.com/listserv>

Provider Education

EDUCATION SCHEDULE

Reminder: The intention of our seminars and teleconferences is to educate all attending providers on the topics outlined in the course descriptions, in the handouts, and in the handbooks. Please note that your specific coding questions are best handled by coding professionals. WPS Medicare Policy, Medical Review, and Provider Education & Outreach staff are not professional coders.

WPS Medicare offers Continuing Education Units (CEUs) for some of our courses. Go to <http://www.wpsmedicare.com/provider/ceu.shtml> for more information on which courses qualify for CEUs and how to obtain CEUs.

Seminars

Beyond the Basics

Date/Time	Course Number	Address
05/15/07 9:00am - 3:00 pm CT	WI2024	Comfort Suites Appleton Airport 3809 W. Wisconsin Avenue Appleton, WI 54911
06/06/07 9:00am - 3:00 pm ET	M2075 FULL	Holiday Inn Lansing West Conf Center 7501 W. Saginaw Highway Lansing, MI 48917
06/08/07 9:00am - 1:00 pm ET	M2074 FULL	Holiday Inn Lansing West Conf Center 7501 W. Saginaw Highway Lansing, MI 48917

Would you like to expand your basic knowledge of Medicare? WPS Medicare is pleased to offer an all-day session for those who wish to increase their knowledge of the Medicare Program. Our 2007 Beyond the Basics workshop offers “hands-on” learning and encourages participants to engage in learning that is both enjoyable and satisfying.

This full-day program, designed for coders, billers, and health care providers, will extend the participants’ knowledge beyond a basic understanding of the Medicare Program. Participants will learn how to better utilize the Medicare Physician Fee Schedule Database and the National Correct Coding Initiative Edits. The program will also include helpful information about Electronic Claim Submission and Electronic Funds Transfer. Among the other topics we will cover are:

- Top Unprocessable Claim Denials
- National Provider Identifier
- Medical Review Process
- Comprehensive Error Rate Testing (CERT) Program
- Advance Beneficiary Notice Initiative
- Physician Quality Reporting Initiative
- Documentation
- Non-covered versus Not Medically Necessary Services
- Medical Policy (includes overview and exercise for Policy PHYS-001)

Due to time limitations, the “Beyond the Basics” program does not include detailed information about specialty claims (e.g. Chiropractic, Ambulance, Physical Therapy, etc.). Information on the training day schedule and other workshop details, including steps for the easy on-line registration process, is available below. Sign up today!

Teleconferences

National Provider Identifier: Question and Answer Teleconference

Date/Time	Course Number	Handouts
04/12/07 10:00 - 11:30 am CT	TNPI8	Handouts Available
05/02/07 10:00 - 11:30 am CT	TNPI9	Handouts Available
06/06/07 10:00 - 11:30 am CT	TNPI10	Handouts Available

Do you have questions on the National Provider Identifier (NPI)? Would you like to know more?

WPS Electronic Data Interchange (EDI) will do a short presentation on current EDI NPI updates. WPS Medicare Provider Outreach and Education will do a short presentation on the current NPI changes, clarifications, and updates. The presentation portion of this program will last approximately 15 minutes.

The remainder of teleconference will be an open question and answer session. WPS Medicare Provider Enrollment will be available to answer questions regarding the provider enrollment process. Providers can ask WPS Medicare any question they have about NPI. The teleconference will be limited to one and one-half hours in length.

How to Register

Registration for **ALL IN-PERSON SEMINARS** begins 30 minutes before the **ACTUAL** start time.

Full-day courses run from 9:00 a.m. to 3:00 p.m.; lunch is on your own. Times may vary for teleconferences and half-day courses (see schedule above for exact times). Handouts for the teleconferences will be available on the Internet two weeks prior to the teleconference date. If you will not be able to download handouts from the Internet, please inform us at the time you register. Please note course availability may vary from state to state. All courses are free of charge. Additional courses will be scheduled at a later time. Watch for future postings to the WPS Medicare Website.

Registration Steps*

1. Go to the schedule on-line at
http://www.wpsmedicare.com/provider/proved_seminar.shtml
2. Select a course
3. Register online:
 - a. Click on the appropriate course number (this can be found in the second column of the table(s) above).
 - b. Fill out the form accordingly.

- c. You will receive a message back from our Website stating we have received your request. This is NOT a confirmation of your registration. You will however receive a confirmation via telephone or email.

PLEASE NOTE: When a confirmation email for this seminar is sent from WPS it will come from a mailbox named **Medsemin**.

*If you experience technical difficulty registering online, or unable to use online registration, please contact us at 618-998-5240.

If you have registered for a course and received a confirmation number but are unable to attend, please contact us at 618-998-5240 as soon as possible so we may accommodate others.

REVISED PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) POWERPOINT PRESENTATION - MODULE ONE

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that a revised version of the 2007 Physician Quality Reporting Initiative (PQRI) Module One PowerPoint presentation has been posted to the CMS website. Updates have been made to the presentation and speaker's notes have been added to assist in the explanation and understanding of the training module.

To access the presentation, visit <http://www.cms.hhs.gov/PQRI> on the CMS website and click on the Educational Resources tab. Once on the Educational Resources page, scroll down to the "Downloads" section and click on the "Physician Quality Reporting Initiative PowerPoint Module One" link.

We would also like to remind you that Frequently Asked Questions (FAQ) about the PQRI are now available on the CMS website. As new FAQs are added regularly, you may want to check this site often. You can access these FAQs by visiting the PQRI webpage at, <http://www.cms.hhs.gov/PQRI>, on the CMS website. Once on the Overview page, scroll down to the "Related Links Inside CMS" section and click on the "Frequently Asked Question" link.

