

M340 Billing provider PIN and NPI mismatch: The legacy provider number and the NPI reported in the 837 do not match the crosswalk. Verify that the NPI on the report (and in your 837) is the correct NPI for the legacy number listed.

M343 Rendering provider PIN and NPI mismatch: The rendering provider PIN and NPI reported in the 837 do not match the crosswalk.

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.wpsic.com/edi/pdf/hipaa_mcs837.pdf

Some common NPI billing experiences:

- Billing provider has an individual's NPI listed, rather than organization's NPI.
- Reporting same NPI at billing and rendering.
- Unincorporated solo provider has registered tax ID with NPPES and therefore obtained an organization NPI that they don't need.
- Reporting NPI for an individual provider at rendering but not referring level.
- Reporting incorrect EIN for NPI.
- NM102 with incorrect value for individual or organization; should = 1 for person and 2 for non person.

The first step in alleviating the error is to go to the NPI enumerator and add any of your current legacy ID numbers, Medicare PIN, UPIN, etc. If after you have added these, you continue to receive the informational errors on your report, please contact the EDI Hotline for assistance at: for IL, MI and WI: 877-567-7261, or for MN: 952-885-2811, 952-885-2881 or 952-885-2882. The NPI enumerator Website is:

<https://NPPES.cms.hhs.gov/NPPES/Welcome.do>

If you fail to prepare, you may not be able to send electronic claims or receive electronic remittances or conduct any of the other HIPAA transactions, significantly impacting your business and cash flow.

General Information

**ADDITIONAL REQUIREMENTS NECESSARY TO IMPLEMENT THE
REVISED HEALTH INSURANCE CLAIM FORM CMS-1500
~REVISED CMS MLN Matters~**

MLN Matters Number: MM5060 Revised
Related CR Release Date: September 15, 2006
Related CR Transmittal #: R1058CP

Related Change Request (CR) #: 5060
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

This article was revised on May 8, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS Website.

Provider Types Affected

Physicians and suppliers who bill Medicare carriers including durable medical equipment regional carriers (DMERCs) for their services using the Form CMS-1500.

Key Points

- The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the National Provider Identifier (NPI).
- The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.
- During this transition time there will be a dual acceptability period of the current and the revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the **split provider identifier fields**.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.
- There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

January 2, 2007 – March 30, 2007	Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version. Note: Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08-05) by January 2, 2007.
April 2, 2007	The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used. Note: All rebilling of claims should use the revised Form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12-90).

Background

Form CMS-1500 is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The CMS-1500 form is being revised to accommodate the reporting of the National Provider Identifier (NPI).

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Thus, small plans may need to receive legacy provider numbers on coordination of benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

In a related Change Request, CR4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report Provider Identification Numbers (PINs) and Unique Physician Identification Numbers (UPINs) as applicable.

There were no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. Change Request 4293 provided guidance for implementing the revised Form CMS-1500 (08-05). This article, based on CR 5060, provides additional Form CMS-1500 (08-05) information for Medicare carriers and DMERCs, related to validation edits and requirements.

Billing Guidelines

- When the NPI number is effective (May 23, 2007, although it can be reported starting January 1, 2007) **and the billed service requires the submission of an NPI**, claims will be **rejected** (in most cases with reason code 16 – “claim/service lacks information that is needed for adjudication”) in tandem with the appropriate remark code that specifies the missing information, **if**
- The appropriate **NPI is not entered** on Form CMS-1500 (08-05) in items:
 - **24J** (replacing item 24K, Form CMS-1500 (12-90));
 - **17B** (replacing item 17 or 17A, Form CMS-1500 (12-90));
 - **32a** (replacing item 32, Form CMS-1500 (12-90)); and
 - **33a** (replacing item 33, Form CMS-1500 (12-90)).

Additional Information

When the NPI Number is Effective and Required (May 23, 2007)

To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.

Legacy identifiers are pre-NPI provider identifiers such as:

- PINs (Provider Identification Numbers)
- UPINs (Unique Physician Identification Numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSCs (National Supplier Clearinghouse numbers) for DMERC claims.

