

ITEMS OF IMPORTANCE

Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500..... 2

Are You Ready? Did You Know? 4

CMS Awards the First of 15 Medicare Administrative Contractors (MACs) to process both Part A & Part B Medicare Claims 5

How Long Should I Keep Records on File for Medicare Purposes?..... 6

Notice Regarding Provider Customer Service Closings 7

Planned Release of a Request for Information (RFI) Concerning The Scope of Work and Specialty Activities that CMS Will Include in the Next Medicare Administrative Contractor (MAC) Procurements 7

CLAIM SUBMISSION

Billing for Implantable Epidural/Subarachnoid Pain Pump Refills..... 8

Key for Evaluation and Management (E/M) Documentation..... 9

Medical Decision Making in the E/M Visit 10

Update of Radiopharmaceutical Imaging Agents Healthcare Common Procedure Coding System (HCPCS) Codes Applicable to Positron Emission Tomography (PET) Scan Services for Carriers..... 12

COMPREHENSIVE ERROR RATE TESTING (CERT)

CERT Error Focus – Subsequent Hospital Visits - CPT 99231-99233 13

COVERAGE – GENERAL

Outpatient Therapy – Additional DRA Mandated Service Edits..... 15

COVERAGE – POLICIES

2007 ICD-9-CM Coverage - Policy Revisions..... 22

Information on Website..... 26

Links to New and Revised Policies..... 27

COVERAGE – NEW POLICIES

CV-040: Cardiac Rhythm Device Evaluation 27

COVERAGE – REVISED POLICIES

CV-033: Non-Invasive Vascular Testing 28

INJ-019: Human Granulocyte/Macrophage Colony Stimulating Factors 29

OPHTH-003: Optometrist Services 30

OPHTH-022: Blepharoplasty, Blepharoptosis and Brow Lift..... 30

PHYS-040: Influenza, Pneumococcal and Hepatitis-B Vaccinations 31

ELECTRONIC DATA INTERCHANGE (EDI)

Electronic MSP Claim Balancing FAQs 32

MCS 837 4010A1 Prepass Edits 34

Standard Paper Remittance (SPR) Suppression 35

GENERAL INFORMATION

Disclosure Desk Reference for Provider Contact Centers 36

Guide to Obtaining Beneficiary Eligibility and Claim Status Information..... 40

Laboratory Competitive Bidding Demonstration 41

Medicare as Secondary Payer (MSP): Liability Situations..... 45

PROGRAM SAFEGUARDS

Sanctioned and Reinstated Providers 45

PROVIDER EDUCATION

Novice Know-How – Unprocessable Claims 47

Provider Education Schedule 48

REIMBURSEMENT

2007 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments 50

Clarification Regarding Effective Dates for Carrier Claim Adjustments: Denied Replacement Defibrillator Claims Lacking a QR Modifier 51

Non-Application of Deductible for Colorectal Cancer Screening Tests 53

Non-Physician Practitioner (NPP) Payment for Care Plan Oversight (CPO)..... 54

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Items of Importance

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

MLN Matters Number: MM5060
Related CR Release Date: July 28, 2006
Related CR Transmittal #: R1010CP

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

Provider Types Affected

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

Key Points

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

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

Background

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

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

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

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

Billing Guidelines

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

Additional Information

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

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

Legacy identifiers are pre-NPI provider identifiers such as:

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

Additional NPI-Related Information

Additional NPI-related information can be found at

<http://www.cms.hhs.gov/NationalProvidentStand/> on the CMS Website.

The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Website at

http://www.nucc.org/images/stories/PDF/change_log.pdf.

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

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

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

CR5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1010CP.pdf> on the CMS Website.

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

ARE YOU READY? DID YOU KNOW?

- Effective October 1, 2006, Medicare will send only Health Insurance Portability and Accountability Act (HIPAA)-compliant Electronic Remittance Advice (ERA) transactions (transaction 835 version 004010A1) to all electronic remittance advice receivers.
- The National Provider Identifier (NPI) compliance deadline date is May 23, 2007. Have you applied for your NPI yet?
- January 3, 2006 – October 1, 2006: Medicare will reject claims with only NPIs and no legacy number.
- October 2, 2006 – May 22, 2007: Medicare will accept claims with legacy number and/or an NPI and will send NPIs in outbound transactions.
- Beginning September 4, 2006, WPS will assist electronic submitters in end-to-end NPI testing.
- May 23, 2007 – Forward: Medicare will only accept claims with NPIs.
- If you use the Medicare PC-Ace software, you must upgrade to the 1.74 version of the software to allow for NPI numbers.
- Flu Season is almost here; will your software enable you to send a HIPAA-compliant file to WPS? Our PC-Ace software can help you.

- Any providers submitting a CMS-855 change request or initially enrolling in the Medicare program will be required to sign up for Electronic Funds Transfer (EFT) payments.
- Effective immediately, Medicare will not accept any termination request of your EFT.
- The WPS EDI departments are experiencing a very high call volume. If you cannot get through to one of our representatives, please leave a message and you will receive a call back within 24 hours.
- The EDI Hotline that serves IL, MI, and WI is a toll-free number: 877-567-7261
- The MN EDI toll-free number is 866-380-4742, or you can reach the staff directly at 952-885-2881, 952-885-2882, and 952-885-2811.
- Please visit our EDI page at http://www.wpsmedicare.com/provider/hipaa_medicare.shtml or see our August 2006 *Communiqué* for more detailed information on each of these points.

CMS AWARDS THE FIRST OF 15 MEDICARE ADMINISTRATIVE CONTRACTORS (MACS) TO PROCESS BOTH PART A & PART B MEDICARE CLAIMS

The Centers for Medicare & Medicaid Services (CMS) today announced the award of the first of 15 contracts for the combined handling in six states of both Part A and Part B Medicare claims. The winning contractor is Noridian Administrative Services, LLC, (NAS), headquartered in Fargo, N.D.

As the new Part A/Part B Medicare Administrative Contractor (A/B MAC), NAS will serve as the first point-of-contact for processing and paying fee-for-service claims from hospitals and other institutional providers, physicians, and other practitioners in Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming.

“The contract award is a major step to improved Medicare service for beneficiaries and providers, and significant cost savings from greater efficiency in managing the original fee-for-service Medicare program,” said CMS Administrator Mark B. McClellan, M.D., Ph.D. “Noridian Administrative Services was selected through a full and open performance-based competition to administer the program as effectively and efficiently as possible.”

The A/B MAC contract, which has a value of \$28.9 million for the first year of performance, is the first of 15 to be awarded by 2011 to fulfill requirements of the contracting reform provisions of the Medicare Modernization Act of 2003. NAS will immediately begin implementation activities and will assume full responsibilities for the claims processing work in its six-state jurisdiction no later than March 2007.

For more information, see:

<http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1919>

HOW LONG SHOULD I KEEP RECORDS ON FILE FOR MEDICARE PURPOSES?

There is a lot of confusion in the provider community about how long to keep records on file. There are several types of records discussed.

Medical documentation is the notes/test results pertaining to services provided to the patient. Medicare uses this documentation to verify the provider performed the service billed and that the services were coded correctly and medically necessary. Accurate and complete records are a worthwhile investment and can save time and money in the event of an audit. Providers should store records in a format that makes it easy for retrieval. If a provider has to go through thousands of boxes to find the record in question, it will cost time and money.

If Medicare requests documentation, the entity Medicare paid for the service is the entity responsible for supplying the documentation. This means that if a provider has billed and Medicare has reimbursed for a visit to a patient in the hospital, nursing facility, etc. or for a purchased diagnostic service, he/she should verify that the documentation to support that service is available. Medicare has received several different types of responses to requests for medical records including, "That's at the hospital, you'll need to contact them," "I don't know where the records are, I just started working here last week." and "Records, what records?"

The second type of record is notification of any payments from any insurance primary to Medicare. This includes the Explanation of Benefits and any appeals the provider may have made pertaining to the claim.

The third type of record is the payment record from Medicare. This includes Remittance notices, overpayment notices, record of payments back to Medicare and any appeals taken on specific claims.

Another type of record is the provider enrollment information. This indicates that a provider is who they say they are and is located where they claim to be. The enrollment information also indicates if the entity is a group and that the members of the group really do exist.

Providers who sign the Electronic Data Interchange (EDI) Enrollment form agree to keep medical records no less than 6 years, three months after Medicare has paid the claim. This means that if a claim for a date of services 1/1/05 and completed processing on 6/30/05, then records should be kept until at least 9/30/11.

Medicare recommends that providers keep records on file for at least 7 years unless state statute or your own comfort level tells you otherwise.

Medicare has received questions on record retention when the provider retires, leaves a practice, or passes away. The same information listed above applies. In some cases, a provider retiring will sell his/her practice to someone else. The retiring provider should verify that they have access to the records should that become necessary. When a provider leaves a group practice, the group verifies that records are accessible. When a provider passes away, the estate verifies that records are available for the time-frames listed above.

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 September, we will be closed on:

Thursday, September 14, 2006, 8:00 am – 10:00 am CT

Thursday, September 21, 2006, 8:00 am – 10:00 am CT

During this time, 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.

PLANNED RELEASE OF A REQUEST FOR INFORMATION (RFI) CONCERNING THE SCOPE OF WORK AND SPECIALTY ACTIVITIES THAT CMS WILL INCLUDE IN THE NEXT MEDICARE ADMINISTRATIVE CONTRACTOR (MAC) PROCUREMENTS

CMS announced on July 31, 2006 the awarding of the first of 15 contracts for the combined administration of Part A and Part B claims activities in a multi-state jurisdiction. That first Medicare Administrative Contractor (MAC) award was for the 6-state jurisdiction of Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming (Jurisdiction 3).

CMS has 14 more Part A/Part B MAC contracts to acquire through the competitive process. These procurements will be conducted in two cycles. Cycle One of the A/B MAC acquisitions will be for 7 jurisdictions, accounting for approximately 45 percent of the Part A/Part B fee-for-service claims workload. CMS will conduct these 7 competitions in two rounds.

The first round of competitions under Cycle One will cover 3 jurisdictions:

- J4 (Colorado, Oklahoma, New Mexico, and Texas)
- J5 (Iowa, Kansas, Missouri, and Nebraska) and
- J12 (Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania)

The Request for Proposal for this first round of competitions under Cycle One will include mandatory options for the following specialty activities:

- Indian Health Services for J4
- Veterans Affairs Medicare Equivalent Remittance Advice for J4
- Centralized Billing for Mass Immunizers and for J4
- Rural Community Hospitals, which will also be required for J4 and J5.