WPS Medicare Tip of the Week

(Published in the 03/26/07 General e-News Listserv)

When calling the IVR, what happens if WPS does not have a claim on file for a specific date of service?

When requesting status for a claim that WPS does not have on file, the IVR asks the provider to check with the patient to make sure they have the correct Medicare number.

Please be aware that if the IVR states this, and you are using the correct Medicare number, there is no claim on file.

To receive our Tips of the Week, sign up to receive our e-News Listserv at:
<http://www.wpsmedicare.com/listserv>

Reimbursement

**APRIL QUARTERLY UPDATE FOR 2007 DURABLE MEDICAL
EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES
(DMEPOS) FEE SCHEDULE
~CMS MLN Matters~**

MLN Matters Number: MM5537 Revised
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R1203CP

Related Change Request (CR) #: 5537
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Note: This article was revised on March 16, 2007, to show the correct effective date of January 1, 2007 above. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5537, which provides the April 2007 quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure billing staff are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly updates process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual (Publication 100-04), Chapter 23, Section 60; <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>).

CR 5537 provides specific instructions regarding the April quarterly update for the 2007 DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in Title 42 of the Code of Federal Regulations (42 CFR 414.102).

Key Changes

The following are key changes in the April 2007 quarterly update of the DMEPOS fee schedule:

L8690 and L8691

The A/B MACs, Local Carriers, and FIs will adjust previously processed claims for L8690 (Auditory Osseointegrated Device, Includes All Internal and External Components) and

L8691 (Auditory Osseointegrated Device, External Sound Processor, Replacement), with dates of service on or after January 1, 2007, if you resubmit such claims as adjustments.

Code E1002 (Wheelchair accessory, Power Seating System, Tilt Only)

Code E1002 was added to the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2004. The fee schedule amounts that were calculated and implemented for this code included systems with tilts less than 45 degrees from horizontal. As described in the November 2006 Policy Article for Wheelchair Options/Accessories, power tilt seating systems (falling under code E1002) must have the ability to tilt to greater than or equal to 45 degrees from horizontal. Therefore as part of this quarterly update, **the fee schedule amounts for code E1002 are being revised in order to remove pricing information for power seating systems with tilts less than 45 degrees.**

The DME MACs, and DMERCs will adjust previously processed claims for code E1002 with dates of service on or after January 1, 2007, if they are resubmitted as adjustments.

Code E2377 (Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics and Mounting Hardware, Upgrade Provided at Initial Issue)

Code E2377 was added to the HCPCS effective January 1, 2007, for use in paying claims for upgraded expandable controllers and mounting hardware provided at initial issue. The fee schedule amounts for code E2377 do not include payment for the proportional joystick and electronics/cables/junction boxes necessary to upgrade from a non-expandable controller. Suppliers need to submit claims for the upgraded proportional joysticks and electronics provided at initial issue for dates of service on or after January 1, 2007, using HCPCS code E2399.

Further Changes for Power Wheelchairs

CMS is in the process of making refinements to the fee schedule amounts for several HCPCS codes for power wheelchairs to be implemented as part of the April quarterly update for the 2007 DMEPOS fee schedule. Additional instructions regarding these changes will be issued in the near future under separate cover.

Additional Information

The official instruction, CR 5537, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1203CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC at their toll-free number, which may be found on the CMS website at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip>

**APRIL UPDATE TO THE 2007 MEDICARE PHYSICIAN FEE
SCHEDULE DATABASE (MPFSDB)
~CMS MLN Matters~**

MLN Matters Number: MM5528
Related CR Release Date: February 26, 2007
Related CR Transmittal #: R1188CP

Related Change Request (CR) #: 5528
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs) for professional services paid under the Medicare Physician Fee Schedule (MPFS).

Background

This article and related Change Request (CR) 5528 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS Final Rule. CR5528 amends those payment files.

The following table reflects the key changes from CR5528:

CPT/HCPCS	ACTION
17311	Multiple Procedure Indicator – 0
17313	Multiple Procedure Indicator – 0
36478	Transitional Non-Facility PE RVU = 41.71 Fully Implemented Non-Facility PE RVU = 26.53 (Informational Only)
37210	Transitional Non-Facility PE RVU = 79.88 Fully Implemented Non-Facility PE RVU = 79.88 (Informational Only)
77056 Global	Fully Implemented Non-Facility PE RVU = 1.96 (Informational Only) Fully Implemented Facility PE RVU = 1.96 (Informational Only)
77056 – TC	Fully Implemented Non-Facility PE RVU = 1.72 (Informational Only) Fully Implemented Facility PE RVU = 1.72 (Informational Only)
93225	Transitional Non-Facility PE RVU = 1.14 Fully Implemented Non-Facility PE RVU = 0.85 (Informational Only) Transitional Facility PE RVU = 1.14 Fully Implemented Facility PE RVU = 0.85 (Informational Only)
93226	Transitional Non-Facility PE RVU = 1.93 Fully Implemented Non-Facility PE RVU = 1.18 (Informational Only) Transitional Facility PE RVU = 1.93 Fully Implemented Facility PE RVU = 1.18 (Informational Only)

CPT/HCPCS	ACTION
93231	Transitional Non-Facility PE RVU = 1.32 Fully Implemented Non-Facility PE RVU = 0.71 (Informational Only) Transitional Facility PE RVU = 1.32 Fully Implemented Facility PE RVU = 0.71 (Informational Only)
93232	Transitional Non-Facility PE RVU = 1.97 Fully Implemented Non-Facility PE RVU = 1.34 (Informational Only) Transitional Facility PE RVU = 1.97 Fully Implemented Facility PE RVU = 1.34 (Informational Only)
95991	Transitional Facility PE RVU = 0.17 Fully Implemented Facility PE RVU = 0.18 (Informational Only)

The codes in the following table are either bundled or not valid for Medicare purposes. Values for these codes have been established as a courtesy to the general public. These codes will remain bundled or not valid for Medicare purposes even though relative value units have been established.

