

Communiqué

Part B

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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May 2008



Items of Importance

ANNOUNCING THE NEW FORMS WEBPAGE

Are you having trouble finding the Medicare forms you need? Please visit our new Forms page at: http://www.wpsmedicare.com/part_b/selfservice/forms.shtml

This page provides "one-stop shopping" for Medicare forms. To serve our provider community better, we have made the forms on the WPS Medicare Website interactive. Simply open the PDF document, enter your information, and click "Print." All you have to do then is sign the form and mail it in at your convenience.

IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS

WPS Medicare will close for the following holidays:

<u>Date</u>	<u>Holiday</u>
May 26, 2008	Memorial Day
July 4, 2008	Independence Day
September 1, 2008	Labor Day

During weekends and evenings, the Interactive Voice Response (IVR) and CMS Secure Net Access Pilot (CSNAP) 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 the following location: <https://medicareinfo.com/apps/cms/home.do>

For more information regarding the IVR, please check out our Website at the following address: http://www.wpsmedicare.com/part_b/selfservice/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.

INTRODUCING THE NEW SYSTEM STATUS FEATURE

WPS Medicare has recently equipped our Website with status functionality. This functionality enables our customers to view system availability by accessing a scroll box, located on every provider homepage, for the various methods of contact that WPS Medicare offers. The benefit of this feature is that it allows providers to determine the most advantageous method of contact to WPS, based on current, real-time availability of systems and telephones. This easy-to-access status feature creates efficiencies for providers and also reduces redundant inquiries coming into our contact center regarding system-related issues.

WEBSITE CUSTOMER SATISFACTION SURVEY

Your Voice Shapes the WPS Medicare Website

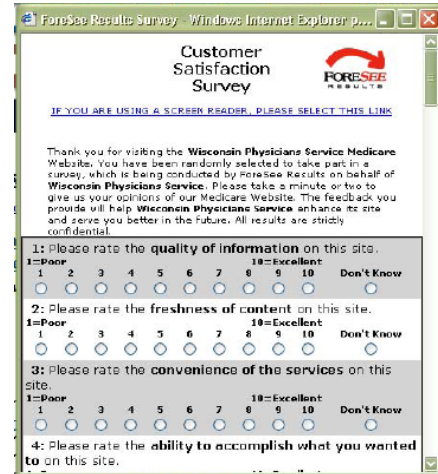
Your feedback is extremely important to the provider community, WPS Medicare, and the Centers for Medicare & Medicaid Services (CMS). Please assist WPS Medicare in ensuring your satisfaction by completing the Customer Satisfaction Survey that pops up when you are on the WPS Medicare (<http://www.wpsmedicare.com>) Website. This quick survey, sponsored by CMS and conducted by ForeSee, gauges your satisfaction with the WPS Medicare Website, and you are strongly encouraged to complete the survey.

WPS Medicare is interested in your feedback on both what you like and what improvements they can make to the [wpsmedicare.com](http://www.wpsmedicare.com) Website. Please be specific in your evaluation of the Website - If WPS offers something on the Website that you feel is valuable, be sure to detail the specific tool/Web page/etc. you are referencing. WPS and CMS review the results of the survey regularly, and your feedback directly influences the layout, look and feel, content, and other aspects of the WPS Medicare Website.

The survey is anonymous, and is intended to measure your satisfaction with the <http://www.wpsmedicare.com> Website. Please do not use this survey to evaluate other Websites. When taking the survey, be sure you are evaluating the appropriate section of the [wpsmedicare.com](http://www.wpsmedicare.com) Website. The Part B Legacy Provider Website, for providers in Illinois, Michigan, Minnesota, and Wisconsin is located at http://www.wpsmedicare.com/part_b

Please note: Once you complete the survey, it will not pop up again until you clear your cookies. However, if in the future you would like to take the survey again to provide additional feedback on the Website, simply clear your cookies (For more information on cookies, go to <http://www.microsoft.com/info/cookies.msp>).

WPS Medicare greatly appreciates your participation and feedback.



Website Customer Satisfaction Survey as it appears on the [wpsmediare.com](http://www.wpsmedicare.com) Website.

Claim Submission

APRIL 2008 UPDATE TO THE AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEM; SUMMARY OF PAYMENT POLICY CHANGES

~CMS MLN Matters~

MLN Matters Number: MM5994

Related Change Request (CR) #: 5994

Related CR Release Date: April 9, 2008

Effective Date: April 1, 2008

Related CR Transmittal #: R1488CP

Implementation Date: April 7, 2008

Provider Types Affected

Providers (ASCs) who submit claims to Medicare Administrative Contractors (A/B MACs) and carriers, for services provided to Medicare beneficiaries which are paid under the ASC payment system.

Provider Action Needed

This article is based on Change Request (CR) 5994 which describes changes to, and billing instructions for, payment policies implemented in the April 2008 ASC update. This update provides updated payment rates for selected separately payable drugs and biologicals and provides rates and descriptors for newly created Level II Healthcare Common Procedure Coding System (HCPCS) codes for drugs and biologicals.

Key Points

Billing for Drugs and Biologicals

- ASCs are strongly encouraged to report charges for all separately payable drugs and biologicals, using the correct HCPCS codes for the items used. ASCs billing for these products must make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of the drug or biological that was used in the care of the patient. ASCs should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.
- If commercially available drug and biological products are being mixed together to facilitate their concurrent administration, the ASC should report the quantity of each product (reported by HCPCS code) that is separately payable in the ASC used in the care of the patient. Alternatively, if the ASC is compounding drugs that are not a mixture of commercially available products, but are a different product that has no applicable HCPCS code, the payment is packaged and no HCPCS coding is required. In these situations, ASCs should not report HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the Food and Drug Administration (FDA) on or after January 1, 2004, for which a HCPCS code has not been assigned.

**Drugs and Biologicals with Payment Based on Average Sales Price (ASP)
Effective April 1, 2008**

- Payments for separately payable drugs and biologicals based on the ASP will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates for previous quarters (January 2008) are necessary based on the most recent ASP submissions, the Centers for Medicare & Medicaid Services (CMS) will incorporate changes to the payment rates in the April 2008 release of the ASC DRUG FILE.
- Your Medicare contractors will make available to the ASCs the list of any newly added codes and previous quarter payment rate changes as identified in CR5994.
- Providers take note that if your claims were processed prior to the installation of the revised January 2008 ASC Drug file, your Medicare AB/MAC or carrier will adjust, as appropriate, claims you bring to their attention that have dates of service on or after January 1, 2008 but prior to April 1, 2008.

New HCPCS Drug Codes Separately Payable under the ASC Payment System as of April 1, 2008

Four new HCPCS codes have been created effective April 1, 2008. These new HCPCS codes and their descriptors are listed in Table 1 below.

Table 1

New Drugs Separately Payable under the ASC Payment System as of April 1, 2008

HCPCS Code	Long Descriptor
C9241	Injection, doripenem, 10 mg
Q4096	Injection, Von Willebrand Factor Complex, human, Ristocetin Cofactor (Not otherwise specified), per I.U. VWF:RCO,
Q4097	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg
Q4098	Injection, iron dextran, 50 mg

The payment rates for the drugs in Table 1 can be found in the April 2008 update of the ASC Addendum BB which will be posted on the CMS Website at the end of March.

HCPCS Drug Codes No Longer Payable under the ASC Payment System Effective April 1, 2008

The following drug codes have been deleted and are no longer payable by Medicare, effective April 1, 2008.

Table 2

Drugs HCPCS codes no longer eligible for payment under Medicare as of April 1, 2008

HCPCS Code	Long Descriptor	ASC Payment Status
J1751	Injection, iron dextran 165, 50 mg	Not payable by Medicare
J1752	Injection, iron dextran 267, 50 mg	Not payable by Medicare

Correct Reporting of Units for Drugs

ASCs are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor.

For example, if the drug's HCPCS code descriptor specifies 6 mg, and 6 mg of the drug were administered to the patient, the units billed should be 1.

As another example, if the drug's HCPCS descriptor specifies 50 mg and 200 mg of the drug were administered to the patient, the units billed should be 4.

ASCs should not bill the units based on how the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, 10 units should be reported on the bill, even though only 1 vial was administered.

HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

Additional Information

To see the official instruction (CR5994) issued to your Medicare Carrier or A/B MAC refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1488CP.pdf> on the CMS Website.

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.

CLARIFICATION REGARDING THE COORDINATION OF BENEFITS AGREEMENT (COBA) MEDIGAP CLAIM-BASED CROSSOVER PROCESS

~CMS MLN Matters~

MLN Matters Number: MM5837 **Revised**
Related CR Release Date: January 25, 2008
Related CR Transmittal #: R1420CP and R135FM

Related Change Request (CR) #: 5837
Effective Date: October 1, 2007
Implementation Date: February 1, 2008

Note: This article was revised on January 30, 2008, to show the correct implementation date (see above), which is February 1, 2008. All other information remains the same.

Provider Types Affected

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

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

This article is based on Change Request (CR) 5837 which clarifies instructions regarding the Coordination of Benefits Agreement (COBA) Medigap claim-based crossover process.

CAUTION – What You Need to Know

CR 5837 provides formal confirmation of a recent Centers for Medicare & Medicaid Services (CMS) decision to **not require** Medicare Part B contractors (including Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to update their internal insurer tables or files with each Medigap insurer's newly assigned Coordination of Benefits Agreement (COBA) Medigap claim-based ID, as was previously prescribed in CR 5662. In addition, CR 5837 conveys clarifying provider billing requirements in relation to Medigap claim-based crossovers.

GO – What You Need to Do

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

Background

Effective October 1, 2007, the CMS transferred responsibility for the mandatory Medigap crossover process (also known as the "Medicare claim-based crossover process") to its Coordination of Benefits Contractor. With this change, Part B contractors, including A/B MACs and DME MACs:

- No longer maintain crossover relationships with Medigap insurers, and
- No longer bill such entities for crossover claims effective with the last claims file that they transmit to these entities no later than October 31, 2007.

In a directive issued on September 18, 2007, CMS communicated to Medicare Part B contractors (carriers, DME MACs, and A/B MACs) its decision that they are not required to update their internal insurer files or tables with the Coordination of Benefits Contractor (COBC)-assigned COBA Medigap claim-based identifiers (IDs). This is because, as discussed in Change Request (CR) 5601, the contractors' front-end system now simply verifies that a Medigap claim-based crossover identifier on an incoming claim is syntactically correct (5 digits, beginning with a "5"). CMS' Common Working File (CWF) system is now tasked with validation of the actual ID submitted on incoming claims.

The September 18, 2007, directive represented a departure from previous guidance communicated in CR5662 (see MLN Matters article, MM5662, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5662.pdf> on the CMS Website), in which CMS provided for transitional updating of the contractors' internal insurer files/tables prior to October 1, 2007, once the COBC had:

- Assigned COBA Medigap claim-based IDs to the various Medigap insurers, and
- Deemed Medigap insurers "production-ready."

CMS also required Medicare contractors to post language on their provider Websites stipulating that:

- Providers are not to begin including the new COBA Medigap claim-based IDs on incoming Part B claims or claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) before October 1, 2007.

