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**Items of Importance****A/B MAC NEWS #1 - FIRST CONTRACT FOR A PART A/PART B  
MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) TO BE  
AWARDED IN NEAR FUTURE****~CMS MLN Matters Special Edition Article~**

**MLN Matters Number: SE0642**  
**Related CR Release Date: N/A**  
**Related CR Transmittal #: N/A**

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

**Provider Types Affected**

All Medicare physicians, providers, and practitioners that bill Medicare fiscal intermediaries (FIs) or carriers for their services, especially those in the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming

**Background**

Section 911 of the Medicare Modernization Act (MMA) requires the Secretary to implement Medicare Contracting Reform by 2011. The law mandates that CMS conduct full and open competitions, in compliance with general federal contracting rules, for the work currently handled by fiscal intermediaries and carriers in administering the Medicare fee-for-service program.

Medicare Contracting Reform will:

- Improve administrative services within the fee-for-service claims processing environment by reducing the number of contracts, focusing on correct claims payment and creating performance incentives related to timeliness, accuracy, and quality of services to CMS and to providers of services to Medicare beneficiaries;
- Lead to more efficiency and greater accountability among companies performing claims administration and provider education, and services by promoting competition and basing awards on good performance;
- Generate operational savings to the federal government and taxpayers through consolidation and competition of large and high value contracts

With Medicare Contracting Reform, providers of health care in the original Medicare program can expect:

- Better educational and training resources on correct claims submission, Medicare coverage rules, and Medicare payment rules;
- Easier communications with a single A/B MAC serving as the point-of-contact for both Part A and Part B claims administration and payment;
- Increased payment accuracy and consistency in payment decisions resulting from CMS' increased focus on financial management by MACs; and
- An opportunity for input in evaluation of their MAC's performance through satisfaction surveys conducted by CMS.

**Key Points for Providers**

CMS soon will announce the result of the first full and open competition for a Part A/Part B Medicare Administrative Contractor (A/B MAC) conducted as part of the agency's Medicare Contracting Reform implementation strategy. This award will be for a single fee-for-service claims processing contract that will combine the workloads for a multi-state jurisdiction currently serviced both by FIs and carriers.

This first A/B MAC award will be for Jurisdiction 3, which includes the states of Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming. Jurisdiction 3 represents three percent of the national fee-for-service Medicare claims volume.

With this contract award, CMS will begin to achieve efficiencies and administrative savings through the consolidation of the traditional cost-reimbursable contracts and by implementing improved contracting processes quickly.

The Request for Proposal (RFP) for the Jurisdiction 3 A/B MAC was released in September 2005. Full implementation of the new contractor is scheduled for July 2007. CMS will work with the current carriers and FIs in Jurisdiction 3, whose contracts will end with the MAC implementation, to ensure a smooth transfer of records and information to the new Jurisdiction 3 A/B MAC.

The carriers and FIs whose contracts will end are Montana Blue Cross Blue Shield, Wyoming Blue Cross, Arizona Blue Cross, and Noridian Administrative Services. CMS recognizes with gratitude the strong commitment by these corporations to serving the Medicare program for more than 40 years.

The Jurisdiction 3 A/B MAC contract award will be the first of 15 A/B MAC contracts. Each of these contracts will be for the administration of both the Medicare Part A and Part B benefits in a specified geographic jurisdiction of the country. (See the *Additional Information* section of this article for the web page containing a map showing the 15 jurisdictions.) All 15 contracts are to be awarded, and all A/B MACs are to be operational, by October 2011.

CMS has extensive experience in overseeing the successful transfer of Medicare claims processing work from one contractor to another. The agency is committed to ensuring that the implementation of the new A/B MAC environment will be as seamless as possible for the Medicare providers and beneficiaries.

CMS will devote full resources and manage the A/B MAC contract implementation so as to ensure continuity, accuracy, and timeliness in claims processing and issuance of payments. In Jurisdiction 3, CMS plans to implement the new A/B MAC contract by transferring the claims processing workload from the current contractors incrementally (rather than all at once) to ensure that neither providers nor beneficiaries will be adversely affected.

**Additional Information**

Information on the Jurisdiction 3 A/B MAC procurement, including the scope of work to be performed, is available on the Federal Business Opportunities web site at <http://www1.fbo.gov/spg/HHS/HCFA/AGG/CMS%2D2005%2D0016/Attachments.html>

A map displaying the 15 A/B MAC jurisdictions is available on the Medicare Contracting Reform web site at

[http://www.cms.hhs.gov/MedicareContractingReform/05\\_A\\_BMACJurisdictions.asp#TopOfPage](http://www.cms.hhs.gov/MedicareContractingReform/05_A_BMACJurisdictions.asp#TopOfPage) on the CMS web site. Individual fact sheets and data on each jurisdiction are also available there.

Suppliers may want to consult *MLN Matters* article SE0628 to see how Medicare Contracting Reform affects durable medical equipment regional carriers (DMERCs). That article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0628.pdf> on the CMS web site.

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

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

Thursday, August 10, 2006, 8:00 – 10:00 a.m. CT

Thursday, August 24, 2006, 8:00 – 10:00 a.m. CT

During these times, the IVR will continue to be available for your use. Thank you for your patience and for allowing us this chance to serve you better.

## **INSTRUCTIONS FOR PROVIDER NOTIFICATION – REMINDER TO ENUMERATE; COUNTDOWN HAS BEGUN**

Countdown has begun; do you have your NPI? Don't risk disruption to your cash flow – Get your NPI now! National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. **Every** healthcare provider needs to get an NPI! Learn more about NPI and how to apply by visiting <http://www.cms.hhs.gov/NationalProvdentStand/> on the CMS website. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A Countdown Clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at <http://www.wedi.org/npioi/index.shtml> on the web.

## **INVALID DIAGNOSIS CODE EDITING FOR CMS-1500 CLAIM FORM**

To edit diagnosis (ICD-9) codes accurately for validity, Medicare systems were updated to apply date range edits beginning October 1, 2002. Effective April 1, 2005, pre-pass editing was implemented to prevent invalid ICD-9 codes from being processed and forwarded to the

Coordination of Benefits trading partners. The April 2005 implementation was specific to electronic claims. For more information about the April 2005 update, see the following web site: <http://www.cms.hhs.gov/transmittals/Downloads/R326CP.pdf>

For claims processed July 31, 2006 and after for any date of service, this diagnosis editing will extend to claim submissions on the CMS 1500 form. If any of the submitted diagnosis codes are invalid, the entire claim will be rejected and returned as unprocessable.

HIPAA rules require Medicare ensures submitted diagnosis codes are HIPAA-compliant, especially because these diagnosis codes are passed on to other payers under Medicare's Coordination of Benefits processes. To be compliant, the diagnosis code must be valid on the date for which it is reported.

Providers should ensure their billing staff know the rules for submitting diagnosis codes for Medicare claims. Only diagnosis codes that are in compliance with HIPAA should be submitted on Medicare claims.

**MEDICARE CONTRACTOR ANNUAL UPDATE OF THE  
INTERNATIONAL CLASSIFICATION OF DISEASES, NINTH  
REVISION, CLINICAL MODIFICATION (ICD-9-CM)  
~CMS MLN Matters~**

**MLN Matters Number: MM5142**  
**Related CR Release Date: June 23, 2006**  
**Related CR Transmittal #: R990CP**

**Related Change Request (CR) #: 5142**  
**Effective Date: October 1, 2006**  
**Implementation Date: October 2, 2006**

**Provider Types Affected**

Physicians, suppliers, and providers billing Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs))

**Provider Action Needed**

**STOP – Impact to You**

Medicare has issued the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9- CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2006, as well as discharges on or after October 1, 2006, for institutional providers.

**CAUTION – What You Need to Know**

An ICD-9-CM code is required for all professional claims, e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologists, ambulatory surgical centers (ASCs), and for all institutional claims, but is **not required** for ambulance supplier claims.

**GO – What You Need to Do**

Be ready to use the updated codes on October 1, 2006. Please refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

**Background**

This instruction is a reminder that Medicare carriers, DMERCs, FIs, and RHHIs will use the annual *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for:

- Dates of service on or after October 1, 2006; and
- Discharges on or after October 1, 2006 for institutional providers



Effective for dates of service on and after October 1, 2004, CMS no longer provided a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR3094, dated February 6, 2004 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3094.pdf> on the CMS web site).

**Implementation**

The implementation date for this instruction is October 2, 2006.

**Additional Information****Publication of ICD-9-CM Codes**

- The Centers for Medicare & Medicaid Services (CMS) places the new, revised, and discontinued codes at [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07\\_summarytables.asp#TopOfPage](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage) on the CMS web site. The update should be available at this site in June.
- The updated codes can also be viewed at the National Center for Health Statistics (NCHS) web site at: <http://www.cdc.gov/nchs/icd9.htm>. This posting should be available at this site in June.
- Providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service). Chapter 23 may be accessed at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS web site.

To view CR5142, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI, regarding changes mentioned in this article. CR5142 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R990CP.pdf> on the CMS web site.

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

## **NEW ZIP CODE NOW INCLUDED IN THE CHIROPRACTIC SERVICES DEMONSTRATION AREA**

Effective June 13, 2006, the Chiropractic Demonstration area has been expanded to include ZIP code 60502 in Aurora, Illinois. Please visit our Chiropractic Services Demonstration page (<http://www.wpsmedicare.com/provider/chiro-demo-links.shtml>) for more information about this demonstration project. Sign up for our Chiropractic e-News messages to keep updated on information about the Chiropractic Demonstration and other information of benefit to chiropractors.

## **NPI ALERT: NPPES DOWNTIME**

**NPI ALERT!** The National Plan and Provider Enumeration System (NPPES) will be down for scheduled maintenance on August 2nd and 3rd, and will return to operation on August 4th after 8:00 a.m., Eastern Time.

## **PROCESSING ALL DIAGNOSIS CODES REPORTED ON CLAIMS SUBMITTED TO CARRIERS**

Within the December 2005 *Communiqué*, WPS Medicare inadvertently omitted business requirement 4097.4. That Requirement was:

CWF shall process and maintain all diagnosis codes reported, including all eight on the header record, on a claim by a carrier for the HUBC.

We apologize for any inconvenience this may have caused. To view this full directive, please go to the following WPS Medicare Website

[http://www.wpsmedicare.com/provider/pdfs/diag\\_code\\_process.pdf](http://www.wpsmedicare.com/provider/pdfs/diag_code_process.pdf)

## **RULES GOVERNING PROVIDER/CLEARINGHOUSE PROTECTION OF MEDICARE BENEFICIARY ELIGIBILITY INFORMATION**

~CMS MLN Matters~

**MLN Matters Number: MM5138**  
**Related CR Release Date: June 23, 2006**  
**Related CR Transmittal #: R991CP**

**Related Change Request (CR) #: 5138**  
**Effective Date: July 24, 2006**  
**Implementation Date: July 24, 2006**

### **Provider Types Affected**

Physicians, providers, suppliers, and clearinghouses who bill Medicare fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs), and who use the HIPAA 270/271 beneficiary eligibility transaction data in a real-time environment via the Centers for Medicare & Medicaid Services (CMS) AT&T communication Extranet

**Background**

CMS is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)

This article is a reminder to physicians/providers/suppliers of the importance of protecting Medicare beneficiary information and to use it only for authorized purposes. Be sure all your representatives and employees who have authorized access to this information are aware of the importance of protecting that information as well.

**Key Points of CR5138**

Change Request (CR) 5138 reiterates the responsibilities of users in obtaining, disseminating, and using beneficiary's Medicare eligibility data. The following key points outline those responsibilities:

**EDI Enrollment**

The Medicare electronic data interchange (EDI) enrollment process must be executed by each physician/provider/supplier that submits/receives EDI either directly to or from Medicare or through a third party, such as a clearinghouse.

Each physician/provider/supplier that uses EDI, either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare, must sign the EDI Enrollment Form and submit it to the carrier, DMERC, or FI with whom EDI transactions will be exchanged before any transaction is conducted.



Physicians/providers/suppliers should remember that they agreed to use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of information are authorized and all beneficiary-specific data is protected from improper access. Acting on behalf of the beneficiary, physicians/providers/suppliers/users of Medicare data are expected to use and disclose protected health information according to the CMS regulations. The HIPAA Privacy Rule mandates the protection and privacy of all health information.

**Authenticating Data Elements for HIPAA 270/271 Eligibility Data**

Authenticating data elements for HIPAA 270/271 Eligibility Data must be provided by the inquirer (physician, provider, supplier, or other authorized third party) prior to the release of any beneficiary-specific eligibility information and must include:

- Beneficiary last name (must match the name on the Medicare card);
- Beneficiary first name or first initial (must match the information on the Medicare card);
- Assigned Medicare Claim Number (also referred to as the Health Insurance Claim Number (HICN) including both alpha and numerical characters; and
- Date of birth.

**Medicare Beneficiary as First Source of Health Insurance Eligibility Information**

The Medicare beneficiary should be your first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare beneficiary, remind them to bring, on the day of their appointment, all health insurance cards showing their health insurance

coverage. This will not only help you determine who to bill for services rendered, but also provide you with the proper spelling of the beneficiary's first and last name and identify their Medicare Claim Number as reflected on the Medicare Health Insurance card. It is important to use the name as shown on the Medicare card.

If the beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, encourage them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-808-0772 to request a replacement Medicare Health Insurance card from RRB.

**Authorized Purposes for Requesting Medicare Beneficiary Eligibility Information**

In conjunction with the intent to provide health care services to a Medicare beneficiary, authorized purposes include the following:

- Verify eligibility for Part A or Part B of Medicare;
- Determine beneficiary payment responsibility with regard to deductible/coinsurance;
- Determine eligibility for services such as preventive services;
- Determine if Medicare is the primary or secondary payer;
- Determine if the beneficiary is in the original Medicare plan or a Part C plan (Medicare Advantage); and
- Determine proper billing.



Medicare eligibility data is only to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

In order to obtain access to eligibility data, as a physician/provider/supplier you will be responsible for the following:

- Before you request Medicare beneficiary eligibility information and at all times thereafter, you will ensure sufficient security measures to associate a particular transaction with the particular employee.
- You will cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry.
- You will promptly inform CMS or one of CMS's contractors (your carrier/DMERC/RHHI/FI) in the event you identify misuse of "individually-identifiable" health information accessed from the CMS database.
- Each eligibility inquiry will be limited to requests for Medicare beneficiary eligibility data with respect to a patient currently being treated or served by you, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

**Note:** Medicare health benefit beneficiary eligibility inquiries are monitored. Providers identified as demonstrating aberrant behavior (e.g., high inquiry error rate or high ratio of eligibility inquiries to claims submitted) may be contacted to verify proper use of the system, made aware of educational opportunities, or when appropriate referred for investigation of possible fraud and abuse or violation of HIPAA privacy law.

**Criminal Penalties' Provisions**

Remember that a number of statutes provide for severe criminal and civil penalties for misuse of information, including:

**1. Trading Partner Agreement Violation**

42 U.S.C. 1320d-6 authorizes criminal penalties against a person who, “knowingly and in violation of this part ... (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person.”

Offenders shall “(1) be fined not more than \$50,000, imprisoned not more than 1 year, or both; (2) if the offense is committed under false pretenses, be fined not more than \$100,000, imprisoned not more than 5 years, or both; and (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than \$250,000, imprisoned not more than 10 years, or both.”

**2. False Claim Act**

Under the False Claims Act, **31 U.S.C. §§ 3729-3733**, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government’s damages plus civil penalties of \$5,500 to \$11,000 per false claim.

**3. Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

HHS may impose civil money penalties on a covered entity of \$100 per failure to comply with a Privacy Rule requirement. That penalty may not exceed \$25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year...A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of \$50,000 and up to one-year imprisonment. The criminal penalties increase to \$100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to \$250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. Criminal sanctions will be enforced by the Department of Justice.

**Implementation**

The implementation date for this instruction is July 24, 2006.

**Additional Information**

CR5138, the official instructions issued to your Medicare FI, carrier, RHHI, and DMERC regarding this change, can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R991CP.pdf> on the CMS web site. The revised section Chapter 31—ANSI X12N Formats Other than Claims or Remittance of the Medicare Claims Processing Manual is attached to CR5138.

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

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

**THERAPY CAPS EXCEPTION PROCESS**  
~CMS MLN Matters~

**MLN Matters Number: MM4364 Revised**  
**Related CR Release Date: February 15, 2006**  
**Related CR Transmittal #: R52BP, R140PI, R855CP**

**Related Change Request (CR) #: 4364**  
**Effective Date: January 1, 2006**  
**Implementation Date: No later than**  
**March 13, 2006**

**Note:** This article was revised on July 3, 2006, to modify the transmittal number and Web address for the change made to the *Medicare Benefit Policy Manual*. All other information remains the same.