CPT/HCPCS	ACTION
78351	Transitional Non-Facility PE RVU = 1.41 Fully Implemented Non-Facility PE RVU = 0.47 (Informational Only)
98960	Transitional Non-Facility PE RVU = 0.57 Fully Implemented Non-Facility PE RVU = 0.57 (Informational Only) Transitional Facility PE RVU = 0.57 Fully Implemented Facility PE RVU = 0.57 (Informational Only)
98961	Transitional Non-Facility PE RVU = 0.27 Fully Implemented Non-Facility PE RVU = 0.27 (Informational Only) Transitional Facility PE RVU = 0.27 Fully Implemented Facility PE RVU = 0.27 (Informational Only)

CPT/HCPCS	ACTION
98962	Transitional Non-Facility PE RVU = 0.20 Fully Implemented Non-Facility PE RVU = 0.20 (Informational Only) Transitional Facility PE RVU = 0.20 Fully Implemented Facility PE RVU = 0.20 (Informational Only)

These changes are effective January 1, 2007. However, providers may wish to note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors will adjust claims that you bring to their attention.

Additional Information

CR5528 is the official instruction (CR5528) issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1188CP.pdf> on the CMS website.

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

CORRECTION TO CR5404: NEW WAIVED TESTS ~CMS MLN Matters~

MLN Matters Number: MM5482
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R1197CP

Related Change Request (CR) #: 5482
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

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

Provider Action Needed
STOP – Impact to You

Change Request (CR) 5482, from which this article is taken, corrects information provided in CR 5404 (released November 24, 2006).

CAUTION – What You Need to Know

CR 5404, which informed carriers and A/B MACS about new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments of 1988 (CLIA), contained an incorrect Current Procedural Terminology (CPT) code for the Gryphus Diagnostics BVBlue test. The correct code for this test is 87999QW (Unlisted microbiology procedure).

GO – What You Need to Do

You should ensure that your billing staffs are made aware of this CPT code correction, and bill accordingly.

Background

CR 5404, which informed carriers and A/B MACS of new waived tests approved by the Food and Drug Administration (FDA) under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), contained an incorrect CPT for the Gryphus Diagnostics BVBlue test. In both the table in the background section of the Recurring Update Notification attachment and in the waived test list attachment, CR 5404 listed the CPT code for the Gryphus Diagnostics BVBlue as CPT Code: 87899QW.

The CPT code 87899 is for infectious agent activity detection tests by immunoassay with direct optical observation; not otherwise specified. In contrast, the Gryphus Diagnostics BVBlue test is an enzyme activity test that detects sialidase activity in vaginal fluid specimens and is not an immunoassay test. The code in this table and in the waived test list attachment should have been 87999QW (Unlisted microbiology procedure). See the table below for the correct codes.

Note: All the other information in CR 5404 remains the same.

**Table 1
CPT Codes for FDA Approved New Waived Tests**

CPT Code/ Modifier	Effective Date	Description
82274QW, G0328QW	June 15, 2006	Immunostics, Inc., hema-screen Specific Immunochemical Fecal Occult Blood Test
87999QW	June 30, 2006	Gryphus Diagnostics BVBlue
83655QW	September 18, 2006	ESA Biosciences LeadCare II Blood Lead Testing System (whole blood)

You should remember that the CLIA regulations require a facility to be appropriately certified for each test performed, and that laboratory claims are currently edited at the CLIA certificate level.

Note: Carriers and A/B MACs will not search their files to correct affected claims processed prior to the implementation date of this change, but will adjust any claims that you bring to their attention.

Additional Information

You can find the official instruction, CR 5482, issued to your carrier or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1197CP.pdf> on the CMS website.

The MLN Matters article, MM5404, related to CR5404 may be found at <http://www.cms.hhs.gov/MLNMArticles/downloads/MM5404.pdf> on the CMS website.

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.

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) DESIGNATION CHANGES

In accordance with Section 1833(m) of the Social Security Act, physicians who provide covered professional services in a geographic Health Professional Shortage Area (HPSA) are entitled to a 10 % incentive payment. The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating Health Professional Shortage Areas.

The address where the service is rendered, not the location of the physician's office or the patient's address, is the determining factor in HPSA incentives. Only physicians furnishing services in a geographic, primary care HPSA are eligible to receive bonus payments. Eligible providers include medical doctors, including psychiatrists, doctors of osteopathy, dentists, doctors of podiatric medicine, licensed chiropractors, and optometrists. In addition, psychiatrists furnishing services in a geographic, mental health HPSA are also eligible to receive a bonus payment.

