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**Items of Importance**

**ASSIGNMENT OF PROVIDERS TO MEDICARE ADMINISTRATIVE CONTRACTORS**  
~ CMS MLN Matters ~

MLN Matters Number: MM5979  
Related CR Release Date: April 18, 2008  
Related CR Transmittal #: R333OTN

Related Change Request (CR) #: 5979  
Effective Date: May 19, 2008  
Implementation Date: May 19, 2008

**Provider Types Affected**

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

**Impact on Providers**

This "One Time Notice" CR describes the Centers for Medicare & Medicaid Services (CMS) approach for assigning providers to MACs and discusses the process of moving providers to MACs.

**Background**

This article is based on CR 5979 and Section 911 of the *Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)*, Public Law 108–173, amended Title XVIII of the *Social Security Act (the Act)* to add section 1874A, Contracts with Medicare Administrative Contractors (MACs).

***I. What are “MACs?”***

Under section 911 of the MMA, Congress requires that CMS replace the current fiscal intermediary (FI) and carrier contracts with competitively procured contracts that conform to the Federal Acquisition Regulation (FAR). Under the new Medicare Administrative Contractor (MAC) contracting authority, CMS has 6 years - between 2005 and 2011 - to complete the transition of Medicare Fee-for-Service (FFS) claims processing activities from the FIs and carriers to the MACs.

For information on CMS' progress in awarding and implementing the MACs, please visit [http://www.cms.hhs.gov/MedicareContractingReform/01\\_Overview.asp](http://www.cms.hhs.gov/MedicareContractingReform/01_Overview.asp) on the CMS Website.

***II. What is “Provider Nomination?”***

“Provider Nomination” is a phrase that describes the former right of an individual provider or a chain of providers to select assignment to the FI of its choice. In section 911(b) of the MMA, Congress repealed the provider nomination provisions of the Social Security Act. Provider nomination has been replaced with the geographic assignment rule. Generally, a provider will be assigned to the MAC that covers the state where the provider is located. The CMS regulation at 42 CFR 421.404 reflects this policy shift. Other CMS regulations and policy manuals are in the process of being updated.

A moratorium was placed on the “change of intermediary” process for individual providers in October of 2005. *Transmittal 291 (CR # 5720)*, dated September 19, 2007, (see <http://www.cms.hhs.gov/Transmittals/downloads/R291OTN.pdf> on the CMS Website) informed all FIs and A/B MACs that CMS would no longer accept a request to move from one FI/MAC to another FI/MAC from a provider moving in or out of a Medicare chain. There remains one exception for qualified chain providers (QCPs) as discussed in Section V below.

### **III. Where will providers eventually be assigned in the MAC environment?**

#### **A. Home Health & Hospice**

All home health and hospice (HH&H) providers will be assigned to the MAC contracted by CMS to administer HH&H claims for the geographic locale in which the provider is physically located. See the following link for a description of the MAC-environment HH&H regions and the four MACs that will administer HH&H claims for those four regions.

[http://www.cms.hhs.gov/MedicareContractingReform/06\\_SpecialtyMACJurisdictions.asp](http://www.cms.hhs.gov/MedicareContractingReform/06_SpecialtyMACJurisdictions.asp)

#### **B. Durable Medical Equipment**

Each supplier of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) will submit claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) contracted by CMS to administer DMEPOS claims for the geographic locale in which the beneficiary permanently resides. The link above under “A” also provides a description of the MAC-environment DMEPOS regions and the four MACs that will administer DMEPOS claims for those four regions.

#### **C. Qualified Railroad Retirement Beneficiaries Entitled to Medicare**

Physicians and other suppliers (except for DMEPOS suppliers) will continue to enroll with and bill the contractor designated by the Railroad Retirement Board (under Section 1842(g) of The Act) for Part B services furnished to these beneficiaries. Suppliers of DMEPOS will bill the DME MACs.

#### **D. Specialty Providers and Demonstrations**

Specialty providers, and providers involved with certain demonstrations, will submit claims to a specific MAC designated by CMS. A list of those specialty services and their designated MACs is reflected in the following table:

**MACs Designated to Process Specialty or Demonstration Claims**

<b>Specialty Service or Demonstration</b>	<b>MAC Jurisdiction</b>
Centralized Billing for Mass Immunizers	4
Indian Health Services	4
Low Vision Demonstration	5,10, 11, 13, and 14
Rural Community Hospital Demonstration	1, 2, 4 and 5
Veterans Affairs Medicare Equivalent Remittance Advice Project	4
Chiropractic Services Demonstration	4 and 5
Home Health Third Party Liability Demonstration Project	14
Medicare Adult Day Care Demonstration	11, 14 and 15
Independent Organ Procurement Organizations	10
Religious Non-medical Health Care Institution (RNHCI)	10
Histocompatibility Lab	10

The following material describes the demonstrations and specialty providers listed above. Generally, a provider will already know whether or not it is participating in one of these categories.

Centralized Billing for Mass Immunizers - In order to encourage providers to supply flu and pneumococcal (PPV) vaccinations to Medicare beneficiaries, CMS currently authorizes a limited number of providers to centrally bill for flu and PPV immunization claims. Centralized billing is an optional program available to providers who qualify to enroll with Medicare as the provider type "Mass Immunizer," as well as to other individuals and entities that qualify to enroll as regular Medicare providers. Centralized billers must roster bill, must accept assignment, and must bill electronically.

To qualify for centralized billing, a mass immunizer must be operating in at least three payment localities for which there are three different carriers processing claims. Centralized billers must send all claims for flu and PPV immunizations to a single carrier for payment, regardless of the carrier jurisdiction in which the vaccination was administered and the carrier must make payment based on the payment locality where the service was provided. IOM Pub. 100-04, Chapter 18, Sections 10.3 and 10.3.1 provide more specific information related to this activity.

Indian Health Services - The Indian Health Service (IHS) is the primary health care provider to Medicare beneficiaries who are members of federally recognized tribes living on or near reservations. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services to its beneficiaries via a network of hospitals (including CAHs), freestanding clinics, FQHCs, RHCs and other entities.

While §§1814(c) and 1835(d) of the Social Security Act (the Act), as amended, generally prohibit payment to any Federal agency, passage of the Indian Health Care Improvement Act (IHCA) in 1976 provided for an exception, amending §1880 of the Act, for facilities of the IHS whether operated by such Service or by an Indian tribe or tribal organization (as defined in section 4 of the IHCA). The exception under § 1880 limited payment to Medicare services provided in hospitals and skilled nursing facilities.

Effective July 1, 2001, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), §432 extended payment on a fee-for-service (FFS) basis to services of physician and non-physician practitioners furnished in IHS hospitals and freestanding clinics. This means that clinics associated with hospitals and freestanding clinics that are owned and/or operated by IHS are authorized to bill only the Jurisdiction 4 MAC. Additionally, Tribal health facilities operated under Indian Self Determination Education and Assistance Act (ISDEAA) authorities are an extension of the IHS and considered facilities of the IHS. By virtue of this, they are authorized to bill the Jurisdiction 4 MAC. ISDEAA authorities provide flexibilities to tribes in the administration of their programs that are not provided to general public providers.

Low Vision Demonstration - The Secretary of the Department of Health and Human Services is directed to carry out an outpatient vision rehabilitation demonstration project as part of the FY 2004 appropriations conference report to accompany Public Law HR 2673. This demonstration project will examine the impact of standardized Medicare

coverage for vision rehabilitation services provided in the home, office, or clinic, under the general supervision of a physician. The services may be supplied by the following:

- Physicians;
- Occupational therapists;
- Certified low vision therapists;
- Certified orientation and mobility specialists; and
- Certified vision rehabilitation therapists.

This demonstration will last for five (5) years through March 31, 2011, and is limited to services provided specifically in New Hampshire, New York City (all 5 boroughs), North Carolina, Atlanta, Kansas, and Washington State.

Rural Community Hospital Association - The RCH Demonstration Program was mandated by section 410A of the MMA. The Secretary is required to conduct the RCH Demonstration, lasting five (5) years, to test the advisability and feasibility of establishing RCHs to provide Medicare covered inpatient hospital services in rural areas. This Demonstration will allow selected rural hospitals to benefit from cost-based reimbursement for inpatient services.

The Secretary is required to select not more than fifteen (15) hospitals to participate in the demonstration in States with low population densities. Currently, thirteen (13) hospitals participate in the program, serviced by seven different Fiscal Intermediaries (FIs).

Veteran Affairs Medicare Equivalent Remittance Advice Project - Current law permits the Department of VA to collect appropriate Medicare coinsurance and deductible amounts from supplemental insurers for claims for supplies and services ordinarily covered by Medicare but furnished:

- At VA facilities; and
- For veterans eligible to receive both VA health and Medicare benefits and also having Medicare supplemental insurance.

To facilitate this process, the Centers for Medicare & Medicaid Services (CMS) entered into an interagency agreement with the VA whereby the CMS will help the VA work with a CMS contractor to adjudicate these claims to produce a remittance advice equivalent to that ordinarily produced for Medicare claims. The remittance advice, sent to the supplemental insurers, will help the insurers determine payment amounts they owe to the VA. The CMS will not pay these claims. Trailblazer was the contractor selected to perform the work.

Chiropractic Services Demonstration - Section 651 of the MMA requires the Centers for Medicare & Medicaid Services (CMS) to conduct the Expansion of Coverage for Chiropractic Services Demonstration. The purpose of the demonstration is to evaluate the feasibility and advisability of expanding coverage of chiropractic services under Medicare. The demonstration is for two years and must be conducted in four geographic areas—two rural and two urban.

Home Health Third Party Liability Demonstration - The CMS and the States of Connecticut, Massachusetts, and New York have developed a demonstration program

that will use a sampling approach to determine the Medicare share of the cost of home health services claims for dual eligible beneficiaries that were submitted to and paid by the Medicaid agencies. Sampling will be used in lieu of individually gathering Medicare claims from home health agencies (HHAs) for every dual eligible Medicaid claim each State may have paid in error. This process will eliminate the need for the HHAs to assemble, copy, and submit large numbers of medical records. The project currently covers the home health claims incurred in fiscal years (FY) 2000 through 2007 for Massachusetts and New York and FY 2001 through 2005 for Connecticut.

Medicare Adult Day Care Demonstration - Section 703 of the MMA directs CMS to conduct a demonstration project that will test an alternative approach to the delivery of Medicare home health services. Under this demonstration, Medicare beneficiaries receiving home health may be eligible to receive medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home. The statute requires the demonstration to run for a period of three (3) years at no more than five (5) HHA sites in states that license certified medical adult day care facilities.

Implementation of the demonstration began at five (5) sites on August 1, 2006. Participation of Medicare beneficiaries is voluntary; up to 15,000 beneficiaries at any time will be eligible to enroll in the three (3)-year demonstration.

Medicare Home Health Agency Provider Enrollment Demonstration - This demonstration is designed to combat fraudulent home health activity in the Houston and Los Angeles areas. The principal provider enrollment task will be the revalidation of all HHAs in said areas.

Independent Organ Procurement Organizations – An Organ Procurement Organization performs or coordinates the retrieval, preservation, and transportation of organs and maintains a system of locating prospective recipients for available organs.

Religious Non-Medical Health Care Institutions – A RNHCI provides care to beneficiaries in need of skilled nursing facility care or hospital care when the beneficiary's religious beliefs preclude admission to one of these institutional providers. This does not mean that the beneficiary will receive hospital or SNF care in the RNHCI, but that the beneficiary elected to pursue a religious approach to healing. Since the use of diagnoses or medical oversight is prohibited in a RNHCI, they are not candidates for any CMS existing PPS and continue to be paid using the TEFRA methodology.

Histocompatibility Lab - Histocompatibility Laboratories provide services related to tissue typing testing for possible organ recipients and donors to determine compatibility for an organ transplant. They operate on a cost reimbursement basis and bill transplant centers for their services.

**E. The Geographic-Assignment Rule**

Providers that are not within one of the categories described above (HH&H, DME, RRB, or specialty & demos) will be assigned to the MAC that covers the state where the provider is located. There are two exceptions.

First a qualified chain provider (QCP) may request that its member providers be serviced by a single A/B MAC - specifically, the A/B MAC that covers the state where the QCP's home office is located. The regulation at 42 CFR 421.404(b)(2) defines a qualified chain provider (QCP) as:

- Ten or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control, collectively totaling 500 or more certified Medicare beds; or
- Five or more hospitals, skilled nursing facilities, and/or critical access hospitals, under common ownership or control in three or more contiguous states, collectively totaling 300 or more certified Medicare beds.