**Provider Types Affected**

Providers, physicians, and non-physician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers) under the Part B benefit for therapy services

**Key Points**

- Effective January 1, 2006, a financial limitation (therapy cap) was placed on outpatient rehabilitation services received by Medicare beneficiaries. These limits apply to outpatient Part B therapy services from all settings except the outpatient hospital (place of service code 22 on carrier claims) and the hospital emergency room (place of service code 23 on carrier claims). Outpatient rehabilitation services include:
  - **Physical therapy** - including outpatient speech-language pathology: Combined annual limit for 2006 is \$1,740; and
  - **Occupational therapy** - annual limit for 2006 is \$1,740.
- In 2006 Congress passed the Deficit Reduction Act (DRA), which allows the Centers for Medicare & Medicaid Services (CMS) to grant, at the request of the individual enrolled under the Part B benefit or a person acting on behalf of that individual, **exceptions to therapy caps for services provided during calendar year 2006**, if these services meet certain qualifications as medically necessary services (Section 1833(g) (5) of the Social Security Act).
- The exception process may be accomplished automatically for certain services, and by request for exception, with the accompanied submission of supporting documentation, for certain other services.
- Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if those beneficiaries:
  - Meet specific conditions and complexities listed in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, (as revised by CR4364) for exception from the therapy cap; or
  - Meet specific criteria for exception, in addition to those listed in the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 5, where the Medicare contractor has published additional exceptions, when the contractor believes, based on the strongest evidence available, that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.

- Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

You may submit a request, with supporting documentation, for a specific number (not to exceed 15 future treatment days for each discipline of occupational therapy, physical therapy, and speech language pathology services) of additional therapy visits.

- Please refer to the *Additional Information* section of this article for more detailed information about the therapy caps exception process.

### Background

Financial limitations on Medicare-covered therapy services (therapy caps) were initiated by the Balanced Budget Act of 1997. These caps were implemented in 1999 and for a short time in 2003. Congress placed moratoria on the limits for 2004 and 2005.

The moratoria are no longer in place, and caps were implemented on January 1, 2006. Congress has provided that exceptions to these dollar limitations of \$1,740 for each cap in 2006 may be made when provision of additional therapy services is determined to be medically necessary.

### Additional Information

#### Billing Guidelines

- **KX Modifier:** You must include a KX modifier on the claim identified as a therapy service with a GN, GO, GP modifier when a therapy cap exception has been approved, or it meets all the guidelines for an automatic exception. This allows the approved therapy services to be paid, even though they are above the therapy cap financial limits.
- **Separate requests:** You must submit separate requests for exception from the combined physical therapy and speech language pathology cap and from the occupational therapy cap. In general, requests for exception from the therapy cap should be received **before** the cap is exceeded because the patient is liable for denied services based on caps.
- **Subsequent requests during the same episode of care:** To request therapy services in addition to those previously approved, you must submit a request for approval along with supporting documentation for a specific number of additional therapy treatment days, not to exceed 15, **each time** the beneficiary is expected to require more therapy days than previously approved. It is appropriate to send documentation for the entire planned episode of care if the episode exceeds the 15 treatment days allowed.
- When those additional visits are approved as reasonable and necessary based on the documentation you submit, an exception to the therapy cap will be approved and bills may be submitted using the KX modifier. If the contractors have reason to believe that fraud, misrepresentation, or abusive billing has occurred, they have the authority to review claims and may deny claims even though prior approval was granted.

**ICD-9 Codes That Qualify for the Automatic Therapy Cap Exception Process Based Upon Clinical Condition or Complexity**

The CR4364 transmittal that contains these codes is the one that revises the *Medicare Claims Processing Manual*, available at

<http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> on the CMS web site. You may wish to bookmark that link so you may easily reference these codes.

**Documentation**

Providers who believe that it is medically necessary for their patient to receive therapy services in excess of the therapy cap limitations (and the patient does not fall into the automatically excepted categories mentioned above) must submit documentation, sufficient to support medical necessity, in accordance with the revised *Medicare Benefit Policy Manual*, Pub.100-02, Chapter 15, Section 220.3; and the revised *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 5, Sections 10.2 and 20, with the request for treatment days in excess of those payable under the therapy cap.

These manual sections contain important definitions, as well as examples of acceptable documentation, and are attached to CR4364. CR4364 is in three parts, one each for the revised manuals, i.e.:

- The *Medicare Benefit Policy Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf> on the CMS web site;
- The *Medicare Claims Processing Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf>; and
- The *Medicare Program Integrity Manual*, located at <http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf> on the CMS web site.

The following types of documentation of therapy services are expected to be submitted in response to any requests for documentation, unless the contractor requests otherwise:

1. **Evaluation and Certified Plan of Care** - 1-2 documents.
2. **Certification** - Physician/NPP approval of the plan required 30 days after initial treatment-or delayed certification.
3. **Clinician-signed Interval Progress Reports** (when treatment exceeds 10 treatment days or 30 days) – These must be sufficient to explain the beneficiary’s current functional status and need for continued therapy with the request for therapy visits in excess of those payable under the therapy cap. This is not required to be provided daily in treatment encounter notes or for an incomplete interval when unexpected discontinuation of treatment occurs.
4. **Treatment Encounter Notes** – The Treatment Encounter Note is acceptable if it records the name of the treatment; intervention, or activity provided; the time spent in services represented by timed codes; the total treatment time; and the identity of the individual providing the intervention. These may substitute for Progress Reports if they contain the requirements of interval progress reports at least once every 10 treatment days or once in the interval.
5. For therapy caps exceptions purposes, **records justifying services over the cap**, either included in the above or as a separate document.

Please see the revised Section 220.3 of the *Medicare Claims Processing Manual* located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> for more details about the types of documentation required and explanations of what that documentation should contain.

When reviewing documentation, Medicare contractors will:

- Consider the entire record when reviewing claims for medical necessity so that the absence of an individual item of documentation does not negate the medical necessity of a service when the documentation as a whole indicates the service is necessary;
- Consider a dictated document to be completed on the day it is dictated if the identity of the qualified professional is included in the dictation;
- Consider a document an evaluation or re-evaluation (for documentation purposes, but not necessarily for billing purposes) if it includes a diagnosis, subjective and/or objective condition, and prognosis. This information may be included in or attached to a plan. The inclusion of this information in the documentation does not necessarily constitute a billable evaluation or reevaluation unless it represents a service; and
- Accept a referral/order and evaluation as complete documentation (certification and plan of care) when an evaluation is the only service provided by a provider/supplier in an episode of treatment.

### Medicare Contractor Decisions

If determined to be medically necessary, your Medicare contractor will grant additional treatment days for occupational therapy, physical therapy, and speech language pathology.

It is preferable that the request for exception be received before the therapy cap is actually exceeded. However, your Medicare contractor will approve additional therapy treatment days retroactively if they are deemed medically necessary, in the exceptional circumstance where a timely request for exception from the therapy cap is not received before the therapy cap is surpassed.

Your Medicare contractor may also approve additional therapy visits already provided when the request is accompanied by documentation supporting medical necessity of the services.

Please note that outpatient therapy services appropriately provided by assistants or qualified personnel will be considered covered services only when the supervising clinician personally performs or participates actively in at least one treatment session during an interval of treatment. Claims for services above the cap that are not deemed medically necessary will be denied as a benefit category denial.



If your Medicare contractor does **not** make a decision within 10 business days of receipt of the request and documentation, then the decision for therapy cap exception is considered to be deemed **approved** as medically necessary for the number of future visits requested (not to exceed 15).

### Notification

You will be notified as to whether or not an exception to the cap has been made (and if so, for how many additional future visits) as soon as practicable once the contractor has made its decision.

This notification is not an initial determination and, therefore, does not carry with it administrative appeal rights. For examples of the standard letters from the *Medicare Program Integrity Manual*, 100-8, Section 3.3.1.2, please refer to the Attachments to CR4364. The examples include:

- Letter #1 - Approved
- Letter #2 - Negative Decision-Medical Necessity
- Letter #3 - Denied-Insufficient Documentation

### **Revised Medicare Summary Notice (MSN) Messages**

The MSN messages (17.13; 38.18) are revised to inform beneficiaries about the therapy caps and approved medically necessary exceptions. These notices are also part of CR4364.

Once again, there are three transmittals that comprise CR4364. They are:

- The *Medicare Benefit Policy Manual* revision at <http://www.cms.hhs.gov/Transmittals/downloads/R52BP.pdf> on the CMS web site;
- The *Medicare Claims Processing Manual* revision, located at <http://www.cms.hhs.gov/Transmittals/downloads/R855CP.pdf> on the CMS web site;
- The *Medicare Program Integrity Manual* revision, located at <http://www.cms.hhs.gov/Transmittals/downloads/R140PI.pdf> on the CMS web site.

If you have any questions, contact your Medicare contractor at their toll free number, which is available at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

## **YOU WILL BE HAPPY TO KNOW**

The CMS-855 Medicare enrollment applications located on the CMS forms web page can be completed on-line in a PDF fillable format or downloaded and completed by hand. All the CMS 855 forms have been posted to the CMS Forms Internet website

<http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage> (note: the Provider Enrollment website has a reference link "All CMS Forms" which takes you to the main CMS Forms list link above, but does not link directly to each individual form.)

The direct link for each form follows:

CMS 855A (06/06)	<a href="http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf">http://www.cms.hhs.gov/cmsforms/downloads/cms855a.pdf</a>
CMS 855B (06/06)	<a href="http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf">http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf</a>
CMS 855I (06/06)	<a href="http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf">http://www.cms.hhs.gov/cmsforms/downloads/cms855i.pdf</a>
CMS 855R (06/06)	<a href="http://www.cms.hhs.gov/cmsforms/downloads/cms855r.pdf">http://www.cms.hhs.gov/cmsforms/downloads/cms855r.pdf</a>
CMS 855S (06/06)	<a href="http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf">http://www.cms.hhs.gov/cmsforms/downloads/cms855s.pdf</a>

**Comprehensive Error Rate Testing****CERT ERROR FOCUS  
EVALUATION AND MANAGEMENT - CPT 99211**

In recent Communiqué articles, we have focuses on CERT errors received by specific provider specialties. In our continuing effort to increase the awareness of all Medicare providers regarding documentation issues found as a result of CERT reviews, we will now begin to focus on specific services that contribute to our CERT error rate. Our focus this month is on CPT procedure code 99211.

The 2006 Current Procedural Terminology (CPT) manual defines code 99211 as an "Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services."

Analysis of our recent CERT error findings shows that in some cases, this evaluation and management service was billed inappropriately. This resulted in CERT errors assessed for insufficient documentation and refund requests of the Medicare payment for the undocumented services.

Below are examples of the CERT reviewer comments in these cases.

- Injection sheet with beneficiary's name recorded and billing roster submitted for the billed date of service. Submitted is documentation of B12 injection. Missing documentation of a face to face encounter with exchange of clinically relevant information that supports a separate evaluation & management service.
- Need a copy of office notes for [DOS] to support billed services. Submitted lab results of CBC with diff., missing documentation to support billed service of 99211. Missing progress notes or any documentation to support E/M service billed.
- Per CPT 2005 and PUB 100-04, Chapter 12 Â§ 30.6.4, documentation includes PT/INR results for date of service, but no indication of presenting problem by patient or nurse education/counseling needed for 99211 to be medically necessary.
- Need a copy of nurse's notes or some documentation for [DOS] to support billed E/M 99211. Submitted notes for other dates of service and prothrombin time results for billed DOS. Additional documentation not received. Missing documentation to support E/M 99211 examples vital signs, weight, how patient is doing, etc.....
- Per CPT 2005 and IOM 100-4, ch 12, 30.6.1, "Physicians must select the code for the service based upon the content of the service" and goes on to state, "A claim for a service must reflect the service actually performed." Flow sheet contains only the results of the test. There is insufficient documentation to indicate that any E/M service was performed. It would appear that the encounter was exclusively for the purpose of venipuncture. Claim history shows billing for PT lab for same date of service.

- Need documentation of the face-to-face evaluation & management service such as vital signs and/or patient teaching for [DOS] to support billed E/M service. Submitted is a lab report for INR on the billed DOS. Documentation does not indicate the beneficiary is being evaluated for a related problem or symptom and there is no medical evaluation & management of the problem. Documentation does not substantiate the billed E/M service.

Services billed to Medicare under CPT 99211 must be reasonable and necessary for the diagnosis and treatment of an illness or injury. Furthermore, a face to face encounter with a patient consisting of elements of both evaluation and management is required. The evaluation portion is substantiated when the record includes documentation of a clinically relevant and necessary exchange of information between provider and patient. The management portion is substantiated when the record demonstrates an influence on patient care (ex.; medical decision making, patient education, etc.).

CPT 99211 should not be used for:

- Phone calls to patients
- Drawing of blood for laboratory analysis or when performing other diagnostic tests
- Administration of medications when an injection or infusion code is submitted separately

Proper documentation of services billed to Medicare is crucial in order to meet CMS' error rate reduction expectations, and WPS continues to identify problem areas contributing most significantly to our jurisdiction's error rate. It is our expectation that these educational efforts will result in a reductions of errors associated with these problem areas.

For more information regarding the CERT program and other issues related to CERT review findings, please visit our website at <http://www.wpsmedicare.com/provider/cert.shtml>.

## Coverage

### CORRECTION TO CR4136: NEW WAIVED TESTS

~CMS MLN Matters~

**MLN Matters Number: MM5131 Revised**  
**Related CR Release Date: June 23, 2006**  
**Related CR Transmittal #: R988CP**

**Related Change Request (CR) #: 5131**  
**Effective Date: January 1, 2006**  
**Implementation Date: July 24, 2006**

CR5131 corrects an incorrect Current Procedural Code (CPT) mentioned in the third sentence of the second paragraph in the background section of the Recurring Update Notification attachment for CR4136. Only this sentence has been revised. All other information remains as it is written in CR4136.

**Note:** This article was revised on July 11, 2006, to show that the effective date is January 1, 2006 and the implementation date at the top of this page is July 24, 2006. These dates were inadvertently transposed on the original article.

**Provider Types Affected**

All providers and suppliers billing Medicare carriers for laboratory tests

**Background**

CR5131 corrects an incorrect Current Procedural Code (CPT) mentioned in the third sentence of the second paragraph in the background section of the Recurring Update Notification attachment for CR4136.

**Key Points**

This article and CR5131 identifies the correction issued by the Centers for Medicare & Medicaid Services (CMS) regarding the “Waived Tests:”

- CPT code **82271** was **incorrectly listed** in the second paragraph of the background section of the Recurring Update Notification attachment of CR4136 as not requiring a QW modifier. The CPT code should have been **82272** and it does not require a QW modifier.
- All other information that outlines which tests require the “QW modifier” and which do not require the “QW modifier” remains the same as listed in CR4136. (The web address for MLN Matters article MM4136 related to CR4136 is <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4136.pdf> on the CMS web site.)

**Implementation**

The effective date for this instruction was January 1, 2006, and the correction by CR5131 will be implemented on July 24, 2006.

**Additional Information**

The official instruction, CR5131, issued to your Medicare carrier regarding this change can be found at <http://www.cms.hhs.gov/transmittals/downloads/R988CP.pdf> on the CMS web site.

If you have questions, please contact your Medicare carrier at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

**HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)  
CORRECTION FOR THE CAFFEINE HALOTHANE CONTRACTURE  
TEST FOR MALIGNANT HYPERTHERMIA SUSCEPTIBILITY  
~CMS MLN Matters~**

MLN Matters Number: MM5113  
Related CR Release Date: June 16, 2006  
Related CR Transmittal #: R984CP

Related Change Request (CR) #: 5113  
Effective Date: January 1, 2006  
Implementation Date: October 2, 2006

**Provider Types Affected**

Providers billing Medicare carriers for laboratory tests

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

Effective January 1, 2006, you do not have to include a Clinical Laboratory Improvement Amendments (CLIA) number on claims that you submit for HCPCS code 89049 [Caffeine

halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report].

**CAUTION – What You Need to Know**

CR5113 provides that HCPCS code 89049 is not considered a test under CLIA. Therefore, performing this test does not necessitate that a facility have any CLIA certificate, nor require a CLIA number on claims for its use.

**GO – What You Need to Do**

Make sure that your billing staffs are aware that they do not have to include a CLIA number on claims for CHPCS code 89049.

**Background**

The CLIA regulations require a facility to be appropriately certified for each test that it performs. Therefore, laboratory claims are currently edited at the CLIA certificate level to ensure that Medicare and Medicaid only pay for laboratory tests that are performed in facilities with valid, current CLIA certificates.

This being said, CR5113, from which this article is taken, notifies carriers of one HCPCS correction for code 89049 [Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report]. While, currently, HCPCS code 89049 is subject to CLIA edits and has a laboratory certification (LC) code of 610 (histopathology), CR 5113 provides that this HCPCS code is not considered a test under CLIA.

Therefore, effective January 1, 2006, carriers will remove CLIA edits for HCPCS code 89049, including the LC code 610, and will not require a CLIA number on claims submitted by facilities for the HCPCS code 89049.

You should be aware that your carriers are not required to search their files to either retract payment or retroactively pay claims processed before this change is made. However, they will adjust claims brought to their attention.