For more information about HPSAs, and to access entire HPSA listings, visit us at: <http://www.wpsmedicare.com/provider/hpsa.shtml>

ILLINOIS

Primary Care HPSA

New eligibility for dates of service on and after September 20, 2006:
Washington County – Entire County
(Please note: only a portion of the county was previously eligible)

Mental Health HPSA

No changes

MICHIGAN

Primary Care HPSA

No longer eligible for dates of service on or after April 1, 2007:
Luce County

No longer eligible for dates of service on or after April 1, 2007:
Wayne County – MacKenzie/Brooks Service Area
Census Tract 5466

New eligibility for dates of service on and after December 18, 2006:
Wayne County – MacKenzie/Brooks Service Area
Census Tracts:
5302 – 5303 5369
5307 5375
5310 5377

5313 – 5316 5423
5334 5426
5357

Mental Health HPSA

No longer eligible for dates of service on or after April 1, 2007:
Chippewa County

WISCONSIN**Primary Care HPSA**

Dane County - Northeast Madison Service Area
Census Tract 24.98 has been changed to 24.02
Census Tract 25.98 has been changed to 25.00

Mental Health HPSA

No changes

MINNESOTA**Primary Care HPSA**

No changes

Mental Health HPSA

No changes

NATIONAL PROVIDER IDENTIFIER (NPI) FOR AMBULANCE SUPPLIERS

All providers/suppliers including Ambulance suppliers need to have a National Provider Identifier (NPI) by May 23, 2007.

What happens if you do not get an NPI?

Medicare and health care payers will not be able to accept your claims. If we cannot accept your claim, we cannot pay your claim.

What is the National Provider Identifier (NPI)?

A single provider identifier used to bill all health care payers in the United States.

When can I apply for my NPI?

Apply today. Be sure to include your existing Medicare Provider Identification Numbers (PINs) on your applications. The Centers for Medicare & Medicaid Services (CMS) encourages providers to include the PIN to help ease the transition to the NPI.

How do I get my NPI?

You can apply on-line at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> , which is the National Plan & Provider Enumeration System (NPPES) Website.

When should I begin using the NPI?

Ambulance suppliers can begin submitting the NPI to Medicare today. CMS encourages all providers and suppliers to continue to submit their current Medicare PIN through May 22, 2007.

Where do I find more information on the NPI?

Find the answers to these important NPI questions and more by visiting our Website today at http://www.wpsmedicare.com/provider/npi_resource.shtml

Find additional information by visiting the CMS NPI Website at http://www.cms.hhs.gov/NationalProvdentStand/01_Overview.asp#TopOfPage

NEW WAIVED TESTS

~CMS MLN Matters~

MLN Matters Number: MM5484

Related CR Release Date: March 9, 2007

Related CR Transmittal #: R1195CP

Related Change Request (CR) #: 5484

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

Provider Types Affected

Providers and suppliers who bill Medicare carriers or Medicare Administrative Contractors (A/B MACs) for clinical diagnostic laboratory services.

Provider Action Needed

CR 5484, from which this article is taken, notifies your carriers and A/B MACs of the new Food and Drug Administration (FDA)-approved tests (effective October 4, 2006) that are waived under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), so that they can accurately process your claims.

Background

First, remember that CLIA regulations require a laboratory facility to be appropriately certified for each test it performs. Further, to ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Some specific background about waived tests may, at this point, also be helpful. These new laboratory tests (which the FDA approves on a flow basis) are valid (and marketed) as soon as they are approved. Therefore, as soon as informed by the FDA of the test approvals, the Centers for Medicare & Medicaid Services (CMS) must immediately notify the carriers and A/B MACs so that they are ready to process claims when submitted. CR 5484, from which this article is taken, announces the latest tests approved by the FDA as waived tests under CLIA. These tests are described in the bulleted paragraph (below), and displayed in red/bold print in Table 1, that follows. Note that each of the Current Procedural Terminology (CPT) codes for these new tests must have the modifier QW to be recognized as a waived test, and that these new waived tests are effective on October 4, 2006.

New FDA Waived Tests Under CLIA

- CPT/HCPCS code, 82042QW, has been assigned for the albumin test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT/HCPCS code, 82150QW, has been assigned for the amylase test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.

- CPT/HCPCS code, 82247QW, has been assigned for the total bilirubin test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT/HCPCS code, 82977QW, has been assigned for the gamma glutamyltransferase (GGT) test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT/HCPCS code, 84075QW, has been assigned for the alkaline phosphatase test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT/HCPCS code, 84157QW, has been assigned for the total protein test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT/HCPCS code, 84520QW, has been assigned for the urea (BUN) test performed using the Arkray SPOTCHEM EZ Chemistry Analyzer.

Table 1 - Latest FDA Waived Tests Under CLIA*

CPT Code/Modifier	Effective Date	Description
84450QW and 84460QW	August 16, 2005	Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}
87899QW	March 30, 2006	Rapid Pathogen Screening RPS Adeno Detector
86308QW	July 27, 2006	PerMaxim RediScreen Mononucleosis {Whole Blood}
82274QW, G0328QW	August 3, 2006	Enterix Insure II Fecal Immunochemical Test
82274QW, G0328QW	August 9, 2006,	Teco Rapid Fecal Occult Blood (FOB) Card Test
82274QW, G0328QW	September 22, 2006	OcculTech Fecal Occult Blood Rapid Test
82042QW, 82150QW, 82247QW, 82977QW, 84075QW, and 84157QW	October 4, 2006	Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}
84520QW	October 4, 2006	Arkray SPOTCHEM EZ Chemistry Analyzer{whole blood} for urea (BUN)
84450QW	October 5, 2006	Arkray SPOTCHEM EZ Chemistry Analyzer{whole blood} for aspartate aminotransferase (AST)(SGOT)
85018QW	October 10, 2006	HemoCue Hb 301 System
87999QW	October 16, 2006	Genzyme Diagnostics OSOM BVBlue Test
87880QW	November 1, 2006	Inverness Medical BioStar Acceava Strep A Test

CPT Code/Modifier	Effective Date	Description
80101QW	November 14, 2006	Branan Medical Corporation, QuickTox Drug Screen Dipcard
80101QW	November 14, 2006	Branan Medical Corporation, FasTox Multiple Drug Dipcard
86308QW	November 22, 2006	LifeSign Status Mono {for whole blood}

*The Current Procedural Terminology (CPT) codes for these new tests must have the modifier QW to be recognized as a waived test.