CMS may assign non-QCP providers, as well as End Stage Renal Disease (ESRD) providers to an A/B MAC outside of the prevailing geographic assignment rule only to support the implementation of the MACs or to serve some other compelling interest of the Medicare program.

The second exception is for providers that meet the "provider-based" criteria of 42 CFR 413.65. Provider-based entities (other than HH+H providers) will be assigned to the MAC that covers the state where the main ("parent") provider is assigned.

#### **IV. Where will providers be assigned in the interim?**

All existing providers with a Medicare claims history will remain in their current FI assignments until their workload is transferred to an A/B MAC. The "change of intermediary" process ended for individual providers in 2005, and ended for chain providers in 2007. A change of ownership now serves only to update CMS provider data with information about the new owner.

The workload currently serviced by a legacy FI will be absorbed by the incoming MAC within the 12 months following the award of MAC contract. In some situations the workload transition may be delayed by an award protest.

New providers enrolling with Medicare will be assigned to the FI or MAC that covers the state where the provider is physically located, with a few exceptions:

- The "Multi-Provider Complex/Sub-Unit" relationship (ref: 42 CFR 483.5(b)). - An initial enrollment for a sub-unit will be assigned to the FI or MAC that currently serves the existing parent hospital – even if the parent hospital is not presently billing in accordance with the "geographic assignment rule."
- An "initial enrollment" connected with a QCP. - If a QCP acquires a new hospital, skilled nursing facility, or critical access hospital that is located outside home office A/B MAC jurisdiction, then CMS will endeavor to assign the provider to the MAC that covers the state where the QCP's home office is located. This special assignment is available only for "initial enrollments" – providers that are joining the Medicare program with neither an existing administrative contractor assignment nor a Medicare claims history.

The other exceptions track the MAC-world assignment rules discussed in Sections III-A through III-D above.

#### **V. How long will my interim assignment last?**

An "out-of-jurisdiction provider" (OJP) is a provider that is not currently assigned to the A/B MAC or FI in accordance with Sections III-A through III-D above (including the geographic

assignment rule.) For example, an individual, freestanding provider located in Oregon, but currently assigned to the Florida FI, would be an OJP.

New MACs will initially service some OJPs until CMS undertakes the final reassignment of all OJPs to their destination MACs based on the geographic assignment rule.

CMS will start the overall transfer of OJPs to their final destination MACs after two events have taken place. The first event is when all 15 A/B MACs have been awarded and implemented. The second event is when all the systems and contractors that support the claims processing, provider enrollment, and cost report auditing functions at the departure and destination MACs are capable of supporting the move.

### **Additional Information**

For complete details regarding this CR please see the official instruction (CR5979) issued to your Medicare FI, A/B MAC, or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R333OTN.pdf> on the CMS Website. To view any of the federal regulations cited in this article or in CR5979, visit <http://www.gpoaccess.gov/cfr/index.html> on the Internet.

If you have questions, please contact your Medicare FI, 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.

## **IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS**

WPS Medicare will close for the following holidays:

<b><u>Date</u></b>	<b><u>Holiday</u></b>
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](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

## PROVIDER AUTHENTICATION BY MEDICARE PROVIDER CONTACT CENTERS

~CMS MLN Matters~

MLN Matters Number: SE0814  
Related CR Release Date: N/A  
Related CR Transmittal #: N/A

Related Change Request (CR) #: 5089, 5277  
Effective Date: N/A  
Implementation Date: N/A

### Provider Types Affected

Physicians, other providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors, (DME MAC)) for services provided to Medicare Beneficiaries.

### What You Need to Know

SE0814 covers the implementation of the National Provider Identifier (NPI) and the Provider Transaction Access Number (PTAN), effective May 23, 2008, as the provider authentication elements used when providers make telephone or written inquiries to the Medicare fee-for-service contractor provider contact centers.

**Note: For providers enrolled in Medicare before May 23, 2008, their PTAN initially will be their legacy provider number. New providers enrolling in Medicare on or after May 23, 2008, will be assigned a PTAN as part of the Medicare enrollment process.**

### Background

In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare provider contact centers (PCC) must properly authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

Please refer to the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9), chapter 3, section 30 and chapter 6, section 80 for a complete discussion of this PCC authentication update. You can find these manual sections at <http://www.cms.hhs.gov/manuals/downloads/com109c03.pdf> and <http://www.cms.hhs.gov/manuals/downloads/com109c06.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

### Provider Authentication

The elements for provider authentication of telephone (either Customer Service Representative (CSR) or Interactive Voice Response (IVR)) and written inquiries are presented in the table below.

**Provider Authentication Elements for Telephone & Written Inquiries**

<b>EFFECTIVE DATES</b>	<b>INQUIRY TYPE</b>	<b>PROVIDER ELEMENTS TO BE AUTHENTICATED (all elements must match unless otherwise specified)</b>
On or after May 23, 2008	IVR	Provider NPI and PTAN
On or after May 23, 2008	CSR	Provider NPI and PTAN
On or after May 23, 2008	Written, including fax and email	Provider name, and either provider NPI or PTAN

***Written Inquiries – Exception to above authentication requirements***

CMS allows an exception for written or faxed inquiries submitted on a provider’s official letterhead, and e-mail inquiries (with an attachment on letterhead). If the provider’s name and address are included in the letterhead and clearly establish the provider’s identity, no NPI or PTAN is required for authentication.

**Additional Information**

If you have any questions, please contact your carrier, FI, 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.

**UNSOLICITED/VOLUNTARY REFUNDS**

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

**Claim Submission**

**JULY QUARTERLY UPDATE TO 2008 ANNUAL UPDATE OF HCPCS  
CODES USED FOR SKILLED NURSING FACILITY (SNF)  
CONSOLIDATED BILLING (CB) ENFORCEMENT  
~ CMS MLN Matters ~**

MLN Matters Number: MM6009  
Related CR Release Date: May 9, 2008  
Related CR Transmittal #: R1501CP

Related Change Request (CR) #: 6009  
Effective Date: January 1, 2008  
Implementation Date: July 7, 2008

**Provider Types Affected**

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

**Provider Action Needed**

This notification provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS). **CR 6009 adds HCPCS code J9303 (Injection, Panitumumab, 10MG)** to the Major Category III.A. Chemotherapy services FI/A/B MAC **Exclusion List** retroactive to January 1, 2008.

**Background**

The Social Security Act (Section 1888) codifies the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) and Consolidated Billing (CB). The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services are added by these routine updates; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are not subject to the consolidated billing provision of the SNF PPS. Services not appearing on this list submitted on claims to FIs/A/B MACs and carriers/A/B MACs, including DME MACs, will not be paid by Medicare to providers, other than a SNF, when **included** in SNF Consolidated Billing (CB).

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay. However, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. Services **excluded** from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems will edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

**CR 6009 adds HCPCS code J9303 to the Major Category III.A. Chemotherapy services FI/A/B MAC Exclusion List retroactive to January 1, 2008.**

Medicare contractors will reopen and reprocess claims affected by this instruction when providers bring such claims to their contractor's attention.

**Additional Information**

The official instruction, CR 6009, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1501CP.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.

**NEW CHAPTER IN MEDICARE CLAIMS PROCESSING MANUAL FOR INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTF)**

~ CMS MLN Matters ~

MLN Matters Number: MM5815  
Related CR Release Date: May 16, 2008  
Related CR Transmittal #: R1504CP

Related Change Request (CR) #: 5815  
Effective Date: June 16, 2008  
Implementation Date: June 16, 2008

**Provider Types Affected**

Independent Diagnostic Testing Facilities (IDTFs) submitting claims to Medicare Administrative Contractors (A/B MACs) fiscal intermediaries (FIs) or carriers for services provided to Medicare beneficiaries.

**Impact on Providers**

Change Request (CR) 5815 alerts providers to the fact that information from the Medicare Program Integrity Manual, Chapter 10, **regarding claims processing instructions for IDTF's is being excerpted and added to Medicare Claims Processing Manual via Chapter 35**—a new chapter in the Medicare Claims Processing Manual. Currently, the Medicare Claims Processing Manual does not have claims processing instructions for IDTFs and this CR notifies providers of the availability of this information in that manual. No changes in policy are conveyed in CR5815.

**Key Points of CR5815**

Providers note that information regarding IDTF claims processing has been excerpted from the Medicare Program Integrity Manual, chapter 10, and **moved to the Medicare Claims Processing Manual, chapter 35**, which is a new chapter. The new chapter 35 is available as an attachment to the official instruction of CR 5815. The new chapter contains information on the following:

- General coverage and payment policies applicable to IDTFs;
- Medicare's definition of an IDTF;
- Claims processing instructions with emphasis on:
  - Billing issues;
  - Transtelephonic and electronic monitoring services; and

- Slide preparation facilities and radiation therapy centers.
- Ordering of tests;
- Purchased diagnostic tests;
- Interpretations of tests performed off the premises of the IDTF; and
- Restrictions that do not allow billing for strictly therapeutic procedures.

**IDTFs are reminded that the National Provider Identifier (NPI) of the ordering physician must be supplied in box 17B of the CMS-1500 form and in the appropriate loop of the ANSI X12 837P electronic claim format, effective for services on or after May 23, 2008.**

#### Additional Information

To see the official instruction (CR5815) issued to your Medicare Carrier, FI, or A/B MAC refer to <http://www.cms.hhs.gov/Transmittals/downloads/R1504CP.pdf> on the CMS Website. As already mentioned, the new Chapter 35 of the Medicare Claims Processing Manual is attached to CR5815.

If you have questions, please contact your Medicare FI, 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.

## PROLONGED SERVICES (CODES 99354 - 99359)

~CMS MLN Matters~

MLN Matters Number: MM5972  
Related CR Release Date: April 11, 2008  
Related CR Transmittal #: R1490CP

Related Change Request (CR) #: 5972  
Effective Date: July 1, 2008  
Implementation Date: July 7, 2008

#### Provider Types Affected

Physicians and other qualified non-physician practitioners (NPP) whose services are billed to Medicare Carriers or Medicare Administrative Contractors (A/B MAC).

#### What You Need to Know

CR 5972, from which this article is taken, updates the sections of the *Medicare Claims Processing Manual* that address prolonged services codes, in order to be consistent with changes/deletions in codes and changes in typical/average time units in the American Medical Association Current Terminology Procedural Terminology (CPT) coding system.

Make sure that your billing staffs are aware of the prolonged services CPT code changes as described in **Background**, below.

#### Background

Since *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Sections 30.6.15.1 Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes) and 30.6.15.2 (Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359) were first written, several code changes, code deletions, and typical/average time units have changed

in the American Medical Association (AMA) Current Procedural Terminology (CPT) coding system.

CR 5972, from which this article is taken, updates these sections that address prolonged services codes, in order to be consistent with the AMA CPT coding changes.

These manual changes:

- (In keeping with current Medicare payment policy for physician presence and supporting documentation) define Prolonged Services and explain the required evaluation and management (E&M) companion codes;
- Correct and update the tables for threshold times (reproduced below) to reflect code changes and current typical/average time units associated with the CPT levels of care in code families; and
- In a new Subsection (30.6.15.1 (H)), explain how to report physician visits for counseling and/or coordination of care when the visit is based on time and when the counseling and/or coordination service is prolonged.

A summary of these manual changes follow.

***Prolonged Services Definitions***

In the **office or other outpatient setting**, Medicare will pay for prolonged physician services (CPT code 99354) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion E&M service as noted in the CPT code. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services with CPT code 99355.

In the **inpatient setting**, Medicare will pay for prolonged physician services (code 99356) (with direct face-to-face patient contact which require one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99357.

**Note:** *You should not separately report prolonged service of less than 30 minutes total duration on a given date, because the work involved is included in the total work of the evaluation & management (E&M) codes.*

*You may use code 99355 or 99357 to report each additional 30 minutes beyond the first hour of prolonged services, based on the place of service. These codes may be used to report the final 15 – 30 minutes of prolonged service on a given date, if not otherwise billed. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.*

***Required Companion Codes***

Please remember that prolonged services codes 99354 – 99357 are **not** paid unless they are accompanied by the companion codes as described here.

The companion E&M codes for 99354 are:

- Office or Other Outpatient visit codes (99201 - 99205, 99212 – 99215),
- Office or Other Outpatient Consultation codes (99241 – 99245),
- Domiciliary, Rest Home, or Custodial Care Services codes (99324 – 99328, 99334 – 99337),
- Home Services codes (99341 - 99345, 99347 – 99350);

The companion E&M codes for 99355 are 99354 and one of its required E&M codes.