**Additional Information**

You can find more information about billing for HCPCS code 89049 [Caffeine halothane contracture test (CHCT) for malignant hyperthermia susceptibility, including interpretation and report] by going to CR5113, located at <http://www.cms.hhs.gov/Transmittals/downloads/R984CP.pdf> on the CMS web site.

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

## MEDICARE TELEHEALTH SERVICES UPDATE

~CMS MLN Matters~

MLN Matters Number: MM5122  
Related CR Release Date: July 7, 2006  
Related CR Transmittal #: R997CP and R53BP

Related Change Request (CR) #: 5122  
Effective Date: January 1, 2006  
Implementation Date: August 7, 2006

### Provider Types Affected

Providers who bill Medicare carriers and fiscal intermediaries (FIs) for telehealth services

### Provider Action Needed

#### **STOP – Impact to You**

When billing for telehealth services provided on or after January 1, 2006, do not use current procedure terminology (CPT) codes 99261-99263 (hospital inpatient follow-up consultations) or 99271-99275 (confirmatory consultations). These codes no longer exist, and using them could impact your reimbursement.

#### **CAUTION – What You Need to Know**

The American Medical Association has deleted CPT codes 99261 – 99263 (hospital inpatient follow-up consultations) and codes 99271 - 99275 (confirmatory consultations). Effective January 1, 2006, these CPT codes no longer exist and were removed from the physician fee schedule.

#### **GO – What You Need to Do**

Make sure that your billing staffs are aware that CPT codes 99261- 99263 and 99271-99275 are no longer usable for telehealth services.

### Background

CR5122, from which this article is taken, is issued to alert you that, effective January 1, 2006, the AMA has deleted the following CPT codes:

- 99271 – 99275 (Confirmatory consultation); and
- 99261 – 99263 (Follow-up inpatient consultation).

Thus, the CPT codes that describe these services (hospital inpatient follow-up consultations – 99261 through 99263 and confirmatory consultations – 99271 through 99275) no longer exist.

In response, also effective January 1, 2006, CMS has removed confirmatory consultation and inpatient follow-up consultation from the list of Medicare telehealth services as referenced in the *Medicare Benefit Policy Manual* (Publication 100-02) and the *Medicare Claims Processing Manual* (Publication 100-04). The relevant sections of these Manuals (Publication 100-02, Chapter 15, Section 270.2 [List of Medicare Telehealth Services] and Publication 100-04 Chapter 12, Section 190.3 [List of Medicare Telehealth Services]) have been revised to reflect these policy changes.

As displayed in Table 1 below, office and other outpatient consultations and initial inpatient consultations are included in Medicare telehealth consultations as described by CPT codes 99241 through 99255. The table displays the current Medicare telehealth services and CPT and HCPCS codes.

**Table 1: Current Medicare Telehealth Services and Associated CPT/HCPCS Codes**

Service	CPT/HCPCS Codes
Consultations	99241 - 99255 as of January 1, 2006
Office or other outpatient visits	99201 - 99215
Individual psychotherapy	90804 - 90809
Pharmacologic management	90862
Psychiatric diagnostic interview examination	90801
End Stage Renal Disease (ESRD) related services	G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318
Individual Medical Nutrition Therapy	G0270, 97802, and 97803

**Additional Information**

You can find more information about current Medicare telehealth services and the associated CPT/HCPCS codes in CR 5122, located at

<http://cms.hhs.gov/Transmittals/downloads/R53BP.pdf> for the changes to Publication 100-02, Chapter 15, Section 270.2 (List of Medicare Telehealth Services) and at

<http://www.cms.hhs.gov/Transmittals/downloads/R997CP.pdf> for the changes to Publication 100-04, Chapter 12, Section 190.3 (List of Medicare Telehealth Services).

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

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

**MMA - PAYMENT FOR ISLET CELL TRANSPLANTATION IN NIH-SPONSORED CLINICAL TRIALS**  
~CMS MLN Matters~

**MLN Matters Number: MM5140**  
**Related CR Release Date: June 16, 2006**  
**Related CR Transmittal #: R986CP**

**Related Change Request (CR) #: 5140**  
**Effective Date: May 1, 2006**  
**Implementation Date: July 31, 2006**

**Provider Types Affected**

Physicians, suppliers, and providers billing Medicare contractors (carriers and fiscal intermediaries (FIs))

**Provider Action Needed**

**STOP – Impact to You**

The Centers for Medicare & Medicaid Services (CMS) is updating the modifier used for claims for islet cell transplantation and for routine follow-up care related to the transplantation in NIH-sponsored clinical trials.

**CAUTION – What You Need to Know**

Please note that effective for islet cell transplantation and routine follow-up services related to the islet cell transplantation on or after **May 1, 2006, the QV modifier is no longer valid. The QR modifier** (item or service provided in a Medicare-specified study) **will replace the QV modifier for services on or after May 1, 2006.**

### GO – What You Need to Do

Refer to the *Background* and *Additional Information* sections of this article for more information. Be ready to use the new QR modifier for payment of islet cell transplantation and routine follow-up care when appropriate.

### Background

As a result of section 733 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (P.L. 108-173), for services performed/ discharges on or after October 1, 2004, Medicare covers islet cell transplantation for patients with Type I diabetes who are participating in an NIH-sponsored clinical trial. The islet cell transplantation may be done alone or in combination with kidney transplantation.

### Additional Information

Effective for services on or after **May 1, 2006**, Medicare will **accept the QR modifier** for payment on claims for patients who participate in an NIH-sponsored clinical trial in conjunction with:

- Islet cell transplantation; and
- Routine follow-up care related to islet cell transplantation, when:
  - Performed in an outpatient department of a hospital; and
  - Billed on type of bill (TOB) 13X or 85X.

For additional information, please refer to MM3385, “MMA-Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial,” which can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3385.pdf> on the CMS web site. Also, refer to the *Medicare National Coverage Determinations Manual*, publication 100-03, Chapter 1, Part 4, Section 260.3.1 “Islet Cell Transplantation in the Context of a Clinical Trial (Effective October 1, 2004),” located at [http://www.cms.hhs.gov/manuals/downloads/ncd103c1\\_Part4.pdf](http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf) on the CMS web site.

CR5140 is the official instruction issued to your Medicare carrier or FI regarding changes mentioned in this article, and the manual attachment to CR5140, the *Medicare Claims Processing Manual*, Publication 100-4, Chapter 32, “Billing Requirements for Special Services,” Section 70 “Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial.” CR5140 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R986CP.pdf> on the CMS web site.

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

## NON-AUTOLOGOUS BLOOD DERIVED PRODUCTS FOR CHRONIC NON-HEALING WOUNDS

~CMS MLN Matters~

MLN Matters Number: MM5123  
 Related CR Release Date: June 9, 2006  
 Related CR Transmittal #: R977CP and R59NCD

Related Change Request (CR) #: 5123  
 Effective Date: April 27, 2006  
 Implementation Date: July 10, 2006

### Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs) and/or regional home health intermediaries (RHHIs) for chronic non-healing wound related services furnished to Medicare beneficiaries.

### Impact on Providers

This article is based on Change Request (CR) 5123 which instructs Medicare contractors (carriers, FIs, and RHHIs) that claims submitted for **becaplermin**, a self-administered, non-autologous growth factor for chronic, non-healing, subcutaneous wounds **will remain non-covered**.

Becaplermin, Healthcare Common Procedure Coding System (HCPCS) **S0157**, is nationally non-covered because it is usually self-administered by the patient.

### Background

After releasing a national non-coverage determination (NCD) on Autologous Blood-Derived Products for Chronic Non-Healing Wounds in December of 2003, an error was printed in the NCD Manual.

To correct that error, the Centers for Medicare & Medicaid Services (CMS) is revising section 270.3 of the *National Coverage Determinations (NCD) Manual* (Publication 100-03, Chapter 1, Part 3, "Blood-Derived Products for Chronic Non-Healing Wounds") to accurately reflect the payment policy for non-autologous blood derived products for chronic non-healing wounds, effective April 27, 2006.

In this revision, the following sentence is being deleted:

"Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous non-healing wounds, will remain at local carrier discretion. Becaplermin is approved by the Food and Drug Administration."

The correct statement should read:

"Coverage for treatments utilizing becaplermin, a non-autologous growth factor for chronic non-healing subcutaneous wounds, **will remain nationally non-covered** under Part B based on §1861(s)(2)(A) and §1861(s)(2)(B) because this product is usually self-administered by the patient."

While CMS makes every effort to provide accurate and complete information, the erroneous coverage statement printed in the NCD Manual regarding nonautologous blood-derived products was not intended, and is not part of the Decision Memorandum (DM) posted on

December 15, 2003. Non-autologous blood-derived products are not in the same class as the products referred to in the December 15, 2003, DM.



NCDs are binding on all carriers, FIs, quality improvement organizations, health maintenance organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR 405.1060)(a)(4), effective May 1, 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).

#### Additional Information

CR5123 is the official instruction issued to your Medicare carrier or FI/RHHI regarding changes mentioned in this article. There are two transmittals for CR5123. Transmittal 59, containing the NCD revision, is available at <http://www.cms.hhs.gov/Transmittals/downloads/R59NCD.pdf> on the CMS web site. Transmittal 977, containing the Medicare claims processing instructions, is at <http://www.cms.hhs.gov/Transmittals/downloads/R977CP.pdf> on the CMS web site.

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

## NON-PHYSICIAN PRACTITIONER (NPP) PAYMENT FOR CARE PLAN OVERSIGHT (CPO) ~CMS MLN Matters~

MLN Matters Number: MM4374  
Related CR Release Date: June 23, 2006  
Related CR Transmittal #: R993CP

Related Change Request (CR) #: 4374  
Effective Date: January 1, 2005  
Implementation Date: October 2, 2006

#### Provider Types Affected

Non-Physician Practitioners (NPPs) and suppliers billing Medicare carriers for home health CPO services

#### Provider Action Needed

##### **STOP – Impact to You**

This article is based on Change Request (CR) 4374 which clarifies the policy associated with NPPs billing for physician home health care plan oversight (CPO).

##### **CAUTION – What You Need to Know**

The manual revision in CR4374 effectuates a revision to the policy that the same provider that signs the plan of care does not have to be the same provider that bills for physician care plan oversight. Effective January 1, 2005, NPPs must meet certain conditions to be eligible for payment for home health care plan oversight services even though they may not sign the plan of care. This CR clarifies those conditions.

CR4374 clarifies the policy associated with NPPs billing for physician hospice CPO and clarifies the HCPCS codes for CPO. It temporarily waives the requirement to include the Home Health

Agency (HHA) or hospice provider number on a CPO claim since there is currently no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number. CR4374 also states that the physician who bills CPO must be the same physician who signs the plan of care.

**GO – What You Need to Do**

See the *Background* section of this article for further details regarding these changes.

**Background**

Physician Care Plan Oversight (CPO) is paid under the Medicare Physician Fee Schedule (MPFS), and due to a provision in the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 12, Section 180), Non-Physician Practitioners (NPPs) have been prohibited from billing for this service in a home health setting.

The current manual section (Section 180) provides that the physician who signs the plan of care for home health services must be the same person that bills for physician CPO. Since only a physician can sign the plan of care for home health services, NPPs have been unable to bill for physician home health CPO.

Under the Final Physician Fee Schedule Rule, published in the *Federal Register* on November 15, 2004, nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs), practicing within the scope of state law, may bill for CPO.

The intention of the Centers for Medicare & Medicaid Services (CMS), as outlined in later portions of the *Medicare Claims Processing Manual*, was to allow NPPs to bill for physician CPO within their state scope of practice. The current inconsistency in Section 180 will not allow NPPs to be paid for this service.

CR4374 revises the policy that states that the same provider that signs the plan of care does not have to be the same provider that bills for physician CPO.

In addition, the *Medicare Claims Processing Manual* (Publication 100-04, Chapter 11, Section 40.1.3.1) has been revised to clarify CPO billing requirements for beneficiaries who have elected the hospice benefit.



Currently there is no place on the HIPAA standard ASC X12N 837 professional format to specifically include the HHA or hospice number required for a CPO claim. For this reason, the requirement to include the HHA or hospice provider number on a CPO claim is temporarily waived until a new version of this electronic standard format is adopted under HIPAA and includes a place to provide the HHA and hospice provider numbers for CPO claims.

For services furnished on or after January 1, 2005, your carrier will allow NPPs to bill for physician home health CPO even though they cannot 1) certify a patient for home health services and 2) sign the plan of care.

For beneficiaries who have elected the hospice benefit, physicians or NPPs who have been identified by a beneficiary to be his or her attending physician may submit claims for CPO.

**Note:** For physicians or NPs who are employed by a hospice agency, CPO is not separately payable.

CR4374 instructs your carrier to:

- Pay for physician home health CPO services (HCPCS code G0181) when billed by an NPP for dates of service on or after January 1, 2005;
- Pay for physician home health plan CPO services (HCPCS code G0181) no more than once per calendar month per patient;
- Pay for physician hospice CPO services (HCPCS code G0182 with GV modifier) when billed by a nurse practitioner for dates of service on or after January 1, 2005;
- Pay for physician home health CPO services under HCPCS code G0182 no more than once per calendar month per patient;
- Re-open and adjust any erroneously denied claims with practitioner CPO services brought to their attention; and
- Not require the provider numbers of the home health agency or hospice for CPO claims effective for dates of service on or after January 1, 2005.

### Implementation

The implementation date for CR4374 is October 2, 2006.

### Additional Information

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R993CP.pdf> on the CMS web site.

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

## Policy

### CARRIER OPEN LOCAL COVERAGE DECISIONS MEETING

Wisconsin Physicians Service (WPS), the Medicare Part B contractor for Wisconsin, Illinois, Michigan, and Minnesota, will hold an open Local Coverage Decisions (LCD) meeting for persons wishing to provide input concerning LCDs that are currently in the development process.

The next Open Policy Meeting will be held **Thursday, August 10, 2006, at 1:00 p.m. CST, 2:00 p.m. EST.**

Details on the meeting are on the WPS Website at:

[http://www.wpsmedicare.com/policies/open\\_mtg\\_on\\_draftpol.shtml](http://www.wpsmedicare.com/policies/open_mtg_on_draftpol.shtml)

## INJECTION LIST UPDATE

**Editor's Note:** This an update to the injection list found on the WPS Medicare Website at the below listed address.

<http://www.wpsmedicare.com/policies/injlist.pdf>

**Revision Effective Date:**

06/30/2006 FDA approval date

Ranibizumab (Lucentis™) (J3490) is covered for "wet" macular degeneration ICD-9 ICD-9 code 362.52.

## LUMBAR ARTIFICIAL DISC REPLACEMENT (LADR)

~CMS MLN Matters~

**MLN Matters Number: MM5057**

**Related CR Release Date: June 23, 2006**

**Related CR Transmittal #: R60NCD and R992CP**

**Related Change Request (CR) #: 5057**

**Effective Date: May 16, 2006**

**Implementation Date: July 17, 2006  
(carriers); October 1, 2006 (FIs)**

**EDITOR'S NOTE:** This NCD supersedes the article published in the April 2005 WPS Medicare *Communiqué* entitled *Artificial Disc*, on page 23.

**Provider Types Affected**

All physicians and providers who bill Medicare carriers and fiscal intermediaries (FIs) for LADR

**Providers Action Needed**

This article and Change Request (CR) 5057 provide specific information regarding the new national coverage determination (NCD) for LADR. The message is three-pronged:

- 1) Effective May 16, 2006, the LADR with the Charite lumbar artificial disc is not covered by Medicare for beneficiaries over 60 years of age, i.e., on or after the beneficiary's 61st birthday;
- 2) Medicare coverage under the investigational device exemption (IDE) and/or clinical trail policy for other lumbar artificial discs is not impacted by this decision and such coverage continues if the billing requirements are met and the appropriate codes are submitted; and
- 3) For patients 60 years of age and younger, there is no NCD, leaving such determinations to continue to be made by the local contractors.

**Background**

The Centers for Medicare & Medicaid Services (CMS), upon completion of a national coverage analysis (NCA) for LADR, determined that LADR with the Charite lumbar artificial disc is not reasonable and necessary for Medicare patients over 60 years of age and is, therefore, non-

covered for this patient population. For Medicare beneficiaries 60 years of age and younger, there is no NCD, leaving such determinations to be made by the local Medicare carrier or FI.

This NCD focuses on the LADR with the Charite lumbar artificial disc because it is the only United States Food and Drug Administration (FDA) approved lumbar artificial disc at this time. The FDA has approved the use of the Charite artificial disc for spine arthroplasty in skeletally mature patients with degenerative or discogenic disc disease (DDD) at one level for L4 to S1.

The addition of section 150.10 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), effective May 1, 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.)

### Billing Requirements

The following are the billing requirements for LADR according to the revised *Medicare Claims Processing Manual*, Chapter 32, Section 170, which is effective May 16, 2006.