CR 5837 instructs Part B contractors (including A/B MACs and DME MACs) that they **are not required to update their internal insurer files/tables** following a Medigap insurer's readiness to move into production with the COBC. This requirement formerly applied to situations where CMS expected that contractors update their internal insurer files/tables prior to October 1, 2007, in accordance with CR 5662 (Transmittal 283). These Part B contractors may retain their older Other Carrier Name and Address (OCNA) or N-key identifiers within their internal insurer files/tables for purposes of avoiding system issues or for the printing of post-hoc beneficiary-requested Medicare Summary Notices (MSNs). However, in accordance with CR 5601, at <http://www.cms.hhs.gov/transmittals/downloads/R1242CP.pdf> on the CMS Website, contractors will have disabled the logic that they formerly used to tag claims for crossover to Medigap insurers effective prior to claims they received for processing on October 1, 2007.

Effective with CR 5837, all Part B contractors (including A/B MACs and DME MACs) will discontinue publication of their routine Medigap newsletters. These contractors may, however, at their discretion, publish one last edition of this newsletter if desired to include the provider education language that follows:

In accordance with the language modification to MSN message 35.3

—“A copy of this notice will not be forwarded to your Medigap insurer because the information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer.” —which contractors made as part of Transmittal 1242, CR 5601, all Part B contractors, including A/B MACs, and DME MACs shall make available a Spanish translation of the modified MSN message, which shall read as follows: “No se enviará copia de esta notificación a su asegurador de Medigap debido a que la información estaba incompleta o era inválida. Favor de someter una copia de esta notificación a su asegurador Medigap.”

All Part B contractors (including A/B MACs, and DME MACs) are to inform their associated billing providers that are exempted from billing their claims electronically under the Administrative Simplification Compliance Act (ASCA) that they should only be entering the newly assigned 5-byte COBA Medigap claim-based ID (range 55000 to 59999) with item 9-D of the CMS-1500 claim form for purposes of triggering a crossing over of the claim to a Medigap insurer.

All Part B contractors (including A/B MACs, and DME MACs) are also to provide a link on their provider Websites (preferably under “Hot Topics”) to the recently published special edition MLN article (SE0743 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0743.pdf> on the CMS Website) that clarifies for providers the differences between:

- Medigap crossover that is accomplished via the automatic, eligibility file-based crossover process, and

- The Medigap claim-based crossover process, which is triggered by information that they include on incoming claim.

Providers should note that the listing at <http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf> on the CMS COB Website is:

- Complete and up-to-date, and
- The only source for the identifiers to be included on incoming claims for purposes of triggering crossovers to those Medigap insurers that **do not** participate fully in the automatic crossover process.

Additional Information

The official instruction, CR 5837, was issued in two transmittals issued to your Medicare carrier, DME MAC, or A/B MAC. Those transmittals may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1420CP.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R135FM.pdf> on the CMS Website. These transmittals make revisions to the Medicare Claims Processing and Medicare Financial Management Manuals, respectively

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

CR 5550 CLARIFICATION - SIGNATURE REQUIREMENTS ~CMS MLN Matters~

MLN Matters Number: MM5971

Related CR Release Date: March 28, 2008

Related CR Transmittal #: R248PI

Related Change Request (CR) #: 5971

Effective Date: September 3, 2007

Implementation Date: April 28, 2008

Provider Types Affected

Physicians and other providers who bill Medicare Contractors (Carriers, Fiscal Intermediaries, Regional Home Health Intermediaries, Part A/B Medicare Administrative Contractors, including Durable Medical Equipment Medicare Administrative Contractors) for care provided to Medicare beneficiaries in hospice.

What You Need to Know

CR 5971, from which this article is taken, clarifies the instructions on signature requirements for the certification of terminal illness for hospice. It provides that Medicare contractors will accept a facsimile of an original written or electronic signature in documenting the certification of terminal illness for hospice.

Make sure that your billing staffs are aware that, to document the certification of terminal illness for hospice, a facsimile of an original written or electronic signature is acceptable

Background

CR 5971, from which this article is taken, clarifies the instructions in *Medicare Program Integrity Manual* Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Subsection 3.4.1.1B (Signature Requirements) that address the signature requirements for the certification of terminal illness for hospice, that were provided in CR 5550 ([Various Medical Review Clarifications](#)).

Subsection 3.4.1.1B of the manual notes that Medicare contractors require a legible identifier for services provided/ordered. It further requires that when this documentation is for medical review purposes, the only acceptable method of documenting the provider signature is by written or an electronic signature. Stamp signatures are not acceptable to sign an order or other medical record documentation for medical review purposes.

CR 5971 provides that there is an exception to this requirement. It announces that a facsimile of an original written or electronic signature is acceptable for the certification of terminal illness for hospice. Please be sure to note however, that while a signature facsimile is acceptable in this instance; it and **hard copies of a physician's electronic signature** must be present in the patient's medical record.

Additional Information

You can find more information about the signature requirements for the certification of terminal illness for hospice by going to CR 5971, located at <http://www.cms.hhs.gov/Transmittals/downloads/R248PI.pdf> on the CMS Website. You will find updated *Medicare Program Integrity Manual* Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Subsection 3.4.1.1B (Signature Requirements) as an attachment to this CR.

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

**MEDICARE SHARED SYSTEMS MODIFICATIONS NECESSARY TO
ACCEPT AND CROSSOVER TO MEDICAID NATIONAL DRUG CODES
(NDC) AND CORRESPONDING QUANTITIES SUBMITTED ON CMS-
1500 PAPER CLAIMS
~CMS MLN Matters~**

MLN Matters Number: MM5835
Related CR Release Date: December 21, 2007
Related CR Transmittal #: R1401CP

Related Change Request (CR) #: 5835
Effective Date: April 7, 2008
Implementation Date: April 7, 2008

Provider Types Affected

All physicians, providers, and suppliers who submit paper claims using Form CMS-1500 to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), and durable medical equipment Medicare Administrative Contractors (DME/MACs)) for certain physician administered drugs provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You - The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5835 that notifies physicians and suppliers who use Claim Form CMS-1500 (those providers who qualify for a waiver from the Administrative Simplification Compliance Act (ASCA)) that changes are being made to Medicare systems to conform with instructions for submitting NDC drug code and quantity information on Form CMS-1500.

CAUTION – What You Need to Know - This article only applies to those providers eligible to submit paper claims and who do so for patients who are dually eligible for Medicaid and Medicare. Such claims need to include NDCs and corresponding quantity amounts for physician-administered drugs. The Key Points section of this CR outlines the changes required in the Form CMS-1500.

GO – What You Need to Do - Make certain your office staffs are aware of these changes in the content requirements of your paper claims.

Background

The Deficit Reduction Act (DRA) of 2005 required State Medicaid agencies to provide for the collection of National Drug Codes (NDC) on all claims for certain physician-administered drugs for the purpose of billing manufacturers for Medicaid drug rebates. Prior to the DRA, physicians' offices, outpatient hospital departments and clinics generally used Healthcare Common Procedure Coding System (HCPCS) codes to bill Medicaid for drugs dispensed to Medicaid patients. However, because State Medicaid agencies are required to invoice manufacturers for rebates using NDCs for drugs for which the States have made payments, often States were not able to fulfill the rebate requirements for physician-administered drugs. The requirements for the collection of NDCs became effective beginning January 1, 2007. In addition, beginning January 1, 2008, in order for Federal financial participation (FFP) to be available for these drugs, State Medicaid agencies must be in compliance with the requirements. These requirements were implemented in a final rule published on July 17, 2007.

Also, the quantity field of the CMS-1500 paper claim should be captured on all crossover claims for Medicaid billing, as provided for by the National Uniform Claims Committee (NUCC). Information regarding the quantities of physician-administered drugs billed to Medicaid is also necessary for States to bill manufacturers for Medicaid drug rebates.

Key Points

When required to submit NDC drug number and quantity information for Medicaid rebates on the CMS-1500 paper claim be aware of the following:

- Submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13.
- The NDC is to be preceded with the qualifier N4 and followed immediately by the 11digit NDC code (e.g. N499999999999).
- Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six positions available for quantity. If the quantity is less than six positions, the entry should be left justified with spaces filling the remaining positions.

Additional Information

To see the official instruction (CR5835) issued to your Medicare Carrier, DME/MAC, or A/B MAC refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1401CP.pdf> on the CMS Website.

If you have questions, please contact your Medicare Carrier, DME/MAC, 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.

**NEW HCPCS CODES FOR THE APRIL 2008 UPDATE
~CMS MLN Matters~**

MLN Matters Number: MM5981

Related Change Request (CR) #: 5981

Related CR Release Date: April 18, 2008

Effective Date: April 1, 2008

Related CR Transmittal #: R1492CP

Implementation Date: April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, 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

This article is based on Change Request (CR) 5981, which instructs Medicare Contractors to implement Healthcare Common Procedure Coding System (HCPCS) code changes effective April 1, 2008. Make sure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) updates the Healthcare Common Procedure Coding System (HCPCS) code set on a quarterly basis.

Effective for claims with dates of service on or after April 1, 2008, the following HCPCS codes will no longer be payable for Medicare:

HCPCS Code	Short Description	Long Description
J7602	Albuterol inh non-comp con	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)

HCPCS Code	Short Description	Long Description
J7603	Albuterol inh non-comp u d	ALBUTEROL, ALL FORMULATIONS INCLUDING SEPARATED ISOMERS, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, PER 1 MG (ALBUTEROL) OR PER 0.5 MG (LEVALBUTEROL)
J1751	Iron dextran 165 injection	INJECTION, IRON DEXTRAN 165, 50 MG
J1752	Iron dextran 267 injection	INJECTION, IRON DEXTRAN 267, 50 MG

Effective for claims with dates of service on or after April 1, 2008, the following HCPCS codes will be payable for Medicare:

HCPCS Code	Short Description	Long Description
J7611	Albuterol non-comp con	ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 1MG
J7612	Levalbuterol non-comp con	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, CONCENTRATED FORM, 0.5 MG
J7613	Albuterol non-comp unit	ALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 1MG
J7614	Levalbuterol non-comp unit	LEVALBUTEROL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE, 0.5 MG
Q4096	VWF complex, NOS	INJECTION, VON WILLEBRAND FACTOR COMPLEX, HUMAN, RISTOCETIN COFACTOR (NOT OTHERWISE SPECIFIED), PER I.U. VWF:RCO
Q4097	Inj IVIG Privigen 500 mg	INJECTION, IMMUNE GLOBULIN (PRIVIGEN), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG
Q4098	Inj iron dextran	INJECTION, IRON DEXTRAN, 50MG
Q4099	Formoterol fumarate, inh	FORMORETOL FUMARATE, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 20 MICROGRAMS

Currently, Alphanate® is the only product that should be billed using code Q4096. J7190 should continue to be billed when Alphanate® is furnished for purposes of administering Factor VIII. The blood clotting furnishing fee is payable when payment is allowed for Q4096. When a payment allowance limit for Q4096 is included on the quarterly Part B drug pricing files, the payment allowance limit will include payment for the blood clotting furnishing fee.