The companion E&M codes for 99356 are the Initial Hospital Care and Subsequent Hospital Care codes (99221 - 99223, 99231 – 99233), the Inpatient Consultation codes (99251 – 99255); Nursing Facility Services codes (99304 -99318).

The companion codes for 99357 are 99356 and one of its required E&M codes.

### **Requirement for Physician Presence**

You may count only the duration of direct face-to-face contact with the patient (whether the service was continuous or not) **beyond** the typical/average time of the visit code billed, to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable.

You cannot bill as prolonged services:

- In the **office setting**, time spent by office staff with the patient, or time the patient remains unaccompanied in the office; or
- In the **hospital setting**, time spent reviewing charts or discussing the patient with house medical staff and not with direct face-to-face contact with the patient or waiting for test results, for changes in the patient's condition, for end of a therapy, or for use of facilities.

### **Documentation**

Unless you have been selected for medical review, you do not need to send the medical record documentation with the bill for prolonged services. Documentation, however, is required to be in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services that you bill.

You must appropriately and sufficiently document in the medical record that you personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. Make sure that you document the start and end times of the visit, along with the date of service.

### **Use of the Codes**

You can only bill the prolonged services codes if the total duration of all physician or qualified NPP direct face-to-face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes).

### **Threshold Times for Codes 99354 and 99355 (Office or Other Outpatient Setting)**

If the total direct face-to-face time equals or exceeds the threshold time for code 99354, but is less than the threshold time for code 99355, you should bill the E&M visit code and code 99354. No more than one unit of 99354 is acceptable.

If the total direct face-to-face time equals or exceeds the threshold time for code 99355 by no more than 29 minutes, you should bill the visit code 99354 and one unit of code 99355. One additional unit of code 99355 is billed for each additional increment of 30 minutes extended duration.

Table 1 displays threshold times that your carriers and A/B MACs use to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings, including outpatient consultation services and domiciliary, rest home, or custodial care services and home services codes. The AMA CPT coding-derived changes are highlighted and noted in bolded italics.

**Table 1**  
**Threshold Time for Prolonged Visit Codes 99354 and/or 99355 Billed with Office/Outpatient and Consultation Codes**

<b>Code</b>	<b>Typical Time for Code</b>	<b>Threshold Time to Bill Code 99354</b>	<b>Threshold Time to Bill Codes 99354 and 99355</b>
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99241	15	45	90
99242	30	60	105
99243	40	70	115
99244	60	90	135
99245	80	110	155
<b>99324</b>	<b>20</b>	<b>50</b>	<b>95</b>
<b>99325</b>	<b>30</b>	<b>60</b>	<b>105</b>
<b>99326</b>	<b>45</b>	<b>75</b>	<b>120</b>
<b>99327</b>	<b>60</b>	<b>90</b>	<b>135</b>
<b>99328</b>	<b>75</b>	<b>105</b>	<b>150</b>
<b>99334</b>	<b>15</b>	<b>45</b>	<b>90</b>
<b>99335</b>	<b>25</b>	<b>55</b>	<b>100</b>
<b>99336</b>	<b>40</b>	<b>70</b>	<b>115</b>
<b>99337</b>	<b>60</b>	<b>90</b>	<b>135</b>
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

To get to the threshold time for billing code 99354 and two units of code 99355, add 30 minutes to the threshold time for billing codes 99354 and 99355. For example, when billing code 99205, in order to bill code 99354 and two units of code 99355, the threshold time is 150 minutes.

***Threshold Times for Codes 99356 and 99357 (Inpatient Setting)***

If the total direct face-to-face time equals or exceeds the threshold time for code 99356, but is less than the threshold time for code 99357, you should bill the visit and code 99356.

Medicare contractors will not accept more than one unit of code 99356. If the total direct face-to-face time equals or exceeds the threshold time for code 99356 by no more than 29 minutes, you should bill the visit code 99356 and one unit of code 99357. One additional unit of code 99357 is billed for each additional increment of 30 minutes extended duration.

Table 2 displays the following threshold times that your Medicare contractors uses to determine if the prolonged services codes 99356 and/or 99357 can be billed with the inpatient setting codes. The AMA CPT coding-derived changes are highlighted and noted in bolded italics.

**Table 2**  
**Threshold Time for Prolonged Visit Codes 99356 and/or 99357 Billed with Inpatient Setting Codes**

Code	Typical Time for Code	Threshold Time to Bill Code 99356	Threshold Time to Bill Codes 99356 and 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110
99251	20	50	95
99252	40	70	115
99253	55	85	130
99254	80	110	155
99255	110	140	185
<b><i>99304</i></b>	<b><i>25</i></b>	<b><i>55</i></b>	<b><i>100</i></b>
<b><i>99305</i></b>	<b><i>35</i></b>	<b><i>65</i></b>	<b><i>110</i></b>
<b><i>99306</i></b>	<b><i>45</i></b>	<b><i>75</i></b>	<b><i>120</i></b>
<b><i>99307</i></b>	<b><i>10</i></b>	<b><i>40</i></b>	<b><i>85</i></b>
<b><i>99308</i></b>	<b><i>15</i></b>	<b><i>45</i></b>	<b><i>90</i></b>
<b><i>99309</i></b>	<b><i>25</i></b>	<b><i>55</i></b>	<b><i>100</i></b>
<b><i>99310</i></b>	<b><i>35</i></b>	<b><i>65</i></b>	<b><i>110</i></b>
<b><i>99318</i></b>	<b><i>30</i></b>	<b><i>60</i></b>	<b><i>105</i></b>

***Prolonged Services Associated With E&M Services Based Counseling and/or Coordination of Care (Time-Based)***

When an E&M service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or the qualified NPP and the patient in the office/clinic or the floor time in the scenario of an inpatient service, the E&M code is selected based on the typical/average time associated with the code levels. The

time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the E&M code) and should not be “rounded” to the next higher level. **Further, in E&M services in which the code level is selected based on time, you may only report prolonged services with the highest code level in that family of codes as the companion code.**

### ***Billing Examples***

Examples of billable and non-billable prolonged services follow.

- **Billable Prolonged Services**

**EXAMPLE 1**

A physician performed a visit that met the definition of an office visit CPT code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills CPT code 99213 and *one* unit of code 99354.

**EXAMPLE 2**

A physician performed a visit that met the definition of a domiciliary, rest home care visit CPT code 99327 and the total duration of the direct face-to-face contact (including the visit) was 140 minutes. The physician bills CPT codes 99327, 99354, and one unit of code 99355.

**EXAMPLE 3**

A physician performed an office visit to an established patient that was predominantly counseling, spending 75 minutes (direct face-to-face) with the patient. The physician bills CPT code 99215 and one unit of code 99354.

- **Non-billable Prolonged Services**

**EXAMPLE 1**

A physician performed a visit that met the definition of visit code 99212 and the total duration of the direct face-to-face contact (including the visit) was 35 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

**EXAMPLE 2**

A physician performed a visit that met the definition of code 99213 and, while the patient was in the office receiving treatment for 4 hours, the total duration of the direct face-to-face service of the physician was 40 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

**EXAMPLE 3**

A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354. The physician must bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.

Finally, you should remember that Medicare contractors will not pay (nor can you bill the patient) for prolonged services codes 99358 and 99359, which do not require any direct

patient face-to-face contact (e.g., telephone calls). These are Medicare covered services and payment is included in the payment for other billable services.

**Additional Information**

You can find more information about billing with prolonged services codes 99354 – 99359 by going to CR 5972, located at <http://www.cms.hhs.gov/transmittals/downloads/R1490CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Sections 30.6.15.1 Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes) and 30.6.15.2 (Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359) 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.

**Comprehensive Error Rate Testing (CERT)**

**CERT ALERT: MD ORDERS REQUIRED FOR LABORATORY SERVICES**

WPS Medicare has identified a recent increase in the number of errors attributed to lack of physician orders for diagnostic laboratory services billed. CMS guidelines define an order as:

*An “order” is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (e.g., if test X is negative, then perform test Y). An order may be delivered via the following forms of communication:*

- *A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility;*
- *A telephone call by the treating physician/practitioner or his/her office to the testing facility; and*
- *An electronic mail by the treating physician/practitioner or his/her office to the testing facility.*

*If the order is communicated via telephone, both the treating physician/practitioner or his/her office, and the testing facility must document the telephone call in their respective copies of the beneficiary’s medical records.*

If you receive a request for medical records from the CERT contractor or your local Medicare contractor, it is critical that the physician orders for all laboratory services be included. Without the orders, the services will be determined to be medically unnecessary and **payment for these services will be rescinded.**

For more information, go to the following Website:

<http://www.cms.hhs.gov/Transmittals/Downloads/R80BP.pdf>

**Coverage – General****AQUEOUS DRAINAGE DEVICES FOR THE TREATMENT OF  
GLAUCOMA**

Glaucoma filtering surgery is indicated when glaucomatous damage progresses despite pharmacological and/or surgical treatment. Trabeculectomy is the most widely used form of filtering surgical treatment for primary open-angle glaucoma. However, its success rate and complication rates are less than ideal. Glaucoma drainage implants designed to shunt the aqueous fluid posteriorly represent an alternative method for lowering intraocular pressure in glaucomatous patients and are commonly used in refractory glaucoma or after failure of filtration surgery.

Since the first mini shunt device was approved by the FDA for marketing in March 2002, over 14,000 implantations have been performed. However, there has been disagreement in the ophthalmology community regarding the correct coding for this procedure. The majority of ophthalmologists billed Current Procedural Terminology (CPT) code 66180 (Aqueous shunt to extraocular reservoir), with some using 66172 (trabeculectomy ab externo) or 66999 (Unlisted procedure, anterior segment of eye). Because of this disagreement, the American Medical Association (AMA) CPT Panel developed a new Category III CPT code, 0192T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach), which will become effective July 1, 2008. The appropriate ICD-9 codes are 365.10 - 365.15 Open-angle glaucoma. The device used must be FDA approved, such as the Ex-PRESS™ mini shunt (Optonol). Until the new code becomes effective, providers do not need to alter their current billing practice.

Another similar procedure, Category III CPT code 0191T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach (effective 07/01/2008), is currently undergoing clinical trials and is considered experimental/investigative, and therefore, not covered by Medicare.

**BLOOD-DERIVED PRODUCTS FOR CHRONIC, NON-HEALING  
WOUNDS**

~CMS MLN Matters~

**MLN Matters Number: MM6043**  
**Related CR Release Date: May 2, 2008**  
**Related CR Transmittal #: R83NCD**

**Related Change Request (CR) #: 6043**  
**Effective Date: March 19, 2008**  
**Implementation Date: June 2, 2008**

**Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), 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) 6043 which provides the Centers for Medicare & Medicaid Services (CMS) updated policy regarding autologous blood-derived products for chronic, non-healing wounds.

**CAUTION – What You Need to Know**

Effective March 19, 2008, CMS is maintaining its current non-coverage determination for autologous platelet rich plasma (PRP) for the treatment of chronic, non-healing cutaneous wounds, and issuing a non-coverage determination for acute surgical wounds when the autologous PRP is applied directly to the closed incision and for dehiscent wounds.

**GO – What You Need to Do**

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

**Background**

In 1992, the Centers for Medicare & Medicaid Services (CMS) issued a national non-coverage determination for autologous, platelet-derived wound healing formulas intended to treat patients with chronic, non-healing wounds.

In December 2003, CMS issued a national non-coverage determination for use of autologous platelet rich plasma (PRP) for the treatment of chronic non-healing cutaneous wounds except for routine costs when used in accordance with the clinical trial policy defined in the Medicare National Coverage Determinations (NCD) Manual (Section 310.1; see [http://www.cms.hhs.gov/manuals/downloads/ncd103c1\\_Part4TXT.pdf](http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4TXT.pdf) on the CMS Website).

In April 2005, CMS issued an NCD to correct the erroneous potential for local coverage of becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous wounds, stating that, because it is usually self-administered, it would remain nationally non-covered under Part B based on the Social Security Act (Section 1861(s)(2)(A) and (B); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1861.htm](http://www.ssa.gov/OP_Home/ssact/title18/1861.htm) on the Internet).

On March 19, 2008, CMS issued a Decision Memorandum following a National Coverage Analysis to evaluate the use of autologous blood-derived products for the treatment of chronic, non-healing cutaneous wounds, specifically the use of autologous PRP for the treatment of acute wounds where PRP is applied directly to the closed incision site, or for dehiscent wounds.

CMS determined that the evidence is inadequate to conclude that autologous PRP for the treatment of chronic non-healing cutaneous wounds, acute surgical wounds when the autologous PRP is applied directly to the closed incision, or dehiscent wounds, improves health outcomes in the Medicare population.