- Assuming the providers bill separately, physicians and hospitals need to **issue the appropriate liability notice**, (Advance Beneficiary Notice (**ABN**) or Hospital Issued Notice of Non-coverage (**HINN**)), to beneficiaries over 60 years of age who choose to have this procedure using the Charite lumbar artificial disc.
- The following language should be included in the ABN:
  - Under the “Items or Service” Section: Lumbar Artificial Disc Replacement (LADR) with the Charite Lumbar Artificial Disc.
  - Under the “Because” Section: After a national coverage analysis (NCA), Medicare issued a national coverage determination (NCD) (Section 150.10 of *Medicare NCD Manual*) that stated that LADR with the Charite Lumbar Artificial Disc is not reasonable and necessary for Medicare beneficiaries over 60 years of age. Therefore, LADR with the Charite lumbar artificial disc is non-covered for beneficiaries over 60 years of age. Medicare never pays for this service for this Medicare population.
- Hospitals need to have a **beneficiary who is over 60 years of age sign a HINN** if he/she wishes to have the procedure done when a Charite lumbar artificial disc is used in the procedure. If the beneficiary is not informed prior to admission that he or she is financially liable for the admission, the provider is liable.

### Information for Providers Billing Carriers

- For patients over 60 years of age. claims submitted with Category III Codes 0091T (Single interspace, lumbar) and/or 0092T (Each additional interspace) will be denied unless performed under an approved IDE/clinical trial. (**Note:** The Charite lumbar artificial disc is the only artificial disc approved by the Food and Drug Administration, therefore the procedure (0091T or 0092T) would be using the Charite unless under an IDE/clinical trial.)
- For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, claims submitted with 0091T or 0092T and the modifier QA will be allowed and normal claims processing criteria for IDEs/clinical trials will be followed.

**Information for Providers Billing FIs**

For patients over 60 years of age, claims submitted with ICD-9 CM procedure code 84.65 (Insertion of total spinal disc prosthesis, lumbosacral) is never payable and will be denied unless performed under an approved IDE/clinical trial.

For patients over 60 years of age for procedures performed under the IDE/clinical trial and approved by the contractor, the FI will pay for LADR only when submitted with ICD-9 procedure code 84.65 with condition code 30 and diagnosis code V70.7 when submitted on type of bill (TOB) 11X.

- For services submitted on TOB 11X in critical access hospitals (CAH), the payment will be 101% of reasonable cost.
- For services submitted on TOB 11X from inpatient hospitals, including Indian Health Services (IHS) inpatient hospitals, will be paid under IPPS based on the DRG.
- For services submitted/performed on TOB 11X, IHS CAHs will be paid under 101% facility specific per diem rate.

**Medicare Summary Notice (MSN) and Claim Adjustment Reason Code Messages for Denied Claims**

- The following MSN: 21.24 will be issued: “This service is not covered for patients over age 60.” along with a Claim Adjustment Reason Code such as: 96 “Non covered charge(s).”

**Implementation**

The implementation date for this instruction is July 17, 2006, for claims submitted to carriers and October 1, 2006, for claims submitted to Medicare FIs. But, in both instances, the change applies to services provided on or after May 16, 2006.

**Additional Information**

The official instructions issued to your Medicare carrier and intermediary regarding this change are in two transmittals for CR5057. Transmittal R60NCD contains the NCD instructions and can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R60NCD.pdf> on the CMS web site. The claims processing instructions are in Transmittal R992CP, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R992CP.pdf>.

If you have questions, please contact your Medicare intermediary or carrier at their toll-free number, which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.



The following section presents National Coverage Decisions (NCDs) issued by the Centers for Medicare & Medicaid Services (CMS), along with Local Coverage Decisions (LCDs), National Coverage Provisions (NCPs), and local coverage articles issued by CMS and WPS. NCPs are Medicare coverage guidelines assembled by WPS from Medicare program manuals. Our intent is to put local and national statements on Medicare Part B coverage in one section for the convenience of readers. Clicking on the policy number or title will link you to the entire policy on our Website. Below each chart is a listing of the policy revisions WPS Medicare has made for this month.



### INFORMATION ON WEBSITE

WPS Medicare publishes LCDs, NCPs, and NCDs, and retired LCDs/ LMRPs for Medicare Part B on its Website: [http://www.wpsmedicare.com/policies/pol\\_home.shtml](http://www.wpsmedicare.com/policies/pol_home.shtml)

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

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



### Revised Policies

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
ASC-001	<i>Ambulatory Surgical Centers (ASC)</i>	NCP	Click here to view	Page 31
HONC-010	<i>Antineoplastics and their Adjuncts</i>	LCD	Click here to view	Page 32
INJ-039	<i>Billing and Coding Guidelines for INJ-039, Gonadotropin-Releasing Hormone Analogs</i>	LCD Companion Article	Click here to view	Page 32
MS-004	<i>Bone Mineral Density (BMD) Studies</i>	LCD	Click here to view	Page 33
OPHTH-003	<i>Optometrist Services</i>	LCD	Click here to view	Page 33

OPHTH-021	<i>Visual Rehabilitation Programs</i>	LCD	Click here to view	Page 34
PHYS-024	<i>Supervising Physicians in Teaching Settings</i>	NCP	Click here to view	Page 35
PHYS-075	<i>Physician Supervision of Diagnostic Tests</i>	NCP	Click here to view	Page 36
RAD-023	<i>Magnetic Resonance Angiography (MRA) RAD-23: Coding and Billing Guidelines</i>	NCD Companion Article	Click here to view	Page 37
RAD-024	<i>Magnetic Resonance Imaging</i>	LCD	Click here to view	Page 37
RAD-026	<i>Radiopharmaceutical Agents</i>	LCD	Click here to view	Page 38
RAD-033	<i>Computerized Tomography (CAT Scans)</i>	LCD	Click here to view	Page 39
RAD-034	<i>Computed Coronary Tomography Angiography</i>	LCD	Click here to view	Page 40

## Revised Policies

### Subject

*Ambulatory Surgical Centers (ASC)*

### NCP Number

ASC-001

### Ambulatory Surgical Center (ASC) Claims Processing Manual Clarification

### Effective Date

\*06/05/2006

### Implementation Date

\*06/05/2006

This instruction clarifies existing policy. Transmittal 942, dated May 5, 2006, is rescinded and replaced with transmittal 975, dated June 9, 2006. An incorrect reference was made in the manual to Chapter 12, section 22.4. It should have been Chapter 12, section 20.4. All other information remains the same.

WPS is updating *ASC-001 Ambulatory Surgical Centers (ASCs) National Coverage Provision* to reflect the change. The asterisked (\*) text indicates changes made since the last publication date. Please refer to the *Ambulatory Surgical Centers (ASCs) National Coverage Provision* in its entirety on the WPS Website: <http://www.wpsmedicare.com/policies/wisconsin/asc001.pdf>



**LCD Title**

Antineoplastics and their Adjuncts

**Contractor's Determination Number**

HONC-010

**Revision Effective Date:**

08/01/2006

**Indications and Limitations:**

Coverage for Bevacizumab has been expanded to include the treatment of metastatic breast cancer, HER-2 negative disease, first line therapy in combination with paclitaxel.

\*6. Bevacizumab (Avastin™) (J9035), 10 mg

breast Cancer	174.0-175.9
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Effective 06/20/2006, the FDA also approved Bevacizumab in combination with intravenous 5-fluorouracil (5-FU) based chemotherapy for second line treatment of metastatic colorectal cancer.

The covered ICD-9 codes for colorectal cancer have not changed (153.0-154.8).

Therefore the following statement has been removed from the LCD:

Used in combination with 5-fluorouracil-based chemotherapy for first-line treatment of patients with metastatic carcinoma of the colon or rectum.

**LCD Companion Document Revision****Companion Article****Article Type**

LCD Companion Article

**Article Title****Billing and Coding Guidelines for INJ-039, Gonadotropin-Releasing Hormone Analogs****Effective Date**

03/17/2006

**Publication Date:**

08/01/2006

**Implementation of Least Costly Alternative (LCA)**

The least costly alternative (LCA) policy will be applied to Lupron/Zoladex/Trelstar/and other similar drugs for ICD-9-CM codes 185 and V10.46 only. Whereas there are other labeled indications for goserelin acetate implant or leuprolide acetate, they are not affected by the least costly alternative (LCA) provisions of this LCD. That is, LCA pricing will only be applied if the covered diagnosis is related to prostate cancer.

“Trelstar and other similar drugs” added to the statement above for the purpose of clarification that they are included in the LCA provisions and are payable by this carrier when medically necessary for diagnostic ICD-9-CM codes 185 or V10.46.

**LCD Policy Revision****Contractor’s Policy Number:**

MS-004

**LCD Title:**

Bone Mineral Density (BMD) Studies

**Revision Effective Date:**

08/01/2006

**Indications:**

- D. There are limited clinical situations, where it may be appropriate to do both axial and peripheral bone mineral density (BMD) studies on the same date of service, or within thirty days of each other. Medicare will not reimburse for both axial and appendicular testing on the same date of service or within thirty days of each other, unless the medical records substantiate that the patient has artificial instrumentation in place in either hip or spine, or other conditions that precludes a reading in those locations.

\*These other conditions may include the following;

1. Hip or spine cannot be measured. (Reason must be documented in the medical record).
2. Hyperparathyroidism
3. Obese patient over the weight limit of the DEXA exam table.
4. Extreme arthritic changes which precludes accurate measurement.

This documentation (medical records/history or and x-ray report) must be available for submission with the original and all subsequent claims upon request.

Conditions that may indicate medical necessity for both axial and peripheral testing on the same date of service added to section D above for the purpose of clarification.

**LCD Revision****LCD Title**

Optometrist Services

**Contractor Policy Number**

OPHTH-003

**Revision Effective Date**

08/01/2006

**CPT/HCPCS Codes****THERAPEUTIC/EXPANDED LICENSURE:****All States:**

CPT code 83516 is added to this policy effective for services performed on or after 08/01/2006.

**LCD Revision****LCD Title**

Visual Rehabilitation Programs

**Contractor's Determination Number**

OPHTH-021

**Revision Effective Date**

\*08/01.2006

**Indications and Limitations of Coverage and/or Medical Necessity**

B. Medicare coverage of low vision rehabilitation services is considered reasonable and necessary for patients with a clear medical need meeting all of the following criteria.

\*In accordance with Medicare regulations all beneficiaries in rehabilitation programs must be under the care of a physician, all rehabilitation services to beneficiaries with a primary vision impairment diagnosis must be provided pursuant to a written treatment plan established by a Medicare physician, and implemented by a qualified professional as defined in CMS Pub.100-02 Ch. 15 §220 A or see PHYSMED-001.

\*7. \*Rehabilitation programs and services may be furnished by a physician and his/her qualified personnel under the physician's direct supervision or an Occupational/Physical Therapist in independent practice. Direct supervision means that a physician must be in the area where the rehabilitation services are performed or in the office suite, and must be immediately available *to furnish assistance and direction throughout the performance of the procedure*. It does not require that the physician be physically present in the treatment room itself.

\*Rehabilitation services covered by Part B are rendered in the physician's or therapist's office or under limited circumstances, in a beneficiary's home.

C. Therapeutic procedures provided in connection with Visual Rehabilitation may be considered reasonable and necessary as follows.

\*3. The ordering physician/non-physician practitioner should review the treatment plan every 30 days.

\*4. Rehabilitation programs are usually short-term and intensive. The visual rehabilitation program will be considered completed when the treatment goals have been attained. Subsequent physical medicine and rehabilitation services,

to sustain the level of function would be regarded as maintenance and not reasonable and necessary. In some situations the specialized knowledge, judgment and skill of a qualified therapist may be required to establish a maintenance program following completion of the visual rehabilitation program. Periodic evaluation of a patient in a maintenance program may be considered reasonable and necessary.

**Documentation Requirements**

\*The patients medical records should be **legible**, contain the relevant history, physical finding conforming to the criteria stated in the “Indications and Limitation of Coverage or Medical Necessity section above. In addition the medical records for therapy service should conform to the documentation requirements established for the treatment plan, certification/recertification and therapy services stated in CMS IOM Pub.100-02 Ch.15 §§ 220-230, and must be made available to the contractor on request. The following types of documentation for therapy services are expected to be submitted in response to any request for documentation, unless the contractor requests otherwise:

- Evaluation and Certified Plan of Care**
- Certification**
- Interval Progress Report**
- Treatment Encounter Notes**

See **OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH-LANGUAGE PATHOLOGY, PHYSMED-001**

**Companion Article**

The companion article for this LCD has been revised and the document reformatted. Please read this article in its entirety on our Website.



**Subject**

*Supervising Physicians in Teaching Settings*

**NCP Number**

PHYS-024

**Exception for Evaluation and Management (E/M) Services in Certain Primary Care Centers**

WPS is updating *PHYS-024 Supervising Physicians in Teaching Settings* National Coverage Provision to update the correct Code of Federal Regulations (CFR) verified in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) Publication 100-04, Chapter 12, Section 100.1.1C. All other information remains the same.

*The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's FI. This requirement is not met when the resident is assigned to a physician's office away from the*

center or makes home visits. In the case of a nonhospital entity, verify with the FI that the entity meets the requirements of a written agreement between the hospital and the entity set forth at \*42 CFR 413.78(e)(3)(ii).

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program. Centers must maintain information under the provisions at \*42 CFR 413.79(a)(6).

The asterisk (\*) text indicates changes made since the last publication date. Please refer to the *PHYS-024 Supervising Physicians in Teaching Settings* National Coverage Provision in its entirety on the WPS Website:

<http://www.wpsmedicare.com/policies/wisconsin/phys024.pdf>



### National Coverage Provision

**Subject:**

Physician Supervision of Diagnostic Tests

**Subject Number:**

PHYS-075

### Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests; Clinical Psychologist Services

**Effective Date:**

01/01/2005

**Implementation Date:**

09/09/06

WPS is updating *PHYS-075 Physician Supervision of Diagnostic Tests* National Coverage Provision per Change Request 4400. Summary of changes: To add that the physician supervision policy does not apply with a physician supervision level of 4 when the procedure is performed under the general supervision of a clinical psychologist. To allow diagnostic psychological testing services to be furnished under the general supervision of a clinical psychologist. All other information remains the same.

**Indications and Limitations:**

The level of physician supervision indicator number 4 has been updated to include services furnished under the general supervision of a clinical psychologist.

\*4 *Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist or furnished under the general supervision of a clinical psychologist; otherwise must be performed under the general supervision of a physician.*



**National Coverage Determination (NCD) Revision****Subject***Magnetic Resonance Angiography***NCD Number**

RAD-023

**COMPANION ARTICLE****Article Title**

Magnetic Resonance Angiography (MRA) RAD-23: Coding and Billing Guidelines

**Article Effective Date**

\*10/01/2005

**Diagnosis Codes**

This NCD is corrected to include the listed ICD-9 codes, effective 10/01/2005.