Effective for dates of service on or after April 1, 2008, the requirements under CR 5713 (See the MLN Matters article for CR5713, which is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5713.pdf> on the CMS Website) are being updated by CR 5981 to apply to claims that bill Intravenous Immunoglobulins (IVIG) using Q4097 as follows:

- Effective for dates of service on or after April 1, 2008, Medicare Contractors will:
 - Only pay a claim for preadministration-related services (G0332) associated with IVIG administration if G0332, the drug (IVIG, HCPCS codes: J1566, J1568, J1569, J1561, J1572 and/or Q4097), and the drug administration service are all billed on the same claim for the same date of service;
 - Return institutional claims for G0332 to the provider if J1566, J1568, J1569, J1561, J1572 and/or Q4097 and a drug administration service are not also billed for the same date of service on the same claim;
 - Reject professional claims as unprocessable for G0332 if J1566, J1568, J1569, J1561, J1572 and/or Q4097 and a drug administration service are not billed for the same date of service on the same claim; and
 - Use the appropriate reason/remark messages such as: M67 “Missing other procedure codes” and/or 16 “Claim/service lacks information” which are needed for adjudication when claims are returned/rejected.

Additional Information

The official instruction, CR 5981, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding these changes may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R1492CP.pdf> on the CMS Website.

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

NPI DROP DEAD DATE MAY 23, 2008

Important Medicare Provider Implementation Dates:

March 1, 2008 – All providers needed to have the NPI numbers in the primary identifier fields on their claims or the claims would reject. Medicare FFS 837P and CMS-1500 claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to, and rendering provider fields). Claims with only legacy identifiers in the primary provider fields are being rejected.

May 23, 2008 – In keeping with the Contingency Guidance issued on April 2, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims

and SPR remittance advice. (Note that this date is one day earlier than that mandated by the National Enforcement Policy)

If the claim contains a legacy identifier in any field, it will be rejected.

- This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction.
- CMS will also stop sending legacy identifiers on COB crossover claims at this time.
- Until you submit claims with an NPI only, you will not have a preview of what your experience will be on May 23. Now is the time to correct any problems that you may find.
- Medicare urges providers that have successfully paid claims containing NPI and legacy provider identifiers to start testing small batches of production claims with NPI only provider information.
- To test NPI only, send a small batch of production claims now with only the NPI on the claims and follow those claims through to adjudication.

REMEMBER, if you test and your claims are processed successfully, you can approach the May 23 date with confidence. If you do not, you will most likely face cash flow problems.

To sum this up, no later than May 24, 2008, NPI only is expected in a compliant manner by all covered entities and all contingency plans should be lifted. (Rare exceptions should see Website listed below)

Note: All current and past CMS NPI communications are available on the CMS site at <http://www.cms.hhs.gov/NationalProvidentStand> by clicking "CMS Communications" in the left column.

If you have any questions, please contact the EDI Department.

Illinois, Michigan, Wisconsin: 877-567-7261
Minnesota: 866-380-4742, Option 2

NURSING FACILITY SERVICES (CODES 99304 - 99318) ~CMS MLN Matters~

MLN Matters Number: MM5968

Related Change Request (CR) #: 5968

Related CR Release Date: April 11, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R1489CP

Implementation Date: July 7, 2008

Provider Types Affected

Physicians and qualified non-physician practitioners who bill Medicare contractors (Carriers or Medicare Administrative Contractors A/B MAC) for services provided to Medicare beneficiaries in skilled nursing facilities (SNF) or nursing facilities (NF)

What You Need to Know

CR 5986, from which this article is taken, updates the *Medicare Claims Processing Manual*, Chapter 12, (Physicians/Non-physician Practitioners), Section 30.6.13 (Nursing Facility Services (Codes 99304 - 99318) Subsection F (Use of the Prolonged Services Codes and Other Time-Related Services) by noting that the typical/average time units

for Evaluation and Management (E/M) visit codes in the Nursing Facility Services code family are reestablished and applicable, as of January 1, 2008.

Effective for services on or after July 1, 2008, you may bill Medicare for medically necessary prolonged services for E/M visits (codes 99356 and 99357) in a SNF or NF with Nursing Facility Services codes (99304 – 99306, 99307 – 99310 and 99318). Additionally, you may use these prolonged services codes (99356 and 99357) with Nursing Facility Services in the code range (99304 – 99306, 99307 – 99310, and 99318) to bill for counseling and/or coordination of care services that are based on time.

Make sure that your billing staffs are aware of these new billing changes.

Background

Effective January 1, 2006, the American Medical Association (AMA) Current Procedural Terminology (CPT) Panel removed the typical/average time units for evaluation and management (E/M) services in the Nursing Facility code family. Until these typical/average times were reestablished, this action precluded the billing of: 1) prolonged services for E/M visits in a skilled nursing facility or nursing facility; and 2) time-based counseling and/or coordination of care for Nursing Facility Services.

CR 5986, from which this article is taken, updates the *Medicare Claims Processing Manual*, Chapter 12, (Physicians/Non-physician Practitioners), Section 30.6.13 (Nursing Facility Services (Codes 99304 - 99318)), Subsection F (Use of the Prolonged Services Codes and Other Time-Related Services) by announcing that the AMA CPT Panel has reestablished these typical/average time units beginning January 1, 2008.

Further, CR 5968 announces that, effective July 1, 2008, you may bill for medically necessary prolonged services for SNF or NF E/M visits (CPT codes 99356 and 99357) with Nursing Facility Services (code range 99304 – 99306, 99307 – 99310 and 99318); and you may also use the medically necessary prolonged services CPT codes (99356 and 99357) to bill for medically necessary E/M visits for time-based counseling and/or coordination of care for Nursing Facility Services in the code range 99304 – 99306, 99307 – 99310, and 99318.

Additional Information

You can find more information about using the prolonged services codes CPT codes (99356 and 99357) billing for medically necessary prolonged services for E/M visits in a SNF or NF, and for time-based counseling and/or coordination of care for Nursing Facility Services by going to CR 5968, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1489CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Claims Processing Manual*, Chapter 12, (Physicians/Non-physician Practitioners), Section 30.6.13 (Nursing Facility Services (Codes 99304 - 99318) Subsection F (Use of the Prolonged Services Codes and Other Time-Related Services) as an attachment to that CR.

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.

Coverage – General**LABORATORY COMPETITIVE BIDDING DEMONSTRATION**
~CMS MLN Matters~

MLN Matters Number: MM5359

Related CR Release Date: March 19, 2008

Related CR Transmittal #: R57DEMO

Related Change Request (CR) #: 5359

Effective Date: April 1, 2007

Implementation Date: April 2, 2007

Note: This article was changed on March 20, 2008, to reflect a change that was made to related CR5389 on March 19, 2008. The CR was modified to delete a business requirement instructing carriers and A/B MACs deny claims with dates of service between April 1, 2007 and March 31, 2010 inclusive and with modifier “90” submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA. Since that requirement was deleted, language regarding that denial requirement was deleted from the article. The CR release date, transmittal number and Web address for accessing CR5389 were also changed. All other information remains the same. **However, it is important to note that a more current article, MM5772, is now available regarding this demonstration at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5772.pdf> on the CMS Website. Where there is disagreement between this article and related CR5359 and MM5772 and related CR5772, the information in CR5772 is more current and takes precedence over CR5359.**

Provider Types Affected

Physicians and hospitals (TOB 14X only) who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites.

Background

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

Key Points

This article and Change Request (CR) 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this

article and CR5359 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the zip code of the beneficiary's residence.
- Hospital inpatient testing is covered by Medicare Part A and is therefore **exempt** from the demonstration.
- Physician office laboratory (POL) testing and hospital outpatient testing **are not included in the demonstration, except** where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.
- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

Required Bidders

Laboratory firms with \$100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for "demonstration tests" provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration.

These laboratory firms will be referred to as "required bidders."

Passive Laboratories

Small laboratories or laboratory firms with less than \$100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will **not be required** to bid in the demonstration. These laboratories are considered "passive" laboratories." Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of \$100,000.

Passive laboratory firms exceeding the annual ceiling of \$100,000 by \$25,000 or more will be:

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.
- **Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considered "passive-ESRD" laboratories.** Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration

tests provided to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007 through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

Winners

Both required and non-required bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled “winners.”

Non-Winners

Both required and non-required bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled “non-winners.”

Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Non-winner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, non-winner laboratories may not charge the beneficiary for Part B laboratory services.

Demonstration-Covered Laboratory Tests

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

Although non-winner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

Demonstration Sites

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's zip code of residence.

CMS will provide the contractors with a list of zip codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

Only CLIA-certified laboratories will be allowed to participate in the demonstration.

Implementation

CR5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

During the first quarter of 2007, CMS will provide Medicare carriers, FIs, and A/B MACs with a national zip code pricing file identifying the zip codes included in the first CBA. Also, in that same timeframe, CMS will provide to the carriers, FIs, and A/B MACs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

Claims submitted by non-winner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code 96 (non-covered charges);
- Remark code M114 (*This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.*); and
- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Medicare will pay claims during the demonstration period submitted by non-demonstration laboratories for beneficiaries residing in the CBA who receive

services outside of those areas (e.g., “snow birds”) according to the laboratory competitive bidding demonstration.

Non-winning laboratories should know that Advance Beneficiary Notices (ABNs) and Notices of Beneficiary Exclusion from Medicare Benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at non-winner laboratories.

Line items for demonstration services and for non-demonstration services may be submitted on the same claim.

A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

Medicare contractors will be prepared to begin processing claims under the laboratory competitive bidding demonstration in the first CBA on April 1, 2007. The tentative start date for the demonstration in the second CBA is April 1, 2008.

Remember that required and non-required bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

Implementation

The implementation date for this instruction is April 2, 2007.

Additional Information

The official instructions issued to your Medicare carrier, FI, or A/B MAC regarding this change can be found at

<http://www.cms.hhs.gov/Transmittals/downloads/R57DEMO.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.

NEW WAIVED TESTS

~CMS MLN Matters~

MLN Matters Number: MM5913

Related CR Release Date: March 14, 2008

Related CR Transmittal #: R1477CP

Related Change Request (CR) #: 5913

Effective Date: April 1, 2008

Implementation Date: April 7, 2008

Provider Types Affected

Physicians, providers and suppliers who bill Medicare Carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical diagnostic laboratory services.

What You Need to Know

The list of tests approved by the Food and Drug Administration (FDA) as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) has been updated.

Background

CLIA regulations require a facility to be appropriately certified for each test they perform. Laboratory claims are edited at the CLIA certificate level in order to ensure the Centers for Medicare & Medicaid Services (CMS) pay only for laboratory tests categorized as waived complexity under CLIA by facilities with a CLIA certificate of waiver.

The chart below identifies the newly added waived tests and their effective dates. The Current Procedural Terminology (CPT) codes for these tests must have the QW modifier to be recognized as a waived test.