Therefore, effective March 19, 2008, CMS is maintaining its current non-coverage determination for autologous PRP for the treatment of chronic, non-healing cutaneous wounds, and issuing a non-coverage determination for acute surgical wounds when the autologous PRP is applied directly to the closed incision and for dehiscent wounds. Effective for claims with dates of service on or after March 19, 2008, the use of autologous PRP for

the treatment of acute surgical wounds where the PRP is applied directly to the closed incision, or dehiscent wounds, will be denied by Medicare contractors.

#### Additional Information

The official instruction, CR 6043, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R83NCD.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.

## ERYTHROPOIESIS STIMULATING AGENTS (ESAS) IN CANCER AND RELATED NEOPLASTIC CONDITIONS

~ Revised CMS MLN Matters ~

MLN Matters Number: MM5818 Revised

Related CR Release Date: January 14, 2008

Related CR Transmittal #: R80NCD and R1413CP

Related Change Request (CR) #: 5818

Effective Date: July 30, 2007

Implementation Date: April 7, 2008

**Note:** This article was revised April 25, 2008, to correct the bullet on page 3 regarding the "Maintenance of ESA therapy" (See bullet in **bold**). It should have stated that the "starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is  $\geq$  1g/dL (hematocrit  $\geq$  3%)." All other information remains the same.

#### Provider Types Affected

Providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC) and Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for administering or supplying Erythropoiesis Stimulating Agents (ESAs) for cancer and related neoplastic conditions to Medicare beneficiaries.

#### What You Need to Know

Following a National Coverage Analysis (NCA) to evaluate the uses ESAs in non-renal disease applications, the Centers for Medicare & Medicaid Services (CMS), on July 30, 2007, issued a Decision Memorandum (DM) that addressed ESA use in non-renal disease applications (specifically in cancer and other neoplastic conditions).

CR 5818 communicates the NCA findings and the coverage policy in the National Coverage Determination (NCD). Specifically, CMS determines that ESA treatment is reasonable and necessary for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions; and not reasonable and necessary for beneficiaries with certain other clinical conditions, as listed below.

The HCPCS codes specific to non-end-stage renal disease (ESRD) ESA use are J0881 and J0885. Claims processed with dates of service July 30, 2007, through December 31, 2007,

do not have to include the ESA modifiers as the modifiers are not effective until January 1, 2008. However, providers are to begin using the modifiers as of January 1, 2008, even though full implementation of related system edits are not effective until April 7, 2008.

Make sure that your billing staffs are aware of this guidance regarding ESA use.

### **Background**

Emerging safety concerns (thrombosis, cardiovascular events, tumor progression, and reduced survival) derived from clinical trials in several cancer and non-cancer populations prompted CMS to review its coverage of ESAs. In so doing, on March 14, 2007, CMS opened an NCA to evaluate the uses of ESAs in non-renal disease applications, and on July 30, 2007, issued a DM specifically narrowed to the use of ESAs in cancer and other neoplastic conditions.

### **Reasonable and Necessary ESA Use**

CMS has determined that ESA treatment for the anemia secondary to a regimen of myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is reasonable and necessary only under the following specified conditions:

- The hemoglobin level immediately prior to the first administration is < 10 g/dL (or the hematocrit is < 30%) and the hemoglobin level prior to any maintenance administration is < 10g/dL (or the hematocrit is < 30%.);
- The starting dose for ESA treatment is up to either of the recommended Food and Drug Administration (FDA) approved label starting doses for cancer patients receiving chemotherapy, which includes the 150 U/kg/3 times weekly or the 40,000 U weekly doses for epoetin alfa and the 2.25 mcg/kg/weekly or the 500 mcg once every three week dose for darbepoetin alpha;
- Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is ≥ 1g/dL (hematocrit ≥ 3%);
- For patients whose hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains < 10 g/dL after 4 weeks of treatment (or the hematocrit is < 30%), the recommended FDA label starting dose may be increased once by 25%. Continued use of the drug is not reasonable and necessary if the hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline by 8 weeks of treatment;
- Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3%) over any 2 week period of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30%). Continuation and reinstatement of ESA therapy must include a dose reduction of 25% from the previously administered dose; and
- ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen.

### **Not Reasonable and Necessary ESA Use**

Either because of a deleterious effect of ESAs on the underlying disease, or because the underlying disease increases the risk of adverse effects related to ESA use, CMS has also determined that ESA treatment is not reasonable and necessary for beneficiaries with the following clinical conditions:

- Any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), or bone marrow fibrosis;
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81);
- Anemia of cancer not related to cancer treatment;
- Any anemia associated only with radiotherapy;
- Prophylactic use to prevent chemotherapy-induced anemia;
- Prophylactic use to reduce tumor hypoxia;
- Erythropoietin-type resistance due to neutralizing antibodies; and
- Anemia due to cancer treatment if patients have uncontrolled hypertension.

### Claims Processing

Effective for claims with dates of service on or after January 1, 2008, Medicare will deny non-ESRD ESA services for J0881 or J0885 when:

- Billed with modifier EC (ESA, anemia, non-chemo/radio) when a diagnosis on the claim is present for any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Billed with modifier EC for any anemia in cancer or cancer treatment patients due to bone marrow fibrosis, anemia of cancer not related to cancer treatment, prophylactic use to prevent cancer-induced anemia, prophylactic use to reduce tumor hypoxia, erythropoietin-type resistance due to neutralizing antibodies, and anemia due to cancer treatment if patients have uncontrolled hypertension.
- Billed with modifier EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.
- Billed with modifier EB (ESA, anemia, radio-induced).

**Note:** Denial of claims for non-ESRD ESAs for cancer and related neoplastic indications as outlined in NCD 110.21 are based on reasonable and necessary determinations. A provider may have the beneficiary sign an Advance Beneficiary Notice (ABN), making the beneficiary liable for services not covered by Medicare. When denying ESA claims, contractors will use Medicare Summary Notice 15.20, *The following policies [NCD 110.21] were used when we made this decision*, and remittance reason code 50, *These are non-covered services because this is not deemed a 'medical necessity' by the payer*. However, standard systems shall assign liability for the denied charges to the provider unless documentation of the ABN is present on the claim. Denials are subject to appeal and standard systems shall allow for medical review override of denials. Contractors may reverse the denial if the review results in a determination of clinical necessity.

Medicare contractors have discretion to establish local coverage policies for those indications not included in NCD 110.21.

Medicare contractors will not search files to retract payment for claims paid prior to April 7, 2008. However, contractors shall adjust claims brought to their attention.

**Additional Information**

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.

This addition/revision of section 110.21 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

The official instruction, CR5818, was issued to your contractor in two transmittals. The first is the NCD transmittal and that is available at <http://www.cms.hhs.gov/Transmittals/downloads/R80NCD.pdf> on the CMS Website. The second transmittal revises the Medicare Claims Processing Manual and it is at <http://www.cms.hhs.gov/Transmittals/downloads/R1413CP.pdf> on the same site.

**INCIDENT TO POLICY UPDATE**  
~ Revised CMS MLN Matters ~

MLN Matters Number: MM5288 Revised  
Related CR Release Date: May 2, 2008  
Related CR Transmittal #: R87BP

Related Change Request (CR) #: 5288  
Effective Date: June 2, 2008  
Implementation Date: June 2, 2008

**Note:** This article was revised on May 16, 2008, to clarify the language in 4th bullet on page 3 (in bold). That statement should have stated "**..services are provided in a home or in a skilled nursing facility.**" All other information remains the same.

**Provider Types Affected**

Physicians, nonphysician practitioners (NPP), and other providers who bill Medicare carriers and A/B MACs for services provided to Medicare beneficiaries

**What You Need to Know**

CR 5288, from which this article is taken, clarifies current Medicare policy regarding services provided as incident to the services of physicians or nonphysician practitioners (NPP) in the office. Specifically, it updates information in the Medicare Benefit Policy Manual (Chapter 15 -- Covered Medical and Other Health Services, Sections:

- 50.3 - Incident To Requirements for Coverage of Drugs and Biologicals That Are Not Usually Self-Administered;
- 60 - Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service;
- 60.1 - Incident To Physician's/NPP's Professional Services in Office or Physician/NPP Owned and Operated Clinic;

- 60.2 - Services of Nonphysician Personnel Furnished Incident To Physician's Services; and
- 60.3 - Incident To Physician's/NPP's Services in Physician/NPP Owned and Operated Clinics)

**For policies relative to hospital outpatient services see the *Medicare Benefit Policy Manual*, Chapter 6, Section 20.5.**

**CR5288 represents no significant change in Medicare policy. It is intended only to clarify current policy and, where local interpretations may differ, to add consistency.**

### Background

The number of services provided as incident to the services of physicians/NPPs has grown continuously. As the benefit is applied in various settings for different services, the original instructions appeared insufficient. Therefore, in CR 5288, from which this article is taken, the Centers for Medicare & Medicaid Services (CMS) is responding to continued requests for clarification of policies related to Part B services provided incident to the services of physicians.

### Key Points

The update of the Medicare Benefit Policy Manual is extensive and will not be repeated in this article. To view the manual update itself, see CR5288 at <http://www.cms.hhs.gov/Transmittals/downloads/R87BP.pdf> on the CMS Website. In this article, we will only emphasize the following key points of CR5288:

- Carriers and A/B MACs will interpret a service as integral to the initial service when it is both essential to, and connected to, that service.
- When carriers and A/B MACs are aware that a service is furnished by staff other than the physician/NPP who is overseeing the patient's care, they will not pay for services incident to a physician's/NPP's service unless the services meet the requirements in *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services, Section 60 (Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service)) and its subsections.
- When carriers and A/B MACs are aware that a service is furnished by staff other than the physician/NPP overseeing the patient's care, carriers and A/B MACs will not pay for services incident to a physician's/NPP's service unless there is documentation authorizing the incident to service.
- Carriers and A/B MACS will not pay for services incident to the services of a physician/NPP if the services are for a new problem.
- Carriers and A/B MACs will use clinical judgment in determining whether the record contains sufficient documentation to indicate that a physician/NPP is overseeing the provision of services appropriately for the patient's condition, and whether the person furnishing the incident to service is appropriately qualified.
- Carriers and A/B MACs will apply the policies for services incident to a physician's/NPP's services in the office only in the identifiable boundary of an office or in a single room.
- **Where services are provided in a home or in a skilled nursing facility (SNF), outside the boundary of an office suite, carriers and A/B MACs will require that the supervisor be in the same room as the patient and the staff furnishing a service, providing the equivalent of personal supervision.**

- For payment purposes, carriers and A/B MACs will require:
  - That documentation in the medical record conform to the policy in CR5288;
  - An authorization for services provided incident to the physician/NPP initial service; and
  - That the name and professional identities of the people who furnished the services must be in the medical record.
- The authorization may be an “order” which may be part of the care plan. The authorization does not have to be in any specific form (it may be an order or part of a plan, treatment note, or team meeting note), but should indicate the physician’s intent that further services will be provided. It is appropriate that the physician may plan to provide a follow-up service personally and later assign the service to qualified staff. It is not necessary that a formal order be written to the staff, but services may not be billed if staff has not been authorized to provide them and that authorization must be present in the medical record.
- The authorization will not be on the claim and therefore, will be identified only when the record is reviewed.
- Services unrelated and not essential to the initial service will not be paid as incident to the initial, covered service. These services may represent new problems for which an initial physician/NPP service is required.
- Carriers and A/B MACs are not required to perform medical review on all claims to determine whether there is a new problem, but if medical review reveals that there is a new problem, they will not pay for that service incident to the physician’s service without a prior physician’s service.
- Staff may be overqualified to provide a service, but the service will not be allowed as incident to if the service should have been provided under another benefit such as a physician’s service or services of another professional. Carriers and A/B MACs will take special care in determining whether services provided by a physician or other professional incident to the services of a physician are actually incidental services or they should be billed, e.g., as physician services by enrolled physicians, or as diagnostic tests.
- CMS requires that the professional title of the person who provides the service be written in the medical record in order that carriers and A/B MACs will know the staffs’ professional qualifications or licensure.

### **Additional Information**

You can find more information in the official instruction, CR 5288, located at <http://www.cms.hhs.gov/Transmittals/downloads/R87BP.pdf> on the CMS Website. You will find the updated *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Sections 50.3 (Incident To Requirements for Coverage of Drugs and Biologicals That Are Not Usually Self-Administered), 60 (Services and Supplies Furnished Incident To a Physician’s/NPP’s Professional Service), 60.1 (Incident To Physician’s/NPP’s Professional Services in Office or Physician/NPP Owned and Operated Clinic), 60.2 (Services of Nonphysician Personnel Furnished Incident To Physician’s Services), and 60.3 (Incident To Physician’s/NPP’s Services in Physician/NPP Owned and Operated Clinics) as an attachment to that CR. All other manuals referenced in CR5288 are available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS Website.