Additional NPI-Related Information

Additional NPI-related information can be found at <http://www.cms.hhs.gov/NationalProvIdentStand/> on the CMS Website.

The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Website at http://www.nucc.org/images/stories/PDF/change_log.pdf.

MLN Matters article MM4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms," can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf> on the CMS Website.

CR4293, Transmittal Number 899, "Revised Health Insurance Claim Form CMS-1500," provides contractor guidance for implementing the revised Form CMS-1500 (08-05). It can be found at <http://www.cms.hhs.gov/transmittals/downloads/R899CP.pdf> on the CMS Website.

MLN Matters article MM4023, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms," can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf> on the CMS Website.

CR5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1058CP.pdf> on the CMS Website.

Please refer to your local carrier or DMERC if you have questions about this issue. To find their toll free phone number, please go to: <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

MEDICARE PROVIDER ENROLLMENT: PHYSICIANS IN RESIDENCY AND FELLOWSHIP PROGRAMS

For Medicare program purposes, the Centers for Medicare & Medicaid Services (CMS) defines "residents" as physicians participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools. Where a senior resident has a staff or faculty appointment or is designated, for example, a "fellow," it does not change the resident's status for the purposes of Medicare coverage and payment. As a general rule, the hospital's Medicare fiscal intermediary pays the hospital for services of residents as provider services.

Services Furnished Within the Scope of Approved Training Programs

Medical and surgical services furnished by residents within the scope of their training program are covered as provider services. The term “provider services” includes services furnished within the provider setting and medical and surgical services furnished in a setting that is not part of the provider, where the hospital has agreed to incur all or substantially all of the costs of training in the nonprovider setting. Such services are reimbursed to the hospital by the hospital’s Medicare fiscal intermediary and are not separately payable by Part B of the Medicare program. Resident physicians providing services only on this basis do not enroll in Part B of the Medicare program.

Note: Where the provider does *not* incur all or substantially all of the training costs in the nonprovider setting, and the services are performed by a licensed physician, the services are payable under Part B by the Medicare carrier, and the resident physician may enroll in Part B of the Medicare program.

Services Furnished Outside the Scope of Approved Training Programs
“Moonlighting” Services

Medical and surgical services furnished by residents that are *not* related to their training program, and that are *performed outside the facility where they have their training program*, e.g., in an urgent care clinic, are covered by Medicare Part B as physician services where both of the following requirements are met:

- The services are identifiable physician services, the nature of which requires performance by a physician in person and which contribute to the diagnosis or treatment of the patient’s condition; and,
- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed.

When both of these requirements are met, the residents’ services are considered to have been furnished by the residents in their capacity as physicians and not in their capacity as residents. Resident physicians meeting these requirements may enroll in Part B of the Medicare program for reimbursement based on the Medicare Physician Fee Schedule Database (MPFSDB).

Medical and surgical services furnished by residents that are *not* related to their training program, and that are *performed in an outpatient department or emergency room of the hospital where they have their training program*, are covered as physicians’ services where all three of the following criteria are met:

- The services are identifiable physician services, the nature of which requires performance by a physician in person and which contribute to the diagnosis or treatment of the patient’s condition;
- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed; *and*,
- The services performed can be separately identified from those services that are required as part of the training program.

When these three criteria are met, the residents’ hospital outpatient department and emergency room services are considered to have been furnished by the residents in their capacity as physicians and not in their capacity as residents. Resident physicians meeting these

requirements may enroll in Part B of the Medicare program for reimbursement based on the MPFSDB.

Resident physicians eligible to enroll in Part B of the Medicare program do so by submitting a CMS 855I enrollment application and, where benefits are reassigned, a CMS 855R enrollment application. The entity to which benefits are reassigned must have enrolled with Medicare by completing a CMS 855B enrollment application. Medicare enrollment forms can be downloaded from the CMS Website: <http://www.cms.hhs.gov/CMSForms/>

Resident physicians themselves, as well as academic medical institutions and other entities involved in enrolling resident physicians in the Medicare program, must ensure that CMS 855 enrollment application forms are complete and accurate when they are submitted; that they are submitted on the current version of the appropriate CMS-855 form(s); and that they contain all required supporting documentation, including a copy of the resident's license and copies of the National Provider Identifier (NPI) notifications received from the NPI Enumerator for both the resident and the entity to which the resident is reassigning Medicare benefits.