CPT Code	Effective Date	Description
87880QW	June 25, 2007	PSS World Medical Select Diagnostics Strep A Dipstick
86308QW	July 12, 2007	Signify Mono Cassette {Whole Blood}
86308QW	July 12, 2007	Poly Stat Mono Test {Whole Blood}
86308QW	July 12, 2007	Clearview MONO Whole Blood, K042272/A016
86318QW	July 25, 2007	Polymedco Poly Stat H. Pylori Test (Whole Blood)
86318QW	July 25, 2007	Henry Schein One Step+ H. Pylori Rapid Test Device (Whole Blood)
87880QW	August 14, 2007	Moore Medical The Supply Experts Strep A Rapid Test – Dipstick
87880QW	August 21, 2007	Jant Pharmacal Accustrip Strep A Value+ Test Strip
87880QW	August 21, 2007	Abbott Laboratories Signify Strep A Dipstick
86318QW	September 11, 2007	Abbott Laboratories Signify H. Pylori Cassette {Whole Blood}
82465QW, 83718QW, 82947QW, 82950QW, 82951QW, 82952QW	September 21, 2007	Polymer Technology Systems CardioChek PA Analyzer (PTS Panels CHOL+HDL+GLUC Panel Test Strips)

CPT Code	Effective Date	Description
82465QW, 83718QW, 82947QW, 82950QW, 82951QW, 82952QW	September 21, 2007	Polymer Technology Systems CardioChek Brand Analyzer (PTS Panels CHOL+HDL+GLUC Panel Test Strips)
85014QW	September 21, 2007	Abbott i-STAT Chem8+ Cartridge {Whole Blood}
82465QW, 83718QW	October 15, 2007	Polymer Technology Systems CardioChek PA Analyzer (PTS Panels CHOL+HDL Panel Test Strips)
82465QW, 83718QW	October 15, 2007	Polymer Technology Systems CardioChek Brand Analyzer (PTS Panels CHOL+HDL Panel Test Strips)
82565QW, 84520QW	October 18, 2007	Abaxis Piccolo xpress Chemistry Analyzer (Kidney Check Panel){Whole Blood}
86703QW	October 22, 2007	Clearview Complete HIV 1/2 {Fingerstick Venipuncture, whole blood}
80051QW	October 30, 2007	Abaxis Piccolo Blood Chemistry Analyzer (Electrolyte Metabolic Reagent Disc){Whole Blood}
80051QW	October 30, 2007	Abaxis Piccolo xpress Chemistry Analyzer (Electrolyte Metabolic Reagent Disc){Whole Blood}
87804QW	November 1, 2007	BinaxNOW Influenza A & B Test {Nasopharyngeal (Np) Swab and Nasal Wash/Aspirate Specimens and Nasal Swabs (NS)}
80101QW	December 13, 2007	Quest Diagnostics Incorporated, Express Results Integrated Multi-Drug Screen Cup {professional use}
80047QW	January 1, 2008	Abbott i-STAT Chem8+ Cartridge {Whole Blood}
80048QW	January 16, 2008	Abaxis Piccolo Blood Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood}
80048QW	January 16, 2008	Abaxis Piccolo xpress Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood}
80053QW	January 16, 2008	Abaxis Piccolo Blood Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood}

CPT Code	Effective Date	Description
80053QW	January 16, 2008	Abaxis Piccolo xpress Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood}

The new waived CPT/HCPCS code, 80047QW, has been assigned for the ionized calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen tests performed using the Abbott i-STAT Chem8+ Cartridge {Whole Blood}. This CPT code may be used for claims submitted by facilities with a valid, current CLIA certificate of waiver with dates of service on or after January 1, 2008.

The new waived CPT/HCPCS code, 80048QW, has been assigned for the calcium, carbon dioxide, chloride, creatinine, glucose, potassium, sodium, and urea nitrogen tests performed using the the Abaxis Piccolo Blood Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood}. This CPT code may be used for claims with dates of service on or after January 16, 2008, submitted by facilities with a valid, current CLIA certificate of waiver.

The new waived CPT/HCPCS code, 80051QW, has been assigned for the carbon dioxide, chloride, potassium, and sodium tests performed using the Abaxis Piccolo Blood Chemistry Analyzer (Basic Metabolic Reagent Disc){Whole Blood}, the Abaxis Piccolo Blood Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood} and the Abaxis Piccolo Blood Chemistry Analyzer (Electrolyte Metabolic Reagent Disc){Whole Blood}. This CPT code may be used for claims submitted by facilities with a valid, current CLIA certificate of waiver with dates of service on or after October 30, 2007.

The new waived CPT/HCPCS code, 80053QW, has been assigned for the alanine amino transferase, aspartate amino transferase, albumin, total bilirubin, total calcium, carbon dioxide, chloride, creatinine, glucose, alkaline phosphatase, potassium, total protein, sodium, and urea nitrogen tests performed using the Abaxis Piccolo Blood Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood} and the Abaxis Piccolo xpress Chemistry Analyzer (Comprehensive Metabolic Reagent Disc){Whole Blood}. This CPT code may be used for claims with dates of service on or after January 16, 2008, submitted by facilities with a valid, current CLIA certificate of waiver.

The following CPT codes do not require the QW modifier in order to be recognized as waived tests:

CPT Code	Description
81002	Dipstick or tablet reagent urinalysis – non-automated for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen
81025	Urine pregnancy tests by visual color comparison

CPT Code	Description
82270, 82272, G0394 (Contact your Medicare carrier or A/B MAC for claims instructions.)	Fecal occult blood
82962	Blood glucose by glucose monitoring devices cleared by the FDA for home use
83026	Hemoglobin by copper sulfate – non-automated
84830	Ovulation tests by visual color comparison for human luteinizing hormone
85013	Blood count; spun microhematocrit
85651	Erythrocyte sedimentation rate - non-automated

Your Medicare Carrier or A/B MAC will not automatically adjust claims processed prior to the implementation of these changes. However, they will adjust such claims that you bring to their attention.

Additional Information

To see the official instruction (CR5913) issued to your Medicare Carrier or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R1477CP.pdf> on the CMS Website. A complete list of tests granted waived status under CLIA is attached to CR5913. For more information about CLIA, refer to http://www.cms.hhs.gov/CLIA/01_Overview.asp#TopOfPage on the CMS Website.

If you have questions, please contact your Medicare 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.

SYSTEMS CHANGES FOR PRESCRIPTION ORDER NUMBERS FOR THE COMPETITIVE ACQUISITION PROGRAM (CAP) FOR PART B DRUGS AND BIOLOGICALS

~CMS MLN Matters~

MLN Matters Number: MM5855

Related Change Request (CR) #: 5855

Related CR Release Date: February 22, 2008

Effective Date: Claims processed on or after July 7, 2008

Related CR Transmittal #: R1453CP

Implementation Date: July 7, 2008

Provider Types Affected

Physicians submitting CAP claims to Medicare contractors (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**

This article is based on Change Request (CR) 5855, which implements system changes for prescription order numbers for the Competitive Acquisition Program (CAP) for Part B drugs and biologicals.

CAUTION – What You Need to Know

Necessary edits will be implemented to the Medicare Part B claims processing system to treat CAP claims received with inappropriate spaces in prescription order numbers as well as claims with prescription order numbers with less than 10 characters as unprocessable. A new Medicare system edit will also treat duplicate prescription order numbers as unprocessable. These edits are necessary for CAP claims to process and pay correctly. Physicians submitting claims under the CAP may not submit new claims with prescription order numbers that have been submitted on previously adjudicated claims, even if the prior claims have been denied.

GO – What You Need to Do

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

Background

The Centers for Medicare & Medicaid Services (CMS) has learned that some providers are submitting Competitive Acquisition Program (CAP) claims with prescription order numbers that have inappropriate spaces inserted thus disrupting the matching process with the vendor claims.

CR 5855 implements Medicare Part B claims processing systems edits that will treat claims processed on or after July 7, 2008, as unprocessable when submitted with inappropriate spaces in the prescription order number. Claims also submitted with prescription order numbers less than 10 characters will be treated as unprocessable.

Note that CR 5855 further instructs that CAP physicians/providers should not submit new claims with prescription order numbers that have been submitted on previously adjudicated claims, even if the prior claims have been denied. These physicians/providers must request an adjustment to the original claim. Claims previously returned as unprocessable may be resubmitted with the original prescription number after being corrected.

Medicare contractors will treat the entire claim as unprocessable when a claim is received with CAP services, but the prescription number is a duplicate of a number on a prior claim. This also applies if the prescription order number has inappropriate spaces or is less than 10 characters. This also applies to claims submitted with the J1 modifier, but lacking a prescription order number.

When claims are returned as unprocessable because the prescription number is missing, is less than 10 characters or has inappropriate spaces, contractors will also return Claim Adjustment Reason Code (CARC) 16 (Claim/service lacks information which is needed for adjudication.) and Remittance Advice Remark Code (RARC) MA130 (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.) and RARC N388 (Missing/incomplete/invalid prescription number).

When claims are returned as unprocessable due to duplicate prescription numbers, contractors will indicate on the returned Remittance Advice for such claims, a CARC 18 (Duplicate claim/service) and RARC MA130 (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.), RARC N389 (Duplicate prescription number submitted), RARC M16 (Please see our Website, mailings, or bulletins for more details covering this policy/procedure/decision), and RARC N185 – (Alert: Do not resubmit this claim/service).

Additional Information

The official instruction, CR 5855, issued to your Medicare carrier and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1453CP.pdf> on the CMS Website.

If you have any questions, please contact your Medicare 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.

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/part_b/policy/index.shtml

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

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 2008

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
CV-014	<i>Automatic Implantable Cardioverter Defibrillator (AICD or ICD)</i>	NCD	Click here to view	29
HONC-010	<i>Antineoplastics and their Adjuncts</i>	LCD	Click here to view	29
INJ-012	<i>Immune Globulins</i>	LCD	Click here to view	29
MS-004	<i>Bone Mass Measurement</i>	LCD	Click here to view	30
PSYCH-014	<i>Psychiatry and Psychological Services</i>	LCD	Click here to view	31

Coverage – Revised Policies**National Coverage Decision****Automatic Implantable Cardioverter Defibrillator (AICD or ICD)****Number**

CV-014

Based on the following from CMS the Q0 modifier has replaced the QR modifier in most sections of this document. Where the QR modifier was appropriate as of 04/07/2008 use the Q0 modifier in its place

Medicare Claims Processing Manual Pub 100-04; Transmittal 1418; Date: JANUARY 18, 2008
Change Request 5805; Effective Date: January 1, 2008; Implementation Date: No Later Than
April 7, 2008; SUBJECT: New HCPCS Modifiers when Billing for Patient Care in Clinical
Research Studies

**LCD Title**

Antineoplastics and their Adjuncts

Contractor's Determination Number

HONC-010

Revision Effective Date:

03/20/08-FDA Approval Date

Indications and Limitations:

Bendamustine hydrochloride (Trenda™) received FDA approval for the treatment of chronic lymphocytic leukemia (CLL) and been added to this LCD.

D. Not otherwise Classified Agents (NOC) (J9999)

- *5. Bendamustine hydrochloride (Trenda™) J9999 (FDA approved 03/20/08)
Chronic lymphocytic leukemia (CLL) 204.10-204.11

**Contractor Name**

Wisconsin Physicians Service (WPS)

LCD Title

Immune Globulins

Contractor's Determination Number

INJ-012

LCD Title

Immune Globulins

Revision Effective Date

04/01/2008

Indications and Limitations of Coverage and/or Medical Necessity

The treatment of livedoid vasculitis (atrophie blanche) (701.3) has been added to this LCD.