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

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

## THErapy PERSONNEL QUALIFICATIONS AND POLICIES EFFECTIVE JANUARY 1, 2008 ~CMS MLN Matters~

MLN Matters Number: MM5921  
Related CR Release Date: May 7, 2008  
Related CR Transmittal #: R88BP

Related Change Request (CR) #: 5921  
Effective Date: January 1, 2008  
Implementation Date: June 9, 2008

### Provider Types Affected

Physicians, non physician practitioners, and other providers who bill Medicare carriers, fiscal intermediaries (FI) or Medicare Administrative Contractors (A/B MAC) for outpatient therapy services provided to Medicare Beneficiaries.

### What Providers Need to Know

CR 5921, from which this article is taken, provides guidance for new regulations (See the Federal Register of November 27, 2007 for the discussion in the Medicare Physician Fee Schedule (MPFS) final rule of 2008.) that address outpatient therapy services, including personnel qualifications and the timing of recertification of plans of care for Part B services. This article summarizes these regulations.

### Background

Professional standards have changed since the qualifications for individuals providing outpatient therapy services (physical therapy, occupational therapy and speech-language pathology services in 42CFR484.4 was last modified. In the calendar year 2008 Medicare Physician Fee Schedule Final Rule with comments, the Centers for Medicare & Medicaid Services (CMS) updated them to address more modern requirements. CR 5921, from which this article is taken, provides guidance for these new regulations.

Effective January 1, 2008, these personnel requirements are being applied to all settings except inpatient hospital, including critical access hospital services, and posthospital SNF care.

Effective July 1, 2008, these personnel qualifications are being applied consistently in all Medicare settings where therapy services are furnished.

Certain other policies concerning therapy services, and policies concerning recertification of plans of care for Part B services, some of which differ by setting are also effective January 1, 2008.

**Note: The regulations in 42CFR409.17 concerning inpatient hospital services and inpatient critical access hospital services, and those in 42CFR409.23 concerning post hospital skill nursing facility (SNF) care will become effective July 1, 2008. Only the personnel qualifications for those settings are addressed in this CR.**

***Qualifications for Individuals Providing Outpatient Therapy Services***

Practice of Physical Therapy

For Medicare program coverage purposes, the new personnel qualifications for physical therapists were discussed in the 2008 Medicare Physician Fee Schedule. See the Federal Register of November 27, 2007 for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008. **To view the official qualifications for physical therapists, see the revised Chapter 15, Section 230.1, of the Medicare Benefit Policy Manual, which is attached to CR5921 at <http://www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.**

Practice of Occupational Therapy

The new personnel qualifications for occupational therapists (OT) were also discussed in the 2008 Physician Fee Schedule. See the Federal Register of November 27, 2007 for the full text. See also the correction notice for this rule, published in the Federal Register on January 15, 2008. **The official personnel qualifications of OTs are in the revised Chapter 15, Section 230.2 of the Medicare Benefit Policy Manual attached to CR5921.**

Practice of Speech-Language Pathology

A qualified speech-language pathologist for program coverage purposes meets one of the following requirements:

- The education and experience requirements for a Certificate of Clinical Competence in (speech-language pathology) granted by the American Speech-Language Hearing Association; or
- Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

For outpatient speech-language pathology services that are provided incident to the services of physicians/NPPs, the requirement for speech-language pathology licensure does not apply; all other personnel qualifications do apply. Therefore, qualified personnel providing speech-language pathology services incident to the services of a physician/NPP must meet the above qualifications.

***Timing of Recertification of Plans for Care for Part B services***

CR 5921 also addresses the timing of recertification of plans for care for Part B services. The following summarizes the changes articulated in the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care).

First, please note that the physician's/NPP's certification of the plan (with or without an order) satisfies all of the certification requirements for the duration of the episode of care, or 90 calendar days from the date of the initial treatment, whichever is less. The initial treatment includes the evaluation that resulted in the plan.

The timing of plan recertification changed on January 1, 2008. Therefore, those certifications that were signed on, or prior to December 31, 2007, follow the rule in effect at that time; which required recertification every 30 calendar days. However, certifications that are signed on, or after January 1, 2008, follow the new rules in CR5921 and are effective for an

appropriate episode length based on individual patient condition up to 90 calendar days from the initial therapy treatment.

Specifically, a physician/NPP may certify or recertify a plan for whatever duration of treatment episode they determine is appropriate, up to a maximum of 90 calendar days. A certification interval will be the same length as an episode, if the episode is less than 90 calendar days. If the episode of care is anticipated to extend beyond the 90 calendar day limit for certification, it is appropriate (although not required) that the clinician who develops the plan estimate the duration of the entire episode for that setting.

**Note: The Progress Report Period has not changed. Progress reports are due at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less. The first day of the first reporting period is the same as the first day of the certification period and the first day of treatment (including evaluation). The first day of the second reporting period is the treatment day after the end of the first reporting period.**

#### **Other Issues in CR5921**

Other issues discussed in CR5921 include:

- Medicare contractors will require that a new or significantly modified (changed) plan of care for outpatient therapy services be certified no more than 30 calendar days after the initial therapy treatment under that plan. Rules for delayed certification have not changed.
- Payment and coverage conditions require that the plan must be reviewed, as often as necessary but at least whenever it is certified or recertified. It is not required that the same physician/NPP who participated initially in recommending or planning the patient's care certifies and/or recertifies the plans.
- Medicare contractors will require recertification of outpatient therapy plans of care in intervals not to exceed 90 calendar days after the initial treatment day.
- Physicians/NPPs who feel that a visit for an examination is necessary prior to certifying the plan, or during the episode of treatment should indicate their requirement for visits, preferably on an order preceding the treatment, or on the plan of care that is certified. If the physician wishes to restrict the patient's treatment beyond a certain date when a visit is required, the physician should certify a plan only until the date of the visit. After that date, services will not be considered reasonable and necessary due to lack of a certified plan.
- Policies continue to allow delayed certification of plans of care. Certifications are acceptable, even when late, if the services appear to have been provided under the care of any physician (not only the one who certifies). Appearance of a physician's care may be in any form and includes orders, e.g., notes, phone conferences, team conferences and billing for physician services during which the medical record or the patient's history would, in good practice, be reviewed and would indicate therapy treatment is in progress.
- The guidance for delayed certification has not changed. A new plan of care is either an initial plan of care or a plan of care that has been significantly modified or changed, resulting in a change in long term goals. It is expected that modifications to the plan concerning short term goals or treatment techniques will be made frequently and these changes do not require certification or recertification.
- Medicare contractors will not require a certification "statement" at the time of certification.

- Medicare contractors will require a clinicians or facilities that appropriately furnish aquatic therapy in a community pool to rent or lease at least a portion of the community pool for the exclusive use of the therapist's patients.
- The same policies, e.g., concerning safety and medical necessity, continue to apply to services provided in part of a pool as were applied when the policy required use of the entire pool.

**Additional Information**

You can find more information about the new therapy personnel qualification requirements and the timing of recertification of plans of care (effective January 1, 2008) by going to CR 5921, located at <http://www.cms.hhs.gov/Transmittals/downloads/R88BP.pdf> on the CMS Website. The updated Medicare Benefit Policy Manual, Chapter 15 (Covered Medical and Other Health Services), Sections 220 (Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance), 220.1.2 (Plans of Care for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services), 220.1.3 (Certification and Recertification of Need for Treatment and Therapy Plans of Care), 220.3 (Documentation Requirements for Therapy Services), 230.1 (Practice of Physical Therapy), 230.2 (Practice of Occupational Therapy), 230.3 (Practice of Speech-Language Pathology), 230.4 (Services Furnished by a Physical or Occupational Therapist in Private Practice) can be found as an attachment to that CR.

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.

**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](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.

<b>Illinois</b>	<b>Michigan</b>
WPS Medicare Freedom of Information PO Box 4433, Marion, IL 62959	WPS Medicare Freedom of Information PO Box 5533, Marion, IL 62959
<b>Minnesota</b>	<b>Wisconsin</b>
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



**New Policies for June 2008**

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
RAD-039	<i>Stereotactic Body Radiation Therapy</i>	LCD	Click here to view	34

**Revised Policies for June 2008**

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
INJ-040	<i>Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions</i>	NCD	Click here to view	35
NEURO-005	<i>Nerve Conduction Studies and Electromyography</i>	LCD	Click here to view	35
PHYS-004	<i>Incident to Services</i>	NCP	Click here to view	36
PHYS-042	<i>Drugs and Biologicals - Coverage and Payment</i>	NCP	Click here to view	36
PHYSMED-001	<i>Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology</i>	NCP	Click here to view	38
PHYSMED-009	<i>Physical Medicine Rehabilitation Procedures and Modalities</i>	LCD	Click here to view	40

**Coverage – New Policies****Local Coverage Determination (LCD)****LCD Title:**

Stereotactic Body Radiation Therapy

**Contractor's Determination Number:**

RAD-039

**Original Determination Effective Date:**

07/16/2008

This is a new policy. Please read this policy in its entirety on our Website at [http://www.wpsmedicare.com/part\\_b/policy/policy\\_active.shtml](http://www.wpsmedicare.com/part_b/policy/policy_active.shtml).

**Coverage – Revised Policies****National Coverage Determination (NCD)**

A typographical error is being corrected. The third bullet under B in the NCD Manual should read as follows: *Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is <30%) 4 weeks after initiation of therapy and the rise in hemoglobin is > 1g/dL (hematocrit > 3%).*

**NCD Title:**

Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions

**Contractor's Determination Number:**

INJ-040

**Contractor Name:**

Wisconsin Physicians Service (WPS)

**B. Nationally Covered Indications**

*The ESA treatment for the anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is only reasonable and necessary under the following specified conditions:*

- \*• *Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is <30%) 4 weeks after initiation of therapy and the rise in hemoglobin is  $\geq$  1g/dL (hematocrit  $\geq$  3%).*

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

Nerve Conduction Studies and Electromyography

**Contractor Determination Number:**

NEURO-005

**Effective Date:**

May 16, 2008

This change does not affect claims processing. The language has been clarified and now reads: *\*Nerve conduction studies performed using automated devices (for example devices such as NC-stat® System cannot support testing of other locations and other nerves as needed depending on the concurrent results of testing and they should not be billed to Medicare with the current CPT codes (95900, 95903, or 95904). Until a specific code for this service is established that describes automated testing, this procedure must be billed with procedure code 95999 and "Automated NCS Device" indicated in Item 19 of the CMS-1500 form. If filing electronically, the description should be included in the comment field.*

When the beneficiary has a high pre-test or a priori probability for having the diagnosis of Carpal Tunnel Syndrome, the NC-stat® System (alone) will be allowed, one service per arm, using CPT code 95999. The diagnosis ICD-9 354.0 should be used and the type of nerve conduction machine should be placed in Item 19 of the CMS-1500 form. If filing electronically, the description should be included in the comment field.

\*When the beneficiary has a high pre-test or a priori probability for having the diagnosis of Carpal Tunnel Syndrome, the NC-stat® System or similar automated nerve conduction device (alone, without any additional nerve conduction studies) will be allowed, one service per arm, using CPT code 95999. The diagnosis ICD-9 354.0 should be used and the type of nerve conduction machine should be placed in Item 19 of the CMS-1500 form. If filing electronically, the description should be included in the comment field.

The words NeuroMetrix, Neuropath have been removed from the LCD.



**National Coverage Provision (NCP)**

**NCP Title:**

Incident to Services

**Subject Number:**

PHYS-004

This document has been completely revised based on updates to Chapter 15 of the Benefit Policy manual.