On Wednesday, August 9, 2006 CMS will publish on the Federal Business Opportunities Website (<http://www.FedBizOpps.gov>) a Request for Information (RFI) containing the planned SOW for the second round of competitions under Cycle One. Public comments will be due on Thursday, August 31. CMS encourages everyone to review the RFI and provide comments or questions. You will find guidance on how/where to submit comments and questions about the RFI on that same FedBizOpps site.

The second round of competitions under Cycle One will include the remaining jurisdictions:

- J1 (American Samoa, California, Guam, Hawaii, Nevada and Northern Mariana Islands)
- J2 (Alaska, Idaho, Oregon and Washington)
- J7 (Arkansas, Louisiana and Mississippi)
- J13 (Connecticut and New York)

The RFP for this second round of competition will include the following mandatory options:

- Competitive Acquisition Program for Part B Drugs (CAP) and
- Rural Community Hospital for J1, and J2

To learn more about the transition to the A/B MAC environment, please visit the Medicare Contracting Reform Website at: <http://www.cms.hhs.gov/MedicareContractingReform/>

Claim Submission

BILLING FOR IMPLANTABLE EPIDURAL/SUBARACHNOID PAIN PUMP REFILLS

The use of infusion pumps is covered by a National Coverage Decision (NCD) (Pub 100-03, Ch 1, sec 280.14).

More specifically, implantable epidural/subarachnoid pain pumps need to be refilled approximately every 30 days. The capacity of these pumps is small (i.e., ~18 milliliters). Therefore, a highly concentrated, sterile, preservative-free solution is needed for these pump refills. These solutions are usually reconstituted/compounded from powdered drug forms, or highly concentrated solutions, by a compounding pharmacy, based on individual patient prescription, and sent/delivered to the physician for pump refilling in the office/clinic setting. Some hospitals and medical centers have the necessary equipment and sterilization facilities to prepare these solutions.

There has been some confusion regarding billing and reimbursement for the medications used for these pain pump refills. At this time, WPS will use the protocol/guidelines listed below to reimburse providers for these drugs and the associated services. Guidelines:

1. The following seven drugs will be paid for by the method described below: baclofen (Lioresal Intrathecal Screening or Refill Kit), bupivacaine (Marcaine, Sensorcaine), clonidine (Duraclon), fentanyl (Sublimaze), hydromorphone (Dilaudid), morphine (Astramorph, Duramorph, Infumorph), sufentanil (Sufenta), and ziconotide (Prialt).
2. Use HCPCS code J3490 (Unclassified drugs), with one unit of service, and with the KD ("drug or biological infused through DME [durable medical equipment]) Modifier, for the entire compounded drug refill.
3. Drug specific "J" codes should not be used for these drug mixtures, for epidural/subarachnoid pain pump refills, as these codes do not specifically describe the actual formulations of the drugs used in this reconstituting/compounding process.
4. An invoice is required for each claim. Electronic submitters should indicate that they have an invoice available upon request by putting "DOCUMENTATION AVAILABLE UPON REQUEST" in the electronic equivalent of Item 19 of the CMS-1500 claim form. The invoice you have, which is needed by Medicare to make its payment determination, will be requested from you by way of a development letter requesting that the invoice be sent to us.

- If you do not indicate the availability of the invoice in item 19 or its electronic equivalent, or it is not returned in a timely fashion, the claim will be denied as unprocessable.
5. The correct CPT code for an implantable epidural/subarachnoid pain pump refill and maintenance is 95990 when performed "incident to" a physician's services, or 95991 when administered by a physician.
 6. The correct CPT code for pump analysis is 62367 and 62368 for analysis with re-programming.
 7. Also in item 19 on the CMS-1500 form, or its electronic equivalent, include:
 - a. Name of the drug
 - b. Exact total dosage (number of milligrams or micrograms) for that patient
 - c. Route of administration, i.e., "internal pump" or the brand name of the pump
 8. A4220 (Refill kit for implantable infusion pump) is considered bundled/excluded from Medicare coverage by CMS.
 9. An Evaluation and Management (E/M) service is allowed, if performed at the time of pump refill for a significant, separately identifiable reason. The applicable appropriate E/M code should be billed with the -25 modifier.
 10. A compounding pharmacy may supply epidural/subarachnoid pain pump refills directly to a patient's home (Place of Service/POS 12). In these circumstances, the Carrier (WPS) reimburses the pharmacy for the compounded drug mixture only. Any associated administration services (of the home health care nurse, etc.) should be billed to the appropriate Intermediary.

The dollar amounts on these invoices should be identical to those that would have been on an invoice sent to a physician's office had the identical drug mixture been supplied by that pharmacy and had been used for that patient in that physician's office.

KEY FOR EVALUATION AND MANAGEMENT (E/M) DOCUMENTATION

Medical record documentation records pertinent facts, findings, and observations about the patient's health history services performed by the physician. According to *A Resource for Residents, Practicing Physicians, and Other Health Care Professionals**, you must document every service billed and the record should be able to show clear evidence that the service was actually performed.

Documentation in the medical record should be complete, clear, and legible. Occasionally, you will receive a request for medical records for review. The reviewer must easily discern the following from the documentation:

- Who is the patient
- When was the service performed
- Who performed the service
- What service was performed
- Reason why the service was performed

Abbreviations or acronyms are a common part of most medical documentation. You can find standard and accepted medical abbreviations in most medical dictionaries. However, a provider's personal or a specific medical specialty's abbreviations and acronyms may not be easily deciphered. Frequently you may use these abbreviations or acronyms in the history and

examination components of the Evaluation and Management (E/M) services. Since you base the selection of the appropriate level of the E/M service on the documentation, it is important to consider all information appropriately. Therefore, when submitting medical records for review, you should include a key with your documentation when using non-standard acronyms or abbreviations to be certain that the reviewer interprets all information clearly and correctly.

The following examples could be misinterpreted and not reviewed in the same context that the provider documented:

- Examination of the chest: "CVA tenderness" (costovertebral angle and not cerebrovascular accident)
- History notation of "PI" and Examination notation of "PI": (indicates Personal Injury in Chiropractic terms and Peripheral Iridectomy in ophthalmologic common abbreviations).

A key to common terms and abbreviations used in specific practices could assist the reviewer in interpreting the medical record and should leave little doubt as to what the provider documented.

*Resource: Medicare Physician Guide: *A Resource for Residents, Practicing Physicians, and Other Health Care Professionals*; April 2006; (Reference I: *1995 Documentation Guidelines for Evaluation and Management Services* and Reference II: *1997 Documentation Guidelines for Evaluation and Management Services*)

MEDICAL DECISION MAKING IN THE E/M VISIT

The three key components of an Evaluation and Management (E/M) visit are the history, examination, and medical decision-making (MDM). This article will focus on the MDM aspect, which is the final component of an E/M visit.

By definition, MDM refers to the complexity of establishing a diagnosis and/or selecting a management option. It is the E/M component in which providers assess, advise, and assist their patients in managing their health. The result is an individual plan of care.

MDMs Four Levels

There are four levels (or categories) of E/M medical decision-making:

1. Straight forward
2. Low complexity
3. Moderate complexity
4. High complexity

Three Elements Within Each Level

There are three elements within each MDM level. Following is a closer look at each individual element.

1) Number of diagnoses or management options

This element is based on the following:

- The number and types of problems addressed during the encounter
- The complexity of establishing a diagnosis
- The management decisions made by the physician

2) Amount and/or complexity of data to be reviewed

The amount and/or complexity of data or other information that must be obtained, reviewed and analyzed in order to establish a diagnosis is another indicator of complexity of diagnostic or management problems. Examples of procedures that increase the difficulty of this component include:

- Obtaining and reviewing old medical records and/or obtaining history from sources other than the patient
- Seeking advice from others
- Discussing contradictory or unexpected diagnostic test results with another physician
- Reviewing the image, tracing, test or specimen ordered to supplement information.

Always remember to document the rationale for ordering diagnostic testing or other ancillary service.

3) Risk of significant complications, morbidity and/or mortality

The determination of risk is complex and not readily quantifiable. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The highest level of risk with any one presenting problem(s) (as well as associated comorbidities), diagnostic procedure(s) or management options(s) determines the overall risk.

Documentation Requirements

Providers can ensure accurate Medicare payments with correct documentation of MDM for E/M services. Either the 1995 or the 1997 E/M Documentation Guidelines may be utilized, but the elements from each set of guidelines may not be mixed. Documentation requirements include:

- Complete, clear, and legible medical records, supporting the medical necessity for the service performed.
- Two of the three elements must be met or exceeded to qualify for a given type of decision-making. If only one component is documented at the highest level, the encounter does not qualify for that level.
- All problems directly addressed in the encounter should be used to determine the level of decision-making.
- For referrals/consults the record should indicate who or where the patient is referred to, the reason for the referral, and who referred them.
- Documented initiation of, or changes in, treatment.
- MDM level billed depends on the status of the patient and/or the services performed by the provider.
- "Rule out" diagnoses should not be counted toward the number of diagnoses managed because it is considered part of a new and undiagnosed problem.
- If predominance of counseling is used to determine the level of an E/M visit, documentation must include the total time of the visit, total time and/or percentage of time spent in counseling, and issues discussed and counseling given. Time counted toward counseling and total time of visit must be relevant to the issue addressed.

Summary

Medical decision-making is generally easier for an already diagnosed problem than for an undiagnosed one. In addition, problems that are improving or resolving are less complex than those that are worsening or failing to change. Keep in mind that MDM should reflect the nature

of the presenting problem. Treatment for a common ailment, such as an ordinary cold, will not usually warrant a comprehensive level exam.

References/Resources

- *Beyond the Basics E/M*, pp. 5 - 45. March 2005
- *Evaluation and Management Seminar*, WPS Medicare Part B, Medical Review and Provider Outreach and Education Department, August 2006
- *Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* at: <http://www.cms.hhs.gov/MLNProducts/downloads/chapter5.pdf>
- *NCP, PHYS-001, General Coverage for Physicians' Services* at: <http://www.wpsmedicare.com/policies/wisconsin/index.shtml>
- **On the CMS Website <http://www.cms.hhs.gov/>**
 - *1995 Documentation Guidelines for Evaluation and Management Services* at: <http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf>
 - *1997 Documentation Guidelines for Evaluation and Management Services* at: <http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf>
 - *Evaluation & Management Services Guide* at: http://www.cms.hhs.gov/MLNProducts/Downloads/eval_mgmt_serv_guide.pdf
 - *Medicare Benefit Policy Manual (Pub.100-2)* at: <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS012673>
 - *Medicare Claims Processing Manual (Pub. 100-4)* at: <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS018912>

UPDATE OF RADIOPHARMACEUTICAL IMAGING AGENTS HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES APPLICABLE TO POSITRON EMISSION TOMOGRAPHY (PET) SCAN SERVICES FOR CARRIERS ~ CMS MLN Matters ~

MLN Matters Number: MM5054
Related CR Release Date: April 28, 2006
Related CR Transmittal #: R923CP

Related Change Request (CR) #: 5054
Effective Date: January 1, 2006
Implementation Date: August 1, 2006

Provider Types Affected

Physicians and non-physician practitioners who bill Medicare carriers for PET scan services provided to Medicare beneficiaries.