19. Severe Vasculitic Syndromes, systemic (polyarteritis nodosa) (446.0) and livedoid vasculitis (atrophie blanche) (701.3). Evidence does not support routine use of IVIG. IVIG may be used for patients with severe active illness for whom other interventions have been unsuccessful or intolerable.

**LCD Revision Article****Contractor's Policy Number**

MS-004

LCD Title

Bone Mass Measurement

Primary Geographic Jurisdiction

Wisconsin, Illinois, Michigan, Minnesota

Revision Effective Date

05/01/2008

LCD Title; Changed title to Bone Mass Measurement from Bone Mineral Density (BMD) Studies.

Indications

*There are limited clinical situations, where it may be appropriate to do both axial and peripheral bone mineral density (BMD) studies on the same date of service, or within thirty days of each other. Medicare will not reimburse for both axial and appendicular testing on the same date of service or within thirty days of each other, unless the medical records substantiate that the BMM initially obtained was unreadable. Conditions that verify to Medicare that a BMM is unreadable and a second BMM is medically necessary include documentation the patient has artificial instrumentation in place in either hip or spine, or other conditions that preclude a reading in those locations.

- D. These other conditions may include the following;
1. *Neither hip nor spine (axial testing) can be measured. (Reason must be documented in the medical record).
 2. Hyperparathyroidism
 3. Obese patient over the weight limit of the DEXA exam table.
 4. Extreme arthritic changes which precludes accurate measurement.

Note: The above section clarified to reflect the intent of the LCD.



LCD Title

Psychiatry and Psychological Services

Contractor's Determination Number

PSYCH-014

Revision Effective Date

05/01/2008

The following ICD-9 codes have been added to PSYCH-014

*Alcohol	303.0 - 303.93
dependence	

Electronic Data Interchange (EDI)

CHANGE IN 837 4010 EMC PRE-PASS EDITING CLINICAL TRIAL NUMBER

The Electronic Media Claims (EMC) system reviews every claim for a number of pre-pass edits to ensure that claim data is valid. If a claim contains missing or incorrect information, one of two things will happen because of a pre-pass edit.

1. If an informational edit is in effect, the claim, batch, or file will process normally. The informational edit identifies the error and alerts the submitter in order to correct future claims.
2. If a delete edit is in effect, the claim, batch, or file will **not** process normally; it deletes from the claims processing system and alerts the submitter to the error.

Effective 4/7/08, if the REF01 is equal to P4 **AND** the REF02 value is greater than 2 positions in length **AND** is not 8 positions in length **OR** the REF02 value is 8 positions in length but contains non-numeric values, edit M058 will temporarily appear as informational.

Effective June 2, 2008, claims will delete if clinical trail number is not 8 digits (all numeric).

Edit	Loop	Description	Edit Logic
M058	2300	Trial # not 8 digits	The REF01 is equal to P4 AND the REF02 value is greater than 2 positions in length AND is not 8 positions in length OR the REF02 value is 8 positions in length but contains non-numeric values.

It is important that you receive and review your prepass reports. A complete list of current 4010A1 pre-pass edits, as well as a detailed description, is available in the WPS Bulletin Board in the EDI file library in the HIPAA directory (file name: 4010A1.doc) or on the WPS Website: http://www.wpsmedicare.com/part_b/business/mcs_prepass_edits.pdf

If you need additional information you may also contact the WPS EDI Hotline:
 IL, MI, and WI: 877-567-7261,
 MN: 952-885-2811, 952-885-2881, or 952-885-2882

CHANGE IN 837 4010 EMC PRE-PASS EDITING MISSING NPI & ENTITY TYPE MIS-MATCH

The Electronic Media Claims (EMC) system reviews every claim for a number of pre-pass edits to ensure that claim data is valid. If a claim contains missing or incorrect information, one of two things will happen because of a pre-pass edit.

1. If an informational edit is in effect, the claim, batch, or file will process normally. The informational edit identifies the error and alerts the submitter in order to correct future claims.
3. If a delete edit is in effect, the claim, batch, or file will **not** process normally; it deletes from the claims processing system and alerts the submitter to the error.

Effective 4/7/08, if the segment Prior Authorization or Referral Number is submitted with a value of 9F in REF01, then the Referring Provider loop (2310A or 2420F) must be present. If the Referring provider loop is not present, edit message M430 or M431 will appear as informational.

Effective June 2, 2008 claims will delete if the referring provider is not present at either the claim or line level when the value of 9F is used in REF01 of the Prior Authorization or Referral Number segment.

Edit	Loop	Description	Edit Logic
M430	2300	Invalid Value	The edit sets when the 2300 REF01 contains 9F and the 2310A or 2420F loops are not present
M431	2330B	Invalid Value	The edit sets when the 2330B REF01 contains 9F and the 2310A or 2420F loops are not present

It is important that you receive and review your pre-pass reports. A complete list of current 4010A1 pre-pass edits, as well as a detailed description, is available in the WPS Bulletin Board in the EDI file library in the HIPAA directory (file name: 4010A1.doc) or on the WPS Website:

http://www.wpsmedicare.com/part_b/business/mcs_prepass_edits.pdf

If you need additional information, you may also contact the WPS EDI Hotline at:

IL, MI, & WI: 877-567-7261

MN: 952-885-2811, 952-885-2881, or 952-885-2882

MEDICARE REMIT EASY PRINT APRIL 4, 2008

The quarterly update to the Medicare Remit East Print (MREP) software has been released by the Center for Medicare and Medicaid (CMS) on April 4, 2008. MREP Version 2.4 is now available.

If you are an electronic biller who does not receive the Electronic Remittance Advice (ERA), please download the ERA information sheet at

http://www.wpsic.com/edi/pdf/edi_ern_medb.pdf and submit it to our office. If you already receive the ERA, please download the MREP software at

http://www.wpsmedicare.com/part_b/business/mrep.shtml

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

For assistance, please contact the appropriate EDI staff.

Illinois, Michigan and Wisconsin (877) 567-7261

Minnesota, (952)-885-2811, 2881 or 2882

Take advantage of this software. Begin using MREP today

Medicare Remit Easy Print v2.4 (Production) Change Summary

1. An issue was reported indicating that an “unhandled exception” error was generating when attempting to produce the Other Adjustments Report. The error generates when the PLB09-1 (for a single remittance) data field contains ‘FB’. A change was made so that the Other Adjustments Report generates when the PLB09-1 (for a single remittance) data field contains ‘FB’.
2. The MREP User Manual will be updated to clarify how the “Totals: provider adjustment amt” is determined. This information is located in Appendix A. Additionally, updates were made to provide guidance for retrieving a file for the purposes of researching issues by the ViPS MREP Team.

Note: Since changes are being made to the MREP software, the updated CARC/RARCs file is included with version 2.4 of the MREP software. However, the separate Codes.ini file is available separately.

General Information**ADMINISTRATIVE SIMPLIFICATION COMPLIANCE ACT (ASCA)
INFORMATION**

Administrative Simplification Compliance Act (ASCA) requires that providers submit claims to Medicare electronically to be considered for payment, with a limited number of exceptions. If a provider does meet one of the exceptions, the provider is waived for a period of two years. At the end of that two-year period, another review process is initiated. The qualifying information for a provider to be waived the first time will need to be reviewed and the waiver reissued if the provider still meets one of the exceptions.

If you have already been waived for ASCA and you receive an ASCA review letter, the qualifying information will need to either be mailed to the address in the letter or faxed to 618-998-5230.

**ANNOUNCING THE RELEASE OF THE REVISED CMS-855
MEDICARE ENROLLMENT APPLICATIONS
~CMS MLN Matters~**

MLN Matters Number: SE0810
Related CR Release Date: N/A
Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

The Centers for Medicare & Medicaid Services (CMS) issued revised CMS-855 Medicare enrollment applications in March 2008. With the exception of providers enrolling as a specialty hospital on the CMS-855A, Medicare contractors will continue to accept the 2006 version of the Medicare enrollment application through June 2008.

Providers and suppliers should begin to use the new Medicare enrollment applications immediately. Initially, these applications will be available only from the CMS provider enrollment Website. The link for that CMS Website is listed in the *Additional Information* section of this article.

Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see *Key Points* below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

Key Points

This Special Edition outlines the significant revisions to the Medicare enrollment applications and they are as follows:

Application-Specific Changes for Physicians and Non-Physician Practitioners (CMS-855I)

- Removed the requirement in Section 17 that providers attached their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.

Application-Specific Changes for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)

- Removed the supplier type “Voluntary Health/Charitable Agency” from Section 2A.
- Clarified reporting timeframes throughout the CMS-855B.
- Added additional information about the National Provider Identifier (NPI)-legacy association and expanded the number of NPI – legacy combinations that a provider may enter in Section 4A from one to five.
- Removed the requirement in Section 17 that providers attach their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System.
- Required that an Independent Diagnostic Testing Facility (IDTF) submit copies of its comprehensive liability insurance policy in Section 17.
- Added a list of the new IDTF standards found in 42 CFR 410.33(g) on a separate page in Attachment 2.
- Added instructions that explain the IDTF liability insurance requirements in 42 CFR 410.33(g)(6) to Attachment 2.

Application-Specific Changes for Institutional Providers (CMS-855A)

- Revised Section 2A2 to include a specific box that specialty hospitals must check when completing the application. Instructions explaining the definition of a “specialty hospital” were also added to the form.
- Clarified the term “primary practice location” in the instructions in Section 4. (The clarification did not change any data elements on the form.)
- Added additional information about the National Provider Identifier (NPI)-legacy association and expanded the number of NPI – legacy combinations that a provider may enter in Section 4A from one to five.
- Removed the data element “Medicare Year-End Cost Report Date” from Section 2.
- Removed the requirement in Section 17 that providers attach their National Provider Identifier notification that is received from the National Plan and Provider Enumeration System

Application-Specific Changes for DMEPOS Suppliers (CMS-855S)

- Added supplier standards 22 – 25 to the list of DMEPOS supplier standards found on page 31.

Additional Information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit <http://www.cms.hhs.gov/MedicareProviderSupEnroll> on the CMS Website.

Special Edition article SE0612 contains helpful information about the Medicare enrollment process. You may review that article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf> on the CMS Website.

EXCEPTION TO 60-DAY LIMIT ON SUBSTITUTE PHYSICIAN BILLING ARRANGEMENTS FOR PHYSICIANS CALLED TO ACTIVE DUTY IN THE ARMED FORCES RESERVES
~CMS MLN Matters~

MLN Matters Number: MM5985
Related CR Release Date: April 4, 2008
Related CR Transmittal #: R1486CP

Related Change Request (CR) #: 5985
Effective Date: January 1, 2008
Implementation Date: May 5, 2008

Provider Types Affected

Physician members of a reserve component of the Armed Forces who bill Medicare Carriers or Medicare Administrative Contractors (A/B MAC) for services provided to Medicare beneficiaries.

Physicians called to active duty in the Armed Forces who wish to bill for substitute physician services during the physician's absence.