**National Coverage Provision (NCP)**

**NCP Title:**

Drugs and Biologicals - Coverage and Payment

**Subject Number:**

PHYS-042

**Description of Benefit:**

*The Medicare program provides limited benefits for outpatient drugs. The program covers drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them.*

**Indications and Limitations of Coverage:**

- \*C. Drugs and Biologicals Furnished Incident To a Physician's/NPP's Services in an Office or Non-facility Based Clinic Setting  
*They meet all the general requirements for coverage of items as incident to a physician's services;*

*In order to meet all the general requirements for coverage under the incident-to provision for services and supplies provided in an office or physician/NPP owned and operated clinic setting, as detailed in section 60 and its subsections in this chapter, an FDA approved drug or biological must be of a form that is not usually self-administered, and must be administered by a physician/NPP, or by auxiliary personnel employed by the physician under the physician's direct supervision.*

*The charge, if any, for the drug or biological must be included in the physician's/NPP's bill, and the cost of the drug or biological must represent an expense to the physician. Drugs and biologicals furnished by other health professionals may also meet these requirements. (See §§170, 180, 190 and 200 for specific instructions.)*

*When a patient purchases a drug that a physician/NPP or auxiliary staff administers in the office or clinic, the cost of the drug is not covered. However, the administration of the drug, regardless of the source, is a service that represents an expense to the physician/NPP. Therefore, administration of the drug is payable if the drug would have been covered had the physician/NPP furnished it. See Pub. 100-04, chapter 12, section 30.6.7, especially (D), for policies relevant to billing.*

*Incident-to Requirements--In order for Medicare payment to be made for a drug, the "incident to" requirements are met. "Incident to" a physician's professional service means that the services are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an illness or injury.*

*Incident to Physician's Professional Services--Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.*

*Commonly Furnished in Physicians' Offices--Services and supplies commonly furnished in physicians' offices are covered under the incident to provision. Where supplies are clearly of a type a physician is not expected to have on hand in his/her office or where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the incident to provision.*

*Supplies usually furnished by the physician in the course of performing his/her services, e.g., gauze, ointments, bandages, and oxygen, are also covered. Charges for such services and supplies must be included in the physicians' bills. **To be covered, supplies, including drugs and biologicals, must be an expense to the physician or legal entity billing for the services or supplies.** For example, where a patient purchases a drug and the physician administers it, the drug is not covered. **However, the administration of the drug, regardless of the source, is a service that represents an expense to the physician. Therefore, administration of the drug is payable if the drug would have been covered if the physician purchased it.***



**National Coverage Provision (NCP)****Subject**

Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology

**NCP Number**

PHYSMED-001

**Effective Date**

01/01/2008

**Implementation Date**

June 9, 2008

CMS Transmittal 88, Change Request (CR) 5921 regarding Therapy Personnel Qualifications and Policies Effective January 1, 2008 may be found at

<http://www.cms.hhs.gov/transmittals/downloads/R88BP.pdf>. It is recommended that providers read this in its entirety.

As result of this CR, a number of changes have been made to the National Coverage Provision (NCP) on Outpatient Physical Therapy, Occupational Therapy, and Speech-Language Pathology. A summary of the changes is below. The policy may be found on the WPS Website at [http://www.wpsmedicare.com/part\\_b/policy/physmed001.pdf](http://www.wpsmedicare.com/part_b/policy/physmed001.pdf).

1. Note that the Progress Report Period has not changed. Progress reports are due at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less. The first day of the first reporting period is the same as the first day of the certification period and the first day of treatment (including evaluation). The first day of the second reporting period is the treatment day after the end of the first reporting period. (5921.4)
2. Note that the policies continue to allow delayed certification of plans of care. Certifications are acceptable, even when late, if the services appear to have been provided under the care of any physician (not only the one who certifies). Appearance of the care of a physician may be in any form and includes orders, e.g., notes, phone conferences, team conferences and billing for physician services during which the medical record or the patient's history would, in good practice, be reviewed and would indicate therapy treatment is in progress. (5921.5)
3. The guidance for delayed certification has not been changed. A new plan of care is either an initial plan of care or a plan of care that has been significantly modified or changed, resulting in a change in long term goals. It is expected that modifications to the plan concerning short term goals or treatment techniques will be made frequently and these changes do not require certification or recertification. (5917.6)
4. Note that the paragraph concerning speech-language pathologist's services being billed by physical therapists has been removed from Pub. 100-02, chapter 15, section 230.2. Contractors are advised that legislation concerning enrollment of speech-language pathologists is pending and that they should continue to pay for SLP services when provided by qualified SLPs in the same manner they are now, according to contractor discretion. (5921.7)

5. The same policies, e.g., concerning safety and medical necessity, review of records, continue to apply to services provided in part of a pool as were applied when the policy required use of the entire pool. (5921.8)
6. The frequency or duration of the treatment may not be used alone to determine medical necessity, but they should be considered with other factors such as condition, progress, and treatment type to provide the most effective and efficient means to achieve the patient's goals. For example, better outcomes at less cost may sometimes be achieved by skilled treatment once or twice weekly to assess and modify the plan with independent exercise by the patient between skilled visits. Continued progress is a sign that treatment is effective and may indicate that skilled treatment should be continued. (5921.10)
7. There is no restriction on the way duration of treatment or a certification interval may be expressed. Variations may include e.g., calendar days, number of treatment sessions, or number of weeks of treatment. Contractors shall interpret the certification interval using the longest of the durations in the plan. As long as the physician approves the plan and the plan does not extend more than 90 calendar days from the first treatment day of that plan, the certification is acceptable for either the number of treatments, the number of weeks, or the number of calendar days that represent the longest interpretation of the duration of treatment. For example, if a plan is written and certified for 3x/week x 4 weeks and the patient receives treatment 3/xweek for 3 weeks but is absent the 4th week, then the planned 4th week of treatment is still certified if it is delivered later, assuming the plan remains appropriate and the treatment remains skilled and necessary. Or, under the same circumstances the plan is still certified when it includes treatment 4 times the first week and 2 times the last week. A reasonable amount of variation in the plan is acceptable. (5921.11)

In addition, there are new personnel qualification for physical therapists, physical therapist assistants (PTA) and occupational therapists.

### **Qualified Speech-Language Pathologist Defined**

*For outpatient speech-language pathology services that are provided incident to the services of physicians/NPPs, the requirement for speech-language pathology licensure does not apply; all other personnel qualifications do apply. Therefore, qualified personnel providing speech-language pathology services incident to the services of a physician/NPP must meet the above qualifications.*

### **Practice of Speech-Language Pathology**

#### **3. Impairments of the Auditory System**

*The terms aural rehabilitation, auditory rehabilitation, auditory processing, lip reading, and speech reading are among the terms used to describe covered services related to perception and comprehension of sound through the auditory system. See Pub. 100-04, chapter 12, section 30.3 for billing instructions. For example:*

*Auditory processing evaluation and treatment may be covered and medically necessary. Examples include but are not limited to services for certain neurological impairments or the absence of natural auditory stimulation that results in impaired ability to process sound. Certain auditory processing disorders require diagnostic audiological tests in addition to speech-language pathology evaluation and treatment.*

*Evaluation and treatment for disorders of the auditory system may be covered and medically necessary, for example, when it has been determined by a speech-language pathologist in collaboration with an audiologist that the hearing impaired beneficiary's current amplification options (hearing aid, other amplification device or cochlear implant) will not sufficiently meet the patient's functional communication needs. Audiologists and speech-language pathologists both evaluate beneficiaries for disorders of the auditory system using different skills and techniques, but only speech-language pathologists may provide treatment.*



**Local Coverage Determination (LCD)**

**Contractor Name**

Wisconsin Physicians Service (WPS)

**LCD Title**

Physical Medicine Rehabilitation Procedures and Modalities

**Contractor's Determination Number**

PHYSMED-009

**Revision Effective Date**

January 1, 2008

**Implementation Date**

June 9, 2008

CMS Transmittal 88, Change Request (CR) 5921 regarding Therapy Personnel Qualifications and Policies Effective January 1, 2008 may be found at <http://www.cms.hhs.gov/transmittals/downloads/R88BP.pdf>. It is recommended that providers read this in its entirety.

This CR has resulted in the changes to LCD PHYSMED-009 listed below:

The re-certification of plans of care for outpatient Part B therapy services is required every 90 days.

- \*9. Interval of certified treatment (certification interval) consists of 90 calendar days or less based on an individual's needs.
- \*3. The plan of care must be reviewed, dated, and signed by a physician/NPP every 90 days. A plan may be certified for less than 90 days. Changes to the plan must be made in writing, dated, and signed. A qualified therapist may not significantly alter a plan of care without documented approval by a physician/NPP.

97002: PT Re-evaluation:

- \*3. Medicare policy requires a re-certification of the treatment plan by the attending physician every 90 days. In order to identify the need for continued treatment, and comply with this regulation, it would be considered reasonable and necessary for the therapist to perform a re-evaluation for the re-certification process.

- \*7. Physician/NNP certification of the significantly modified plan of care shall be obtained within 30 days of the initial therapy treatment under the revised plan of care.

\*\*\*\*\*

**Billing and Coding Guidelines**

**LCD Title**

Physical Medicine Rehabilitation Procedures and Modalities

**Contractor's Determination Number**

PHYSMED-009

**Non-Covered:**

- \*4. PM&R services are not covered when the certification/recertification is not performed by the attending physician every 90 days.

**Electronic Data Interchange (EDI)**

**ELECTRONIC REMITTANCE ADVICE (ERA) REQUESTS ONLY  
PROCESSED WHEN RECEIVED FROM PROVIDERS**

Medicare receives requests every day for Electronic Remittance Advice (ERA) notices. Due to privacy issues, we can no longer honor the requests that come from billing services or clearinghouses.

THESE REQUESTS MUST BE SIGNED AND FORWARDED TO MEDICARE FROM THE PROVIDER REQUESTING THIS SERVICE.

Many clearinghouses are currently sending us lists of provider numbers to change, but it has been our experience that some of these providers are not ready to change. This can result in payment information being forwarded to parties that are not entitled to the information.

ERA requests received from clearinghouses may be returned to the clearinghouse for correct processing. You can obtain a copy of the ERA Input sheet from the following Web page:  
[http://www.wpsic.com/edi/pdf/edi\\_ern\\_medb.pdf](http://www.wpsic.com/edi/pdf/edi_ern_medb.pdf).

If you have questions about this or any other Medicare electronic billing issue, please contact us at the following telephone numbers:

IL, MI, and WI: (877) 567-7261

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

**LET'S GO GREEN**

**Did You Know...?**

**All Medicare claims can be submitted electronically.**

The Electronic Data Interchange (EDI) Connection gives contact information for vendors, billing services and clearinghouses with approved electronic media claims capabilities. You can find this at [http://www.wpsic.com/edi/pdf/medicare\\_connection.pdf](http://www.wpsic.com/edi/pdf/medicare_connection.pdf).

PC-Ace Pro32 is a "stand alone" software package that creates a patient database and allows your office to electronically submit Medicare Part B claims in a HIPAA-compliant format. You can find more information on our Website at <http://www.wpsic.com/edi/pacepro32.shtml>.

You can find our EDI enrollment form on our Website at [http://www.wpsic.com/edi/pdf/medb\\_enroll.pdf](http://www.wpsic.com/edi/pdf/medb_enroll.pdf).

**All Medicare providers can receive electronic remits.**

No more paper Explanation of Benefits (EOBs) to wait for in the mail. All you have to do is download them from our Bulletin Board System or get them from your vendor or clearinghouse. You can find the ERA authorization form on our Website at [http://www.wpsic.com/edi/pdf/edi\\_ern\\_medb.pdf](http://www.wpsic.com/edi/pdf/edi_ern_medb.pdf).

You can download your remits from our bulletin board. Then use our Medicare Remit Easy Print (MREP) software to access and print remittance advice information, including special reports, from the HIPAA 835. The accompanying User Guide explains the functionalities and how to implement the software. This software is available free to Medicare providers and suppliers.

**All Medicare providers can receive their payments electronically.**

Electronic Funds Transfer (EFT) automatically deposits Medicare reimbursement into a provider's designated bank account, eliminating the wait for reimbursement by mail. All you have to do is complete the EFT authorization, which you can find at <http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf>

Mail the EFT 588 form to:

Wisconsin Physicians Service  
Attn: EDI  
8120 Penn Ave So  
Suite 200  
Bloomington, MN 55431

**Program Safeguards****MEDICAL RECORDS REQUESTS**

Wisconsin Physicians Service (WPS) Medicare, in its role as an Affiliated Contractor and a Medicare Administrative Contractor (MAC), is authorized to access any records deemed necessary for the processing of Medicare claims. Furthermore, Medicare requires that the services are verifiable in order to be paid. WPS, the Affiliated Contractor and Medicare Administrative Contractor for the Program Safeguard Program, has the responsibility of conducting random internal audits to verify services reported to the Medicare program against what is contained in the patient's medical record information.

When a provider receives a request for medical records from WPS, it is the responsibility of the provider to comply with the request within 14 days from the date of the request. Failure to submit the requested records may result in the identification of a total overpayment for the services billed for the patient(s) in question. Additionally, further action could be taken to suspend all payments made to the billing provider from the Medicare Program.

Where a provider has multiple office sites or the records are housed at a different site, the provider is obligated to retrieve the information from the appropriate site and submit it to WPS.