**Lower Extremities:**

\*585.5, \*585.6

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

RAD-024

**LCD Title:**

Magnetic Resonance Imaging

**Primary Geographic Jurisdiction:**

Wisconsin, Illinois, Michigan, Minnesota

**Revision Effective Date:**

08/01/2006

**ICD-9 Codes that Support Medical Necessity:****UPPER EXTREMITY (73218-73223)****Arthropathies/Related Disorders, Rheumatism, Osteopathies**

711.01-711.04, 715.00, 715.04, 715.09, 715.10-715.14, 715.20-715.24, 715.30-715.34, 715.80, 715.89, 715.90-715.94, 716.11-716.14, 718.00-718.04, 718.10-718.14, 718.20-718.24, 718.30-718.34, 718.40-718.44, 718.50-718.54, 718.70-718.74, 718.80-718.84, 718.90-718.94, 719.01-719.04, 719.11-719.14, 719.21-719.24, 719.41-719.44, 726.0, 726.10-726.12, 726.19, 726.2, 726.30-726.33, 727.02-727.05, 727.40-727.42, 727.61-727.64, 729.5, 729.81, 730.01-730.04, 730.11-730.14, 730.20-730.24, 733.00-733.09, 733.11, 733.12, 733.20-733.22, \*733.40, 733.41, 733.81, 733.82, 733.90

**LOWER EXTREMITY (73718-73723)**
Arthropathies/Related Disorders, Rheumatism, Osteopathies

711.05-711.07, 715.00, 715.09, 715.10, 715.15-715.17, 715.20, 715.25-715.27, 715.30, 715.35-715.37, 715.80, 715.90, 715.95-715.97, 716.15-716.17, 717.0-717.3, 717.40-717.49, 717.5-717.7, 717.81-717.9, 718.00, 718.05, 718.07, 718.09, 718.10, 718.15, 718.17, 718.19, 718.20, 718.25-718.27, 718.29, 718.30, 718.35-718.37, 718.39, 718.40, 718.45-718.47, 718.49, 718.50, 718.55-718.57, 718.59, 718.60, 718.65, 718.70, 718.75-718.77, 718.79, 718.80, 718.85-718.87, 718.89, 718.90, 718.95, 718.97-718.99, 719.05-719.07, 719.15-719.17, 719.25-719.27, 719.40, 719.45-719.47, 726.5, 726.60-726.65, 726.71, 726.72, 727.02, 727.06, 727.40-727.42, 727.50, 727.51, 727.65-727.68, 727.83, 728.3, 729.5, 729.81, 730.05-730.07, 730.09, 730.15-730.17, 730.19, 730.25-730.27, 733.00-733.09, 733.14-733.16, 733.20-733.22, \*733.40, 733.42-733.44, 733.81, 733.82, 733.90

**Revision Explanation:** Addition of ICD-9 code 733.40 (Aseptic necrosis of bone, site unspecified) to LCD RAD-024.


**LCD Title**

Radiopharmaceutical Agents

**Contractor's Determination Number**

RAD-026

**\*Revision Effective Date**

01/01/2006

**Indications and Limitations**

The following code descriptors have been revised:

A4642 Indium-111 Satumomab pendetide, diagnostic, per study dose, up to 6 mCi's  
 A9500 Technetium Tc-99m, Sestamibi, diagnostic, per study dose, up to 40 mCi's,  
 A9503 Technetium Tc 99m, Medronate, (MDP), diagnostic, per study dose, up to 30 mCi's  
 A9504 Technetium Tc 99m Apcitide (Acu Tect®), diagnostic, per study dose, up to 20  
 millicuries A9505 Thallous Chloride TL-201, diagnostic, per mCi,  
 A9507 Indium IN 111 Capromab Pendetide (ProstaScint®) per study dose, up to 10 mCi's  
 A9510 Technetium Tc-99m Disofenin (Hepatolite®, DISIDA) per study dose, up to 15 mCi's  
 A9524 Iodinated I-131-Serum Albumin, diagnostic, per 5 microcuries,  
 A9559 Cobalt CO-57 Cyanocobalamin, oral, Diagnostic, per study dose, up to 1 microcurie



**LCD Policy Revision****Contractor's Policy Number:**  
RAD-033**LCD Title:**  
Computerized Tomography (CAT Scans)**Primary Geographic Jurisdiction:**  
Wisconsin, Illinois, Michigan, Minnesota**Revision Effective Date;**  
08/01/2006**UPPER EXTREMITY (73200-73206)**Arthropathies/Related Disorders, Rheumatism, Osteopathies

711.01-711.04, 715.00, 715.04, 715.09, 715.10-715.14, 715.20-715.24, 715.30-715.34, 715.80, 715.89, 715.90-715.94, 716.11-716.14, 718.00-718.04, 718.10-718.14, 718.20-718.24, 718.30-718.34, 718.40-718.44, 718.50-718.54, 718.70-718.74, 718.80-718.84, 718.90-718.94, 719.01-719.04, 719.11-719.14, 719.21-719.24, 719.41-719.44, 726.0, 726.10-726.12, 726.19, 726.2, 726.30-726.33, 727.02-727.05, 727.40-727.42, 727.61-727.64, 729.5, 729.81, 730.01-730.04, 730.11-730.14, 730.20-730.24, 733.00-733.09, 733.11, 733.12, 733.20-733.22, \*733.40, 733.41, 733.81, 733.82, 733.90

**LOWER EXTREMITY (73700-73706)**Arthropathies/Related Disorders, Rheumatism, Osteopathies

711.05-711.07, 715.00, 715.09, 715.10, 715.15-715.17, 715.20, 715.25-715.27, 715.30, 715.35-715.37, 715.80, 715.90, 715.95-715.97, 716.15-716.17, 717.0-717.3, 717.40-717.49, 717.5-717.7, 717.81-717.9, 718.00, 718.05, 718.07, 718.09, 718.10, 718.15, 718.17, 718.19, 718.20, 718.25-718.27, 718.29, 718.30, 718.35-718.37, 718.39, 718.40, 718.45-718.47, 718.49, 718.50, 718.55-718.57, 718.59, 718.60, 718.65, 718.70, 718.75-718.77, 718.79, 718.80, 718.85-718.87, 718.89, 718.90, 718.95, 718.97-718.99, 719.05-719.07, 719.15-719.17, 719.25-719.27, 719.40, 719.45-719.47, 726.5-726.65, 726.71, 727.02, 727.06, 727.40-727.42, 727.50, 727.51, 727.65-727.68, 727.83, 728.3, 729.5, 729.81, 730.05-730.07, 730.09, 730.15-730.17, 730.19, 730.25-730.27, 733.00-733.09, 733.14-733.16, 733.20-733.22, \*733.40, 733.42-733.44, 733.81, 733.82, 733.90

**Revision Explanation:** Addition of ICD-9 code 733.40 (Aseptic necrosis of bone, site unspecified) to LCD RAD-033.

## LCD Policy Revision

**Contractor's Policy Number:**  
RAD-034

**LCD Title:**  
Computed Coronary Tomography Angiography

**Primary Geographic Jurisdiction:**  
Wisconsin, Illinois, Michigan, Minnesota

**Revision Effective Date:**  
04/15/2006

**ICD-9 Codes that Support Medical Necessity**  
*Note: ICD-9 codes must be coded to the highest level of specificity.*  
TRUNCATED DIAGNOSIS CODES ARE NOT ACCEPTABLE.

413.0	*Angina decubitus
413.1	*Prinzmetal angina
*413.9	Other and unspecified angina pectoris
414.8	Other specified forms of chronic ischemic heart disease
425.4	Other primary cardiomyopathies
427.31	Atrial fibrillation
427.32	Atrial flutter
428.0	Congestive heart failure, unspecified
746.85	Congenital anomalies of the heart
747.41	Total anomalous pulmonary venous connection
747.42	Partial anomalous pulmonary venous connection
786.05	Shortness of breath
786.50	Chest pain, unspecified
786.51	Chest pain, precordial pain
786.59	Other chest pain
794.30	Cardiovascular, abnormal function study, unspecified

Correction of definition of ICD-9 codes 413.0 and 413.1. Addition of ICD-9 code 413.9 that was inadvertently omitted from this LCD.

## Electronic Data Interchange

### CHANGE IN 837 4010 EMC PRE-PASS EDITING

**Editor's Note:** This article was originally included within the 06/19/2006 Listserv. It has since been revised.

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

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

**M313 2410/REF02 Missing Data**

The edit will set if 2400/SV101-3, 2400/SV101-4, 2400SV101-5 or 2400SV101-6 has the value J1 AND the 2410 REF02 segment (where REF01 is equal to XZ) is not present.

**M361 2410/REF01 Missing Data**

The edit will set if when 2410 REF01 equals XZ and 2410 REF02 is present and there is no 2410 LIN02 with the value N4.

The edits will temporarily be set as informational and effective August 1, 2006 delete. It is important that you receive and review your prepass reports.

A complete list of current 4010A1 pre-pass edits, as well as a detailed description, is available in the WPS Bulletin Board in the EDI file library in the HIPAA directory (file name: 4010A1.doc) or on the WPS Website: [http://www.wpsic.com/edi/pdf/hipaa\\_mcs837.pdf](http://www.wpsic.com/edi/pdf/hipaa_mcs837.pdf)

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

## **EDI HOTLINE HAS HIGH CALL VOLUME**

As more and more Medicare Part B claims are being sent electronically, the EDI Hotline is experiencing extremely high call volumes in all four of our states. High call volumes result in frustration for both providers and hotline staffers. WPS Medicare is taking measures to reduce this frustration, including additional staffing and analyst assistance in software support calls, but the callers themselves can help us in making sure these calls are handled correctly, competently and with quality customer service.

The EDI Hotline that services *ILLINOIS, MICHIGAN and WISCONSIN* is a toll-free number (**877-567-7261**) that offers a variety of choices. Your first option is for General EDI Information. You would press 1 at that point to speak to a hotline representative. If all the representatives are busy, you will have an option to either hold or leave a message. If you choose to hold, you will be put into a queue and your call will be answered in the order it was received. If you leave a message, you will receive a call back from one of the representatives – usually within 24 hours. If you choose to leave a message, please leave your name (first and last if possible), your phone number with area code and extension, your submitter ID, your Medicare provider number and the nature of your call. If you are requesting reports or remittances to be reloaded, please include the dates needed.

If you have tested with us and wish confirmation of your test file, the analyst assigned to the test will contact you with the results. You do not need to call us unless more than 10 workdays have passed since you submitted the test file.

Option 2 is more detailed. If you are working with an analyst on a current problem, Option 2 will allow you to dial directly to the analyst. Listen to the list of names and choose the analyst with whom you are working. This is only for current problems or if the analyst has requested your call. New issues need to go through the EDI Hotline for screening and referral to the appropriate analyst. Our analysts also will return your call as soon as possible, so please leave a message.

If you don't choose either option, you will continue to be on hold. If there is a representative available, the call will go to them. If no one is available, you will be given the choice to either continue holding in queue or leave a message. The messages are checked frequently throughout the day and calls are returned as soon as possible – usually within 24 hours.

The *MINNESOTA* representatives each have a separate phone number to reach them directly. Those numbers are listed below. These representatives are also receiving an extremely large call volume. If they are out of the office, they will indicate this on their voicemails and will direct you to either leave a message or call one of the other representatives. Calling and leaving messages on all of the lines just creates more delays.

You can reach the Minnesota EDI Department at the following numbers: **(952) 885-2811, (952) 885-2881 or (952) 885-2882**. You may also reach the Minnesota staff at their toll-free line at **866-380-4742**. When you dial the toll-free line, you can enter one of these extensions; **2881, 2882 or 2811**, and your call will be connected.

Our goal in EDI is to give you the best customer service possible. We want to work together with you to ease frustration and promote quick and easy submission of your electronic Medicare claims.

## ENDING THE HIPAA CONTINGENCY FOR REMITTANCE ADVICE ~CMS MLN Matters Special Edition Article~

**MLN Matters Number: SE0646**  
**Related CR Release Date: N/A**  
**Related CR Transmittal #:**

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

### Provider Types Affected

All providers and suppliers who bill Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs))

### What You Need to Know

Effective October 1, 2006, Medicare will send only HIPAA-compliant Electronic Remittance Advice (ERA) transactions (transaction 835 version 004010A1) to all electronic remittance advice receivers.

### Background

In 2003, the Centers for Medicare & Medicaid Services (CMS) addressed compliance with the HIPAA transaction and code sets, and encouraged health plans (such as Medicare) to:

- Intensify their efforts toward compliance;
- Assess the readiness of their provider communities; and

- Determine the need to implement contingency plans to maintain the flow of payments while continuing toward compliance.

Consistent with that guidance, Medicare has aggressively worked with providers to achieve HIPAA compliance. Effective October 16, 2003, in order to ensure the continuation of normal program operations, CMS implemented a contingency plan through which Medicare continued to accept and send both HIPAA-compliant and non-HIPAA transactions from/to trading partners.

CMS ended the contingency plan that addressed **inbound** claims on October 1, 2005, and at that time began denying non-compliant electronic claims.

Now, CMS is moving to end the contingency plan for Electronic Remittance Advice (ERA) transactions. Currently, 99% of all Electronic Remittance Advice (ERA) receivers (providers, clearinghouses, billing agencies, and others who receive ERAs on behalf of providers) are receiving the HIPAA compliant ERA.

Further, the overall compliance rate for all Medicare providers in May, 2006, was 96%. (The rate for professional providers was 97% and for institutional providers was 93%.)

Therefore, CMS announces that, effective October 1, 2006, it will end the contingency plan for the remittance advice transaction.

After that date, your carriers, FIs, DMERCs, DME MACs, and RHHIs will send only HIPAA-compliant remittance advice (transaction 835) to all electronic remittance advice receivers. In doing so, Medicare will stop sending electronic remittance advice in any version other than the standard HIPAA version (835 version 004010A1), or in any other format (e.g., NSF).

#### **Additional Information**

You can find more information about HIPAA at <http://www.cms.hhs.gov/HIPAAGenInfo/> on the CMS web site.

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.pdf> on the CMS web site.

## **IMPORTANT CHANGE TO ELECTRONIC FUNDS TRANSFER PAYMENTS**

The revised Medicare enrollment applications require that providers initially enrolling in the Medicare program and providers submitting a CMS-855 change request receive payment via EFT. In the past CMS has encouraged, but not required, providers to receive payment by EFT. In an effort to sustain compliance, Medicare contractors shall also not approve any requests to change payment method from EFT to paper check.

Effectively immediately, Medicare will not accept any termination request of your EFT. However, providers may revise a current EFT authorization or make such changes necessary to continue receiving payment via EFT.

Before terminating an account, please allow us time to process your EFT change. When you are making changes to your account, you must also allow a 10-15 day pre-certification period. For the 10-15 day pre-certification period only, you will receive paper checks. We will contact you when all changes have been completed.

If you have any questions contact the EDI Department toll-free at: 866-380-4742

Or call us directly at:	952-885-2881	Sharon
	952-885-2882	Tracy
	952-885-2811	Rhonda

## PC ACE AND NPI

Are you preparing for NPI? The National Provider Identifier (NPI) is an integral piece of the HIPAA strategy.

If you are using the Medicare provided PC-Ace software, you must upgrade to the 1.74 version of the software. Previous versions do not allow for NPI numbers. For upgrade instructions, please go to [https://www.wpsic.com/edi/pcacepro32\\_p.shtml?mm=3](https://www.wpsic.com/edi/pcacepro32_p.shtml?mm=3) on the internet.

Remember to print out the new 1.74 User Guide for your NPI setup instructions.

For assistance with PC-Ace, please call 877-567-7261 for Illinois, Michigan and Wisconsin. For Minnesota, please call one of the following numbers: 952-885-2811, 952-885-2881 or 952-885-2882 or call toll free to phone number 866-380-4742.

## STAGE 2 NATIONAL PROVIDER IDENTIFIER (NPI) CHANGES FOR TRANSACTION 835, AND STANDARD PAPER REMITTANCE ADVICE, AND CHANGES IN MEDICARE CLAIMS PROCESSING MANUAL, CHAPTER 22 – REMITTANCE ADVICE ~CMS MLN Matters~

MLN Matters Number: MM5081  
Related CR Release Date: June 30, 2006  
Related CR Transmittal #: R996CP

Related Change Request (CR) #: 5081  
Effective Date: October 1, 2006  
Implementation Date: October 2, 2006

### Provider Types Affected

All Medicare physicians, providers, suppliers, and billing staff who submit claims for services to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) and durable medical equipment administrative contractors (DME MACs))

### Background

This article instructs the Shared System Maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advice (ERA) –

transaction 835, and Standard Paper Remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007.

The Centers for Medicare & Medicaid Services (CMS) has defined legacy provider identifiers to include OSCAR, National Supplier Clearinghouse (NSC), Provider Identification Numbers (PIN), National Council of Prescription Drug Plans (NCPDP) pharmacy identifiers, and Unique Physician Identification Numbers (UPINs). CMS's definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as Employer Identification Numbers (EINs) or Social Security Numbers (SSNs).

Medicare has published CR4320 (<http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf>) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via Direct Data Entry screens, or on paper claim forms.

Providers need to be aware that these instructions that impact contractors will also impact the content of their SPR, ERA, and their PC print and MREP software.

The following dates outline the regulations from January 2006 forward and are as follows:

- **January 3, 2006 – October 1, 2006:** Medicare rejects claims with only NPIs and no legacy number.
- **October 2, 2006 – May 22, 2007:** Medicare will accept claims with a legacy number and/or an NPI, and will be capable of sending NPIs in outbound transaction e.g., ERA
- **May 23, 2007 – Forward:** Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

Medicare providers may want to be aware of the following Stage 2 scenarios so that they are compliant with claims regulations and receive payments in a timely manner.

**Key Points**

**During Stage 2**, if an NPI is received on the claim, it will be cross walked to the Medicare legacy number(s) for processing. The crosswalk may result in:

<b>Scenario I:</b>	Single NPI	cross walked to	Single legacy number
<b>Scenario II:</b>	Multiple NPIs	cross walked to	Single Medicare legacy number
<b>Scenario III:</b>	Single NPI	cross walked to	Multiple Medicare legacy numbers

**Note:** The Standard Paper Remittance for institutional providers would include NPI information at the claim level. NPI information for professional providers and suppliers would be sent at the service level.

CMS will adjudicate claims based upon Medicare legacy number(s) even when NPIs are received and validated. The Remittance Advice (RA) may be generated for claims with the same legacy numbers but and different NPIs. These claims with different NPIs will be rolled up and reported in a single RA accompanied by one check or electronic funds transfer (EFT).

During Stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers. The Companion Documents will be

updated to reflect these changes and the updated documents will be posted at [http://www.cms.hhs.gov/ElectronicBillingEDITrans/11\\_Remittance.asp#TopOfPage](http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage) on the CMS web site.

**Scenario I – Single NPI cross walked to single legacy number:**

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed.
2. SPR: Insert the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
3. PC Print Software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

**Scenario II: Multiple NPIs cross walked to Single Medicare legacy number:**

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the specific NPIs at the claim and/or at the service level, if needed. The specific NPI associate with the claim(s)/service lines included in the ERA will need to be identified using additional information provided on the claim.
2. SPR: Insert the legacy number at the header level. Add the specific NPIs at the claim and/or at the service level, if needed.
3. PC Print Software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

**Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:**

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the appropriate legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed. (Under this scenario, if there are 50 claims with the same NPI and that NPI crosswalks to 5 legacy numbers, we will issue 5 separate RAs and 5 separate checks/EFTs per each legacy number.
2. SPR: Insert the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
3. PC Print Software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

**Implementation**

The implementation date for this instruction is October 2, 2006.