What You Need to Know

CR 5985, from which this article is taken, announces a 6-month extension of the exception to the 60-day limit on substitute physician billing for physicians called to active duty in the Armed Forces. This means that a physician who is called to active duty may continue to bill for substitute physician services furnished from January 1, 2008 through June 30 2008, which may be beyond the 60-day limit.

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

Background

Section 1842(b)(6)(D)(iii) of the Social Security Act (the Act) and *Medicare Claims Processing Manual* Chapter 1 (General Billing Requirements), Sections 30.2.10 (Payment Under Reciprocal Billing Arrangements - Claims Submitted to Carriers) and 30.2.11 (Physician Payment Under Locum Tenens Arrangements - Claims Submitted to Carriers) state that when a physician is unavailable to provide services, a substitute physician's services (either on a reciprocal or locum tenens basis) are not to be provided for a period longer than 60 continuous days.

On August 3, 2007, Public Law 110-54 amended the Act to provide an exception to this 60-day limit for physicians who are ordered to active duty in the Armed Forces.

By striking "January 1, 2008" and inserting "July 1, 2008," Section 116 of the "Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007" (signed on December 29, 2007) extended this exception for another 6 months.

CR 5985, from which this article is taken updates these sections in *Medicare Claims Processing Manual* to reflect this change in the law.

Effective January 1, 2008, physicians called to active duty will be able to bill for substitute physician services furnished from January 1, 2008, through June 30 2008.

Additional Information

You can find more information about the exception to the 60-Day limit on substitute physician billing arrangements for physicians called to active duty in the Armed Forces reserves by going to CR 5985, located at

<http://www.cms.hhs.gov/transmittals/downloads/R1486CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Claims Processing Manual* Chapter 1 (General Billing Requirements), Sections 30.2.10 and 30.2.11 as an attachment to that CR.

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.

INTERACTIVE VOICE RESPONSE (IVR) SYSTEM SATISFIES MOST NON-COMPLEX REQUESTS

WPS Medicare recognizes the time demands placed on staff of a busy provider office. To lesson these demands - take advantage of the many self-service resources available from WPS Medicare. The Interactive Voice Response (IVR) system is valuable for gathering routine information. The IVR can provide patient eligibility, claims status, provider summary, checks deductibles, and pricing. The IVR is available 24 hours a day, 7 days a week. However, the standard operating hours when all options are available are 6:00 a.m. to 6:00 p.m. CT, Monday through Friday, and 7:00 a.m. through 12:00 p.m. CT on Saturday. Outside of these times, functions such as claim status and eligibility and others requiring a Provider Transaction Access Number (PTAN) may be limited based on system availability.

To access the IVR, use the PTAN (provider number) of the billing provider submitted on the claim. This means if you submitted the claim under a group PTAN, please enter or say the group PTAN when using the IVR. If you submitted the claim under an individual PTAN, enter or say the individual PTAN when using the IVR.

The eligibility function provides the Medicare effective dates, whether Medicare is primary or secondary and whether a Health Insurance Claim Number (HICN) is updated. The claim status function answers questions about our receipt and disposition of a specific claim, provides any applied deductible amount and the check number. The provider summary can show information on the number of pending claims, and the amount and date of the most recent check issued, and total amounts paid for a year.

The check function provides status on specific checks including amounts and the date cashed. The deductible function lets you know the amounts applied to the patient's deductible for current

and prior years. The pricing information section will allow you to enter information such as procedure code, modifier, and zip code to retrieve Medicare's allowed amount.

WPS Medicare has complete instructions on the use of the IVR system on our Website at the following Web address:

http://www.wpsmedicare.com/part_b/selfservice/ivr.pdf

By using this system for more routine requests, our Customer Service Representatives have the time to respond to your more complex inquiries.

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, 2008.

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

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

WEBSITE FOR ADDITIONS AND DELETIONS OF ZIP CODES REQUIRING A PLUS FOUR ZIP CODE EXTENSION

~CMS MLN Matters~

MLN Matters Number: MM5970

Related CR Release Date: March 21, 2008

Related CR Transmittal #: R1480CP

Related Change Request (CR) #: 5970

Effective Date: April 21, 2008

Implementation Date: April 21, 2008

Provider Types Affected

Physicians, providers, and other health care providers submitting claims to Medicare Fiscal Intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs) or Regional Home Health Intermediaries (RHHs) for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services.

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

The ZIP code where services are rendered determines the payment locality for services paid under the MPFS and for anesthesia services. Certain ZIP codes fall into more than one payment locality and require a plus four ZIP code extension to ensure proper payment. (See the MLN Matters article at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5208.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website for further details regarding ZIP code reporting.)

CAUTION – What You Need to Know

The CMS will begin posting additions and deletions to the list of ZIP codes that require a plus four ZIP code extension on their Website. A complete list of all ZIP codes requiring a plus four ZIP code extension will also be posted.

GO – What You Need to Do

Make certain your billing staffs are aware of these resources for checking plus four ZIP code extension requirements.

Key Points of CR5970

- To access a file containing the quarterly additions and deletions to the list of ZIP Codes requiring a plus four extension refer to http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/01_overview.asp on the CMS Website. The file is named “ZIP Code to Carrier Locality” and can be found in the Downloads section of this Web page.
- To access a file containing all ZIP Codes requiring a plus four extension, refer to http://www.cms.hhs.gov/prospmedicarefeesvcpmtgen/01_overview.asp on the CMS Website. The file is named “ZIP Codes Requiring +4 Ext” and can be found in the Downloads section of this Web page.
- Upon release of a new quarterly update, the previous quarter’s additions and deletions are incorporated into the file name “ZIP Codes Requiring +4 Ext” file and are not included in the “ZIP Code Changes” file.

Additional Information

To see the official instruction (CR5970) issued to your Medicare FI, carrier, A/B MAC or RHHI refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1480CP.pdf> on the CMS Website.

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

Provider Education

EDUCATION SCHEDULE

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 Outreach & Education staff are not professional coders.

Registration information is available on our Website:
http://www.wpsmedicare.com/part_b/education/education_schedule.shtml

~SEMINAR SCHEDULE~

Save Dollars, Avoid Denials

Date/Time	Course Number	Address
06/04/08 9:00am - 1:00 pm CT	Please visit http://www.wpsmedicare.com to register	Ramada Hotel and Conference Center 1517 16th St. SW Rochester, MN 55902 (507) 529-7330
06/06/08 9:00am - 1:00 pm ET	Registration is Full	Courtyard by Marriot 5205 Gateway Centre Dr. Flint, MI 48507 (810) 232-3500

Do Medicare denials confuse you? Would you like us to help you through the process?

Attend this four-hour workshop to get a better understanding of common Medicare denials, resources to help you avoid denials, and how all this can save you or your employer money. The workshop is designed as an interactive learning session containing exercises, questions, and answers. The focus is to give everyone attending the necessary tools and steps to resolve the top Medicare denials. Together let's explore:

- Modifiers
- There will be National Correct Coding Initiative (NCCI) examples & exercises using the Medicare Physician Fee Schedule Database (MPFSDB).
- Duplicate denials
- Unprocessable Denials
- Tips for getting claims paid on the first submission

This program offers 4.0 Continuing Education Units from the American Academy of Professional Coders.

Basic Principles of Medicare

Date/Time	Course Number	Address
05/08/08 9:00am - 1:00 pm CT	Registration is Full	WPS-Nordby 1707 W Broadway Madison, WI 53713
05/09/08 8:00am - 12:00 pm ET	Registration is Full	Comfort Inn Metro Airport 31800 Wick Rd. Romulus, MI 48174 (734) 326-2100
05/21/08 9:30am - 1:30 pm CT	Registration is Full	Clock Tower Resort and Conference Center E. State Street Rockford, IL 61108 (615) 398-6000
06/19/08 9:00am - 1:00 pm CT	Please visit http://www.wpsmedicare.com to register	Best Western Kelly Inn 100 4th Ave S St. Cloud, MN 56301 (320) 258-8406
06/24/08 9:00am - 1:00 pm CT	Please visit http://www.wpsmedicare.com to register	Quality Inn 809 Clairemont Ave Eau Claire, WI 54701 (715) 834-8611

Do you need help with Medicare? Would you like to learn the basics of Medicare or refresh your memory on Medicare?

Attend this four-hour seminar designed to help both new and experienced Medicare providers and billers understand claim submissions, medical necessity, medical documentation, and much more. Other topics included in this seminar:

- Correct Coding Initiatives
- Advance Beneficiary Notice
- Medical Review
- Provider Enrollment
- Preventive Services
- Limiting Charge
- Medicare Secondary Payer (MSP)
- Medigap and Crossover
- Appeals Process
- Financial

Registration begins 30 minutes before event start time.

The American Academy of Professional Coders has approved this program for 4 Continuing Education Units (CEUs).

Beyond the Basics

Date/Time	Course Number	Address
05/08/08 9:00am - 3:00 pm CT	Registration is Full	Ramada Ltd. North 3281 Northfield Dr. Springfield, IL 62702 (217) 523-4000
05/14/08 9:00am - 3:00 pm CT	Please visit http://www.wpsmedicare.com to register	Comfort Suites Lake County N 14 W24121 Tower Place Pewaukee, WI 53702
05/21/08 9:00am - 3:00 pm CT	Registration is Full	Best Western Americana Inn 520 Hwy 10 S St. Cloud, MN 56304
06/05/08 9:00am - 3:00 pm CT	Registration is Full	Courtyard by Marriot 5205 Gateway Centre Dr. Flint, MI 48507
06/17/08 9:00am - 3:00 pm CT	Please visit http://www.wpsmedicare.com to register	Comfort Inn Airport 1321 E 78th St Bloomington, MN 55425 (952) 854-3400

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 2008 "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. Among the other topics we will cover are:

- Top Unprocessable Claim Denials
- Medicare Policy (overview & exercise)
- National Provider Identifier (NPI)
- Physician Quality Reporting Initiative (PQRI)
- Medical Review Process
- Documentation
- Comprehensive Error Rate Testing (CERT) Program
- Non-Covered Versus Not Medically Necessary Services
- Advance Beneficiary Notice

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!

The American Academy of Professional Coders has approved this program for 5 Continuing Education Units (CEUs).

~REGISTRATION INFORMATION~

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

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 Website.

Registration Steps*

1. Review the schedule
2. To Register online:
 - a. Select the "Click here to register" option within the second column of the appropriate table(s)).
 - b. Fill out the e-mail accordingly.
 - c. You will receive an e-mail confirming your registration.

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

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

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

Reimbursement

2008 MEDICARE PHYSICIAN FEE SCHEDULE (MPFSDB) APRIL QUARTERLY UPDATE

For a complete listing of the 2008 fees, please visit the Wisconsin Physicians Service (WPS) Website at: http://www.wpsmedicare.com/part_b/fees/fees.shtml

To access the 2008 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 will be made to the 2008 Medicare Physician Fee Schedule. These changes apply to claims processed on or after April 1, 2008, for dates of service January 1, 2008 and after.