Note that the questions in CMS 855I Section 2.C. "Resident/Fellow Status" must be answered correctly and completely, and that the answers must be consistent both within Section 2.C. itself and with the information provided in Section 4, "Practice Location Information." The name and address of the *teaching hospital* ("facility") at which the physician is a resident or fellow must be reported in response to Question 1 in Section 2.C., and subsequent questions must be answered in light of the response to Question 1. When this section, or other required sections of the application, are not completed correctly, processing of the application is delayed because the needed information must be developed.

Questions regarding the provider enrollment process may be directed to our Provider Enrollment Department at these telephone numbers:

- 1-877-908-8476 for Wisconsin, Illinois, and Michigan; and,
- 1-866-564-0315 for Minnesota.

Completed enrollment applications for physicians practicing in Wisconsin, Illinois, and Michigan should be sent to: Wisconsin Physicians Service, Medicare Part B, Provider Enrollment Department, P.O. Box 8248, Madison, WI 53708-8248. Applications being sent via courier should be delivered to 1707 W Broadway, Madison, WI 53713-1834.

Completed enrollment applications for physicians practicing in Minnesota should be sent to Wisconsin Physicians Service, Medicare Part B, Provider Enrollment Department, 8120 Penn Avenue South, Suite 200, Bloomington, MN 55431-1394.

MODIFICATION TO THE MODEL MEDICARE REDETERMINATION NOTICE (MRN) (FOR PARTLY OR FULLY UNFAVORABLE REDETERMINATIONS) AND THE ADMINISTRATIVE LAW JUDGE (ALJ) FILING LOCATIONS WHERE THE PLACE OF SERVICE WAS IN DELAWARE, KENTUCKY, PUERTO RICO, VIRGINIA, &/OR THE US VIRGIN ISLANDS
~CMS MLN Matters~

MLN Matters Number: MM5554
Related CR Release Date: April 27, 2007
Related CR Transmittal #: R1229CP

Related Change Request (CR) #: 5554
Effective Date: July 2, 2007
Implementation Date: July 2, 2007

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

The Centers for Medicaid & Medicare Services (CMS) issued change request (CR) 5554 in order to modify the Reconsideration Request Form and to amend the ALJ filing locations.

CAUTION – What You Need to Know

Providers and suppliers do not need to resubmit documentation when requesting a Qualified Independent Contractor (QIC) reconsideration if the documentation was previously submitted as part of the redetermination process. This documentation is forwarded to the QIC as part of the case file utilized in the reconsideration process. Make certain that any additional evidence is submitted prior to the reconsideration decision. If all additional evidence is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence to the ALJ or further appeal unless you can demonstrate good cause for withholding the evidence from the QIC.

Be aware that when the service was rendered in **Delaware, Kentucky, Virginia, Puerto Rico, and/or the US Virgin Islands**, the filing locations for ALJ requests **are modified** to identify the appropriate Office of Medicare Hearings and Appeals (OMHA) field office. All other jurisdictions remain unchanged.

GO – What You Need to Do

Make certain that your billing staff or other staff that handle reconsideration requests for you are aware of these changes.

Background

CR5554 is the official document that announces these changes in Medicare processes. Attached to this CR are three documents that assist with the appeals process:

- A sample form letter titled: Medicare Appeal Decision,

- A paper outlining Important Information About Your Appeal Rights, and
- A modified **Reconsideration Request Form** containing revised introductory instructions, as follows: “At a minimum, you must complete/include information for items 1, 2a, 6, and 7 but to help us serve you better, please include a copy of the redetermination notice you received with your reconsideration request.”