**Additional Information**

The official instructions issued to your Medicare FI, Carrier, RHHI, DMERC, or DME MAC regarding this change can be found at

<http://www.cms.hhs.gov/transmittals/downloads/R996CP.pdf> on the CMS web site. The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* is attached to CR5081

If you have questions, please contact your Medicare carrier, FI, RHHI, DMERC, 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 web site.

The MLN Matters article that provides additional information about Stage 1 Use of NPI is at the following address is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf> on the CMS web site.

## **STANDARD PAPER REMITTANCE (SPR) SUPPRESSION**

Are you receiving Medicare payments without the payment voucher attached? As of June 1, 2006, any provider who was set up to receive electronic remittance for 45 days or more was flagged for paper remittance suppression.

Not using your electronic remittance? Not aware that you were set up for electronic remittance and would prefer the Standard Paper Remittance? EDI would like to encourage you to be aware of the EDI forms you complete and what each request will do for you.

Before you call EDI, you have a couple of options: Medicare has FREE software called Medicare Remit Easy Print (MREP) that allows you to print out an Electronic Remittance Advice (ERA) in the same format as a paper EOB. For more information on this software go to [http://www.wpsmedicare.com/provider/easy\\_print.shtml](http://www.wpsmedicare.com/provider/easy_print.shtml)

You can download a WPS ERA Deactivation request form from the following URL: <http://www.wpsmedicare.com/provider/pdfs/eradeactivate.pdf> and fax it to EDI to save you time. If you need a copy of the Standard Paper Remittance, complete the deactivation request form, and be sure to specify the check numbers and dates of the needed SPRs. The EDI fax number for WI/IL/MI is (618) 998-5170 for MN (952) 885-2899

## **WPS CAN PROVIDE NPI END-TO-END TESTING**

We have been communicating to you for many months about the NPI (National Provider Identifier). The NPI compliance date of May 23, 2007, is just around the corner. Beginning September 4, 2006, WPS will be able to provide end-to-end testing to electronic submitters. If you have obtained your NPI, currently receive electronic remittance and would like to test your software's capability for NPI processing, WPS can assist you with this testing.

Please call the EDI Hotline for Illinois, Michigan and Wisconsin at 877-567-7261 or for Minnesota at 952-885-2811, 952-885-2881 or 952-885-2882 to request testing as soon as possible.

**General Information****AMBULATORY SURGICAL CENTER (ASC) CLAIMS PROCESSING  
MANUAL CLARIFICATION  
~CMS MLN Matters~**

MLN Matters Number: MM5026 **Revised**  
Related CR Release Date: June 9, 2006  
Related CR Transmittal #: R975CP

Related Change Request (CR) #: 5026  
Effective Date: June 5, 2006  
Implementation Date: June 5, 2006

**Note:** This article was revised on June 12, 2006, to reflect changes made to CR5026 on June 9, 2006. The article was revised to reflect a new CR release date, Transmittal number and Web address for CR5026. All other information remains the same.

**Provider Types Affected**

Providers and suppliers of ambulatory surgical center (ASC) services

**Provider Action Needed**

This article is for informational purposes. CR5026 revises the *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services) and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) to clarify policy regarding the provision, coverage, and payment of services furnished in an ASC.

**Background**

Medicare conventionally reimburses ASCs in the form of a single payment that includes all “facility services” that the ASC furnishes in connection with a covered procedure. However, an ASC (perhaps as part of a medical complex that may include other entities, such as an independent laboratory, supplier of durable medical equipment, or a physician’s office) may also furnish a number of covered items and services that are not considered facility services.

Be aware that such entities, which are separate from the ASC, are covered separately under Part B. Further, in general, the items or services that these entities provide are not considered ASC services, and are therefore not included in the ASC payment, but are rather covered and paid for under the applicable Part B provisions.

Examples of such services include:

- Physicians’ services;
- Durable medical equipment (DME);
- Implantable DME;
- Prosthetic devices;
- Ambulance services;
- Leg, arm, back and neck braces;
- Artificial legs, arms and eyes; and
- Services of an independent laboratory.

More details about each of these services are shown in Table 1, below.

**Table 1 - Examples of Services Not Included in the ASC Facility Rate**

Items or Services	Who Receives Payment	Submit Bills To
<p><b>Physicians' services</b> Physicians who perform covered services in ASCs receive separate payment under Part B. Such services include:</p> <ul style="list-style-type: none"> <li>- Anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patients' recovery from the anesthesia;</li> <li>- Routine pre- or post- operative services, such as office visits, consultations, diagnostic tests, suture removal, dressing changes, and other services which are usually included in the physician fee for a given surgical procedure.</li> </ul>	Physician	Carrier
<p><b>Non-implantable durable medical equipment (DME) to ASC patients for in-home use</b> ASCs who sell, lease, or rent items of DME to patients, are treated as DME suppliers. All of the ordinary DME-applicable rules and conditions apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	Supplier An ASC can be a supplier of DME if it has a DME supplier number from the National Supplier Clearinghouse.	DMERC
<p><b>Implantable DME and accessories</b> ASCs who furnish implantable DME items to patients, bill the local carrier for the surgical procedure and the implantable device.</p>	ASC	Carrier
<p><b>Non-implantable prosthetic devices</b> ASCs who furnish non-implantable prosthetic devices to patients are treated as suppliers, and all the ordinary DME-applicable rules and conditions apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	Supplier An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the National Supplier Clearinghouse.	DMERC
<p><b>Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs [new technology intraocular lenses]), and accessories</b> ASCs may bill and receive separate payment for prosthetic devices (other than intraocular lenses [IOLs]) that are implanted, inserted, or otherwise applied by surgical procedures on the ASC list of approved procedures. The ASC bills the local Carrier and receives payment according to the DMEPOS fee schedule.</p> <p>An intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC is included in the facility payment rate. ASCs may receive additional payment for approved</p>	ASC	Carrier

Items or Services	Who Receives Payment	Submit Bills To
NTIOLs that are furnished in an ASC during or subsequent to certain cataract procedures.		
<p><b>Ambulance services</b> ASCs who furnish ambulance services, may obtain approval as ambulance suppliers to bill covered ambulance services.</p>	Certified ambulance supplier	Carrier
<p><b>Leg, arm, back, and neck braces</b> These items of equipment are not included in the ASC facility payment amount, but are covered under Part B. ASCs who furnish these items to patients are treated as suppliers, and all the rules and conditions ordinarily applicable to suppliers apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	Supplier	DMERC
<p><b>Artificial legs, arms, and eyes</b> These items of equipment are not included in the ASC facility payment rate, but are covered under Part B. ASCs who furnish these items to patients are treated as suppliers, and all the rules and conditions ordinarily applicable to suppliers apply to the ASC, including obtaining a supplier number and billing the DMERC as required.</p>	Supplier	DMERC
<p><b>Services furnished by an independent laboratory</b> Only very limited numbers and types of diagnostic tests are considered ASC facility services and these are included in the ASC facility payment rate.</p> <p>Since coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics or hospitals is limited to facilities that meet the statutory definition of an independent laboratory, in most cases diagnostic tests performed directly by an ASC are not considered ASC facility services (in fact are usually not covered under Medicare).</p> <p>ASC laboratories must be CLIA certified and will need to enroll with the carrier as a laboratory. Otherwise, the ASC makes arrangements with a covered laboratory or laboratories for laboratory services. If the ASC has a certified independent laboratory, the laboratory itself bills the carrier.</p>	Certified lab. ASCs can receive lab certification and a CLIA number.	Carrier
<p><b>Procedures NOT on the ASC list</b> Physicians bill the carrier for the procedures and any implantable prosthetics/DME, using the ASC as the place of service</p>	Physician	Carrier

**Additional Information**

You can find more information about services not included in the ASC facility rate (and the coverage of such services) by reviewing CR5026, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R975CP.pdf> on the CMS web site.

The revised *Medicare Claims Processing Manual*, Chapter 14 (Ambulatory Surgical Centers), Sections 10.3 (Services Furnished in ASCs Which Are Not ASC Facility Services) and 10.4 (Coverage of Services in ASCs Which Are Not ASC Facility Services) are attached to CR5026.

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

**CHANGES CONFORMING TO CHANGE REQUEST 3648 (CR3648)  
FOR THERAPY SERVICES  
~CMS MLN Matters~**

**MLN Matters Number: MM4014 Revised**  
**Related CR Release Date: June 14, 2006**  
**Related CR Transmittal #: R980CP and R55NCD**

**Related Change Request (CR) #: 4014**  
**Effective Date: October 1, 2006**  
**Implementation Date: October 2, 2006**

**Note:** This article was revised on June 15, 2006, to reflect changes made to CR4014, which was re-issued on June 14, 2006. The transmittal number, CR release date (see above), and the Web address for viewing CR4014 were revised. All other information remains the same.

**Provider Types Affected**

Physicians, suppliers, and providers billing Medicare carriers including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for therapy services

**Provider Action Needed**

**STOP – Impact to You**

This article is based on Change Request (CR) 4014, which updates language in the *Medicare National Coverage Determinations Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) by changing the term “speech therapy” to “speech-language pathology.”

**CAUTION – What You Need to Know**

To conform to changes in CR3648, CR4014 removes from the *Medicare Claims Processing Manual* (Publication 100-04) the requirement to include the date last seen by a physician for outpatient services provided by a physical or occupational therapist or speech-language pathologist. Requirements for therapy services incident to a physician have not been changed.

**GO – What You Need to Do**

See the *Background* section of this article for further details regarding these changes.

**Background**

The Centers for Medicare & Medicaid Services (CMS) is updating language in the *Medicare National Coverage Determinations (NCD) Manual* (Publication 100-03) and the *Medicare Claims Processing Manual* (Publication 100-04) as follows: The term “speech therapy” is being changed to “speech-language pathology.”

In addition, CMS is changing requirements in Chapter 1 of the *Medicare Claims Processing Manual* where therapists are to provide information on CMS-1500 (Health Insurance Claim Form) and the UB-92 claim form concerning the date last seen by the physician to conform with instructions in CR3648, Transmittal 36, dated June 24, 2005; subject: Publication 100-02,

Chapter 15, Sections 220 and 230 Therapy Services. CR3648 can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R36BP.pdf> on the CMS web site.

Health Insurance Portability and Accountability Act (HIPAA) guidelines require the following information only when it impacts the payer's adjudication process:

- Date last seen; and
- The Unique Provider Identification Number (UPIN) of the physician.

Medicare payment is not impacted by this information except when the service is provided "incident to" the services of a physician's or non-physician practitioner's (NPP), in which case it is required. CR4014 updates instructions in CR3648 (related to claims for services "incident to" a physician's/NPP's service) by acknowledging that:

- The "incident to" service can be identified only on prepay or postpay review;
- Manual review of all therapy claims is not required; and
- "Incident to" policies have not changed and still apply to therapy services.

CR4014 also clarifies selected business requirements in CR3648 to indicate that some contractor actions:

- Will occur on prepay or postpay review. For example, compare the following:
  - Business Rule (BR) 3648.8 – Contractors shall pay for therapy services only when the service qualifies as a therapy service and the service is furnished by qualified professionals, or qualified personnel as defined in the manuals; with
  - BR 4014.8 – On prepay or post pay review of outpatient therapy claims for services provided on or after July 25, 2005, contractors shall pay for physical therapy and occupational therapy services only when the service is furnished by qualified professionals, or qualified personnel as defined in the appropriate Medicare manuals.
- Should not be applied to services "incident to." (e.g., BR 3648.3 – Medicare contractors shall not deny therapy claims based on missing documentation of a visit to the physician on prepay or postpay review).

CR3648 omitted the requirement for a physician visit when therapy services are billed. This change omits the requirement that the physician visit be documented on the claim.

This change does not affect the requirements for services billed "incident to" a physician.

Therefore, when a therapy service is billed "incident to," the following requirements remain in effect because they are required by "incident to" policies:

- An initial physician visit (date last seen); and
- Identification of the ordering (and supervising) physicians/NPPs.

### Implementation

The implementation date for this instruction is October 2, 2006.

### Additional Information

CR3648 (Transmittal 36 dated June 24, 2005, subject Pub. 100-02, Chapter 15, Sections 220 and 230 Therapy Services) can be reviewed at [http://www.cms.hhs.gov/manuals/pm\\_trans/R36BP.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R36BP.pdf) on the CMS web site.

The MLN Matters article, MM3648 can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3648.pdf> on the CMS web site.

For complete details, please see the official instructions (CR4014) issued to your carrier/intermediary regarding this change. There are two transmittals for CR4014, the NCD, transmittal 55 is available at

<http://www.cms.hhs.gov/Transmittals/downloads/R55NCD.pdf>. Transmittal 941 is the *Medicare Claims Processing Manual* update, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R980CP.pdf> on the CMS site.

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

## CLAIM STATUS CATEGORY CODE AND CLAIM STATUS CODE UPDATE ~CMS MLN Matters~

**MLN Matters Number: MM5137**  
**Related CR Release Date: June 23, 2006**  
**Related CR Transmittal #: R987CP**

**Related Change Request (CR) #: 5137**  
**Effective Date: October 1, 2006**  
**Implementation Date: October 2, 2006**

### **Provider Types Affected**

Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

### **Provider Action Needed**

#### **STOP – Impact to You**

This article is based on Change Request (CR) 5137, which provides the October 2006 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHIs).

#### **CAUTION – What You Need to Know**

Medicare contractors are to use codes with the “**new as of 10/06**” designation and prior dates, and they must inform affected providers of the new codes. CR5137 applies to Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277.

#### **GO – What You Need to Do**

Please refer to the *Background* section of this article for further details.

**Background**

Claim Status Category codes indicate the general category of a claim's status (accepted, rejected, additional information requested, and so on). Further detail is provided by the Claim Status Code(s).

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction.

The Health Care Code Maintenance Committee maintains the Claim Status Category and Claim Status codes. The Committee meets at the beginning of each X12 trimester meeting and makes decisions about additions, modifications, and retirement of existing codes.



The updated Claim Status Category and Claim Status codes list is posted three times a year (after each Health Care Code Maintenance Committee X12 trimester meeting) at the Washington Publishing Company web site at <http://www.wpc-edi.com/codes>. At this web site, select "Claim Status Codes" or "Claim Status Category Codes" to access the updated code list. Included in the code lists are specific details, including the date when a code was added, changed or deleted. All code changes approved in June 2006 are to be listed to this web site approximately thirty (30) days after the meeting concludes. For this update, Medicare will begin using the codes in place as of October 2006 in claim status responses issued on or after October 2, 2006.

**Implementation**

The implementation date for this instruction is October 2, 2006.

**Additional Information**

For complete details, please see CR5137, the official instruction issued to your Medicare carrier/DMERC or FI/RHHI regarding changes mentioned in this article. CR5137 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R987CP.pdf> on the CMS web site.

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

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

**COLLECTION OF FEE-FOR-SERVICE PAYMENTS MADE DURING PERIODS OF MANAGED CARE ENROLLMENT (PREVIOUSLY CR2801 PROGRAM MEMORANDUM TRANSMITTAL AB-03-101) –  
MANUALIZATION  
~CMS MLN Matters~**

**MLN Matters Number: MM5105 Revised**  
**Related CR Release Date: July 3, 2006**  
**Related CR Transmittal #: R100FM**

**Related Change Request (CR) #: 5105**  
**Effective Date: October 1, 2003**  
**Implementation Date: June 26, 2006**

**Note:** This article was revised on July 6, 2006, to reflect revisions made to CR5105, which CMS released on July 3, 2006. The Transmittal number, CR release date, and web address for accessing CR5105 have been changed. In addition, some references to MA (Medicare Advantage) have been changed to refer to managed care plans. All other information remains the same.

**Provider Types Affected**

Physicians, providers, and suppliers submitting fee-for-service claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services furnished to Medicare beneficiaries enrolled in Medicare Advantage (MA) Organizations.

**Impact on Providers**

This article is based on Change Request (CR) 5105, which was issued to manualize the process that ensures that any duplicate payments for services rendered to Medicare beneficiaries are collected. CR5105 ensures that any fee-for-service claims that were approved for payment during a period when the beneficiary was enrolled in a Managed Care Organization are submitted to the normal collection process used by the Medicare contractors (carriers/DMERCs/FIs) for overpayments.

**Background**

The Centers for Medicare & Medicaid Services (CMS) pays for a beneficiary's medical services more than once when a specific set of circumstances occurs. When CMS data systems recognize a beneficiary has enrolled in a MA Organization, the MA Organization receives capitation payments for the Medicare beneficiary. In some cases, enrollments with retroactive payments are processed.