**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 March 20, 2008, 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**

<b>Name/Specialty/Address/Date of Birth</b>
Sherry D. Holmes Health Care Aide 1415 East 69 <sup>th</sup> Place Chicago, IL 60637 12/26/1963

<b>Name/Specialty/Address/Date of Birth</b>
Jason D. Smith, D.O. Osteopath 3023 N. Clark St, Ste 295 Chicago, IL 60615 07/15/1948

**Illinois Reinstated Providers**

<b>Name/Specialty/Address/Date of Birth</b>
Jenny Alexander, CSW Clinical Social Worker 6054 N. Claremont Ave., #35 Chicago, IL 60659 <b>REINSTATED: 04/28/2008</b>

**Michigan Sanctioned Providers**

<b>Name/Specialty/Address/Date of Birth</b>
Elena Victoria Perry-Thornton, M.D. Family Practice Physician P O Box 14525, #39965-039 Lexington, KY 40512 03/18/1951

<b>Name/Specialty/Address/Date of Birth</b>
Ty Young Sanders, D.P.M. Podiatrist 815 High Street Williamston, MI 48895 02/28/1963

**Michigan Reinstated Providers**

<b>Name/Specialty/Address/Date of Birth</b>
John F. Kenna, Pharmacy Technician 15626 Isabel St. Union Pier, MI 49129 <b>REINSTATED: 02/22/2008</b>
Christopher Lamkin, D.C. Chiropractor 44444 John Alden Road Plymouth, MI 48170 <b>REINSTATED: 04/02/2008</b>

<b>Name/Specialty/Address/Date of Birth</b>
Ramon Rogelio Rodriguez Therapist 337 S. State St. Reed City, MI 49677 <b>REINSTATED: 02/22/2008</b>

**Minnesota Reinstated Providers**

<b>Name/Specialty/Address/Date of Birth</b>
Ethel Ann Arita Nurses Aide 907 Pearl Street, #231 Prescott, WI 54021 <b>REINSTATED: 03/25/2008</b>

<b>Name/Specialty/Address/Date of Birth</b>
Tammy Jo Liddle, L.P.N. Licensed Practical Nurse 2439 135 <sup>th</sup> Ave, NW Andover, MN 55304 <b>REINSTATED: 04/24/2008</b>

**Wisconsin Reinstated Providers**

<b>Name/Specialty/Address/Date of Birth</b>	<b>Name/Specialty/Address/Date of Birth</b>
Ethel Ann Arita Nurses Aide 907 Pearl Street, #241 Prescott, WI 54021 <b>REINSTATED: 03/25/2008</b>	Mary E. Trahan, R.N. Registered Nurse 4975 S. 43 <sup>rd</sup> Street Greenfield, WI 53220 <b>WITHDRAWN: 10/20/2003</b>
Daniel Frank Cichon, D.O. Osteopath 12231 W. White Oak Dr. Greenfield, WI 53228 <b>REINSTATED: 02/27/2008</b>	

**Provider Education****ARE YOU BILLING GROUP PSYCHOTHERAPY CORRECTLY?**

The Current Procedural Terminology (CPT) defines procedure code 90853 as “Group Psychotherapy (other than that of a multiple-family group.)” Procedure code 90853, Group Psychotherapy, describes psychotherapy services administered in a group setting with a trained therapist simultaneously providing therapy to several patients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instructions, insight, and support. The group size should be of a size that can be successfully led (i.e., maximum of 12 people).

A trained therapist authorized by state statute to perform the services must lead group Psychotherapy (i.e., physician, clinical psychologists, clinical social worker, physician assistant, certified nurse practitioners, clinical nurse specialists), or other persons authorized by the state to perform this service.

The documentation must support the patient has a covered diagnosis and the provider must submit this diagnosis with the claim. Group psychotherapy is psychotherapy provided in a group setting and as such, the documentation must support psychotherapy services. The goals must be specific, measurable, individualized, and related to the participant’s diagnosis. Documentation must support the group psychotherapy services rendered to the beneficiary on the given date of service. The documentation must be “reasonably expected to improve the patient’s condition.” Medicare does not reimburse for Psychotherapy services when documentation indicates there is cognitive defect of such severity as to prevent the psychotherapy from being effective (i.e., severe mental retardation, Alzheimer’s or dementia patients).

Medicare coverage of Group Psychotherapy does not include socialization, self-care topics, music therapy, recreational activities, art classes, psycho education, excursions, motion therapy, cognitive stimulation, sensory stimulation, or eating together. Self-help groups or support groups without a qualified professional are not billable to Medicare.

**EDUCATION SCHEDULE**

Please visit the WPS Medicare Education Schedule at [http://www.wpsmedicare.com/part\\_b/education/education\\_schedule.shtml](http://www.wpsmedicare.com/part_b/education/education_schedule.shtml) to learn more about the educational events we have scheduled for the upcoming months. Coming up, we will host events such as:

- Save Dollars, Avoid Denials Seminar
- Basic Principles of Medicare Seminar
- Beyond the Basics Seminar
- Ask-the-Contractor Teleconference (ACT)

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

**Reimbursement**

**ADJUSTMENT TO PAYMENT UNDER HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) AND AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEM FOR PARTIAL DEVICE CREDIT**

~CMS Special Edition MLN Matters~

MLN Matters Number: SE0732  
 Related CR Release Date: N/A  
 Related CR Transmittal #: N/A

Related Change Request (CR) #: CR5668  
 Effective Date: N/A  
 Implementation Date: N/A

**Provider Types Affected**

Providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries, which are paid under the OPPS or the ASC payment system.

**Provider Action Needed**

**STOP – Impact to You**

This article informs affected providers of how partial credits for medical devices are to be reported and paid under the OPPS and ASC payment systems.

**CAUTION – What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) is implementing a partial device credit policy for hospitals paid under the OPPS and for ASCs paid under the revised ASC payment system (for services furnished on or after January 1, 2008). The partial credit policy applies to the same devices, Ambulatory Payment Classifications (APCs), and ASC procedures to which the no cost or full credit policy applies. Medicare payment will be reduced by 50 percent of the estimated cost of the device (i.e., the device offset percentage) in cases in which the hospital or ASC reports that it received a partial credit of 50 percent or more of the cost of the new device that is being implanted. See the table of applicable APCs at

[http://www.cms.hhs.gov/HospitalOutpatientPPS/01\\_overview.asp](http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp) for the percentage reduction to the payment when the hospital reports a partial credit of 50 percent or more for a specified replacement device (also listed in those tables).

A table of covered ASC surgical procedures to which the partial device credit policy applies is available at [http://www.cms.hhs.gov/ASCPayment/01\\_Overview.asp](http://www.cms.hhs.gov/ASCPayment/01_Overview.asp). Table 58 provides the device offset percentages for the selected OPPS APCs to which the partial device credit policy applies under the revised ASC payment system. ASCs will receive the same amount of payment reduction (in dollars) as a hospital when reporting a partial credit for a new replacement device.

**GO – What You Need to Do**

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

**Background**

In general, CMS includes the full payment for devices with the payment for the service in which the device is used by using only outpatient hospital claims that contain the full cost of medical devices in setting the Medicare payment rates.

In some cases, the cost of the device is a very large proportion of the cost of the procedure on which the APC payment for the procedure is based. Thus, when the provider receives partial credit for the device and therefore, does not incur the full cost of the procedure, it is necessary to adjust the payment so that the payment reflects the reduced cost of the device. This is necessary to:

- Provide an appropriate payment for the service, and
- Ensure that the Medicare beneficiary's co-payment liability is reduced when appropriate.

CMS determined that partial credits occur more commonly than do full credits or no cost devices. In addition, CMS has learned that typical industry practice for some types of devices is to:

- Provide a 50 percent credit in cases of device failure (including battery depletion) under warranty if a device failed before 3 years of use, and
- Prorate the credit over time between 3 and 5 years after the initial device implantation, as the useful life of the device declines.

In these cases, neither the hospital nor ASC is incurring the full cost of the device, although the Medicare payment is calculated based on the full cost of the device.

Effective for services furnished on or after January 1, 2007, CMS implemented a policy to adjust the OPPS payment for procedures assigned to selected APCs when any of the specified devices was implanted in a beneficiary (and remained in the patient at least temporarily) and was furnished either without cost or with full credit for the cost of the device being replaced. See CR5263 (Transmittal 1103, November 3, 2006; <http://www.cms.hhs.gov/transmittals/downloads/R1103CP.pdf>) or related MLN Matters article (MM5263: <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5263.pdf>) and the *Medicare Claims Processing Manual* (Pub.100-4, Chapter 4, Section 61.3; <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>) on the CMS Website.

Hospitals report the occurrence of a no cost or full credit device to CMS by reporting the –FB modifier on the line with the procedure code in which the no cost or full credit device is used when the device is on the list of specified devices to which this policy applies. The lists of affected devices and APCs is located at [http://www.cms.hhs.gov/HospitalOutpatientPPS/01\\_overview.asp](http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp) on the CMS Website.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA; Section 626) requires implementation of a revised ASC payment system no later than January 1, 2008. The revised payment system to be implemented January 1, 2008, is based on the relative payment weights established under the OPPS and many of the payment policies of the OPPS, including the full device credit policy. A special edition MLN Matters article outlining the new ASC payment system is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf> on the CMS Website.

Effective January 1, 2008, CMS is also implementing a partial device credit policy under both the OPPS and the ASC payment system.

Hospitals and ASCs report the occurrence of a partial credit device to CMS by reporting the –FC modifier on the line with the procedure code in which the partial credit device is used when the device is on the list of specified devices to which this policy applies. The devices, APCs, and covered ASC surgical procedures to which the partial device credit policy applies are the same as the devices, APCs, and covered ASC surgical procedures to which the full device credit policy applies (–FB modifier).

For services furnished on or after January 1, 2008, hospitals and ASCs are required to report modifier –FC, with the procedure code for all cases in which:

- The device being implanted is on the list of creditable devices;
- The procedure code in which the device is used is assigned to an APC that is on the list of APCs to which the policy applies in the case of hospitals, or on the list of procedures to which the policy applies in the case of ASCs; and
- The hospital or ASC received a credit of 50 percent or more of the estimated cost of the new replacement device.

The list of devices, APCs, and ASC procedures to which this policy applies is available at [http://www.cms.hhs.gov/HospitalOutpatientPPS/01\\_overview.asp](http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp) on the CMS Website. The reduction to the APC payment amount when the hospital reports a partial credit for the new replacement device is available on that Website as well. An ASC will receive the same amount of payment reduction (in dollars) as a hospital when it reports receiving a partial device credit for a particular procedure.

Remember that both hospitals and ASCs are required to report the –FC modifier with the code for the device implantation procedure, not with the code for the device. Failure to include the proper modifiers on claims as appropriate may result in payment to which the provider is not entitled. If hospitals report the modifier with the device code instead of the procedure code, the claim will be returned.

Because hospitals may not know the amount of credit the manufacturer will provide for the replacement device when the replacement procedure takes place, hospitals will have the option of either: (1) submitting the claim for the device replacement procedure to their Medicare contractor immediately without the FC modifier and then submitting a claim adjustment with the FC modifier at a later date once a credit determination is made; or (2) holding the claim for the device replacement procedure until a determination is made by the manufacturer on the partial credit amount, and submitting the claim with the FC modifier appended to the implantation procedure code if the partial credit is 50 percent or more of the cost of the replacement device.

ASCs have the same two billing options as outlined above for hospitals, but if an ASC chooses Option 1 and bills for a replacement device procedure prior to receiving a manufacturer's credit determination, it must subsequently contact the Medicare contractor regarding a claims adjustment if a credit of 50 percent or more is received.

When hospitals or ASCs use Option 1, they should be mindful that the initial Medicare payment for the procedure involving the replacement device is conditional and subject to adjustment.

Following are some hypothetical examples that illustrate the revised policy:

**OPPS Examples (all payment amounts are hypothetical):**

Example	HCPCS	Description	SI	Units	APC	Unadjusted Payment	Offset Value	New Unadj. Payment
Claim 1: Full Credit or No Cost Replacement Device	33240 FB	Implant ICD	T	1	0107	\$18,000	\$17,000	\$1,000
	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	\$24	---	\$24

Because Claim 1 is being billed as a full credit or no cost replacement device, it receives the full offset of \$17,000.

Claim 2: Partial Credit Replacement Device	33240 FC	Implant ICD	T	1	0107	\$18,000	\$8,500 (\$17,000 x 0.5)	\$9,500 (\$8,500 + \$1,000)
	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	\$24	---	\$24

Because Claim 2 is being billed with a partial credit replacement device, the offset is half of the full offset value.