The revised filing locations for sending documentation for requesting ALJ hearings are as follows:

- **Cleveland, Ohio** is the filing location for services rendered in **Delaware and Kentucky**,
- **Arlington, Virginia** for services in **Virginia**, and
- **Miami, Florida** for services in **Puerto Rico and the US Virgin Islands**.

The following table lists the addresses of all filing locations along with the place of service.

HHS OMHA Field Office & Mailing Address	Jurisdiction (Based on the place of service)			
Cleveland, OH BP Tower & Garage 200 Public Square, Suite 1300 Cleveland, OH 44114-2316	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	New York New Jersey Puerto Rico Virgin Islands	Pennsylvania Delaware West Virginia Kentucky	Illinois Indiana Ohio Michigan Minnesota Wisconsin
Miami, FL 100 SE 2nd Street, Suite 1700 Miami, FL 33131-2100	Alabama Florida Georgia Mississippi North Carolina South Carolina Tennessee	Arkansas Louisiana New Mexico Oklahoma Texas Puerto Rico US Virgin Islands		
Irvine, CA 27 Technology Drive, Suite 100 Irvine, CA 92618-2364	Iowa Kansas Missouri Nebraska	Colorado Montana North Dakota South Dakota Utah Wyoming	Arizona California Hawaii Nevada Guam Trust Territory of the Pacific Islands American Samoa	Alaska Idaho Oregon Washington
Arlington, VA 1700 N. Moore St., Suite 1600 Arlington, VA 22209	Virginia Maryland District of Columbia			

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5554) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to

<http://www.cms.hhs.gov/Transmittals/downloads/R1229CP.pdf> on the CMS Website.

If you have questions, please contact your Medicare carrier, FI or A/B MAC, DME 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 NOTIFICATION REGARDING MEDICARE DURABLE MEDICAL EQUIPMENT PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) COMPETITIVE BIDDING PROGRAM

The Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Final Regulation is now published at the Federal Register at: <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/Downloads/CMS-1270-F.pdf>

CMS has also announced the first 10 metropolitan areas in which competition will occur, as well as the first items to be competitively bid. Visit the CMS Website at <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/> to view the rule and for additional information.

WHEN SHOULD I UTILIZE MODIFIER 53 (DISCONTINUED PROCEDURES)?

Appropriate usage guidelines for Modifier 53 instruct that, under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Extenuating circumstances or those that threaten the well-being of the patient may make it necessary to indicate that a surgical or diagnostic procedure was started, but discontinued.

Any procedure code billed with modifier 53 will be subject to carrier medical review. Supporting documentation in the patient medical records must be available upon request. Reimbursement will be made on an individual basis. Refer to WPS Medicare's Modifier 53 Fact Sheet at http://www.wpsmedicare.com/provider/pdfs/modifier_53.pdf for examples of appropriate and inappropriate use of Modifier 53.

WPS Medicare Tip of the Week

(Published in the 05/21/07 General e-News Listserv)

In order to serve you better, WPS Medicare is redesigning the Complex Inquiries (found at http://www.wpsmedicare.com/provider/complex_inquiry.shtml) into tip sheets and articles, which will be available on topic-specific pages.

These pages will provide "one-stop shopping" for the information you need. Any bookmarks you have for the Complex Inquiry pages may not work in the future. We will keep you informed of any changes to the page as they occur.

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

Program Safeguards**SANCTIONED AND REINSTATED PROVIDERS**

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

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

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

WPS will not issue payments for services performed, ordered, or referred by these providers after the indicated dates. All providers are excluded as of April 19, 2007, unless otherwise indicated after their name.