Background

This article is based on CR5054, which updates Publication 100-04, *The Medicare Claims Processing Manual*, Chapter 13, Section 60.3.2 (Tracer Codes Required for PET Scans) to include two new HCPCS codes for radiopharmaceutical diagnosis imaging agents (tracers) applicable to PET scan services. A prior Change Request, CR4270, Transmittal 822, released on February 1, 2006, addressed manual updates for Medicare fiscal intermediaries (FIs), but did not update the manual for carriers.

Key Points

- Effective for claims dates of service on or after January 1, 2006:
 - **A9555** (Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium RB-82, Diagnostic, Per study dose, Up To 60 Millicuries) replaces Q3000; and
 - **A9552** (Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18, FDG, Diagnostic, per study dose, Up to 45 Millicuries) replaces C1775.

- Effective for dates of service on or after January 1, 2006:
 - HCPCS codes Q3000 and C1775 are deleted.
 - A9555 is a Tracer code applicable to CPT 78491 and 78492.

Additional Information

Note: For claims with dates of service prior to January 1, 2006, OPPS hospitals report **C1775** and other providers billing fiscal intermediaries report **A4641** for supply of radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F1.

For claims with dates of service January 1, 2006, and later, providers billing fiscal intermediaries report **A9552** for radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F18 in place of C1775 and A4641.

The Medicare Learning Network (MLN) article addressing the updated codes for FIs, MM4270, "Update of Radiopharmaceutical Imaging Agents Healthcare Common Procedure Coding System (HCPCS) Codes Applicable to Positron Emission Tomography (PET) Scan Services," can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4270.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

CR5054, the official instruction issued to your carrier regarding changes mentioned in this article, may be found by going to

<http://www.cms.hhs.gov/Transmittals/downloads/R923CP.pdf> on the CMS Website.

Please refer to your local carrier if you have questions about this issue. To find their toll free phone number, go to

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

Comprehensive Error Rate Testing (CERT)**CERT ERROR FOCUS – SUBSEQUENT HOSPITAL VISITS - CPT
99231-99233**

In recent *Communiqué* articles, we focused on Comprehensive Error Rate Testing (CERT) errors specific provider specialties receive. In our continuing effort to increase the awareness of all Medicare providers regarding documentation issues found as a result of CERT reviews, we have now begun to focus on specific services that contribute to our CERT error rate. Our focus this month is on insufficient documentation issues related to subsequent hospital visits, Current Procedural Terminology (CPT) procedure codes 99231-99233.

Analysis of our recent CERT error findings shows that these services account for a large portion of our errors for insufficient documentation. In the majority of these cases, the provider has submitted documentation other than what the CERT contractor requested. CERT reviewer comments indicate that oftentimes an admission report, consultation note, discharge summary, etc., is submitted, rather than the requested subsequent hospital visit progress note(s).

Furthermore, when CERT makes a follow-up contact for the missing documentation, they often receive the same documentation submitted initially or are referred to the hospital to obtain the additional information. At this point, CERT assesses an error for insufficient documentation, and the contractor is required to request a refund of the undocumented service(s).

Providers should be aware that, as stated in the CERT medical record request letter, **“It is your responsibility to obtain additional supporting documentation from a third party (hospital, nursing home, etc.) as necessary.”** In our own follow-up contacts, office medical record staff often explains that the records are not onsite and therefore they are not responsible for obtaining them. In most cases, further explanation of the documentation requirements results in the office staff facilitating the retrieval of the records from the facility. However, there are also cases in which we must make an additional contact with management staff or a compliance officer in order to initiate this process.

Proper documentation of services billed to Medicare is vital in order to meet CMS' error rate reduction expectations. WPS continues to identify problem areas contributing most significantly to our jurisdiction's error rate. Continued cooperation from providers in educating staff on the CERT program, and the importance of complying with CERT medical record requests is essential in order to reach these goals.

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>

If you have questions related to the CERT process or a specific CERT sampled claim, you may e-mail us at medicareadmin@wpsic.com. Be sure to include "CERT Question" in the subject line. Please also include your full name, telephone number, and Provider Identification Number (if available) in the body of the e-mail. This will assure a prompt and accurate reply to your question.

When e-mailing WPS Medicare, please do not include sensitive information. If your question pertains to a specific claim, include the Internal Control Number, not your patient's Medicare Health Insurance Claim Number.

Coverage – General

**OUTPATIENT THERAPY –
ADDITIONAL DRA MANDATED SERVICE EDITS**

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1019	Date: AUGUST 3, 2006
Change Request 5253	

NOTE: Transmittal 1016, dated July 28, 2006 is rescinded and replaced with Transmittal 1019, dated August 3, 2006. This instruction is being re-issued to correct the Business Requirements that were originally issued. In BR5253.4, Medicare Summary Notice was incorrectly referred to 16.26, and corrected to 16.25. Also, BR5253.45 was listed incorrectly and corrected to BR5253.5. The Business Requirement has been revised. All other information remains the same.

SUBJECT: Outpatient Therapy - Additional DRA Mandated Service Edits

I. SUMMARY OF CHANGES: This instruction provides additional limitations on outpatient therapy services, consistent with the provisions of the Deficit Reduction Act of 2005. Certain services are limited to certain numbers of units per day for physical therapy, occupational therapy, and speech-language pathology, separately to control inappropriate billing.

NEW / REVISED MATERIAL
EFFECTIVE DATE: JANUARY 1, 2007
IMPLEMENTATION DATE: JANUARY 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/20.2/Reporting of Service Units With HCPCS

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

**IV. ATTACHMENTS:
Manual Instruction
Business Requirements**

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1019	Date: August 3, 2006	Change Request 5253
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NOTE: Transmittal 1016, dated July 28, 2006 is rescinded and replaced with Transmittal 1019, dated August 3, 2006. This instruction is being re-issued to correct the Business Requirements that were originally issued. In BR5253.4, Medicare Summary Notice was incorrectly referred to 16.26, and corrected to 16.25. Also, BR5253.45 was listed incorrectly and corrected to BR5253.5. The Business Requirement has been revised. All other information remains the same.

SUBJECT: Outpatient Therapy - Additional DRA Mandated Service Edits

I. GENERAL INFORMATION

A. Background: Deficit Reduction Act of 2005 Section 5107 requires limitations on outpatient therapy services, for the purpose of identifying and eliminating improper payments.

B. Policy: Certain services are limited to certain numbers of units per day for physical therapy, occupational therapy and speech-language pathology, separately to control inappropriate billing.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)							
		F I	R H I	C A R I E R	D M R C	Shared System Maintainers			
					F I S S	M C S	V M S	C W F	
5253.1	Contractors shall pay for outpatient therapy services, when covered, as described in the Claims Processing Manual chapter 5, section 20.2, allowing units per beneficiary, per HCPC, per day, per therapy discipline (PT, OT, SLP, physician/NPP) up to and including the number of units indicated.	X	X	X		X	X		

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C A R I E R	D M E R C S	Shared System Maintainers				O T H E R
						F I S S	M C S	V M S	C W F	
5253.2	Contractors shall line item deny as medically unnecessary any units on each claim line greater than the number of units designated in the Claims Processing Manual, chapter 5, section 20.2.	X	X	X		X	X			
5253.2.1	Contractors shall pay as appropriate for the number of allowed units on each claim line per the Claims Processing Manual, chapter 5, section 20.2	X	X	X		X	X			
5253.4	When denying units of therapy services greater than the number of units designated in the Claims Processing Manual, contractors shall use Medicare Summary Notice 16.25 – Medicare does not pay for this much equipment, or this many services or supplies.	X	X	X		X	X			
5253.5	If local coverage determinations (LCDs) do not agree with the units allowed in this manual section for covered services, contractors shall modify their LCDs to conform to this instruction.	X	X	X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		F I	R H I	C A R I E R	D M E R C S	Shared System Maintainers				O T H E R
						F I S S	M C S	V M S	C W F	
5253.6	Contractors shall post the entire IOM instruction, or a direct link to this instruction, on their Website and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire IOM instruction must be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Business requirements and transmittal forms are for contractors and shall not be posted for providers and suppliers.	X	X	X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
5253.2	Appeals are allowed according to the policies for medical necessity denials. Issuance of an ABN is appropriate for such denials.

X-Ref Requirement #	Instructions
5253.3	Adjustment reason code B5 is defined “ Payment adjusted because coverage/program guidelines were not met or were exceeded.

B. Design Considerations: NA

C. Interfaces: NA

D. Contractor Financial Reporting /Workload Impact: NA

E. Dependencies: NA

F. Testing Considerations: NA

V. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date*: January 1, 2007 Implementation Date: January 2, 2007 Pre-Implementation Contact(s): Dorothy Shannon 63396 for therapy policy, Wil Gehne 66148 for FI</p> <p>Post-Implementation Contact(s): Pam West 62302 for code questions, Dorothy Shannon 63396 for therapy policy, Wil Gehne 66148 for FI payment issues, Claudette Sikora 65618 for carrier payment issues.</p>	<p>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.</p>
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*Unless otherwise specified, the effective date is the date of service.

Medicare Claims Processing Manual Chapter 5 – Part B Outpatient Rehabilitation and CORF/OPT Services

Table of Contents
(Rev.1019, 08-03-06)

20.2 - *Reporting of Service Units With HCPCS*

20.2 - *Reporting of Service Units With HCPCS*
(Rev.1019, Issued: 08-03-06, Effective: 01-01-07, Implementation: 01-02-07)

A. General

Effective with claims submitted on or after April 1, 1998, providers billing on Form CMS-1450 *were* required to report the number of units for outpatient rehabilitation services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. This was already in effect for billing on the Form CMS-1500, *and* CORFs *were required to* report their full range of CORF services on the Form CMS-1450. *These unit-reporting requirements continue with the standards required for electronically submitting health care claims under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) - the currently adopted version of the ASC X12 837 transaction standards and implementation guides. The Administrative Simplification Compliance Act mandates that claims be sent to Medicare electronically unless certain exceptions are met.*

B. Timed and Untimed Codes

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe (“untimed” HCPCS), the provider enters “1” in *the field labeled* units. *For untimed codes,*

units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day).

EXAMPLE: *A beneficiary received a speech-language pathology evaluation represented by HCPCS “untimed” code 92506. Regardless of the number of minutes spent providing this service only one unit of service is appropriately billed on the same day.*

Providers billing *to FIs and RHHIs* should report Value Code 50, 51, or 52, the total number of physical therapy, occupational therapy, or speech–language pathology visits provided from start of care through the billing period. This item is visits, not service units. *Value codes do not apply to claims sent to carriers.*

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any single calendar day** using CPT codes and the appropriate number of *15 minute* units of service.