Claim 3: Multiple Procedure Discount and Partial Credit Replacement Device	33240 FC	Implant ICD	T	1	0107	\$18,000	\$8,500 (\$17,000 x 0.5)	\$9,500 (\$8,500 + \$1,000)
	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	\$24	---	\$24
	35180	Fistula Repair	T	1	0093	\$1,500	---	\$750 (\$1,500 x 0.5)

Because Claim 3 is being billed with a partial credit replacement device, the offset is half of the full offset value. Also, APC 0093 is discounted according to the multiple procedure discount rule. If the payment for APC 0093 were greater than the payment for APC 0107 after discount for the partial device credit, the multiple procedure discount would have been applied to further discount payment for APC 0107. The post-offset payment rate is used in discount determination, rather than the pre-offset payment rate.

Claim 4: Terminated Procedure and Partial Credit Replacement Device	33240 FC and 73	Implant ICD	T	1	0107	\$18,000	\$8,500 (\$17,000 x 0.5)	\$4,750 (((\$8,500 + \$1,000) x 0.5)
	C1721	ICD	N	1	==	---	---	---
	93005	EKG	S	1	0099	\$24	---	\$24
Because Claim 4 is being billed with a partial credit replacement device, the offset is half of the full offset value. Also, APC 0107 is discounted due to the presence of modifier 73, which identifies the service as being terminated prior to the administration of anesthesia or initiation of the procedure.								

Claim 5: FC Modifier on Partial Credit Replacement Device Line	33240	Implant ICD	T	1	0107	I/OCE Edit #75: Incorrect billing of FB or FC modifier
	C1721 FC	ICD	N	1	==	
	93005	EKG	S	1	0099	
Because the FC modifier is located on the line for the device, instead of the procedure used to implant the device, the claim is returned to the provider due to I/OCE Edit #75.						

**ASC Examples (All payment amounts are hypothetical):**

Note: Payment for devices, with the exception of pass through devices, are packaged into payment for the device implantation procedure. In the below examples, the device is not shown as a separate line item on the ASC claim because, in order to ensure appropriate payment, ASCs should not report packaged devices as separate line items on the claim.

Example	HCPSCS	Description	PI	Units	Unadjusted ASC Payment	Offset Value	New Unadj. Payment
Claim 1: Full Credit or No Cost Replacement Device  ASC implants ICD replacement device (procedure 33240, device C1721) and receives full credit or incurs no cost for the replacement device.	33240 FB	Implant ICD	J8	1	\$17,500	\$17,000	\$500

<b>Claim 2:</b> Partial Credit Replacement Device  ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device.	33240 FC	Implant ICD	J8	1	\$17,500	\$8,500  (\$17,000 x 0.5)	\$9,000  (\$8,500 + \$500)
---	----------	-------------	----	---	----------	---------------------------------	----------------------------------

<b>Claim 3:</b> Multiple Procedure Discount and Partial Credit Replacement Device  ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device. ASC also performs an additional procedure (33218), to which the multiple procedure discount applies.	33240 FC	Implant ICD	J8	1	\$17,500	\$8,500  (\$17,000 x 0.5)	\$9,000  (\$8,500 + \$500)
	33218	Electrode Repair	G2	1	\$1000	--	\$500  (\$1000 x 0.5)

<p><b>Claim 4:</b> Terminated Procedure and Partial Credit Replacement Device  ASC brings patient into operating room to implant ICD</p>	33240 FC and 73	Implant ICD	J8	1	\$17,500	\$8,500 (\$17,000 x .5)	\$4,500 (((\$8,500 + \$500) x 0.5)
<p>replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device. ASC terminates the procedure prior to the administration of anesthesia or initiation of the procedure.</p>							

<p><b>Claim 5:</b> FC modifier on Partial Credit Replacement Device Line  ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement device.</p>	33240	Implant ICD	J8	1	<p><b>Incorrect billing</b> because ASCs may not report device HCPCS codes or device charges on a separate line on the claim. Device payment is packaged into payment for the device implantation procedure, and charges for the device should be included in the line-item charge for the device implantation procedure. This bill will not result in accurate payment because there is no ASC payment rate for the device, and the payment for the implantation procedure will be made at the lesser of the ASC charges or the ASC rate.</p>
	C1721 FC	ICD	N1	1	

<p><b>Claim 6:</b> Partial Credit Replacement Device But FC Modifier Not Reported on Procedure Code  ASC implants ICD replacement device (procedure 33240, device C1721) and receives partial credit for the replacement</p>	<p>33240</p>	<p>Implant ICD</p>	<p>J8</p>	<p>1</p>	<p><b>Incorrect billing</b> if partial credit is known at the time of billing. FC modifier should have been appended to the procedure code. If partial credit is unknown at the time of billing and the partial credit is received by the ASC at a later time, the ASC should contact the contractor to request an adjustment.</p>
<p>device, but fails to append the FC modifier to the procedure code.</p>					

**Disclaimer:** The above claim examples are hypothetical only and aim to reflect the pricing concepts, effective January 1, 2008. The rates above do not represent actual payment rates.

**Additional Information**

To view the official instruction (CR5668) on which this article is based, providers may visit <http://www.cms.hhs.gov/transmittals/downloads/R1383CP.pdf> on the CMS Website.

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

## **AMBULANCE FEE SCHEDULE - CONVERSION FACTOR FILE FOR CY 2009 AMBULANCE INFLATION FACTOR**

~ Revised CMS MLN Matters ~

**MLN Matters Number: MM6000 Revised**  
**Related CR Release Date: May 2, 2008**  
**Related CR Transmittal #: R1499CP**

**Related Change Request (CR) #: 6000**  
**Effective Date: January 1, 2009**  
**Implementation Date: October 6, 2008**

**Note:** This article was revised on May 6, 2008, to correct the implementation date of the instruction. That date is October 6, 2008. All other information remains the same.

### **Provider Types Affected**

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

### **What Providers Need to Know**

This article is based on Change Request (CR) 6000, which revises the ambulance fee schedule file layout for Calendar Year (CY) 2009. Specifically, only the conversion factor field is being modified to:

- Remove the sign in the numeric field; and
- Expand the length of the Conversion Factor field.

For claims with dates of service on or after January 1, 2009, Medicare contractor(s) will recognize the new Ambulance Fee Schedule file layout. For claims with dates of service prior to January 1, 2009, Medicare contractors will recognize the current layout.

### **Additional Information**

The official instruction, CR 6000, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1499CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

The ambulance fee schedule public use files are available at

[http://www.cms.hhs.gov/AmbulanceFeeSchedule/02\\_afspuf.asp](http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp) 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.

## **MEDICARE AND THE MEDICAID TRADING PARTNER PROCESS**

WPS has received questions from providers regarding Medicaid trading partners and on-going concerns providers have with Medicare crossover claims. Medicare was informed previously that Medicaid Agencies have an internal provider crosswalk, where they match the Medicare provider number with an internal Medicaid provider number. Medicaid maintains this crosswalk, as the Medicare system only has Medicare information in it. If the Medicaid crosswalk contains

incorrect information, or if the Medicaid provider profile changes, it could affect Medicaid's processing of the claims. We would like to offer the following advice to a provider having an issue with Medicaid crossover claims.

**Scenario 1: No claims are crossing to Medicaid**

**Advice:** If none of your claims are crossing over, check with Medicaid enrollment and verify your provider numbers are set up accurately with Medicaid.

**Example:** Recently an Iowa provider's claims suddenly stopped crossing to Medicaid. She called, and Medicaid said they did not have the claims. Medicare stated we crossed them over and did not get any rejects. Upon further research, Medicaid had changed something on her profile, and Medicaid was not matching her Medicare provider number with their Medicaid number. The claims were simply dropping off the system where their CSR could not see them.

**Scenario 2: Some claims are crossing to Medicaid**

**Advice:** This could be due to selection criteria the Trading Partner has elected. Look for a pattern, like adjusted claims, denied, 100% paid, etc. Remember Medicaid does have selection criteria.

**Scenario 3: Medicare is paying you appropriately, under the correct Medicare provider number.**

**Advice:** Medicare payment information including your Medicare provider number is sent to Trading Partners including Medicaid. If the Trading Partner processes your claims under a different provider number, this is a change made by their system. Medicare does not maintain provider numbers used by Trading Partner in the Medicare system.

**Scenario 4: The person's claims were previously crossing, but now they are not.**

**Advice:** Again, the first question to consider is whether all of the claims have stopped crossing, or just select ones. Most likely, the beneficiary no longer has crossover information associated with their Health Insurance Claim Number (HICN) within Common Working File (CWF). Customer Service Representatives (CSRs) or anyone at Medicare can check to see what each beneficiary has set up for crossover information under this national program. All information is stored within CWF and is loaded by the COBC. CWF will list past and current Trading Partner (TP) details with their start and termination dates.

**Scenario 5: The beneficiary's Trading Partner details are incorrect.**

**Advice:** WPS Medicare cannot update any crossover information. In fact, we are no longer directly involved in the crossover process. The TP files an eligibility file with the COBC. All the beneficiaries, whose claims should be crossed over, are contained in this file. Only the TP can modify their eligibility file and change crossover information related to a beneficiary. Beneficiaries will need to work directly with the TP to be added or have information updated.

## **NATIONAL COORDINATION OF BENEFITS CONTRACTOR (COBC) PROCESS**

The Centers for Medicare & Medicaid Services (CMS) streamlines the claims crossover process to better serve customers. The National crossover process has been in place for over two years, with the final phase, Medigap claim-based, transitioning to the Coordination of Benefits Contractor (COBC) in October 2007. The National crossover process is now complete and includes the following types of insurers: Supplemental insurers, Eligibility based Medigap, Claim-Based Medigap, Tricare, and Medicaid. Going forward, this article will refer to all of these as either a Trading Partner or a Supplemental Insurer. All crossover claims are sent electronically to the COBC. Medicare no longer sends any paper claim as a crossover claim.

Supplemental insurers enter into a Coordination of Benefits Agreement (COBA) with CMS to join the National crossover program. Trading Partners now submit their eligibility file to the National Coordination of Benefits Contractor (COBC). Individual Medicare Contractors no longer receive eligibility files nor send claim files directly to the trading partners. Where previously Medicare contractors had a direct role in the setup and crossover process, the insurer works directly with the COBC and CMS to implement the national program for their company. Since this is a National program, a Trading Partner can now submit a single eligibility file to the COBC, and opt to receive Medicare crossover claims for Part A and Part B, in every state. As in the past, each Trading Partner can opt to exclude certain types of claims (i.e. adjustments or denied claims). As individual contractors process Medicare claims, crossover information is identified at a National level, based upon information supplied by the Trading Partner. All Medicare contractor claims flow through the same data repository that houses this crossover information. Medicare contractors will then forward the claims identified as crossover, to the National Coordination of Benefits Contractor (COBC). The National COBC actually sends the claims to the Trading Partner.

Claims that are sent to the COBC for crossover purposes will have the appropriate Reason/remark code on your remittance advice. (MA18 -Supplemental crossover and MA07-Medicaid crossover.) There are two reasons a claim identified as crossed over on your remittance notice *may not* actually make it to the Trading Partner. Both the COBC and/or the Trading Partner may reject a crossover claim for various reasons. If this occurs, the Medicare contractor will send you a letter, identifying the claim(s) which did not actually cross. You may already be familiar with letters that identify claims previously crossed that were not actually sent due to claim errors or rejections by the supplemental insurer. These letters are generated as a result of a crossover claim reject by either the National COBC or the Trading Partner. The letters may be sent as soon as a week after the claim processed date. If you receive one of these letters, you will need to follow the instructions and submit the secondary claim to the supplemental insurer. The letter also contains important information that identifies the beneficiary, trading partner, ICN and the reason the claim was rejected. Sometimes the cause of the reject may be due to information that came in on the inbound claim to Medicare. If that is the case, you would want to ensure future new claims are corrected, to avoid the same type of crossover rejects. In other cases, the crossover reject may be due to a HIPAA edit at the COBC, or simply a trading partner rejecting the claim because they do not accept certain types of claims. In any case, please forward the claim to the appropriate supplemental insurer.

Effective October 2007, Claim-Based Medigap is also part of the National COBA process. A list of COBA Medigap insurers can be found at

<http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf> on the CMS Website. These are the only Medigap insurer IDs that should be used when filing Medicare claims. Currently there are only nine (9) Medigap trading partners for use on the claim.

Providers should continue to contact their local Medicare carrier with any question related to crossover. If providers have claim issues with a certain Supplemental insurer, CMS has provided customer service contacts at each COBA insurer. The list of contacts is located at <http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf> on the CMS Website.

## **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.

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

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