MPFSDB Fee Changes Effective 01/01/08

Illinois

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
93501	12	\$ 839.47	\$ 797.50	\$ 917.13	\$ 839.47	\$ 797.50	\$ 917.13
93501/TC	12	\$ 675.98	\$ 642.18	\$ 738.51	\$ 675.98	\$ 642.18	\$ 738.51
93508	12	\$ 972.11	\$ 923.50	\$1,062.03	\$ 972.11	\$ 923.50	\$1,062.03
93508/TC	12	\$ 741.25	\$ 704.19	\$ 809.82	\$ 741.25	\$ 704.19	\$ 809.82
93510	12	\$1,512.50	\$1,436.88	\$1,652.41	\$1,512.50	\$1,436.88	\$1,652.41
93510/TC	12	\$1,269.14	\$1,205.68	\$1,386.53	\$1,269.14	\$1,205.68	\$1,386.53
93526	12	\$1,960.80	\$1,862.76	\$2,142.17	\$1,960.80	\$1,862.76	\$2,142.17
93526/TC	12	\$1,622.99	\$1,541.84	\$1,773.12	\$1,622.99	\$1,541.84	\$1,773.12
93642	12	\$ 498.43	\$ 473.51	\$ 544.54	\$ 498.43	\$ 473.51	\$ 544.54
93501	15	\$ 950.25	\$ 902.74	\$1,038.15	\$ 950.25	\$ 902.74	\$1,038.15
93501/TC	15	\$ 777.58	\$ 738.70	\$ 849.51	\$ 777.58	\$ 738.70	\$ 849.51
93508	15	\$1,106.29	\$1,050.98	\$1,208.63	\$1,106.29	\$1,050.98	\$1,208.63
93508/TC	15	\$ 861.23	\$ 818.17	\$ 940.90	\$ 861.23	\$ 818.17	\$ 940.90
93510	15	\$1,712.76	\$1,627.12	\$1,871.19	\$1,712.76	\$1,627.12	\$1,871.19
93510/TC	15	\$1,454.55	\$1,381.82	\$1,589.09	\$1,454.55	\$1,381.82	\$1,589.09
93526	15	\$2,217.05	\$2,106.20	\$2,422.13	\$2,217.05	\$2,106.20	\$2,422.13
93526/TC	15	\$1,858.66	\$1,765.73	\$2,030.59	\$1,858.66	\$1,765.73	\$2,030.59
93642	15	\$ 550.75	\$ 523.21	\$ 601.69	\$ 550.75	\$ 523.21	\$ 601.69
93501	16	\$ 971.37	\$ 922.80	\$1,061.22	\$ 971.37	\$ 922.80	\$1,061.22
93501/TC	16	\$ 795.24	\$ 755.48	\$ 868.80	\$ 795.24	\$ 755.48	\$ 868.80
93508	16	\$1,125.75	\$1,069.46	\$1,229.88	\$1,125.75	\$1,069.46	\$1,229.88
93508/TC	16	\$ 875.93	\$ 832.13	\$ 956.95	\$ 875.93	\$ 832.13	\$ 956.95
93510	16	\$1,753.89	\$1,666.20	\$1,916.13	\$1,753.89	\$1,666.20	\$1,916.13
93510/TC	16	\$1,490.62	\$1,416.09	\$1,628.50	\$1,490.62	\$1,416.09	\$1,628.50
93526	16	\$ 2,271.01	\$2,157.46	\$ 481.08	\$2,271.01	\$2,157.46	\$ 481.08
93526/TC	16	\$1,905.57	\$1,810.29	\$2,081.83	\$1,905.57	\$1,810.29	\$2,081.83

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
93642	16	\$ 561.22	\$ 533.16	\$ 613.13	\$ 561.22	\$ 533.16	\$ 613.13
93501	99	\$ 775.77	\$ 736.98	\$ 847.53	\$ 775.77	\$ 736.98	\$ 847.53
93501/TC	99	\$ 619.46	\$ 588.49	\$ 676.76	\$ 619.46	\$ 588.49	\$ 676.76
93508	99	\$ 908.98	\$ 863.53	\$ 993.06	\$ 908.98	\$ 863.53	\$ 993.06
93508/TC	99	\$ 688.30	\$ 653.89	\$ 751.97	\$ 688.30	\$ 653.89	\$ 751.97
93510	99	\$1,389.95	\$1,320.45	\$1,518.52	\$1,389.95	\$1,320.45	\$1,518.52
93510/TC	99	\$1,157.40	\$1,099.53	\$1,264.46	\$1,157.40	\$1,099.53	\$1,264.46
93526	99	\$1,801.31	\$1,711.24	\$1,967.93	\$1,801.31	\$1,711.24	\$1,967.93
93526/TC	99	\$1,478.58	\$1,404.65	\$1,615.35	\$1,478.58	\$1,404.65	\$1,615.35
93642	99	\$ 469.65	\$ 446.17	\$ 513.10	\$ 469.65	\$ 446.17	\$ 513.10

Michigan

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
93501	01	\$ 953.04	\$ 905.39	\$1,041.20	\$ 953.04	\$ 905.39	\$1,041.20
93501/TC	01	\$ 775.41	\$ 736.64	\$ 847.14	\$ 775.41	\$ 736.64	\$ 847.14
93508	01	\$1,095.26	\$1,040.50	\$1,196.58	\$1,095.26	\$1,040.50	\$1,196.58
93508/TC	01	\$ 844.07	\$ 801.87	\$ 922.15	\$ 844.07	\$ 801.87	\$ 922.15
93510	01	\$1,724.52	\$1,638.29	\$1,884.03	\$1,724.52	\$1,638.29	\$1,884.03
93510/TC	01	\$1,459.68	\$1,386.70	\$1,594.71	\$1,459.68	\$1,386.70	\$1,594.71
93526	01	\$2,235.38	\$2,123.61	\$2,442.15	\$2,235.38	\$2,123.61	\$2,442.15
93526/TC	01	\$1,867.70	\$1,774.32	\$2,040.47	\$1,867.70	\$1,774.32	\$2,040.47
93642	01	\$ 554.09	\$ 526.39	\$ 605.35	\$ 554.09	\$ 526.39	\$ 605.35
93501	99	\$ 811.81	\$ 771.22	\$ 886.90	\$ 811.81	\$ 771.22	\$ 886.90
93501/TC	99	\$ 652.45	\$ 619.83	\$ 712.80	\$ 652.45	\$ 619.83	\$ 712.80
93508	99	\$ 949.64	\$ 902.16	\$1,037.48	\$ 949.64	\$ 902.16	\$1,037.48
93508/TC	99	\$ 724.35	\$ 688.13	\$ 791.35	\$ 724.35	\$ 688.13	\$ 791.35
93510	99	\$1,456.79	\$1,383.95	\$1,591.54	\$1,456.79	\$1,383.95	\$1,591.54
93510/TC	99	\$1,219.39	\$1,158.42	\$1,332.18	\$1,219.39	\$1,158.42	\$1,332.18
93526	99	\$1,887.34	\$1,792.97	\$2,061.92	\$1,887.34	\$1,792.97	\$2,061.92
93526/TC	99	\$1,557.88	\$1,479.99	\$1,701.99	\$1,557.88	\$1,479.99	\$1,701.99
93642	99	\$ 485.99	\$ 461.69	\$ 530.94	\$ 485.99	\$ 461.69	\$ 530.94

Minnesota

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
93501	MN	\$ 815.85	\$ 775.06	\$ 891.32	\$ 815.85	\$ 775.06	\$ 891.32
93501/TC	MN	\$ 660.46	\$ 627.44	\$ 721.56	\$ 660.46	\$ 627.44	\$ 721.56
93508	MN	\$ 975.42	\$ 926.65	\$1,065.65	\$ 975.42	\$ 926.65	\$1,065.65
93508/TC	MN	\$ 754.59	\$ 716.86	\$ 824.39	\$ 754.59	\$ 716.86	\$ 824.39
93510	MN	\$1,453.53	\$1,380.85	\$1,587.98	\$1,453.53	\$1,380.85	\$1,587.98
93510/TC	MN	\$1,221.05	\$1,160.00	\$1,334.00	\$1,221.05	\$1,160.00	\$1,334.00
93526	MN	\$1,878.90	\$1,784.96	\$2,052.70	\$1,878.90	\$1,784.96	\$2,052.70

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
93526/TC	MN	\$1,556.40	\$1,478.58	\$1,700.37	\$1,556.40	\$1,478.58	\$1,700.37
93642	MN	\$ 488.06	\$ 463.66	\$ 533.21	\$ 488.06	\$ 463.66	\$ 533.21

Wisconsin

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
93501	WI	\$ 776.79	\$ 737.95	\$ 848.64	\$ 776.79	\$ 737.95	\$ 848.64
93501/TC	WI	\$ 623.09	\$ 591.94	\$ 680.73	\$ 623.09	\$ 591.94	\$ 680.73
93508	WI	\$ 923.36	\$ 877.19	\$1,008.77	\$ 923.36	\$ 877.19	\$1,008.77
93508/TC	WI	\$ 705.65	\$ 670.37	\$ 770.93	\$ 705.65	\$ 670.37	\$ 770.93
93510	WI	\$1,385.13	\$1,315.87	\$1,513.25	\$1,385.13	\$1,315.87	\$1,513.25
93510/TC	WI	\$1,155.85	\$1,098.06	\$1,262.77	\$1,155.85	\$1,098.06	\$1,252.77
93526	WI	\$1,792.46	\$1,702.84	\$1,958.27	\$1,792.46	\$1,702.84	\$1,958.27
93526/TC	WI	\$1,474.35	\$1,400.63	\$1,610.72	\$1,474.35	\$1,400.63	\$1,610.72
93642	WI	\$ 470.26	\$ 446.75	\$ 513.76	\$ 470.26	\$ 446.75	\$ 513.76

APRIL 2008 QUARTERLY AVERAGE SALES PRICE (ASP) MEDICARE PART B DRUG PRICING FILES AND REVISIONS TO PRIOR QUARTERLY PRICING FILES
~CMS MLN Matters~

MLN Matters Number: MM5982
 Related CR Release Date: March 26, 2008
 Related CR Transmittal #: R1484CP

Related Change Request (CR) #: 5982
 Effective Date: April 1, 2008
 Implementation Date: April 7, 2008

Provider Types Affected

All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare Administrative Contractors (A/B MACs), Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 5982, from which this article is taken, instructs Medicare contractors to download and implement the April 2008 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs; and if released by CMS, also the revised January 2008, January 2007, April 2007, July 2007, October 2007, and October 2006 files.

Background

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the

average sales price (ASP) methodology, and pricing for compounded drugs has been performed by the local contractor.

Additionally, beginning in 2006, all end-stage renal disease (ESRD) drugs (that both independent and hospital-based ESRD facilities furnish), as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), are paid based on the ASP methodology.

The ASP methodology is based on quarterly data that drug manufacturers submit to the Centers for Medicare & Medicaid Services (CMS), which CMS then provides (quarterly) to Medicare contractors (carriers, DME MACs, FIs, A/B MACs, and/or RHHIs) through the ASP drug pricing files for Medicare Part B drugs.

As announced in late 2006, CMS has been working further to ensure that accurate and separate payment is made for single source drugs and biologicals as required by Section 1847A of the Social Security Act. As part of the effort to ensure compliance with this requirement, CMS has also reviewed how the terms “single source drug,” “multiple source drug,” and “biological product” have been operationalized in the context of payment under section 1847A.