EXAMPLE: *A beneficiary received occupational therapy (HCPCS “timed” code 97530 which is defined in 15 minute units) for a total of 60 minutes. The provider would then report revenue code 043X and 4 units.*

C. Counting Minutes for Timed Codes in 15 Minute Units

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

Units	Number of Minutes
<i>1 unit:</i>	<i>≥ 8 minutes through 22 minutes</i>
<i>2 units:</i>	<i>≥ 23 minutes through 37 minutes</i>
<i>3 units:</i>	<i>≥ 38 minutes through 52 minutes</i>
<i>4 units:</i>	<i>≥ 53 minutes through 67 minutes</i>
<i>5 units:</i>	<i>≥ 68 minutes through 82 minutes</i>
<i>6 units:</i>	<i>≥ 83 minutes through 97 minutes</i>
<i>7 units:</i>	<i>≥ 98 minutes through 112 minutes</i>
<i>8 units:</i>	<i>≥ 113 minutes through 127 minutes</i>

The pattern remains the same for treatment times in excess of 2 hours.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes.

When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of units billed.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes . This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes.

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

If more than one *15 minute timed* CPT code is billed during a *single* calendar day, then the total number of *timed* units that can be billed is constrained by the total treatment *minutes for that day*.

Pub. 100-02, chapter 15, section 230.3B Treatment Notes indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented. These examples indicate how to count the appropriate number of units for the total therapy minutes provided.

Example 1 –

*24 minutes of neuromuscular reeducation, code 97112,
23 minutes of therapeutic exercise, code 97110,
Total timed code treatment time was 47 minutes.*

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes.

*Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more *timed* units to the service that took the most time.*

Example 2 –

*20 minutes of neuromuscular reeducation (97112)
20 minutes therapeutic exercise (97110),
40 Total timed code minutes.*

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Example 3-

*33 minutes of therapeutic exercise (97110),
7 minutes of manual therapy (97140),
40 Total timed minutes*

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example 4 –

18 minutes of therapeutic exercise (97110),
 13 minutes of manual therapy (97140),
 10 minutes of gait training (97116),
 8 minutes of ultrasound (97035),
 49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Example 5 –

7 minutes of neuromuscular reeducation (97112)
 7 minutes therapeutic exercise (97110)
 7 minutes manual therapy (97140)
 21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See definition in Pub 100-02/15, sec. 220) shall select one appropriate CPT code (97112, 97110, 97140) to bill since each unit was performed for the same amount of time and only one unit is allowed.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The *total minutes of active treatment counted for all 15 minute timed codes* includes all direct treatment time for the timed codes. Total treatment minutes-- including minutes spent providing services represented by untimed codes— are also documented. For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 230.3: Documentation, Treatment Notes.

D. Specific Limits for HCPCS

The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day. When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary (according to 1862(a)(1)(A)). Denied claims may be appealed and an ABN is appropriate to notify the beneficiary of liability.

This chart does not include all of the codes identified as therapy codes; refer to section 20 of this chapter for further detail on these and other therapy codes. For example, therapy codes called “always therapy” must always be accompanied by therapy modifiers identifying the type of therapy plan of care under which the service is provided.

Use the chart in the following manner:

- *The codes that are allowed one unit for “Allowed Units” in the chart below may be billed no more than once per provider, per discipline, per date of service, per patient.*
- *The codes allowed 0 units in the column for “Allowed Units”, may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP).*

- *When physicians/NPPs bill “always therapy” codes they must follow the policies of the type of therapy they are providing e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed units on the chart below for PT, OT or SLP depending on the plan. A physician/NPP shall not bill an “always therapy” code unless the service is provided under a therapy plan of care. Therefore, NA stands for “Not Applicable” in the chart below.*
- *When a “sometimes therapy” code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart below per patient, per provider/supplier, per day.*

HCPCS	Code Description and Claim Line Outlier/Edit Details	Timed or Untimed	PT Allowed units	OT Allowed units	SLP Allowed units	Physician/NPP NOT under Therapy POC
92506	Speech/hearing evaluation	Untimed	0	0	1	NA
92597	Oral speech device eval	Untimed	0	1	1	NA
92607	Ex for speech device rx, 1hr	Timed	0	1	1	NA
92611	Motion fluroscopy/ swallow	Untimed	0	1	1	1
92612	Endoscope swallow test(fees)	Untimed	0	1	1	1
92614	Laryngoscopic sensory test	Untimed	0	1	1	1
92616	Fees w/ laryngeal sense test	Untimed	0	1	1	1
95833	Limb muscle testing, manual	Untimed	1	1	0	1
95834	Limb muscle testing, manual	Untimed	1	1	0	1
96110	Developmental test, lim	Untimed	1	1	1	1
96111	Developmental test, extend	Untimed	1	1	1	1
97001	PT evaluation	Untimed	1	0	0	NA
97002	PT re-evaluation	Untimed	1	0	0	NA
97003	OT evaluation	Untimed	0	1	0	NA
97004	OT re-evaluation	Untimed	0	1	0	NA

Coverage – Policies

2007 ICD-9-CM COVERAGE - POLICY REVISIONS

Effective for claims submitted with dates of service on or after 10/01/2006, WPS will cover the new 2007 ICD-9-CM codes for the policies and procedures listed below. We will post the listed changes to these effected policies to the Website after 10/01/2006.

Policy Name/Number	Policy Procedure Code	2007 ICD-9-CM Changes
Allergy Testing & Immunotherapy ALRG-001	95004, 95010, 95024, 95027 95180	478.19, 995.20, 995.27, 995.29 995.20, 995.27, 995.29 Delete 478.1, 995.2
Cardiac Stress Testing CV-004	93015, 93016, 93017, 93018, 93350	429.83, 995.20 Delete 995.2
Cardiac Catheterization CV-006	93501, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529	Add 429.83

Policy Name/Number	Policy Procedure Code	2007 ICD-9-CM Changes
Myocardial Perfusion Imaging CV-017	78460-78465, 78478, 78480	429.83, 995.2 Delete 995.2
Transthoracic Echocardiography CV-026	93303, 93304, 93307, 93308, 93320, 93321, 93325	277.30, 277.31, 277.39, 429.83, 518.7, 995.2 Delete: 277.3 995.2
Non-invasive Vascular Testing CV-033	93965, 93970, 93971 93875-93872	289.83 377.43
T-Wave Alternans Testing CV-036	93025	995.20 Delete: 995.2
Foot Care FT-001	G0127, 11055-11057, 11719-11721	277.30, 277.31, 277.39 Delete 277.3
Diagnostic Pap Tests GU-020	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175	Add 616.81, 616.89, 795.06 Delete: 616.8
Antineoplastics and their Adjuncts HONC-010	J0917, J9025, J9350, J9211 J9213, J9214	238.72-238.76 238.71 Delete: 238.7
Immune Globulin INJ-012	J1566, J1567	288.09 Delete: 288.0
Botulinum Toxin INJ-018	64613, 64614, 64640	333.71, 333.72, 333.79 Delete: 333.7
Human Granulocyte/Macrophage Colony Stimulating Factors INJ-019	J1440, J1441 J2505 J2820	288.00-288.04, 238.72-238.76 288.03 288.01, 288.03, 238.72-238.76 Delete: 288.0, 238.7, 963.1
Erythropoiesis Stimulating Proteins INJ-023	Q0136, Q0137, J0880	238.72-238.75, 995.20 Delete 238.7, 995.2
Bone Mineral Density (BMD) Studies MS-004	76070, 76071, 76075, 76076, 76078, 76977, 78350, 78351, G0130	995.20 Delete: 995.2
Nerve Conduction Studies and Electromyography NEURO-005	51785, 92265, 95900, 95903, 95904, 95933, 95934, 95936, 95937, 95860-95874	333.71, 333.72, 333.79, 341.20-341.22 Delete: 333.7, 341.2

Policy Name/Number	Policy Procedure Code	2007 ICD-9-CM Changes
Optical Coherence Topography (OCT) OPHTH-015	92135	377.43
Retinal/Choroidal Angiography OPHTH-016	92235 92240	377.43 995.20 Delete 995.2
Flow Cytometry PATH-016	88184-88189	238.71-238.76, 238.79, 288.00-288.04, 288.09, 288.50, 288.51, 288.59, 288.61-288.65, 288.69 Delete: 238.7, 288.0, 288.5, 288.6
Cytogenetic Studies PATH-027	88230, 88245, 88248, 88249, 88283 88237, 88239, 88262, 88271-88275, 88283	238.71-238.76, 238.79, 284.01, 284.09, 288.00-288.04, 288.09, 288.4 238.71-238.76, 238.79, 284.01, 284.89, 288.00-288.04, 288.09, 288.4 Delete: 238.7, 284.0, 288.0
Syphilis Testing PATH-031	86592, 86593, 86781	616.81, 616.89 Delete: 616.8
Physical Medicine & Rehabilitation PHYSMED-009	97022, 97036, 97110, 97112, 97113, 97116, 97530, 97535, 97537, 97542 97124, 97140 97124 G0283, 97018, 97022, 97024, 97026, 97032, 97034, 97035, 97036, 97110, 97112, 97113, 97116, 97124, 97140, 97530	341.20-341.22 333.71, 333.72, 333.79, 519.11, 519.19 338.21, 338.29, 338.4 Delete: 338.2, 341.2, 519.1
Psychiatry and Psychological Services PSYCH-014	90802, 90804-90815-90819, 90821-90824, 90826-90829, 90846-90847, 90849, 90853, 90857, 90862, 90865, 90870, M0064	333.72, 995.20 Delete: 333.7, 995.2