In addition, it is also important that you note that the tests displayed in table 2, below, do not require a QW modifier to be recognized as a waived test.

**Table 2
Waived Tests That Do Not Require the QW Modifier**

CPT CODE(S)	TEST NAME	MANUFACTURER	USE
81002	Dipstick or tablet reagent urinalysis – non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen	Various	Screening of urine to monitor/diagnose various diseases/conditions, such as diabetes, the state of the kidney or urinary tract, and urinary tract infections
81025	Urine pregnancy tests by visual color comparison	Various	Diagnosis of pregnancy
82270 82272 G0394 (Contact your Medicare carrier for claims instructions.)	Fecal occult blood	Various	Detection of blood in feces from whatever cause, benign or malignant (colorectal cancer screening)
82962	Blood glucose by glucose monitoring devices cleared by the FDA for home use	Various	Monitoring of blood glucose levels
83026	Hemoglobin by copper sulfate – non-automated	Various	Monitors hemoglobin level in blood
84830	Ovulation tests by visual color comparison for human luteinizing hormone	Various	Detection of ovulation (optimal for conception)
85013	Blood count; spun microhematocrit	Various	Screen for anemia

CPT CODE(S)	TEST NAME	MANUFACTURER	USE
85651	Erythrocyte sedimentation rate – non-automated	Various	Nonspecific screening test for inflammatory activity, increased for majority of infections, and most cases of carcinoma and leukemia

Final note: Carriers and A/B MACs do not need to search their files to either retract payment or retroactively pay affected claims processed prior to the implementation of this change, however, they will adjust claims that you bring to their attention

Additional Information

You can find the official instruction, CR5484, issued to your carrier or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1195CP.pdf> on the CMS website. As an attachment to that CR, you will find the complete list of laboratory tests granted waived status under CLIA.

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.

SERVICES NOT PROVIDED WITHIN UNITED STATES

~CMS MLN Matters~

MLN Matters Number: MM5427
 Related CR Release Date: February 23, 2007
 Related CR Transmittal #: R66BP

Related Change Request (CR) #: 5427
 Effective Date: November 13, 2006
 Implementation Date: April 2, 2007

Provider Types Affected

Physicians, suppliers and providers who submit claims to Medicare carriers, fiscal intermediaries (FIs) and A/B Medicare Administrative Contractors (A/B MACs).

Key Points

CR5427 clarifies that payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States.

Take Note: Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States. **For example**, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India.

Background

This article and related Change Request (CR) 5427 outlines the limited items and services that are reimbursable by Medicare outside the United States according to Section 1862(a)(4) of the Social Security Act.

The law specifies the following **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:
 - emergency arose within the U.S.; or
 - 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.
- Physician and ambulance services in connection with, and during, a foreign inpatient hospital stay that is covered in accordance with either of the above.

Additional Information

CR5427 is the official instruction issued to your Medicare carrier, FI or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R66BP.pdf> on the CMS website.

If you have questions, please contact your Medicare carrier, FI or A/B MAC, at their toll-free number which may be found at:

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

NOTE: The previously published CR3781

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3781.pdf> also provides information and instructions about services not provided within the United States by defining “United States” for the purposes of the Social Security Act (Section 1814 (f) along with the parameters of this Medicare rule.

UPDATES TO THE 2007 MEDICARE PHYSICIAN FEE SCHEDULE

For a complete listing of the 2007 fees, please visit the Wisconsin Physicians Service (WPS) Medicare Website at: http://www.wpsmedicare.com/provider/pricing_fees.shtml

To access the 2007 Relative Value Units (RVUs) and other indicators associated with each procedure code on the MPFSDB, please see the Centers for Medicare & Medicaid Services (CMS) Website at:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage>

The following changes have been made to the 2007 Medicare Physician Fee Schedule. Unless otherwise indicated, these changes will apply to claims processed on or after April 1, 2007, for dates of service January 1, 2007 and after.