The result is that Medicare may pay for the services rendered during a specific period twice:

- First, for the specific service that was paid by the fee-for-service Medicare contractor to the provider; and
- Second, by the MA Payment Systems in the monthly capitation rate paid to the MA plan for the beneficiary.

### Overview of the MA plan Enrollment Process

When an MA plan enrollment is processed retroactively:

- Fee-for-service claims with dates of service that fall under the managed care plan enrollment period are identified by Medicare's Common Working File (CWF); and
- An Informational Unsolicited Response (IUR) record is created.

In essence, the retroactive enrollment triggers a search for fee-for-service claims that were incorrectly paid for services rendered when the beneficiary was covered by the managed care plan. If such claims are found, the system generates an adjustment and initiation by Medicare systems of overpayment recovery procedures. The current policy/procedures, as outlined in CR2801 (Transmittal AB-03-101, dated July 18, 2003) and CR 5105, dictates that:

- Claims paid in error (due to enrollment or disenrollment corrections) will be adjusted; and
- Medicare contractors will initiate overpayment recovery procedures.

**Note:** CR 2801 (Transmittal AB-03-101, dated July 18, 2003) can be found at <http://www.cms.hhs.gov/Transmittals/Downloads/AB03101.pdf> on the CMS web site:

Because of the inherent retroactivity in the enrollment process, (e.g., beneficiaries can enroll in plans up to the last day of the month, and the effective date would be the first of the following month), the CWF may receive this information after the enrollment is effective. For this reason, these kinds of adjustments occur routinely.

A variety of the CMS systems issues over the past 18 months have prompted CMS to recently synchronize MA enrollment and disenrollment information for the period September 2003 to April 2006. As a result, providers may have claims that were affected by this synchronization. For details of the impact of this synchronization on providers, please see *MLN Matters* article, SE0638, which is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0638.pdf> on the CMS web site.

When claims are identified as needing payment recovery, the related remittance advice for the claim adjustment will indicate Reason Code 24, which states: "Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan." Upon receipt, providers are to contact the managed care plan for payment.

- Providers who bill carriers will be alerted by their carrier (via letter or alternate method) of the following:
  - That the beneficiary was in a managed care plan on the date of service;
  - That the provider should bill the managed care plan;
  - What the plan identification number is; and
  - Where to find the plan name and address associated with the plan number on the CMS web site.
- For providers who bill FIs, the adjustment will occur automatically and information on which plan to contact must be determined through an eligibility inquiry or by contacting the beneficiary directly.

**Note:** To associate plan identification numbers with the plan name, go to [http://www.cms.hhs.gov/HealthPlansGenInfo/claims\\_processing\\_20060120.asp#TopOfPage](http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20060120.asp#TopOfPage) on the CMS web site.

In summary, CMS issued CR5105 to:

- Ensure that any fee-for-service claims that were approved for payment erroneously are submitted to the normal collection process used by the Medicare contractors (carriers, DMERCs, FIs, and RHHIs) for overpayments; and
- Instruct Medicare contractors to follow the instructions outlined in the *Medicare Financial Management Manual* (Publication 100-06, Chapter 3, Section 190), which is included as part of CR5105. Instructions for accessing CR5105 are in the *Additional Information* section of this article.

### **Implementation**

The implementation date for the instruction is June 26, 2006.

### **Additional Information**

For complete details, please see the official instruction issued to your carrier, DMERC, intermediary, or RHHI regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R100FM.pdf> on the CMS web site.

Also, if you have any questions, please contact your carrier/DMERC/intermediary/RHHI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

## **CONSULTATION SERVICES**

Medicare talks with many providers in the community when presenting information on the appropriate use of consultation codes. The following are two examples of questions where a consultation procedure is not appropriate. Please review and compare with your office practices.

WPS Medicare published a National Coverage Provision (NCP) PHYS-006, Consultations that contains information on correctly submitting claims for consultation services. You can find more information on this subject on the following website:  
<http://www.wpsmedicare.com/policies/wisconsin/phys006.pdf>

The Centers for Medicare & Medicaid Services (CMS) also has published information on the rules for consultation services. You can find this information in the Internet Only Manual (IOM) 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.10. Please see the reference below.  
<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

### **Question 1**

The physician has admitted the patient to a palliative care unit in the hospital or nursing facility. Can the palliative care physician responsible for the care in that unit bill for a consultation?

### **Answer 1**

No. The admitting physician is not requesting the advice, opinion, suggestions etc. from the palliative care physician. The palliative care physician has a new or subsequent patient visit

code as appropriate. In addition, depending on how the facility classifies the patient, the billing would reflect the place of service.

### Question 2

A patient has made an appointment with a specialist's office. The patient's attending physician suggested that the patient make the appointment with the specialist. The attending physician and the specialist have not had any contact, either verbal or written, concerning this patient's care. The specialist will send a written report to the attending physician. Is this a consultation?

### Answer 2

No. The attending physician is not requesting the advice, opinion, suggestion etc from the specialist. The specialist does not have any documentation indicating a request from the attending physician. While it is good medical practice for the specialist to share his/her findings with the attending physician, this does not make the service a consultation. The specialist should be an initial or subsequent care visit as appropriate.

## FULL REPLACEMENT OF AND RESCINDING CHANGE REQUEST (CR) 3504 - MODIFICATION TO ONLINE MEDICARE SECONDARY PAYER QUESTIONNAIRE ~CMS MLN Matters~

MLN Matters Number: MM4098 **Revised**  
Related CR Release Date: October 21, 2005  
Related CR Transmittal #: 41

Related Change Request (CR) #: 4098  
Effective Date: January 21, 2006  
Implementation Date: January 21, 2006

**Note:** This article was revised on June 15, 2006, because CR4098, on which this article is based, has been superseded by CR5087. To view modifications to the online Medicare Secondary Payer Questionnaire that are effective as of September 11, 2006, please see MLN Matters article MM5087, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5087.pdf> on the CMS web site.

### Provider Types Affected

Medicare providers who, upon inpatient or outpatient admissions of Medicare beneficiaries, use a questionnaire to determine other insurance coverage that may be primary to Medicare.

### Provider Action Needed

#### **STOP – Impact to You**

CR4098 clarifies recent changes made to the “Medicare Secondary Payer Questionnaire.”

#### **CAUTION – What You Need to Know**

This CR identifies all of the changes that were made to CR3504 **and** makes additional changes to the model questionnaire. These changes will assist providers in identifying other payers that may be primary to Medicare.

#### **GO – What You Need to Do**

Please refer to the *Background* and *Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified.

**Background**

The Centers for Medicare & Medicaid Services (CMS) received information that a prior instruction (CR3504) did not specifically mention all of the changes that were made to the “Medicare Secondary Payer (MSP) Questionnaire.” CR4098 identifies all of the changes made as part of CR3504 and makes additional changes to the model questionnaire.

The *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1, available as an attachment to CR4098, provides a model: “Admission Questions to Ask Medicare Beneficiaries.”

The model contains questions that may be printed out and used as a guide to help identify other payers. (The website for accessing CR4098 is provided in the *Additional Information* section of this article.)

The following bullets identify the changes within the model MSP Questionnaire:

- **Parts IV and V** of the model questionnaire adds the response: “No, Never Employed.”
- In **Parts IV, V, and VI** of the model questionnaire, providers should use “Policy Identification Number” to mean a number that is sometimes referred to as the health insurance benefit package number.
- **Parts IV, V, VI** of the model questionnaire adds “Membership Number” and it refers to the unique identifier assigned to the policyholder/patient.
- **Part V**, question 2 of the model questionnaire uses “spouse” instead of “family member.”
- **Part V**, question 4 changes the model questionnaire to read:

*Are you covered under the group health plan of a family member other than your spouse? \_\_\_\_\_ Yes \_\_\_\_\_ No.*

*Name and address of your family member’s employer:\_\_\_\_\_*

- **Part V** of the old question 4 is changed to ask whether the beneficiary is covered under a group health plan (GHP) and a question number 5 is added to gather the pertinent information about the GHP.
- In **Part VI**, question 6 now reads: “Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?”

Providers who use the model questionnaire to elicit MSP information from their Medicare patients should take special note of these changes.

**Implementation**

The implementation date for the instruction is January 21, 2006.

**Additional Information**

The official instructions issued to your Medicare carrier or intermediary regarding this change and the model questionnaire can be found at

**<http://www.cms.hhs.gov/transmittals/downloads/R41MSP.pdf>** on the CMS web site.

If you have questions, please contact your carrier/intermediary at their toll-free number which may be found at

**<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>** on the CMS web site.

## HOSPICE AND BILLING OF EVALUATION AND MANAGEMENT SERVICES

*When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payment for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an "attending physician."* For purposes of administering the hospice benefit provision, an attending physician means a physician who: is a doctor of medicine or osteopathy; and is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.

When an attending physician is under a payment arrangement with the hospice, services related to the patient's terminal condition should be billed by the hospice to its intermediary. Hospice physician services are paid by the hospice intermediary at 100 percent of Medicare approved charges.

An attending physician who provides services that are **not furnished under a payment relationship with the hospice** should bill Medicare Part B for these services. These services are reimbursed under the physician fee schedule.

The attending physician would code services with the GV modifier..."Attending physician not employed or paid under agreement by the patient's hospice provider" when billing his/her professional services furnished for the treatment and management of a hospice patient's terminal condition.

Medical documentation should note if the provider is the attending physician selected by the beneficiary. Use of the GV modifier attests that the attending physician is under no payment arrangements with the hospice.

See National Coverage Provision (NCP) PHYS-051, Indication and Limitations for Coverage, C. Physicians Services, under numbers 1, 3 and 4 and the Coding Guidelines number 2 for the guidelines on Hospice care and attending physician services.

### Program Safeguards

## SANCTIONED AND REINSTATED PROVIDERS

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

When an exclusion is imposed, no payment is made after the date of the exclusion to anyone for any item or service (other than emergency items or services not provided in a hospital

emergency room) furnished, ordered or prescribed by an excluded party. This is based upon Sections 1128 and 1156 of the Social Security Act.

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

Wisconsin Physicians Service (WPS) will not issue payments for services performed, ordered or referred by these providers after the indicated dates. All providers are excluded as of June 20, 2006 unless otherwise indicated after their name.

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

Illinois Sanctioned Providers

Name/Specialty/Address/Date of Birth
Dana Rashawn Dove Therapist 6 Manchester Lane Vernon Hills, IL 60061 11/08/1969

Name/Specialty/Address/Date of Birth
Russell Aaron Morgan, C.P. Psychological Practice 14227 S. Hanford Court Plainfield, IL 60544 10/10/1956

Illinois Reinstated Providers

Name/Specialty/Date of Birth/Effective Date
Penny Lynn Chenoweth, L.P.N. AKA: Penny L. Bainter Licensed Practical Nurse 804 East Murray Macomb, IL 61455 12/30/1962 <b>REINSTATED: June 5, 2006</b>
Jo Anne O'Marrah Pharmacy Technician 13560 Kristoffer Lane Orlando Park, IL 60467 10/14/1951 <b>REINSTATED: 05/23/2006</b>

Name/Specialty/Date of Birth/Effective Date
Kenneth E. Robinson, M.D. General Practice Physician 3912 W. Gladys Ave. Chicago, IL 60624 11/28/1955 <b>REINSTATED: 05/24/2006</b>
Kelly G. Worth, D.C. Chiropractor 2634 Grand Ave., Ste 100 Waukegan, IL 60085 01/28/1961 <b>REINSTATED: 05/03/2006</b>

Michigan Reinstated Providers

Name/Specialty/Date of Birth/Effective Date
William Leon Bennett, R.N. Registered Nurse 857 E. Rowland Avenue Madison Heights, MI 48071 01/01/1964 <b>REINSTATED: 06/22/2006</b>
John Victor King, III, D.D.S. Dentist 22900 Thorncliffe Dr. Southfield, MI 48034 09/01/1944 <b>REINSTATED: 05/16/2006</b>

Name/Specialty/Date of Birth/Effective Date
Guercy Saint Phard, D.P.M. Podiatrist 550 Maplewood Ct., #F64 Berrien Springs, MI 49103 04/05/1955 <b>REINSTATED: 06/06/2006</b>

Minnesota Sanctioned Providers

Name/Specialty/Address/Date of Birth
Brittany M. Koehler Nurse/Nurses Aide 433 Turril St., #5 Le Sueur, MN 56058 09/19/1983
Rebecca Jean Ledford Employee P O Box 191 Good Thunder, MN 56037 09/10/1983

Name/Specialty/Address/Date of Birth
Oliver U. Obi, R. Ph. Pharmacist P O Box 1000, #31629-039 Duluth, MN 55814 11/30/1954

Minnesota Reinstated Providers

Name/Specialty/Date of Birth/Effective Date
Stephen D. Scotti, M.D. Medical Doctor 6839 Langford Dr. Edina, MN 55436 11/16/1957 <b>REINSTATED: 06/01/2006</b>

Name/Specialty/Date of Birth /Effective Date
John R. Stroemer, M.D. General Practice Physician 1121 Jackson St., N. E., Ste 105 Minneapolis, MN 55413 06/02/1950 <b>REINSTATED: 05/16/2006</b>

Wisconsin Sanctioned Providers

Name/Specialty/Address/Date of Birth
Amy S. Darling Nurse/Nurses Aide 21425-A Spring St., #00481927 Union Grove, WI 53182 01/15/1965
Jason Gendrich Employee 450 Kimberly Dr., #20 Waukesha, WI 53188 11/09/1982

Name/Specialty/Address/Date of Birth
Sheryl A. Hayes Health Care Aide 312 Martin Street Fort Atkinson, WI 53538 07/07/1958
Linda Kluge Health Care Aide 524 Wells Street, #107 Lake Geneva, WI 53147 12/25/1960

**Provider Education**

**LET CMS KEEP YOU UP-TO-DATE!**

In the fast-paced, ever-changing world in which we live, it's all too easy to find yourself inundated with information. The Centers for Medicare & Medicaid Services (CMS) offers a way for you to receive consistent and accurate information regarding recent news, policy changes, and updates: CMS Mailing Lists. Also referred to as listservs, these electronic mailing lists enable you to receive e-mails about the latest CMS Fee-for-Service (FFS) initiatives. All that is required to subscribe is your name and a valid e-mail address, and you can start receiving electronic updates automatically!

A fast sheet about CMS Listservs may be obtained at [http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists\\_FactSheet.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf)

Hardcopies can also be ordered by going to the MLN Products Ordering Page at: [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) and then click on the first item under 'Informational Resources.'

**MEDICARE LEARNING NETWORK PRODUCTS FOR PHYSICIANS**

The Facilitator's Guide, which provides facilitators with everything needed to prepare for and conduct a Medicare Program training course and is a companion to the Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals, is now available in downloadable format on the MLN Publication Page located at <http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp> on the Centers for Medicare & Medicaid Services (CMS) website.

The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals in CD-ROM format is available free of charge from the MLN Product Ordering Page located at <http://www.cms.hhs.gov/mlngeninfo/> on the CMS website.

## NOVICE KNOW-HOW – A TREASURE TROVE OF EDUCATIONAL MATERIALS FOR YOU!

Wisconsin Physicians Service (WPS) Medicare recognizes the need to provide you with educational resources designed to keep you informed about Medicare. You may easily reach the WPS Medicare Website at: <http://www.wpsmedicare.com>

To access educational materials on our Website, click on the “Providers” tab, next, click on the Provider Education bullet (on the left side of the page), and click on Educational Materials. This will transfer you to a listing of Educational Materials. Among the items offered are Topic Specific Guides including:

- General Medicare
- Surgery Fundamentals
- Eye Care
- Common Medicare Modifiers
- Practical Solutions to Your Medicare Claim Denials – Reference Guide

In addition, you can access Audio/Video files of Webinars/iLinc Sessions, Audio files of various Teleconferences, including Ask the Contractor Teleconferences, and the downloadable CD-Rom containing presentations and handouts from A Day with Medicare & Partners – February 13, 2006. Archived educational materials are also available. To transfer directly to the Educational Materials page on our Website, go to:  
[http://wpsmedicare.com/provider/provider\\_ed\\_online.shtml](http://wpsmedicare.com/provider/provider_ed_online.shtml)

Please note: All educational materials are current as of the dates listed on the Website. You can get the most up-to-date information by attending WPS Medicare seminars, teleconferences, and Webinars/iLinc sessions. For more information about our educational sessions, refer to the Education Schedule available at the following address on our Website:  
[http://wpsmedicare.com/provider/proved\\_seminar.shtml](http://wpsmedicare.com/provider/proved_seminar.shtml)

## UPCOMING NPI OUTREACH EVENTS

CMS and the Workgroup for Electronic Data Interchange (WEDI) are working together to ensure that all healthcare providers are educated and informed on the new National Provider Identifier (NPI). As such there are a few upcoming outreach events, sponsored by WEDI, that healthcare providers may find helpful:

- \* Taxi-ing to the Taxonomy Code Audiocast  
July 26th from 2 - 3:30PM Eastern Time  
<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=22D40000004>
- \* WEDI NPI Industry Forum IV: NPI Is Knocking At Your Door—Will You Let It In?  
August 15th and 16th at the Hyatt Fair Lakes in Fairfax, VA  
<http://www.wedi.org/forms/meeting/MeetingFormPublic/view?id=1EFC0000000A>

Please note that there is a cost to participate in these events. To learn more about the events, as well as the latest news on WEDI NPI outreach, visit <http://www.wedi.org/npioi/index.shtml> on the web.