Policy Name/Number	Policy Procedure Code	2007 ICD-9-CM Changes
Radiologic Examination of the Chest, Including Portable RAD-004	71010, 71015, 71020-71023, 71030, 71034, 71035	052.2, 053.14, 054.74, 238.71- 238.76, 238.79, 277.30, 277.31, 277.39, 284.01, 284.09, 284.1, 284.2, 289.53, 289.83, 429.83, 518.7, 519.11, 519.19, 768.7, 770.87, 770.88, 775.81, 775.89, 779.85, 780.32, 995.20-995.23, 995.27, 995.29 Delete: 238.7, 277.3, 519.1, 995.2
Radiation Oncology Including Intensity Modulated Radiation Therapy/IMRT RAD-014	77261-77470 (except 77432)	238.71-238.76, 238.79 Delete: 238.7
MRA RAD-023	71555, 73725	995.20 Delete 995.2
MRI RAD-024	70336, 70540, 70542, 70543, 70551-70553 71550-71552 72195-72197, 74181-74183 72141, 72142, 72156 72146, 72147, 72157 72148, 72149, 72158	053.14, 054.74, 323.01, 323.02, 323.41, 323.42, 323.51, 323.52, 323.61-323.63 323.71, 323.72, 323.81, 323.82, 331.83, 333.71, 333.72, 333.79, 333.85, 333.94, 341.20-341.22, 377.43, 379.60-379.63, 389.15, 389.16, 478.11, 478.19, 780.32, 784.99 238.71-238.76, 238.79, 518.7, 519.11, 519.19 277.30, 277.31, 277.39, 289.53, 629.89, 958.93 Add 793.91, 793.99 Add 793.91, 793.99 Add 793.91, 793.99 Delete: 238.7, 277.3, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8, , 333.7, 478.1, 519.1, 629.8, 784.9, 793.9
Percutaneous Vertebroplasty RAD-032	22520, 22521, 22522, 22523, 22524, 22525, 22899, 76012, 76013, 76499	238.79, 995.20 Delete: 238.7, 995.2

Policy Name/Number	Policy Procedure Code	2007 ICD-9-CM Changes
Computerized Tomography (CAT Scans) RAD-033	70450, 70460, 70470, 70480-70482, 70486-70488, 70490-70492, 70496, 70498 71250, 71260, 71270 72125-72127 72128-72130 72191-72194, 74150, 74160, 74170, 74175, 75635	323.01, 323.02, 323.41, 323.42, 323.51, 323.52, 323.61-323.63, 323.71, 323.72, 323.81, 323.82, 331.83, 333.71, 333.72, 333.79, 333.85, 333.94, 341.20-341.22, 377.43, 379.60-379.63, 389.15, 389.16, 478.11, 478.19, 780.32, 784.91, 784.99 238.71-238.76, 238.79, 518.7, 519.11, 519.19 793.99 793.99 277.30, 277.31, 277.39, 289.53, 629.89, 958.93 Delete: 238.7, 277.3, 323.0, 323.4, 323.5, 323.6, 323.7, 323.8-, 333.7, 341.2, 478.1, 519.1, 629.8, 784.9, 793.9
Brachytherapy RAD-036		238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79 Delete: 238.7
DENT-002 Dental Services, Billing and Coding Instructions	Non-Covered Services	521.81, 521.89, 523.00, 523.01, 523.10, 523.11, 523.30, 523.31, 523.32, 523.33, 523.40, 523.41, 523.42, 525.60, 525.61, 525.62, 525.63, 525.64, 525.65, 525.66, 525.67, 525.69, 526.61, 526.62, 526.63, 526.69. Delete: 523.0, 523.1, 523.3, 523.4, 523.6

INFORMATION ON WEBSITE

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

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

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

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



New Policies for September 2006

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
CV-040	<i>Cardiac Rhythm Device Evaluation</i>	LCD	Click here to view	Page 27

Revised Policies for September 2006

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
CV-033	<i>Non-Invasive Vascular Testing</i>	LCD	Click here to view	Page 28
INJ-019	<i>Human Granulocyte/Macrophage Colony Stimulating Factors</i>	LCD	Click here to view	Page 29
OPHTH-003	<i>Optometrist Services</i>	LCD	Click here to view	Page 30
OPHTH-022	<i>Blepharoplasty, Blepharoptosis and Brow Lift</i>	LCD and Companion Article	Click here to view	Page 30
PHYS-040	<i>Influenza, Pneumococcal and Hepatitis-B Vaccinations</i>	NCP	Click here to view	Page 31

Coverage – New Policies

Local Coverage Decision (LCD)

Contractor Number

00951, 00952, 00953, 00954

Contractor Type

Carrier

LCD Title

Cardiac Rhythm Device Evaluation

Contractor's Determination Number

CV-040

This is a new policy. Please read this policy in its entirety on our Website.

Coverage – Revised Policies
Local Coverage Decision (LCD)
LCD Title:

Non-Invasive Vascular Testing

Contractor's Determination Number:

CV-033

Primary Geographic Jurisdiction:

Wisconsin, Illinois, Michigan, Minnesota

Revision Effective Date:

09/01/2006

ICD-9 Codes that Support Medical Necessity

Peripheral Venous Examinations (CPT-4 Codes 93965 - 93971)

Hypercoagulability syndromes	289.81-289.89
Suspected pulmonary embolism	415.11; 415.19; 786.00; 786.05, 786.09; 786.3; 786.50; 786.52; 786.59; 794.2
Aneurysm of artery of lower extremity	442.3
Phlebitis/thrombophlebitis	451.0 - 451.9; 453.1; 453.40 - 453.42; 453.8; 671.20 - 671.44
Chronic Venous Insufficiency	454.0 - 454.9; 459.10- 459.89; 707.10-707.19; 707.8
Venous complications of pregnancy and purpura	671.00-671.44
Cellulitis leg/foot	682.6; 682.7
Other anomalies of peripheral vascular system	747.60-747.69
Localized Edema	782.2; 782.3; 729.81
Erythema	695.9
Limb Tenderness (on palpation)	729.5
Congenital Vascular Anomalies	747.63; 747.64; 789.60-789.69
Extremity Gangrene	785.4
Respiratory distress	518.81; 786.00-786.09; 799.01; 799.02
Abnormal lung scan	794.2
Lower extremity fracture	820.00-820.9; 821.00-821.39; 823.00-824.9
Injury to Blood Vessels	903.00 - 904.9
Complications of procedures or devices	996.1; 996.62; 996.70, 996.74; 997.2; 997.79; 998.11-998.13; 998.2; 999.2
Phlebitis or thrombophlebitis following infusion, perforation or transfusion	999.2
*Organ or tissue replaced by other means, Hip	V43.64
*Organ or tissue replaced by other means, Knee	V43.65

*Aftercare for healing traumatic fracture of hip	V54.13
*Aftercare for healing traumatic fracture of leg, unspecified	V54.14
*Aftercare for healing traumatic fracture of upper leg	V54.15
*Aftercare for healing traumatic fracture of lower leg	V54.16
*Aftercare for healing pathological fracture of hip	V54.23
*Aftercare for healing pathological fracture of leg, unspecified	V54.24
*Aftercare for healing pathological fracture of upper leg	V54.25
*Aftercare for healing pathological fracture of lower leg	V54.26
Pre-operative examination for potential harvest vein grafts, or pre-operative examination of vessel prior to hemodialysis access surgery	V72.83

V-Codes V43.64–V43.65, V54.13–V54.16, and V54.23–V54.26 added to policy as payable diagnoses for CPT procedures 93965-93971.



Local Coverage Decision (LCD)

LCD Title

Human Granulocyte/Macrophage Colony Stimulating Factors

Contractor's Determination Number

INJ-019

Revision Effective Date

10/01/2006

This serves as notification that ICD-9 code 963.1 Poisoning by Antineoplastic and Immunosuppressive Drugs will be **deleted** from this policy. This code had been used to indicate drug induced neutropenia in this LCD.

Effective 10/01/2006, a new ICD-9 code is available that more accurately describes drug induced neutropenia. ICD-9 code 963.1 will be replaced with 288.03-Drug induced neutropenia.

The LCD will be updated with this change and the new ICD-9 codes October 1.



Local Coverage Decision (LCD)**LCD Title**

Optometrist Services

Contractor's Determination Number

OPHTH-003

Revision Effective Date

08/01/2006

CPT/HCPCS CodesALL OPTOMETRISTS:All States:

CPT code 92136 is added to this policy effective for services performed on or after 08/01/2006.

**Local Coverage Decision (LCD)****LCD Title**

Blepharoplasty, Blepharoptosis and Brow Lift

Contractor's Determination Number

OPHTH-022

Revision Effective Date

*09/01/2006

ICD-9 Codes that Support Medical Necessity*Note: ICD-9 codes must be coded to the highest level of specificity.**Neoplasms

*171.0, *172.1, *173.1, *173.3, *232.1, *232.1, *232.3,

*Injuries/Burns*743.9, *744.89, *870.1, *870.2, *870.8, *871.1, *921.1, *940.0, *940.1, *941.32,
*941.42, *941.52, 959.09**OPHTH-022 Companion Article****Article Title**

Blepharoplasty, Blepharoptosis and Brow Lift OPHTH-022: Billing and Coding Guidelines

Article Effective Date

*09/01/2006

Article Text

*This article contains the coding guidelines for reporting Blepharoplasty, Blepharoptosis or Brow Lift services and reasons for denial of these services. This article should be used in combination with the Blepharoplasty, Blepharoptosis and Brow Lift OPHTH-022 LCD.

Coding Information

5. If a patient wishes to have a blepharoplasty or brow lift for cosmetic purposes:
- a. The physician should explain to the patient, in advance, that Medicare will not cover cosmetic eyelid or brow surgery and that the beneficiary will be liable for the cost of the service. Charges should be clearly stated. A claim for cosmetic services does not need to be submitted to the Medicare carrier, unless the patient requests that the claim be submitted on his/her behalf.
 - *b. When the patient requests the claim for cosmetic services be submitted on his/her behalf, the services should be reported with modifier GY (items or services statutorily excluded or does not meet the definition of any Medicare benefit) **and** diagnosis code **V50.1**. The diagnosis code V50.1 should be placed in the first position in item 21 on the CMS 1500 claim form or the equivalent diagnosis code field for electronic claims. A Notice of Exclusion from Medicare Benefits (NEMB) may be used with services excluded from Medicare benefits. See <http://www.cms.hhs.gov/BN1>

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

Influenza, Pneumococcal and Hepatitis-B Vaccinations

Subject Number:

PHYS-040

Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine**Effective Date:**

October 1, 2006

Implementation Date:

October 2, 2006

WPS is updating PHYS-040 *Influenza, Pneumococcal and Hepatitis-B Vaccinations* National Coverage Provision per Change Request (CR) 5037. CR 5037 provides specific information regarding payment for Influenza and/or PPV vaccines and their administration. Effective for dates of service on or after October 1, 2006, the following are the new instructions:

- **Report diagnosis code V06.6** on claims that contain Influenza Virus and/or PPV **vaccines and their administration** when the purpose of the visit was to **receive both** vaccines.
- Continue reporting **diagnosis code V03.82** on claims that contain **only PPV vaccine** and its administration.
- Continue reporting **diagnosis code V04.81** on claims that contain **only Influenza Virus** vaccine and its administration.
- Use **CPT code 90660** on claims when **billing for** Influenza Virus vaccine, live, for Intranasal use.

- Neither a deductible nor a coinsurance will be applied to Influenza Virus vaccine, CPT code 90660, and its administration.
- Use **HCPCS code G0008** when billing for the **administration of code 90660**.