MPFSDB Fee Changes Effective 01/01/07

Illinois

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
36478	IL-12	\$1,738.91	\$1,651.96	\$1,899.75	\$338.90	\$321.96	\$370.25
37210	IL-12	\$3,245.94	\$3,083.64	\$3,546.19	\$511.82	\$486.23	\$559.16
93225	IL-12	\$45.83	\$43.54	\$50.07	\$45.83	\$43.54	\$50.07
93226	IL-12	\$77.89	\$74.00	\$85.10	\$77.89	\$74.00	\$85.10
93231	IL-12	\$54.20	\$51.49	\$59.21	\$54.20	\$51.49	\$59.21
93232	IL-12	\$78.66	\$74.73	\$85.94	\$78.66	\$74.73	\$85.94
95991	IL-12	\$84.57	\$80.34	\$92.39	\$36.12	\$34.31	\$39.46
36478	IL-15	\$2,021.47	\$1,920.40	\$2,208.46	\$357.84	\$339.95	\$390.94
37210	IL-15	\$3,786.08	\$3,596.78	\$4,136.30	\$537.13	\$510.27	\$586.81
93225	IL-15	\$53.19	\$50.53	\$58.11	\$53.19	\$50.53	\$58.11
93226	IL-15	\$90.33	\$85.81	\$98.68	\$90.33	\$85.81	\$98.68
93231	IL-15	\$62.66	\$59.53	\$68.46	\$62.66	\$59.53	\$68.46
93232	IL-15	\$91.40	\$86.83	\$99.85	\$91.40	\$86.83	\$99.85
95991	IL-15	\$95.08	\$90.33	\$103.88	\$37.51	\$35.63	\$40.97
36478	IL-16	\$2,043.42	\$1,941.25	\$2,232.44	\$363.41	\$345.24	\$397.03
37210	IL-16	\$3,826.70	\$3,635.37	\$4,180.68	\$545.77	\$518.48	\$596.25
93225	IL-16	\$54.30	\$51.59	\$59.33	\$54.30	\$51.59	\$59.33
93226	IL-16	\$92.25	\$87.64	\$100.79	\$92.25	\$87.64	\$100.79
93231	IL-16	\$64.09	\$60.89	\$70.02	\$64.09	\$60.89	\$70.02
93232	IL-16	\$93.26	\$88.60	\$101.89	\$93.26	\$88.60	\$101.89
95991	IL-16	\$96.39	\$91.57	\$105.31	\$38.25	\$36.34	\$41.79
36478	IL-99	\$1,626.90	\$1,545.56	\$1,777.39	\$325.19	\$308.93	\$355.27
37210	IL-99	\$3,033.68	\$2,882.00	\$3,314.30	\$491.53	\$466.95	\$536.99
93225	IL-99	\$41.32	\$39.25	\$45.14	\$41.32	\$39.25	\$45.14
93226	IL-99	\$70.16	\$66.65	\$76.65	\$70.16	\$66.65	\$76.65
93231	IL-99	\$48.62	\$46.19	\$53.12	\$48.62	\$46.19	\$53.12
93232	IL-99	\$71.04	\$67.49	\$77.61	\$71.04	\$67.49	\$77.61
95991	IL-99	\$79.50	\$75.53	\$86.86	\$34.45	\$32.73	\$37.64

Michigan

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
36478	MI-01	\$1,944.45	\$1,847.23	\$2,124.31	\$371.68	\$353.10	\$406.07
37210	MI-01	\$3,632.70	\$3,451.07	\$3,968.73	\$561.18	\$533.12	\$613.09
93225	MI-01	\$53.81	\$51.12	\$58.79	\$53.81	\$51.12	\$58.79
93226	MI-01	\$91.56	\$86.98	\$100.03	\$91.56	\$86.98	\$100.03

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
93231	MI-01	\$64.08	\$60.88	\$70.01	\$64.08	\$60.88	\$70.01
93232	MI-01	\$92.14	\$87.53	\$100.66	\$92.14	\$87.53	\$100.66
95991	MI-01	\$94.49	\$89.77	\$103.24	\$40.06	\$38.06	\$43.77
36478	MI-99	\$1,707.26	\$1,621.90	\$1,865.19	\$334.06	\$317.36	\$364.96
37210	MI-99	\$3,186.26	\$3,026.95	\$3,480.99	\$504.50	\$479.28	\$551.17
93225	MI-99	\$44.36	\$42.14	\$48.46	\$44.36	\$42.14	\$48.46
93226	MI-99	\$75.36	\$71.59	\$82.33	\$75.36	\$71.59	\$82.33
93231	MI-99	\$52.35	\$49.73	\$57.19	\$52.35	\$49.73	\$57.19
93232	MI-99	\$76.20	\$72.39	\$83.25	\$76.20	\$72.39	\$83.25
95991	MI-99	\$83.01	\$78.86	\$90.69	\$35.49	\$33.72	\$38.78

Minnesota

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
36478	MN	\$1,824.75	\$1,733.51	\$1,993.54	\$326.45	\$310.13	\$356.65
37210	MN	\$3,415.77	\$3,244.98	\$3,731.73	\$489.68	\$465.20	\$534.98
93225	MN	\$44.69	\$42.46	\$48.83	\$44.69	\$42.46	\$48.83
93226	MN	\$75.72	\$71.93	\$82.72	\$75.72	\$71.93	\$82.72
93231	MN	\$52.01	\$49.41	\$56.82	\$52.01	\$49.41	\$56.82
93232	MN	\$77.10	\$73.25	\$84.24	\$77.10	\$73.25	\$84.24
95991	MN	\$85.40	\$81.13	\$93.30	\$33.55	\$31.87	\$36.65

Wisconsin

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
36478	WI	\$1,694.04	\$1,609.34	\$1,850.74	\$323.82	\$307.63	\$353.77
37210	WI	\$3,163.90	\$3,005.71	\$3,456.57	\$487.96	\$463.56	\$533.09
93225	WI	\$42.10	\$40.00	\$46.00	\$42.10	\$40.00	\$46.00
93226	WI	\$71.41	\$67.84	\$78.02	\$71.41	\$67.84	\$78.02
93231	WI	\$49.26	\$46.80	\$53.82	\$49.26	\$46.80	\$53.82
93232	WI	\$72.51	\$68.88	\$79.21	\$72.51	\$68.88	\$79.21
95991	WI	\$81.26	\$77.20	\$88.78	\$33.84	\$32.15	\$36.97

USE OF NINE-DIGIT ZIP CODES FOR DETERMINING THE CORRECT PAYMENT LOCALITY FOR SERVICES PAID UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) AND ANESTHESIA SERVICES

~CMS MLN Matters~

MLN Matters Number: MM5208 Revised
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R1193CP

Related Change Request (CR) #: 5208
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Note: This article was revised on March 9, 2007, to reflect a revised CR Transmittal number and CR release date (see above). Also the Web address for accessing CR5208 has been changed. All other information remains the same.