## SEMINAR SCHEDULE

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

### Seminars

#### Beyond the Basics

Date/Time	Course Number	Location	Address
08/03/2006 9:00am - 3:00pm	MN2011	Rochester, MN	Ramada Inn 1517 16th St SW

#### CMS Chiropractic Demonstration Education Project

Date/Time	Course Number	Location	Address
08/17/2006 9:00am - 12:00pm	ICH8	Willowbrook, IL	Holiday Inn 7800 Kingery Rd

#### New Provider Medicare Basics

Date/Time	Course Number	Location	Address
08/02/2006 9:00am - 3:00pm	MN1010	Rochester, MN	Ramada Inn 1517 16th St SW

#### Beyond the Basics

Want to expand your Medicare knowledge and understand it to the fullest? The "hands-on" design of our Beyond the Basics seminar will take you to the next level. Together, we will explore educational opportunities to meet WPS Medicare's ultimate goal; to pay claims correctly the first time, every time.

The design of this program will benefit participants with a good deal of Medicare billing experience, not beginners. Join us for this full-day comprehensive session, divided into three educational modules:

- Module 1 - Day to Day Information
- Module 2 - Medical Review, Medical Policy and Modifiers
- Module 3 - Timely Topics

Because it is our intent to focus on instruction that is beyond the basics, we are interested in hearing about the topics each participant would like addressed at our session. Our new and improved easy on-line registration process allows you to tell us what you would like to know more about. Sign up today - we look forward to seeing you soon!

The American Academy of Professional Coders awarded "Beyond the Basics," 5 Continuing Education Units effective January 20, 2006.

**CMS Chiropractic Demonstration Education Project**

At this half-day session WPS will assist Chiropractors and their staff with the most current information regarding Medicare billing as it relates to the Chiropractic Demonstration Project claim filing. In addition, this session will provide up-to-date information on the expansion of coverage for Chiropractic services in selected areas. If you provide Chiropractic services in any of the following 26 counties in **Illinois** and currently are or plan on participating in the Chiropractic demonstration project, this seminar will provide you with the most up-to-date information on this project.

Boone	Henry	Lee	Stark	Bureau
JoDaviess	Marshall	Stephenson	Carroll	Kane
McHenry	Whiteside	Cook	Kankakee	Mercer
Will	DeKalb	Kendall	Ogle	Winnebago
DuPage	Lake	Putnam	Grundy	LaSalle
Rock Island				

Scott County, Iowa is also included in this Chiropractic demonstration.

Specific topics for review of coverage provisions and billing requirements include:

Modifiers: AT, GP, 25, 59, KX	Services provided "Incident to"
Modifier positions	New vs. established patients
Medical Necessity	Requirements for separate claims
E/M services and documentation	Demo 45 documentation requirements
Diagnostic services	Electronic claims filing instructions
Therapy services	Project participation
Referrals by chiropractors	Effectiveness measures
Non-covered services	Provider Education resources
(Modifier GY)	Medicare Part D Prescription Drug Benefit

**Please note: You will only be able to participate in the demonstration if you provide services in the counties listed above.**

**New Provider Medicare Basics**

We designed this all-day session to provide a general overview of the Medicare Program for those just starting to bill the Medicare Program. This session will help those billing Medicare to understand claim submissions, medical necessity, beneficiary information and much more. Other topics that we will cover include:

- Correct Coding Initiatives
- Claim Filing (electronic)

Unprocessable Guidelines  
 Medicare Secondary Payer  
 Reimbursement  
 Financial  
 Advanced Beneficiary Notices  
 Provider Enrollment  
 Limiting Charge  
 Medigap and Crossover  
 Appeals Process  
 Health Insurance Portability and Accountability Act (HIPAA)

WPS Medicare's intent is to provide you with a valuable learning experience. Please use our new and improved registration process to tell us what you are interested in learning about. As always, we look forward to hearing from you.

The American Academy of Professional Coders awarded "New Provider Medicare Basics," 5 Continuing Education Units effective January 20, 2006.

## Teleconferences

### Ask the Contractor Teleconferences (ACTs)

Topic	Date	Day	Time	Handouts
Topic to be Announced	09/20/06	Wednesday	9:00 - 10:30 a.m. CDT	Not Yet Available

### Comprehensive Error Rate Testing (CERT) Program Teleconference

Date/Time	Course Number	Handouts
08/16/06 08:00 - 9:00 am CST	TCRT3	Not Yet Available

### Medical Decision Making Component for E/M Services and Probe Findings for CPT Codes 99214 and 99215

Date/Time	Course Number	Handouts
08/23/06 8:00am - 9:30am CDT	TPEM4 <b>FULL</b>	Not Yet Available

### Mental Health Teleconference

Date/Time	Course Number	Handouts
08/24/06 1:30pm - 3:00pm CDT	TMH2 <b>FULL</b>	Not Yet Available

### Comprehensive Error Rate Testing (CERT) Program Teleconference

The foundation of what makes the Medicare program viable is simple: correctly paid claims. Learn what you can do to assist in the crucial success of reducing claim error rates in this one hour teleconference designed to enhance your understanding of the Comprehensive Error Rate Testing (CERT) program. Registration is simple; it only takes a few minutes to sign up. There

are no registration fees or costs. Handout materials will be available on at [http://www.wpsmedicare.com/provider/proved\\_seminar.shtml](http://www.wpsmedicare.com/provider/proved_seminar.shtml) one week prior to the teleconference.

Topics will include:

- What is the CERT Program and process?
- CERT Contractor Role
- Types of Error Rates
- Top CERT Program Errors and tips to avoid them
- Corrective Actions taken by the Affiliated Contractor
- Available Tools and Resources
- Questions and Answers

This teleconference is designed to help providers and their staff gain insight into the CERT program. If you are unable to attend this program, a similar program will be repeated on a quarterly basis. The goal of this session is to provide participants with all the necessary tools to meet WPS Medicare's goal to pay claims correctly the first time, every time.

### **Medical Decision Making Component for E/M Services and Probe Findings for CPT Codes 99214 and 99215**

Medical decision making component should always be a part of each patient E & M encounter. Medical decision making is the third key component in an Evaluation and Management (E & M) visit. This is the last presentation in our "Principles of E/M" teleconference series. This seminar on medical decision making will address definitions and specific guidelines for the following issues:

- Four Levels of Medical Decision Making
- Diagnoses or Management Options
- Complexity of Data Reviewed
- Risk of Significant Complications, Morbidity, and/or Mortality

We will discuss our recent Provider Specific Probe findings for CPT codes 99214 and 99215 and specific guidelines for the following issues:

- Documentation of Level of Service Billed
- Medical Necessity of Level of Service Billed

### **Mental Health Teleconference**

Medicare Part B helps pay for outpatient mental health services, such as services that are usually given outside a hospital and those that are given in the hospital's outpatient department and do not require an overnight stay. Join us for this teleconference and expand your Medicare Mental Health knowledge. Billers, coders, and people who perform mental health services for their Medicare patients will benefit from this session.

Participation in this educational opportunity affords you an opportunity to learn about Medicare's Mental Health Provider qualifications, the types of treatment considered for Medicare payment, and the specific criteria which determines whether a mental health service is covered by Medicare and under what circumstances. We will include a review of information available in Medicare's Psychiatry and Psychology Services policy.

You may choose a date that is convenient for you since this teleconference will take place in May and will be repeated in August. Each session will focus on the basics necessary to understand and properly bill for Medicare Part B Mental Health benefits. Join us - our on-line registration process is easy!

## Webinars

### Subsequent Hospital Care Codes CPT 99321-99233

Date/Time	Course Number	Handouts
09/27/06 2:00pm - 3:30pm CDT	iSCC1 <b>FULL</b>	Not Yet Available

### Provider Enrollment

Date/Time	Course Number	Handouts
08/10/06 10:00am - 11:30am CDT	iPE6	Not Yet Available
08/17/06 10:00am - 11:30am CDT	iPE7	Not Yet Available
08/24/06 10:00am - 11:30am CDT	iPE8	Not Yet Available
08/31/06 10:00am - 11:30am CDT	iPE9	Not Yet Available

### Subsequent Hospital Care Codes CPT 99321-99233

Would you benefit from a review of the key documentation guidelines, which are required in order to bill the Subsequent Hospital codes? If so, this iLinc presentation is for you. The presentation will review the documentation basics of the Evaluation and Management components and then focus on the issues specific to Subsequent Hospital Care. Presenters include clinical specialists and Provider Education Staff that will also conduct a Q & A session. Billers, coders, and clinicians will benefit from this session. **Space is limited for this course, so please be sure to sign up soon.**

### Provider Enrollment

Do you have questions regarding the Medicare provider enrollment process? If so, you will want to attend the Medicare Provider Enrollment Webinar via iLinc. The Webinar will cover:

- Which application to use (855B, 855I, 855R)
- Tips for completing the application
- Why you need a National Provider Identifier (NPI)
- What Electronic Funds Transfer (EFT) is and how to get it
- Open question and answer session with WPS Medicare Provider Outreach and Medicare Provider Enrollment staff

Let us help you make your application process as easy as possible.

We have a limited number of spaces available. To ensure your space, please register soon. All you will need is a phone line and separate Internet access.

Once you have registered, we will send you a confirmation with the following four pieces of information:

- The Web address you will need to access the video portion of the session
- The telephone number to call for the audio portion of the session
- The telephone passcode
- The directions for printing the handouts

If you are not familiar with iLinc and would like to take our on-line tutorial, please go to:  
[http://www.wpsmedicare.com/provider/ilinc\\_files/frame.html](http://www.wpsmedicare.com/provider/ilinc_files/frame.html)

Please note: More than one person can observe a session from a single computer.

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

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

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

## Reimbursement

### DEFICIT REDUCTION ACT OF 2005 – NINE DAY PAYMENT HOLD

This message is a reminder for all providers and physicians who bill Medicare contractors for their services.

A brief hold will be placed on Medicare payments for all claims during the last 9 days of the Federal fiscal year (September 22 through September 30, 2006). These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or individual by reason of this one-time hold on payments. All claims held during this time will be paid on October 2, 2006.

This policy only applies to claims subject to payment. It does not apply to full denials, no-pay claims, and other non-claim payments such as periodic interim payments, home health requests for anticipated payments, and cost report settlements.

Please note that payments will not be staggered and no advance payments will be allowed during this 9-day hold.

For more information, please view the MLN Matters Article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf>

## **INTEREST RATE ON CLEAN CLAIMS NOT PAID TIMELY**

Per Change Request (CR) 3557, carriers and fiscal intermediaries (FIs) that do not pay clean claims in a timely manner (i.e., 30 days after the day of receipt of a claim) must pay interest. Interest accrues until and including the day of late payment.

For the Period beginning July 1, 2006, and ending December 31, 2006, the rate of interest applicable for the purpose of the cited sections is 5.75% (5.75 per centum) per annum. This rate was published in the Federal Register, Volume 71, Number 126, Pages 37638-37639 on Friday, June 30, 2006.

To read more about how the Centers for Medicare & Medicaid Services (CMS) defines a clean claim and how to calculate interest payments, please refer to the Medlearn Matters article available at: <http://www.cms.hhs.gov/transmittals/Downloads/R416CP.pdf>

## **JULY 2006 QUARTERLY AVERAGE SALES PRICE (ASP) MEDICARE PART B DRUG PRICING FILE, EFFECTIVE JULY 1, 2006, AND REVISIONS TO JANUARY 2006 AND APRIL 2006 QUARTERLY ASP MEDICARE PART B DRUG PRICING FILES**

~ CMS MLN Matters ~

**MLN Matters Number: MM5110 Revised**  
**Related CR Release Date: June 9, 2006**  
**Related CR Transmittal #: R974CP**

**Related Change Request (CR) #: 5110**  
**Effective Date: July 1, 2006**  
**Implementation Date: July 3, 2006**

**Note:** This article was revised on July 17, 2006, to include an additional web address in the "Additional Information" section. This address houses Part B Drug information and the quarterly ASP Medicare Drug Pricing Files.

### **Provider Types Affected**

Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), and carriers including durable medical equipment regional carriers (DMERCs)) for services.

### **Provider Action Needed**

#### **STOP – Impact to You**

CR5110 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective July 1, 2006 through September 30, 2006, as well as revised payment files for the January 2006, and April 2006 Quarterly ASP Medicare Part B Drug Pricing Files.

**CAUTION – What You Need to Know**

Certain Medicare Part B drug payment limits have been revised and the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance quarterly. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR5110.

**GO – What You Need to Do**

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

**Background**

According to Section 303(c) of the Medicare Modernization Act of 2004 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis.

As mentioned in previous articles (see MM4319 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf>), beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on **106 percent** of the average sales price (ASP).

Pricing for compounded drugs is performed by the local Medicare contractor.

**ESRD Drugs**

Additionally, in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPTS, are paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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

Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPTS, will be paid based on **106 percent** of the ASP. CMS will update the payment allowance limits quarterly.

**Exceptions**

There are exceptions to these general rules and those exceptions are outlined in MLN Matters article MM4319, which can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4319.pdf> on the CMS web site.

With regard to the exceptions listed in MM4319, note that the payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded.

The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP, unless the drug is compounded.

***Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir***

Physicians (or other authorized practitioners) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to do so. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir, is determined under the ASP methodology.

Note that the use of the implantable pump or reservoir must be found medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.


If a physician or other practitioner is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if:

- The medication administered is accepted as a safe and effective treatment of the patient's illness or injury;
- There is a medical reason that the medication cannot be taken orally; and
- The skills of the nurse are needed to infuse the medication effectively.

***How the ASP Is Calculated***

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter:

- The revised January 2006 payment allowance limits apply to dates of service January 1, 2006, through March 31, 2006.
- The revised April 2006 payment allowance limits apply to dates of service April 1, 2006, through June 30, 2006.
- The July 2006 payment allowance limits apply to dates of service July 1, 2006, through September 30, 2006.

	<p>The absence or presence of a HCPCS (Healthcare Common Procedure Coding System) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The carrier processing your claim will make these determinations.</p>
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**Implementation**

The implementation date for the instruction is July 3, 2006.

**Additional Information**

The *Medicare Claims Processing Manual*, Publication 100-04, Chapter 17, Drugs and Biologicals, contains information that is pertinent to MM5110. It is located at <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf> on the CMS web site.

Quarterly Part B Drug Pricing files and information are also available at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice> on the CMS web site.

CR5110 is the official instruction issued to your Medicare carrier/FI/RHHI/DMERC regarding changes mentioned in this article. CR5110 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R974CP.pdf> on the CMS web site.

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

## REQUIREMENTS FOR DIAGNOSTIC X-RAY, DIAGNOSTIC LABORATORY, AND OTHER DIAGNOSTIC TESTS; CLINICAL PSYCHOLOGIST SERVICES ~CMS MLN Matters~

MLN Matters Number: MM4400  
Related CR Release Date: June 23, 2006  
Related CR Transmittal #: R51BP

Related Change Request (CR) #: 4400  
Effective Date: January 1, 2005  
Implementation Date: September 21, 2006

### Provider Types Affected

Physicians, providers, and/or clinical psychologists who submit claims to Medicare carriers, for diagnostic psychological testing services

### Impact on Providers

- CR4400 alerts providers that Medicare may now pay for the services of a clinical psychologist when they supervise the performance of diagnostic psychological testing.
- Under the physician supervision level of four, Medicare's physician supervision policy is modified so the policy does not apply when the procedure is furnished under the general supervision of a clinical psychologist.
- Medicare carriers are not required to retroactively process claims for the period between January 1, 2005, and the implementation date. Carriers are to reprocess claims that are brought to their attention that have been denied with dates of service on or after January 1, 2005.

### Background

Diagnostic psychological testing may now be performed under the general supervision of a clinical psychologist. This change may be found in the revised *Medicare Benefit Policy Manual*, Chapter 15 - Covered Medical and Other Health Services, Section 160 - Clinical Psychologist Services.

As a reminder, to qualify as a clinical psychologist (CP), a practitioner must meet the following requirements:

- Hold a doctoral degree in psychology; and
- Be licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

### Implementation

The implementation date for this instruction is September 21, 2006.

**Additional Information**

The revised *Medicare Benefit Policy Manual*, Chapter 15 - Covered Medical and Other Health Services, Sections 80 and 160 - Clinical Psychologist Services, is attached to CR4400, which is the official instruction issued to your carrier regarding this change. CR 4400 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R51BP.pdf> on the CMS web site.

If you have questions, please contact your Medicare carrier at their toll-free number which may be found at <http://www.cms.hhs.gov/apps/contacts/> on the CMS web site.

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

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