Please refer to the revised PHYS-040 *Influenza, Pneumococcal and Hepatitis-B Vaccinations* National Coverage Provision in its entirety on the WPS Website.

<http://www.wpsmedicare.com/policies/wisconsin/phys040.pdf>

The asterisk (*) text indicates changes made since the last publication date.

The official instructions issued to your Medicare carrier and intermediary regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R921CP.pdf> on the CMS Website.

Electronic Data Interchange (EDI)

ELECTRONIC MSP CLAIM BALANCING FREQUENTLY ASKED QUESTIONS

Effective July 3, 2006, Electronic Medicare Secondary Payer (MSP) claims are required to have CAS segments and balance (see June Communiqué for MSP billing instructions). Medicare will reject MSP claims if the paid amounts and the adjusted amounts by the primary payer do not equal the billed amounts or if the claim lacks standard claim adjustment reason codes to identify adjustments (<http://www.cms.hhs.gov/Transmittals/downloads/R831CP.pdf> and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm4261.pdf>)

The following are some FAQs regarding electronic MSP claim balancing requirements.

Question 1: Must the service line level billed amount, adjustment amounts, and paid amount balance?

Answer 1: No. A significant number of non-Medicare payers currently report adjustments that apply to all services contained in a claim at the claim level in a paper remittance notice, and report adjustments that apply only to specific services at the service line level. Since the claim level adjustments also apply to the services, it would be necessary to apportion those claim level adjustments among the services to allow the service line to balance in those instances. As result, CMS will not require balancing at that low of a level, nor require that providers apportion claim level adjustments made by a primary payer.

Question 2: How should a shared system determine whether a primary payer's claim information balances in a Medicare Secondary Payer (MSP) claim?

Answer 2: An X12 837 MSP claim is supposed to represent a combination of claim data and remittance data. As result, the 835 balancing rules can also be used to balance primary payer billed, adjusted and paid amounts in an 837 MSP claim. Translated from the 835 segments and loops to the corresponding 837 segments and loops, the formula to use to determine whether primary payer claim data balances is:

The total billed amount (CLM02) minus the total of all CAS adjustment amounts ([Loop 2320 CAS03+CAS06+CAS09+CAS12+CAS15+CAS18] + [Loop 2430 CAS03+CAS06+CAS09+CAS12+CAS15+CAS18]) must equal AMT02 in the COB Payer Paid Amount segment in Loop 2320. If it does not equal that AMT02 COB Payer Paid Amount, either some primary payer information is missing or was reported incorrect in the MSP claim.

If the total billed to the primary payer less the total of all adjustments made by that primary payer does not equal the total paid by the primary payer, the primary payer data does not balance and that claim must be rejected for resubmission when corrected.

Question 3: How should I balance the primary payer information when there is more than one primary payer?

Answer 3: As indicated in §90.2 of Chapter 24 of the Medicare Claims Processing Manual (Pub. 100-04), it is not possible to submit a HIPAA-compliant electronic claim to Medicare when there is more than one payer that is primary. The X12N 837version 4010A1 does not permit reporting of allowed amount for more than one primary payer. As result, these claims are to be submitted on paper with the Explanation of Benefits issued by each of the primary payers.

Since claims submitted on paper are still sent to COB trading partners as X12N 837 version 4010A1 transactions, however, when manually entering the paper primary and MSP claim data, a contractor must still make sure that the amount paid by the primary payers is equal to the amount billed to each of those primary payers less the amount of the adjustments made by those payers.

If that data does not balance when Medicare transmits to a COB trading partner, that trading partner could reject the claim and neither the COBC nor the contractor that processed the MSP claim would be able to correct the primary payer data to allow the claim to fully balance. As result, even paper MSP claims need to be rejected if the primary payer information does not balance.

Question 4: What should I do if a tertiary payer that is a COB trading partner refuses to accept the COB claim because the service level billed, adjusted and paid amounts from a primary payer do not balance?

Answer 4: Point out that the 837 implementation guides do not require that the service line data from a primary payer balance. As result of industry variations in reporting of adjustments at the claim and service levels, it is not always possible to balance at that level.

Question 5: The balancing edit could result in the rejection of many MSP claims. Can I apply the edit on an informational basis for one month, and postpone actual rejection of claims that contain out-of-balance primary payment information until the following month? Since I cannot apply this edit on an informational basis until the shared system release is issued, this means that I would apply the edit on an informational basis in July and begin rejection of claims for this reason in August.

When I apply an edit on an informational basis, each provider that would have had that claim reject if submitted in July will be notified of that fact. This will help to reinforce the educational information we issue about this new edit and let the providers know of the personal impact of the edit on their claims.

Answer 5: Yes, that would be acceptable, and even preferable, if you have the ability to apply this first on an informational basis.

Question 6: Why is CMS requiring that primary payer data balance on claims now? We never had to do this before and the 837 implementation guides do not actually say that primary payer information must balance.

Answer 6: Although the 837 implementation guides do not specifically require this, it is reasonable to expect that the information supplied on an MSP or a COB claim be complete and accurate. Although the primary payer information is used on only a limited basis by Medicare, some COB trading partners make more extensive use of that data. A number of trading partners have refused to accept COB claims from the COBC if primary payer information does not balance at the claim level (loop 2320), reasoning that if that information does not balance, it must be incorrect or incomplete. Since only the submitter of the MSP claim can correct that information, it is important that these claims be rejected by Medicare for correction by those submitters to enable those claims to be accepted by tertiary payers.

A complete list of current 4010A1 pre-pass edits 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

MCS 837 4010A1 PREPASS EDITS

Before an electronic claim is accepted, it is edited to ensure that information in the electronic segment and element is logical and validly formatted. The Multi-Carrier System (MCS) subjects every flat file record to a number of Prepass edits. These edits determine whether a file, claim or batch will be accepted into the claim cycle.

There are five types of edits that a record may encounter:

- I – Informational
- C – Claim deletion
- B – Batch deletion
- F – File delete
- O – Error turned off

An informational edit identifies an error and alerts the submitter to correct future claims. Informational edits will allow the claim or batch to continue into the batch cycle. Claim, batch, or file delete errors will continue to be edited (unless a sequencing error occurs), but will not be accepted into the batch cycle.

To view the complete listing of MCS 837 4010A1 Prepass Edits, go to:
http://www.wpsmedicare.com/provider/pdfs/mcs_prepass_edits.pdf

Additional Notes

The implementation of new edits will appear as provider news and in the *Communiqué*. Please see <http://www.wpsmedicare.com/provider/provhome.shtml>

All Dates must be in the format as defined by the ANSI element (e.g. D8 CCYYMMDD or RD8 CCYYMMDDCCYYMMDD); 00000000 is not a valid Date.

STANDARD PAPER REMITTANCE (SPR) SUPPRESSION

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

To review all of the changes that were made please read Special Edition Medicare Learning Network (MLN) Matters Article SE0627 - "Options for Providers/Suppliers Affected by CR 4376: Suppression of Standard Paper Remittance Advice (SPR) to Providers and Suppliers Also Receiving Electronic Remittance Advice (ERA) for 45 Days or More." This article is available at the following address on CMS' Website:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0627.pdf>

Not using your electronic remittance? Not aware that you were setup for electronic remittance and would prefer the Standard Paper Remittance? Electronic Data Interchange (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 Explanation of Benefits (EOB). For more information on this software go to **http://www.wpsmedicare.com/provider/easy_print.shtml**

You can download a WPS ERA Deactivation request form from the following URL:

<https://www.wpsic.com/edi/pdf/eradeactivate.pdf> and fax it to EDI to save you time. If you need a copy of the Standard Paper Remittance, (SPR) complete the deactivation request form, and be sure to specify the checks and dates of the needed SPRs. The EDI fax number for IL/MI/WI is (618) 998-5170 for MN (952) 885-2899.

General Information

DISCLOSURE DESK REFERENCE FOR PROVIDER CONTACT CENTERS

~CMS MLN Matters~

MLN Matters Number: MM5089
 Related CR Release Date: July 21, 2006
 Related CR Transmittal #: R16COM

Related Change Request (CR) #: 5089
 Effective Date: October 1, 2006
 Implementation Date: October 2, 2006

Provider Types Affected

All physicians, providers, and suppliers billing Medicare

Provider Action Needed

STOP – Impact to You

When you call or write a Medicare fee-for-service provider contact center (PCC) to request beneficiary protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, will authenticate your identity prior to disclosure.

CAUTION – What You Need to Know

CR5089 revises *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3, Section 30, and Chapter 6, Section 80, to update the guidance to PCCs for authenticating providers who call or write to request beneficiary protected health information, and to clarify the information they may disclose after authentication.

GO – What You Need to Do

Be prepared to supply the required authentication information when contacting a PCC to request protected health information.

Background

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

CR5089, from which this article is taken, completely revises Section 30 in Chapter 3 and Section 80 in Chapter 6 of the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9). It updates the PCC Disclosure Desk Reference, the main purpose of which is to protect the privacy of Medicare beneficiaries by ensuring that protected health information is disclosed to providers only when appropriate, to include:

- Guidance for authenticating providers who call or write to request beneficiary protected health information; and
- Clarification of the information that may be disclosed after authentication of writers and callers.

Please note that while new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements.

Below is the authentication guidance that the PCCs will be using:

Telephone Inquiries

Provider Authentication

CSR Telephone Inquiries - Through May 22, 2007, Customer Service Representatives (CSR) will authenticate providers using provider number and provider name.

Interactive Voice Response (IVR) Telephone Inquiries - Through May 22, 2007, IVRs will authenticate providers using only the provider number.

Note: See "Final Note" below to learn more about provider authentication after May 22, 2007.

Written Inquiries

Provider Authentication

Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider number and provider name.

Note: See "Final Note" below to learn more about provider authentication after May 22, 2007.

At this point, there are some specific details about provider authentication in written inquiries of which you should be aware.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider's official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider's name and address are included in the letterhead and clearly establish the provider's identity.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered to be written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you.

Rather, they will send you the requested information by regular mail, or respond to these requests by telephone. In either of these response methods, or if they elect to send you an automated e-mail reply (containing no beneficiary-specific information), they will remind you that such information cannot be disclosed electronically via email or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

And lastly, inquiries received without letterhead, including hardcopy, fax, e-mail, pre-formatted inquiry forms, or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs), will be authenticated the same as written inquiries, (explained above) using provider name and the provider number.

Insufficient or Inaccurate Requests

You should also understand that for any protected health information request in which the PCC determines that the authentication elements are insufficient or inaccurate, you will have to provide complete and accurate input before the information will be released to you.

Such requests that are submitted in written form and those on pre-formatted inquiry forms, will be returned in their entirety by regular mail, with a note stating that the requested information will be supplied upon submission of all authentication elements, and identifying which elements are missing or do not match the Medicare record.