Provider Types Affected

Physicians and providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors (MACs)) for services paid under the MPFS and for anesthesia services

Provider Action Needed

STOP – Impact to You

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed in Table 1 (below), if you do not include the full nine-digit ZIP code on your claims for services paid by Medicare carriers or MACs under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services, your claim will be treated as unprocessable.

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed in Table 1, if a valid full nine-digit ZIP code is not present on the Provider Master File Address ZIP code, services paid by the FIs/MACs under the MPFS and for anesthesia services, your claim will be treated as unprocessable.

CAUTION – What You Need to Know

Effective October 1, 2007, for services rendered in the areas defined by the ZIP codes in Table 1, Medicare will require that you provide the nine-digit ZIP code for the location where services were rendered on your claims for services paid by carriers/MACs under the MPFS and for anesthesia services. CMS is implementing this requirement to prevent payment issues generated by ZIP codes that cross payment localities.

Effective October 1, 2007, for services rendered in the areas defined by the nine-digit ZIP codes in Table 1, Medicare will require a valid nine-digit ZIP code on the Provider File Master Address for services paid by the FIs/MACs under the MPFS and for anesthesia services.

GO – What You Need to Do

Make sure that your billing staffs are aware that if you provide services paid by carriers/MACs under the MPFS or anesthesia services in a payment locality whose ZIP code appears in Table 1, below; effective for dates of service on or after October 1, 2007, they must include the nine-digit ZIP code in the claim.

Make sure that if you provide services paid by FIs/MACs under the MPFS or anesthesia services in a payment locality whose ZIP code appears in Table 1, a valid nine-digit ZIP code is present on the Provider File Master Address. If a valid nine-digit ZIP code is not on the file, submit a CMS-855A, the Medicare Enrollment Application, with a valid nine-digit ZIP code.

Background

Reimbursement Based on the Location Where the Service Was Rendered

Where you actually provide services paid under the MPFS and anesthesia services determines the amount of your reimbursement. More specifically, Medicare reimburses you for these services based on the locality, which is determined from the ZIP code that is on the claim submitted to carriers/MACs. The ZIP code on the Provider File Master Address is used to determine the locality on the claims submitted to FIs/MACs.

The ZIP codes that your Medicare contractors use to determine the payment locality come from the CMS ZIP code file, which conforms to the United States Postal Service convention of assigning ZIP codes into dominant counties.

CMS has become aware that some ZIP codes cover more than one payment locality; in some cases, while the service may actually be rendered in one county, because of the ZIP code it may be assigned into a different county. This causes a payment issue when each of the counties is associated with a different payment locality and therefore a different payment amount.

Nine-Digit ZIP Codes

CR5208, from which this article was taken, corrects this issue. Effective October 1, 2007, you will have to include the full nine-digit ZIP code for anesthesia services and for services paid under the MPFS by carriers/MACs when those services are provided in a ZIP code area that crosses payment localities (see Table 1, below). Note that services on the Purchased Diagnostic Abstract File are all payable under the MPFS, thus the 9-digit ZIP code requirement also applies to those services.

There are some important details that you should know:

Exceptions

There are two instances in which you do not need to submit the nine-digit ZIP code in claims for services payable under the MPFS and for anesthesia services:

- You may continue to submit claims with five-digit ZIP codes if you provide these services in ZIP code areas that do not cross payment localities (not listed in Table 1);
- There is no current requirement for the submission of a ZIP code when the place of service (POS) is "Home" or any other places of service that your Medicare contractor currently considers to be the same as "Home."

As necessary, CMS will provide quarterly updates of the list of the ZIP codes that cross localities.

You should submit your claims for ambulance and lab services using five-digit ZIP codes, as your carrier/MAC will continue to use the five-digit codes for determining payment.

Claims for ambulance services will continue to be priced using 5-digit ZIP codes by the FIs/MACs. Laboratory services will continue to be priced by the FIs/MACs using the locality for non-fee based services.

Master Address

FIs determine locality based upon the ZIP code of the provider’s physical address, which, including the ZIP code is stored on the provider file as the master address.

Effective July 1, 2007, institutional providers, with a ZIP code displayed in Table 1, will need to submit a valid nine-digit ZIP code on the CMS 855-A when the Provider File Master Address ZIP code is 5-digits, the last 4-digits of a 9-digit ZIP code are zeroes, or the last 4-digits of a 9-digit ZIP code do not match a 4-digit extension on the ZIP code file.

Claims Returned as Unprocessable

To re-emphasize, if you provide only a 5-digit ZIP code on a claim for services payable under the MPFS and for anesthesia services that you provide in one of the ZIP code areas that crosses localities (and therefore requires a nine-digit ZIP code to be processed), your carrier/MAC will return this claim as unprocessable. Returned claims will have the following Remittance Advice and Remark Code messages:

- **Adjustment Reason Code 16** – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.
- **Remark Code MA 130** – Your claim contains incomplete and/or invalid information, and no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- **Remark Code MA114** – “Missing/incomplete information on where the services were furnished.”