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

Illinois Sanctioned Providers

Name/Specialty/Address/Date of Birth
Ronald Alan Mikos, D.P.M. Podiatrist P O Box 12015, #20716-424 Terre Haute, IN 47801 12/10/1948
Sergius Alexander Rinaldi, D.D.S. Dentist P O Box 1000, #12746-026 Marion, IL 62959 07/10/1935

Name/Specialty/Address/Date of Birth
Mark Steven Weinberger, M.D. Medical Physician 57 E. Delaware Pl., Apt. 2404 Chicago, IL 60611 05/22/1963

Michigan Sanctioned Providers

Name/Specialty/Address/Date of Birth
Bruno Real Choiniere, D.C. Chiropractor P O Box 1000, #08346-027 Milan, MI 48160 10/06/1964
Lawrence Morton, D.D.S. Dentist 5249 Simpson Lake Road West Bloomfield, MI 48323 07/23/1935

Name/Specialty/Address/Date of Birth
Queen Esther Pfeifer Health Care Aide 1910 Woodside Circle Walled, MI 48390 11/13/1975

Minnesota Reinstated Providers

Name/Specialty/Address/Date of Birth
Michael A. Appleman, Ph.D. Psychologist 2530 Lake of Isles Minneapolis, MN 55414 11/19/1946 REINSTATED: 03/23/2007

Name/Specialty/Address/Date of Birth
Linda Lee Ziemski, R.N. AKA: Linda L. Carothers, R.N. AKA: Linda L. Wight, R.N. 8251 South Shore Drive Canyon, MN 55717 04/20/1953 REINSTATED: 04/02/2007

WPS Medicare Tip of the Week
(Published in the 05/29/07 General e-News Listserv)

Have you heard of the PTAN? Do you know what it is?

Provider Transaction Account Number (PTAN) is what the Provider Identification Number (PIN) will be called after May 23, 2007. Providers will continue to receive a PTAN (PIN) and can be required to use it in certain transactions or contacts. So, if you are asked for your PTAN, give the requester your PIN.

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

Provider Education

EDUCATION SCHEDULE

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

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

Seminars

Note: WPS Medicare has posted all currently scheduled face-to-face seminars for the Fiscal Year 2007 (October 2006 - September 2007). If you do not see the location near you, we hope that you will try out one of our many Webinars or teleconference. We will be adding more of these throughout the year.

Beyond the Basics

Date/Time	Course Number	Address
06/06/07 9:00am - 3:00 pm ET	M2075 FULL	Holiday Inn Lansing West Conf Center 7501 W. Saginaw Highway Lansing, MI 48917
06/08/07 9:00am - 3:00 pm ET	M2074 FULL	Holiday Inn Lansing West Conf Center 7501 W. Saginaw Highway Lansing, MI 48917

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

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

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

Due to time limitations, the "Beyond the Basics" program does not include detailed information about specialty claims (i.e. 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 at the bottom of this page. Sign up today!

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

Basic Principles of Medicare

Date/Time	Course Number	Address
06/14/07 8:00am - 12:00 pm CT	IL100 FULL	Ramada Limited North 3281 Northfield Drive Springfield, IL 62702
07/11/07 8:00am - 12:00 pm ET	M2076 FULL	SpringHill Suites Marriot 450 Center Drive NW Grand Rapids, MI 49544
07/25/07 8:00am - 12:00 pm CT	WI2026	The Plaza Hotel and Suites 201 N 17th Ave Wausau, WI 54401
08/22/07 8:00am - 12:00 pm CT	MN100	Best Western Kelly Inn 100 4th Ave S St Cloud, MN 56301
09/11/07 8:00am - 12:00 pm CT	IL101	Four Points by Sheraton 319 Fountains Parkway Fairview Heights, IL 62208

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

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

Save Dollars, Avoid Denials

Date/Time	Course Number	Address
06/14/07 1:00pm - 5:00 pm CT	ILSD1 FULL	Ramada Limited North 3281 Northfield Drive Springfield, IL 62702
07/11/07 1:00pm - 5:00 pm ET	MSD1 FULL	SpringHill Suites Marriot 450 Center Drive NW Grand Rapids, MI 49544
07/25/07 1:00pm - 5:00 pm CT	WSD2	The Plaza Hotel and Suites 201 N 17th Ave Wausau, WI 54401
08/22/07 1:00pm - 5:00 pm CT	MNSD1	Best Western Kelly Inn 100 4th Ave S St Cloud, MN 56301
09/11/07 1:00pm - 5:00 pm CT	ILSD2	Four Points by Sheraton 319 Fountains Parkway Fairview Heights, IL 62208