Alternatively, if you sent the request by e-mail (containing no protected health information), the PCC may return it by e-mail, or may elect to respond by telephone to obtain the rest of the authentication elements.

Beneficiary Authentication

Regardless of the type of telephone inquiry (CSR or IVR) or written inquiry, PCCs will authenticate four beneficiary data elements before disclosing any beneficiary information:

- 1) Last name;
- 2) First name or initial;
- 3) Health Insurance Claim Number; and
- 4) Either date of birth (eligibility, next eligible date, Certificate of Medical Necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) [pre-claim]) or date of service (claim status, CMN/DIF [post-claim]).

Please refer to the disclosure charts attached to CR5089 for specific guidance related to these data elements as well as details on the beneficiary information that will be made available in response to authenticated inquiries. CR5089 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf> on the CMS Website.

Special Instances

Below are three special instances that you should know about.

Overlapping Claims

Overlapping claims (multiple claims with the same or similar dates of service or billing period) occur when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

Sometimes this happens when the provider is seeking to avoid have a claim be rejected, for example:

- When some End State Renal Disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill

being generated, thus allowing the facility to code the claim appropriately and bill around the inpatient hospital stay/stays; or

- Skilled nursing facility and inpatient hospital stays.

These situations fall into the category of disclosing information needed to bill Medicare properly, and information can be released as long as all authentication elements are met.

Pending Claims

A pending claim is one that is being processed, or has been processed and is pending payment. CSRs can provide information about pending claims, including Internal Control Number (ICN), pay date/amount or denial, as long as all authentication requirements are met.

Providers should note, however, that until payment is actually made or a remittance advice is issued, the information provided could change.

Deceased Beneficiaries

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, PCCs will comply with authentication requirements when responding to requests for information related to deceased beneficiaries.



Final note: More information will be provided in a future MLN Matters article about authentication on and after May 23, 2007, the implementation date for the National Provider Identifier or NPI.

Additional Information

You can find more information about Provider Contact Center guidelines concerning authentication by going to

<http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf> on the CMS Website.

Attached to that CR, you will find the updated *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100.09), Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information); and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information).

If you have any questions, please contact your carrier, durable medical equipment (DME) regional carrier, DME Medicare Administrative Contractor (DME MAC), fiscal intermediary, or regional home health intermediary at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

GUIDE TO OBTAINING BENEFICIARY ELIGIBILITY AND CLAIM STATUS INFORMATION

Section 921 of the Medicare Modernization Act (MMA) requires providers to use self-service technology to access information about claims status and beneficiary eligibility. WPS Medicare offers providers two self-service tools to check beneficiary eligibility and claim status. Providers are required to use one of the two self-service tools below for these types of inquiries in order to free up our customer service team for more complex issues such as Medicare denials, and policy and coverage questions. This guideline applies to both telephone inquiries and written inquiries (e.g., claim tracers).

Interactive Voice Response (IVR)

Providers can check beneficiary eligibility and claim status quickly and efficiently 24 hours a day by calling our Interactive Voice Response (IVR). Providers and suppliers receive the same status information from the IVR as they do from the Medicare customer service staff. You can access this service by calling the toll-free telephone number below and selecting the option that you would like to use. You have the ability to speak or touch-tone your responses. You can find more information about the features of the IVR and instructions for its use on the WPS Medicare Website at the following address:

<http://www.wpsmedicare.com/provider/pdfs/ivr.pdf>

Wisconsin 877-567-7176

Illinois 877-908-9499

Michigan 877-567-7201

Minnesota 877-908-8470

C-SNAP (CMS Secure Net Access Pilot)

WPS Medicare offers a self-service Internet tool called C-SNAP (CMS Secure Net Access Pilot). C-SNAP is available 24 hours a day. Providers who register with C-SNAP will be able to view claim status and check patient eligibility within a secured environment. In order for you to access C-SNAP, you must be a registered user and have access to provider location information. You will need to have your group billing provider number available for registration. If you have questions with registration, please contact a member of our C-SNAP Support team at 877-476-8116. You may register for C-SNAP at the following address:

<http://www.medicareinfo.com/>

LABORATORY COMPETITIVE BIDDING DEMONSTRATION

~CMS MLN Matters~

MLN Matters Number: MM5205
Related CR Release Date: August 1, 2006
Related CR Transmittal #: R49DEMO

Related Change Request (CR) #: 5205
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Physicians and all providers who bill Medicare carriers and fiscal intermediaries (FIs) for laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites

Background

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

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

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

Key Points

This article and Change Request (CR) 5205 provides instructions for the implementation of a laboratory competitive bidding demonstration. CR5205 is being implemented in multiple phases. The requirements specified in this article and CR5205 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

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

Required Bidders

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

These laboratory firms will be referred to as “required bidders.”

Passive Laboratories

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

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

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

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Winners

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

Non-Winners

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

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

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

Demonstration-Covered Laboratory Tests

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

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

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

Demonstration Sites

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

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

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

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

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

Implementation

CR5205 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

By January 1, 2007, CMS will provide Medicare carriers and fiscal intermediaries (FIs) with a national zip code pricing file identifying the zip codes included in the first CBA. Also, by the same date, CMS will provide to the carriers/FIs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

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

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

- Reason code 96 (non-covered charges);
- Remark code M114 (*This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding*)

Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.); and

- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Using these same reason and remark codes, Medicare will reject any laboratory claims with a date of service between April 1, 2007, and March 31, 2010 with a modifier of “90” submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA, regardless of the referring laboratory’s participation status.


Medicare will pay claims during the demonstration period submitted by nondemonstration laboratories for beneficiaries residing in the CBA who receive services outside of those areas (e.g., “snow birds”) according to the laboratory competitive bidding demonstration.

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

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

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

The demonstration in the first CBA is scheduled to begin on April 1, 2007 and the tentative start date for the demonstration in the second CBA is April 1, 2008.

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

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

Additional Information

The official instructions issued to your Medicare carrier/FI regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R49DEMO.pdf> on the CMS Website.

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

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

MEDICARE AS SECONDARY PAYER (MSP): LIABILITY SITUATIONS

WPS Medicare understands that there can be confusion in the provider community about billing Medicare or a liability insurer. Providers also are unsure of what amounts they can collect from the patient when a liability situation exists. If a provider is aware that a liability situation exists, the provider should bill the liability insurer first within a 120-day "promptly paid" period. If the liability insurer does not make payment within this timeframe, the provider has a decision to make. The provider can bill Medicare or pursue the liability claim.

A provider choosing to bill Medicare would bill the charges as usual. Providers not accepting assignment can collect amounts up to the Limiting Charge. Providers accepting assignment can collect deductibles and coinsurance amounts. The provider cannot pursue a lien or claim against the liability insurer or the beneficiary for amounts collected from the liability insurer.

A provider choosing to pursue the liability claim should be aware that they cannot collect any amounts from the patient until the liability claim is completed. Once the liability claim is completed, the provider can collect actual charges up to the amount of the liability claim. Medicare's timely file limit still applies. Therefore, if the provider pursues the liability claim and there is no payment by the liability insurer, the provider can only collect amounts for any non-covered service and the equivalent of the Medicare coinsurance once the timely file limit has expired.

Continued pursuit of collection of the payment of actual charges from the proceeds of the liability insurance after the provider has billed Medicare violates the provider agreement. The Centers for Medicare & Medicaid Services (CMS) currently has inaccurate information in the Internet-Only Manual (IOM) pertaining to this issue and they are updating the section in question.

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 July 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
Lisa A. Devries Nurse/Nurses Aide 1237 West 6 th Staunton, IL 62088 03/02/1969

Illinois Reinstated Providers

Name/Specialty/Date of Birth /Effective Date
Penny Lynn Chenoweth Nurse/Nurses Aide 804 East Murray Macomb, IL 61455 12/30/1962 REINSTATED: 06/05/2006

Name/Specialty/Date of Birth /Effective Date
Edward Jana Counselor 467 Longcommon Road Riverside, IL 60546 10/17/1951 REINSTATED: 07/03/2006

Michigan Reinstated Providers

Name/Specialty/Date of Birth /Effective Date
William Leon Bennett Counselor 857 E. Rowland Ave. Madison Hghts, MI 48071 01/01/1964 REINSTATED: 06/22/2006

Minnesota Sanctioned Providers

Name/Specialty/Address/Date of Birth
Rebecca Angela Waskosky Business Manager 1107 Kingswood Crescent Faribault, MN 55021 06/04/1984

Minnesota Reinstated Providers

Name/Specialty/Date of Birth /Effective Date	Name/Specialty/Date of Birth /Effective Date
James E. Maccani, R.N. Registered Nurse 3325 Pillsbury Avenue Minneapolis, MN 55408 07/05/1948 WITHDRAWAL: 11/20/1997	Stephen Douglas Scotti, M.D. Radiologist 6839 Langford Dr. Edina, MN 55436 11/16/1957 REINSTATED: 06/01/2006
Catherine M. Phillips, P.A. AKA: Catherine M. Trimble, P.A. Physicians Assist PO Box 112 Glencoe, MN 55336 01/18/1960 REINSTATED: 07/03/2006	

Provider Education

NOVICE KNOW-HOW – UNPROCESSABLE CLAIMS

Medicare considers a claim unprocessable if it is submitted with incomplete or missing required information or if it contains complete and necessary information that is invalid. Such information may be required for all claims or may be required conditionally. Because Medicare made no "initial determination" on a claim returned as unprocessable, the submitter may not ask for a redetermination or appeal. The provider must correct the claim and resubmit it with the appropriate information needed for payment.

For help in identifying the claims processing specifications that describe whether a data element is required, not required, or conditional, please refer to the Health Insurance CMS-1500 Claim Form Instructions in the WPS General Medicare guidebook. Items followed by an "R" are required, followed by a "C" are conditional, and followed by an "O" are optional. You can view the General Medicare guidebook at the following Website address:

http://wpsmedicare.com/provider/pdfs/general_medicare.pdf

Providers, billing services, and clearinghouses that submit claims electronically must submit all of their claims in X12N 837, version 4010, by October 16, 2003. To assist you with electronic billing, WPS Medicare created a cross-reference guide to help users become compliant. The status column on the crosswalk indicates whether a data element is required (noted by an "R") or situational/conditional (noted by an "S"). The crosswalk is available in the General Medicare guidebook at the aforementioned Website address.

Required situations indicate data elements needed to process a claim (e.g., provider name, date of service). Situations that are conditional/situational indicate any data element that must be completed if other conditions exist (e.g., if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim or if the insured is different from the patient, the insured's name must be entered on a claim).