Effective for dates of service on or after October 1, 2007, if an invalid ZIP code is present on the Provider File Master Address for claims payable under the MPFS and for anesthesia services provided in one of the ZIP code areas that crosses localities, your FI/MAC will return the claim as unprocessable.

Table 1 - ZIP Codes that Cross Payment Localities by State

State	ZIP Code
Arkansas (AR)	71749 71953 72338 72395 72444 72644
Arizona (AZ)	85534
California (CA)	90265 90623 90630 90631 90638 91304 91307 91362 91709 91766 91792 93013 93243 93252 94303 94514 94515 94550 94571 95023 95033 95377 95391 95476 95616 95690 95694 96056 91311 91361 93536 93560 95076 95304
Delaware (DE)	19952 19973
Florida (FL)	32948 33440 33917 33920 33955 33972 34141 34142 34972 34974
Georgia (GA)	30011 30014 30019 30025 30040 30055 30056 30101 30102 30107 30120 30135 30143 30153 30178 30179 30180 30183 30184 30185 30187 30205 30223 30224 30228 30233 30234 30248 30268 30276 30506 30517 30518 30519 30534 30548 30559 30620 30641 30650 30663 30730 31029
Idaho (ID)	83342 83856
Illinois (IL)	60007 60010 60013 60015 60021 60042 60050 60051 60074 60081 60089

State	ZIP Code
	60090 60102 60103 60118 60120 60126 60133 60140 60142 60151 60172 60178 60401 60407 60410 60416 60423 60431 60432 60439 60447 60449 60464 60466 60467 60468 60475 60477 60481 60504 60506 60511 60521 60523 60527 60538 60543 60544 60554 60559 60935 60940 60950 62031 62044 62052 62053 62054 62075 62080 62081 62082 62083 62231 62237 62238 62253 62262 62263 62268 62272 62280 62286 62355 62361 62366 62538 62546 62553 62557 62558 62630 62638 62643 62667 62690 62692 62801 62808 62831 62877 62882 62883 62907 62916
Iowa (IA)	51630 51640 52542 52573 52626 52761
Kansas (KS)	66012 66013 66018 66021 66025 66083 66102 66109 66112
Kentucky (KY)	40965 42079 42223 42602
Massachusetts (MA)	01432 01930 02339 02762 01434 02324
Maryland (MD)	20601 20607 20613 20714 20736 20754 20842 20871 21757 21771 21776 21787 21791
Michigan (MI)	48005 48041 48062 48118 48137 48160 48166 48169 48178 48189 48353 48371 48380 48428 48430 48438 48439 48442 48455 48462 49229 49236 49240 49285
Minnesota (MN)	56136 56144 56164 56219 56220 56257 56744
Missouri (MO)	63005 63015 63020 63023 63028 63030 63041 63060 63069 63071 63072 63087 63348 63357 63535 63548 63627 64024 64034 64048 64061 64062 64070 64075 64077 64080 64082 64147 64439 64444 64484 64492 64733 64784
Montana (MT)	59030 59847
Nebraska (NE)	68719 68755 68777 69168 69212 69216 69352 69358
Nevada (NV)	89061
New Hampshire (NH)	03579 03813
New Jersey (NJ)	07735 07747 08512 08525 08530 08540 08558 08560
New York (NY)	10505 10541 10579 11001 11040 11096 12167 12434 13750
North Dakota (ND)	58030 58041 58043 58053 58225 58413 58436 58439 58568 58623 58653
Oregon (OR)	97002 97014 97032 97056 97064 97071 97119 97123 97128 97132 97140 97231 97362 97375
Pennsylvania (PA)	17527 17555 18036 18041 18042 18055 18070 18077 18092 18951 19087 19310 19344 19362 19363 19464 19504 19505 19512 19520 19525 19543
South Dakota (SD)	57005 57026 57030 57034 57255 57260 57270 57430 57446 57457 57523 57632 57642 57645 57648 57660 57068 57078 57437 57441 57638 57641 57717 57724
Tennessee (TN)	37317 37391 37821 38326
Texas (TX)	75007 75019 75028 75044 75048 75050 75051 75052 75054 75067 75080 75082 75088 75089 75098 75104 75115 75125 75146 75148 75154 75159 75182 75248 75252 75287 75839 75844 75847 75851 75856 75862 76008 76020 76028 76036 76051 76052 76063 76065 76071 76092 76108 76126 76177 76262 77047 77053 77082 77083 77085 77099 77339 77357 77365 77381 77382 77426 77430 77444 77447 77450 77474 77477 77480 77484 77485 77489 77493 77494 77511 77520 77521 77532 77535 77539 77546

State	ZIP Code
	77550 77568 77581 77583 77622 77656 77665 77833 78610 78612 78613 78615 78617 78620 78621 78634 78641 78652 78654 78657 78663 78664 78669 78727 78728 78729 78734 78736 78737 78738 78750 78759 78933 78940 78950 78954 79835 79922 79932
Virginia (VA)	20120 20135
Washington (WA)	98019 98022 98047 98072 98077 98092 98177 98251 98354 99033 99128
Wisconsin (WI)	54540
Wyoming (WY)	82063 82082 82240 82716 82725 82731 82930 83114 83120 83127

Additional Information

You can find more information about the use of nine-digit ZIP codes for determining the correct payment locality for anesthesia services and services paid under the (MPFS) by going to CR5208, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1193CP.pdf> on the CMS website.

You might also want to look at updated Medicare Claims Processing Manual, Publication 100-04, Chapter 1 (General Billing Requirements), Section 10.1.1 (Payment Jurisdiction among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services) which you will find as an attachment to this CR.

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

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