Are you having trouble with Medicare payments? Are you trying to avoid unprocessable denials? Are you struggling to understand duplicates? Attend this four-hour workshop to get a better understanding of all these things and more. WPS designed this workshop as an interactive learning session containing, exercise, questions, and answers. The focus is to teach providers what resources are available and how to use them. We will cover:

- Modifiers
- Duplicate Denials
- Medicare billing reports
- Unprocessable Denials
- Medicare Physician Fee Schedule Database
- Tips for getting claims paid on the first submission

This program offers 3.5 Continuing Education Unit from the American Academy of Professional Coders.

Teleconferences
National Provider Identifier: Question and Answer Teleconference

Date/Time	Course Number	Handouts
06/06/07 10:00 - 11:30 am CT	TNPI10	Handouts Available

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

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

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

Registration Information

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

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

Registration Steps*

1. Review the above schedule
2. Select a course near you
3. Register online at http://www.wpsmedicare.com/provider/proved_seminar.shtml:
 - a. Click on the appropriate course number (this can be found in the second column of the appropriate table(s) above).
 - b. Fill out the form accordingly.
 - c. You will receive a message back from our Website stating we have received your request. This is **NOT** a confirmation of your registration. You will however receive a confirmation via telephone or email.

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

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

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

If you treat a Medicare Advantage enrolled beneficiary and you have questions about their Medicare Advantage Plan, you may wish to contact that plan.

A plan directory and MA claims processing contact directory are available at <http://www.cms.hhs.gov/MCRAdvPartDENrolData/> on the CMS Website. CMS updates this site on a monthly basis.

Reimbursement**CMS PROPOSES PAYMENT, POLICY CHANGES FOR INPATIENT REHABILITATION FACILITIES IN FISCAL YEAR 2008**

Inpatient rehabilitation facilities (IRFs) are projected to receive approximately \$6.3 billion in payments from the Medicare program in fiscal year (FY) 2008, under a proposed rule announced today by the Centers for Medicare & Medicaid Services (CMS). The proposed rule would update payment rates and modify payment policies for services furnished to Medicare beneficiaries for discharges occurring on or after October 1, 2007 through September 30, 2008. The rule's provisions are estimated to increase Medicare payments to approximately 1,234 IRFs in FY 2008 by approximately \$150 million.

To view the Press Release, please click here:

http://www.cms.hhs.gov/apps/media/press_releases.asp

To view the Display Copy, please click here:

<http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms1551P.pdf>

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) DESIGNATION CHANGES**Minnesota**Mental Health HPSA

The following county is eligible as a Mental Health HPSA for dates of service on or after March 5, 2007.

- Cass County

There were no changes to any other HPSA areas.

WPS Medicare Tip of the Week

(Published in the 04/30/07 General e-News Listserv)

When calling WPS Medicare regarding a denial of a claim, be sure to state, "I have a denial on a claim" as opposed to saying that you want to check the status of a claim. This will help us resolve your issue much more quickly.

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

WPS MEDICARE PROVIDER SERVICES

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

Wisconsin WPS Medicare Customer Service PO Box 1706 Madison, WI 53701-1268 (866) 359-1599	Illinois WPS Medicare Customer Service PO Box 4433 Marion, IL 62959 (866) 234-7340
Michigan WPS Medicare Customer Service PO Box 5533 Marion, IL 62959 (866) 234-7331	Minnesota WPS Medicare Customer Service 8120 Penn Avenue South, Ste. 200 Bloomington, MN 55431-1394 (866) 359-1598

WPS MEDICARE e-NEWS MESSAGES

Stay up-to-date on Medicare issues by signing up for our free WPS Medicare e-News Listserv. By subscribing, you can enjoy a free, easy, and secure way to stay current on the latest Medicare information, with the option to unsubscribe at any time. To receive our e-News Messages, go to:

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

Follow our site's instructions for signing up and simply check your e-mail regularly to receive the latest Medicare information.