For the purpose of identifying “single source drugs” and “biological products” subject to payment under section 1847A, CMS (and its contractors) will generally utilize a multi-step process that will consider:

- The FDA approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

The payment limit for the following will be based on the pricing information for products marketed or sold under the applicable FDA approval:

- A biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval), first sold in the United States after October 1, 2003; or
- A single source drug (a drug for which there are not two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book), first sold in the United States after October 1, 2003.
- As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may be operationalized through use of “not otherwise classified, (NOC)” HCPCS codes.

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities); and
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the OPPS.

Beginning January 1, 2008, under the OPSS, payment allowance limits for specified covered outpatient drugs are paid based on 105 percent of the ASP. Drugs and biologicals with pass-through status under the OPSS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits are updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPSS at the amount specified for the Ambulatory Payment Class (APC) to which the product is assigned.
- Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded or the drug is furnished incident to a professional service. **The payment allowance limits will not be updated in 2008.** The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded or the drug is furnished incident to a professional service.
- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File, other than new drugs and biologicals that are produced or distributed under a new drug application (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPSS where the payment allowance limit is 95 percent of the published AWP. In determining the payment limit based on WAC, the contractors follow the methodology specified in Pub. 100-04, Chapter 17, Drugs and Biologicals, for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of \$0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. **For 2008, the blood clotting furnishing factor of \$0.158 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.**

- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs and biologicals that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to the ASP payment methodology. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after March 18, 2008, the April 2008 ASP file will be available for download along with revisions to prior ASP payment files, if CMS determines that revisions to these prior files are necessary. On or after March 18, 2008, the April 2008 ASP NOC files will be available for retrieval from the CMS ASP Webpage along with revisions to prior ASP NOC files, if CMS determines that revisions to these prior files are necessary. The payment limits included in revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

The payment files will be applied to claims processed or reprocessed on or after the implementation date of CR5982 for the dates of service noted in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2008 ASP and ASP NOC files	April 1, 2008, through June 30, 2008
January 2008 ASP and ASP NOC files	January 1, 2008, through March 31, 2008
October 2007 ASP and ASP NOC files	October 1, 2007, through December 31, 2007
July 2007 ASP and ASP NOC files	July 1, 2007, through September 30, 2007
April 2007 ASP and ASP NOC files	April 1, 2007, through June 30, 2007
January 2007 ASP and ASP NOC files	January 1, 2007, through March 31, 2007
October 2006 ASP and ASP NOC files	October 1, 2006, through December 31, 2006

NOTE: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a

payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim makes these determinations.

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

To see the official instruction (CR5982) issued to your Medicare contractor visit <http://www.cms.hhs.gov/Transmittals/downloads/R1484CP.pdf> on the CMS Website.

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

**APRIL UPDATE TO THE 2008 MEDICARE PHYSICIAN FEE
SCHEDULE DATABASE (MPFSDB)
~CMS MLN Matters~**

MLN Matters Number: MM5980

Related CR Release Date: March 21, 2008

Related CR Transmittal #: R1482CP

Related Change Request (CR) #: 5980

Effective Date: January 1, 2008

Implementation Date: April 7, 2008

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 5980 which amends payment files previously issued to Medicare contractors based upon the 2008 Medicare Physician Fee

Schedule Final Rule. CR 5980 also includes new/revised codes for the Physician Quality Reporting Initiative (PQRI).

Background

Attachment 1 of CR 5980 contains changes included in the April Update to the 2008 MPFSDB, and CR5980 can be reviewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1482CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. Specific changes are detailed in Attachment 1 of CR 5980 and are summarized as follows:

CPT/HCPCS code revisions

A number of CPT/HCPCS codes have been modified to reflect revised bilateral indicators, Relative Value Unit (RVU) revisions, or procedure status changes retroactive to January 1, 2008.

Reinstated “J” Codes

A number of “J” Codes (J7611 through J7614) are reinstated with a status indicator of “E” and the reinstated codes are effective for dates of service on or after April 1, 2008. Descriptors and payment indicators for the reinstated codes are in attachment 1 of CR5980.

New “Q” Codes

There are several new “Q” codes (Q4096 through Q4098) with a status indicator of “E” and which are effective for dates of service on or after April 1, 2008. The codes with their descriptors are in the following table:

Code	Long Descriptor	Short Descriptor
Q4096	Injection, Von Willebrand Factor Complex, Human, Ristocetin Cofactor (Not Otherwise Specified), Per I.U. VWF:RCO	VWF complex, not Humate-P
Q4097	Injection, Immune Globulin (Privigen), Intravenous, Non-Lyophilized (E.G., Liquid), 500 mg	Inj IVIG Privigen 500 mg
Q4098	Injection, Iron Dextran, 50 mg	Inj iron dextran
Q4099	Formoterol fumarate, inhalation solution, FDA approved final product, non-compounded, administered through DME, unit dose form, 20 micrograms	Formoterol fumarate, inh

New Category II Codes for PQRI

There are new Category II codes for the PQRI for dates of service on or after April 1, 2008. These new codes and their descriptors are in the following table:

Code	Long Descriptor	Short Descriptor
0525F	Initial visit for episode	Initial visit for episode
0526F	Subsequent visit for episode	Subs visit for episode

Code	Long Descriptor	Short Descriptor
1130F	Back pain and function assessed, including all of the following: Pain assessment AND functional status AND patient history, including notation of presence or absence of “red flags” (warning signs) AND assessment of prior treatment and response, AND employment status	Bk pain + fxn assessed
1134F	Episode of back pain lasting six weeks or less	Epsd bk pain for =< 6 wks
1135F	Episode of back pain lasting longer than six weeks	Epsd bk pain for > 6 wks
1136F	Episode of back pain lasting 12 weeks or less	Epsd bk pain for <= 12 wks
1137F	Episode of back pain lasting longer than 12 weeks	Epsd bk pain for > 12 wks
2040F	Physical examination on the date of the initial visit for low back pain performed, in accordance with specifications	Bk pn xm on init visit date
2044F	Documentation of mental health assessment prior to intervention (back surgery or epidural steroid injection) or for back pain episode lasting longer than six weeks	Doc mntl tst b/4 bk trxmnt
3330F	Imaging study ordered	Imaging study ordered (bkp)
3331F	Imaging study not ordered	Bk imaging tst not ordered
3340F	Mammogram assessment category of “incomplete: need additional imaging evaluation”, documented	Mammo assess inc xray docd
3341F	Mammogram assessment category of “negative”, documented	Mammo assess negative docd
3342F	Mammogram assessment category of “benign”, documented	Mammo assess bengn docd
3343F	Mammogram assessment category of “probably benign”, documented	Mammo probably bengn docd
3344F	Mammogram assessment category of “suspicious”, documented	Mammo assess susp docd
3345F	Mammogram assessment category of “highly suggestive of malignancy”, documented	Mammo assess hghlymalig doc
3350F	Mammogram assessment category of “known biopsy proven malignancy”, documented	Mammo bx proven malig docd
4240F	Instruction in therapeutic exercise with follow-up by the physician provided to patients during episode of back pain lasting longer than 12 weeks	Instr xrcz 4bk pn >12 weeks
4242F	Counseling for supervised exercise program provided to patients during episode of back pain lasting longer than 12 weeks	Sprvsd xrcz bk pn >12 weeks
4245F	Patient counseled during the initial visit to maintain or resume normal activities	Pt instr nrml lifest

Code	Long Descriptor	Short Descriptor
4248F	Patient counseled during the initial visit for an episode of back pain against bed rest lasting 4 days or longer	Pt instr-no bd rest>= 4 days
4250F	Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 30 minutes immediately after anesthesia end time	Wrmng 4 surg - normothermia
5060F	Findings from diagnostic mammogram communicated to practice managing patient's on-going care within 3 business days of exam interpretation	Fndngs mammo 2pt w/in 3 days
5062F	Findings from diagnostic mammogram communicated to the patient within 5 days of exam interpretation	Doc f2fmammo fndng in 3 days
6040F	Use of appropriate radiation dose reduction devices OR manual techniques for appropriate moderation of exposure, documented	Appro rad ds dvcs techs docd
6045F	Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented	Radxps in end rpt4fluro pxd
7020F	Mammogram assessment category [eg, Mammography Quality Standards Act (MQSA), Breast Imaging Reporting and Data System (BI-RADS®), or FDA approved equivalent categories] entered into an internal database to allow for analysis of abnormal interpretation (recall) rate	Mammo assess cat in dbase
7025F	Patient information entered into a reminder system with a target due date for the next mammogram	Pt Infosys alarm 4 nxt mammo

Revised Descriptors for PQRI Codes

Attachment 1 of CR5980 also contains a list of editorial changes to the short and/or long descriptors for a number of PQRI codes.

Additional Information

The official instruction, CR 5980, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1482CP.pdf> on the CMS Website.

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

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

CLINICAL LABORATORY FEE SCHEDULE - IMPLEMENTATION OF SECTION 113 MEDICARE, MEDICAID AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (MMSCHIP) LEGISLATION

~CMS MLN Matters~

MLN Matters Number: MM5987

Related Change Request (CR) #: 5987

Related CR Release Date: April 11, 2008

Effective Date: April 1, 2008

Related CR Transmittal #: R331OTN

Implementation Date: May 12, 2008

Provider Types Affected

Clinical laboratories billing Medicare contractors (carriers, fiscal intermediaries, or Part A/B Medicare Administrative Contractors (A/B MACs)) for services to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 5987 which alerts clinical laboratories that, effective for tests furnished on or after April 1, 2008, the MMSCHIP Extension Act of 2007 sets payment for code 83037 and 83037QW (Hemoglobin; glycosylated (A1c) by device) by crosswalking it to be the same as 83036 (glycosylated (A1c)). Make certain your billing staffs are aware of this change.

Background

The MMSCHIP Extension Act of 2007 passed in December 2007 and included Section 113. Section 113 of the legislation set the price for any diagnostic test for HbA1C that is labeled by the Food and Drug Administration (FDA) for home use equal to the payment rate for a glycosylated hemoglobin test (identified as of October 1, 2007, by Healthcare Common Procedure Coding System (HCPCS) code 83036 (and any succeeding codes)). **The legislation is effective for tests furnished on or after April 1, 2008.**

- For Calendar Year (CY) 2006, the Current Procedural Terminology (CPT) established new code 83037 Hemoglobin; glycosylated (A1C) by device cleared by the FDA for home use. CPT code 83036, glycosylated (A1c), already existed and was priced at \$13.56 on the clinical laboratory fee schedule.
- For calendar year 2006, CMS determined that code 83037 should be paid via carrier gap filling.
- For calendar year 2007, CMS set the payment for code 83037 by crosswalking it to code 82985 (Glycosylated protein).
- For tests furnished on or after April 1, 2008, the payment for 83037 or 83037QW will be the same as the payment on the clinical laboratory fee schedule for 83036.

Your Medicare contractor will adjust claims for services on or after April 1, 2008, processed prior to implementation of this change if you bring such claims to the contractor's attention.

Additional Information

To see the official instruction (CR5987) issued to your Medicare contractor visit <http://www.cms.hhs.gov/Transmittals/downloads/R331OTN.pdf> on the CMS Website.

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

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