To view additional information about unprocessable claim denials and to find a link to the Centers for Medicare & Medicaid Services (CMS) 1500 Claim Form instructions, visit our Website at the following address: <http://wpsmedicare.com/provider/claim-denials.shtml>

PROVIDER EDUCATION SCHEDULE

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 coding professionals best handle your specific coding questions. WPS Medicare Policy, Medical Review, and Provider Education & Outreach staff are not professional coders.

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

Teleconferences

Ask the Contractor Teleconferences (ACTs)

Topic	Date	Day	Time
Topic to be Announced	09/20/06	Wednesday	9:00 - 10:30 a.m. CDT
Please go to http://www.wpsmedicare.com/provider/ask.shtml to find out more information about ACTs.			

Chiropractic Care Teleconference

Date/Time	Course Number	Handouts
09/28/06 09:00 - 10:30 am CST	TCHC1	Not Yet Available

On September 28, WPS Medicare will hold a teleconference to address Chiropractic Services. The call will begin at 9:00 AM CST and will last approximately one and a half hours. Education specialists from our Provider Outreach and Education unit, and clinical staff from our Medical Review area will be presenting information and answering questions.

This teleconference proactively educates the provider community on all aspects of Chiropractic Care Services. We will address coverage provisions, review basic billing instructions, active corrective treatment vs maintenance treatment and documentation requirements.

Specific topics for this teleconference include:

- Local Coverage Decision (LCD) CHIRO-001
- Documentation Guidelines
- Modifiers - AT, GA, GY and GZ
- ABN
- CERT
- Billing Essentials

Please Note-This teleconference will not address the additional services billable in the Chiropractic Demonstration Area.

Webinars

Subsequent Hospital Care Codes CPT 99321-99233

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

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.**

Registration Information

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

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

Registration Steps*

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

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

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

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

Reimbursement**2007 ANNUAL UPDATE FOR THE HEALTH PROFESSIONAL
SHORTAGE AREA (HPSA) BONUS PAYMENTS
~CMS MLN Matters~****MLN Matters Number:** MM5237**Related CR Release Date:** August 4, 2006**Related CR Transmittal #:** R1021CP**Related Change Request (CR) #:** 5237**Effective Date:** January 1, 2007**Implementation Date:** January 2, 2007**Provider Types Affected**

Physicians and providers submitting claims to Medicare carriers and fiscal intermediaries (FIs) for services provided in HPSAs

Impact on Providers

This article is based on Change Request (CR) 5237, which alerts affected physicians, providers, carriers, and FIs that the new HPSA bonus payment information for 2007 will soon be available.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (Section 413(b)) mandated an annual update to the automated HPSA bonus payment files, and the Centers for Medicare & Medicaid Services (CMS) creates these new automated HPSA bonus payment files annually.

CR5237 instructs carriers and FIs to use the new HPSA bonus payment file for the automated bonus payment for claims with dates of service on or after January 1, 2007, through December 31, 2007.

In addition, CMS is notifying affected physicians/providers that it will post the new HPSA information to the CMS Website on or about October 1, 2006.

Implementation

The implementation date for the instruction is January 2, 2007.

Additional Information

For complete details, please see the official instruction issued to your carrier or FI regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1021CP.pdf> on the CMS Website.

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

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

CLARIFICATION REGARDING EFFECTIVE DATES FOR CARRIER CLAIM ADJUSTMENTS: DENIED REPLACEMENT DEFIBRILLATOR CLAIMS LACKING A QR MODIFIER

~CMS MLN Matters~

MLN Matters Number: MM5104
Related CR Release Date: June 2, 2006
Related CR Transmittal #: R971CP

Related Change Request (CR) #: 5104
Effective Date: April 1, 2005
Implementation Date: September 5, 2006

Provider Types Affected

Providers who bill carriers for Automatic Implantable Cardiac Defibrillator (ICD) services rendered to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

If you have a claim for a replacement ICD that was denied solely because it lacked a QR modifier, you may request an adjustment for that claim for any date of service for which the replacement ICD was otherwise covered.

CAUTION – What You Need to Know

CR5104 clarifies CR4273 to establish that your carrier will consider any payable date of service when you seek an adjustment of a replacement ICD claim previously denied solely because it did not contain a QR modifier.

GO – What You Need to Do

Make sure that your billing staff are aware that they can seek an adjustment for your replacement ICD claim denied due to lack of the QR modifier for any date of service for which the claim would otherwise have been payable.

Background

CR3604 (Transmittal 497), effective January 27, 2005, gave CMS carriers instructions on how to process Automatic Implantable Cardiac Defibrillator (ICD) claims for services provided under expanded coverage for new indications. One of these instructions was the requirement that the patient be enrolled in a data collection system.

Such patient enrollment is noted on the claim by the QR modifier, which identifies services being covered under a clinical study, and is required as a condition for payment on claims for ICD services rendered as:

- Part of the new indications (effective on January 27, 2005); or
- For any other ICD services rendered as a primary prevention of cardiac arrest (i.e., no history of induced or spontaneous arrhythmias).

To identify these instances, CMS systems maintainers created an edit to check the diagnosis code on the claim. If the diagnosis code was not a secondary prevention diagnosis code, then the QR modifier was required in order to cover the services.

Carriers turned on this edit, effective April 1, 2005. In order to ensure that the QR modifier was being applied to the extent possible to claims for ICD services rendered for the primary prevention of cardiac arrest, carriers were instructed to turn on the original edit such that

claims with dates of service prior to April 1, 2005, would also be checked for this modifier as appropriate.

Note: When any of the secondary prevention diagnosis codes appear on an ICD claim, the QR modifier is not required. However, you can append the QR modifier for secondary prevention diagnoses when it is appropriate, i.e., when the data is submitted to a data collection registry.

After CR3604's publication, CMS became aware of additional possible diagnoses which show neither primary nor secondary prevention of cardiac arrest, for example when the ICD is replaced, due to ICD recall or device complication (such as the end of battery-life).

Since claims such as these should not be denied because they lack a QR modifier, on January 27, 2006, CMS issued CR4273 (Transmittal 819). CR4273 added two new ICD-9-CM diagnosis codes to the list of those that do not require a QR modifier and which do not, by themselves, represent a condition where primary or secondary prevention can be ascertained:

- **996.04**, Mechanical complication of cardiac device, implant, and graft, due to automatic implantable cardiac defibrillator; and
- **V53.32**, Fitting and adjustment of other device, automatic implantable cardiac defibrillator.

To ensure that replacement ICD claims are not erroneously denied for a lack of QR modifier, the new edit accompanying CR4273 affects claims with dates of service on and after April 1, 2005. However, because the original carrier edit considered all dates of services as it checked for a QR modifier, including dates prior to April 1, 2005, it is possible that there will be replacement ICD claims erroneously denied with dates of service prior to April 1, 2005.

For this reason, when this issue is brought to their attention, Medicare carriers are to consider for possible adjustment all payable dates of service for replacement ICD claims when these claims have been denied solely for the lack of a QR modifier.

CR5104, from which this article is taken, makes this clarification and instructs carriers to inform you that you may have had claims for replacement ICDs erroneously denied for lack of a QR modifier and requiring such an adjustment.

Be aware, however, that the carriers do not have to search their files to retroactively pay claims, nor does this instruction apply to claims submitted to fiscal intermediaries (FIs), who implemented the original and revised edits according to dates of service.

Additional Information

You can find more information about the effective dates for carrier claim adjustments for replacement ICD claims denied because they lacked a QR modifier by going to CR5104, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R971CP.pdf> on the CMS Website.

Additionally, more information about ICD claims may be found in MLN Matters articles MM3604 and MM4273, which you can find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3604.pdf> and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4273.pdf>, respectively.

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.zip> on the CMS Website.

NON-APPLICATION OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS ~CMS MLN Matters~

MLN Matters Number: MM5127
Related CR Release Date: July 21, 2006
Related CR Transmittal #: R1004CP

Related Change Request (CR) #: 5127
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Physicians and providers who provide colorectal cancer screening services to Medicare beneficiaries.

Impact on Providers

Effective January 1, 2007, Medicare will waive the annual Medicare Part B deductible for colorectal cancer screening tests billed with the HCPCS codes listed in the following chart. While the deductible will be waived, and will not apply for colorectal cancer screening test services furnished on or after January 1, 2007, the Medicare Part B coinsurance still applies for these screening tests.

HCPCS Screening Code	Code Description
G0104	Colorectal cancer screening: Flexible sigmoidoscopy
G0105	Colorectal cancer screening: Colonoscopy on individual at high risk
G0121	Colorectal cancer screening: Colonoscopy on individual not meeting criteria for high risk
G0106	Colorectal cancer screening: Barium enema as an alternative to G0104, screening sigmoidoscopy
G0120	Colorectal cancer screening: Barium enema as an alternative to G0105, screening colonoscopy

Currently (prior to January 1, 2007, for colorectal cancer screening test services furnished before January 1, 2007), **the annual Medicare Part B deductible AND coinsurance apply to the above codes.**

Please note that the annual Medicare Part B deductible and coinsurance **do not apply** for the following tests.

- **G0107** (colon cancer screening; fecal occult blood tests (FOBT), 1-3 simultaneous determinations); and
- **G0328** (colon cancer screening; as an alternative to G0107; fecal occult blood test, immunoassay, 1-3 simultaneous determinations).

Background

This policy is directed by Section 5113 of the Deficit Reduction Act (DRA) of 2005. It amends Section 1833(b) of the Social Security Act (SSA) by eliminating the requirement of the annual Part B deductible for colorectal cancer screening tests furnished on or after January 1, 2007.

Additional Information

SE0613 “Colorectal Cancer: Preventable, Treatable, and Beatable: Medicare Coverage and Billing for Colorectal Cancer Screening” contains pertinent information. It can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0613.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. This special edition also includes links to other resources related to colorectal cancer screening and Medicare-covered preventive services.

The manual attachment to CR5127 (*Medicare Claims Processing Manual*, Chapter 18, “Preventive and Screening Services,” Section 60.1 “Colorectal Cancer Screening; Payment”) contains additional information about colorectal cancer screening. CR 5127 is the official instruction issued to your Medicare carrier or fiscal intermediary (FI) regarding changes mentioned in this article. CR 5127 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1004CP.pdf> on the CMS Website.

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 Website.

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

MLN Matters Number: MM4374 Revised
Related CR Release Date: July 14, 2006
Related CR Transmittal #: R999CP

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

Note: This article was revised on July 17, 2006, to reflect a correction made to related CR4374. CR4374 was corrected to show, in one statement, that HCPCS code G0182 refers to hospice oversight services, not home health services. This article was revised to replace “home health” to “hospice” in the 4th bullet point on page 3. The CR release date, transmittal number and web address were also changed, but all other information remains the same.

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 hospice 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/R999CP.pdf> on the CMS Website.

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 Website.

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