

ITEMS OF IMPORTANCE

Important Notice Regarding Provider Customer Service Closings 2
 Billing for Postoperative Wound Infusion Pumps 2
 CMS-855 To Report National Provider Identifiers 3
 Help Us Reduce Consultation Service Errors 4
 Mammography Reminder for IDTF's 4
 Prior Authorization, Prior Approval, and Predetermination of Benefits Requests 5
 Revised Information on PET Scan Coding 5

CLAIM SUBMISSION

Claim Status Category Code and Claim Status Code Update 10
 Correct Reporting of Diagnosis Codes on Screening Mammography Claims 11
 Laboratory and Radiology: Adjustment to Medicare System Common Working File (CWF) Duplicate Claim Edit for the Technical Component (TC) of Radiology and Pathology Laboratory Services Provided to Hospital Patients 13
 Response to Competitive Acquisition Program (CAP) for Part B Drugs and Biologicals Claims When the Medicare System Common Working File (CWF) 69 XD Error Code is Received 14

COVERAGE – GENERAL

2008 ICD-9-CM Coverage – Policy Revisions 16
 Clarification of Percutaneous Transluminal Angioplasty (PTA) Billing Requirements Issued in CR 3811 20
 Instructions for Implementing the Centers for Medicare & Medicaid (CMS) Ruling CMS 1536-R; Astigmatism-Correcting Intraocular Lens (A-C IOLS) 25
 Retired LCD/NCDS 30

COVERAGE – POLICIES

Information on Website 31
 Links to New Policies 31
 Links to Revised Policies 32

COVERAGE – NEW POLICIES

RAD-018 Cranial Stereotactic Radiosurgery (SRS) and Cranial Stereotactic Radiotherapy (SRT) 33
 RAD-038 Selective Internal Radiation Therapy (SIRT) for Primary and Secondary Hepatic Malignancy (90Y-Microsphere Hepatic Brachytherapy) 33

COVERAGE – REVISED POLICIES

CV-007 Transesophageal Echocardiography 34
 CV-026 Transthoracic Echocardiography 34
 CV-039 *Percutaneous Transluminal Angioplasty (PTA) (Carotid and Intracranial Stents) 35
 HONC-002 Chemotherapy and Drug Administration 36

HONC-010 Antineoplastics and their Adjuncts 36
 OPPTH-003 Optometrist Services 37
 PHYS-031 Prolonged Evaluation and Management Services and Standby Services 37
 PHYS-078 Billing and Enrollment Guideline for PHYS-078 Independent Diagnostic Testing Facilities (IDTF) 37
 PHYSMED-009 Physical Medicine Rehabilitation Procedures and Modalities 38

ELECTRONIC DATA INTERCHANGE (EDI)

Claims Not Showing Up on C-SNAP or the Medicare IVR System 41
 EDI Hotline Has High Call Volume 41
 Electronic Funds Transfer Standardizations and Revisions to the Medicare Claims Processing Manual (Chapter 24) 42
 Healthcare Provider Taxonomy Code (HPTC) Update 44
 NPI: Claims Will Begin to Reject 45
 NPI: Lifting the National Provider Identifier (NPI) Crosswalk Bypass Logic 46
 NPI: WPS Announces Schedule for Turning On NPI Prepass Edits: Why NPI Prepass Edits Occur and How To Correct 46

GENERAL INFORMATION

Revision to Medicare Publication 100-09, Chapter 3-Provider Inquiries and Chapter 6 – Provider Customer Service Program Updates 48
 The 2007 Medicare Contractor Provider Satisfaction Survey (MCPSS) Shows Positive Results for Medicare's Fee-for-Service Contractors 51

PROGRAM SAFEGUARDS

Sanctioned and Reinstated Providers 53

PROVIDER EDUCATION

Education Schedule 56

REIMBURSEMENT

Health Professional Shortage Area (HPSA) Designation Changes 59

Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. Current Dental Terminology copyright © 2002, 2005 American Current Procedural Terminology (CPT) is copyright 2005 American Dental Association. All rights reserved.

Items of Importance*** IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS***

WPS Medicare has not scheduled any training closings for Provider Customer Service for the month of September.

WPS Medicare Provider Customer Service will close for the following federal holiday:

- September 3, 2007 (Labor Day)

At this time, the Interactive Voice Response (IVR) and CMS Secure Net Access Pilot (C-SNAP) will continue to be available for your use to check eligibility and claim status.

The IVR's standard hours of operation are Monday - Friday 6:00 am - 6:00 pm CT; Saturday 7:00 am - 12:00 pm CT.

C-SNAP is available 24 hours a day. For more information regarding C-SNAP, please call the C-SNAP support line Monday - Friday 8:00 am - 4:00 pm CT 1-877-476-8116, or visit our Website at <https://medicareinfo.com/apps/cms/home.do>

For more information regarding the IVR, please visit our Website at:

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

Alternatively, to use the IVR, call:

Illinois (877) 908-9499

Michigan (877) 567-7201

Minnesota (877) 908-8470

Wisconsin (877) 567-7176

Thank you for your patience and for allowing us this opportunity to serve you better.

BILLING FOR POSTOPERATIVE WOUND INFUSION PUMPS

We have had several inquiries concerning the proper billing for the insertion of pain pumps placed at the end of major thoracic and orthopedic cases. Some of the better-known devices are the ON-Q Pain Buster, the Stryker Pain Pump System, and the DonJoy Pain Control Device. These provide pain management by a continuous infusion of a local anesthetic through a catheter directly into the patient's surgical site. The four main arguments for payment that we have heard are: 1) the pump insertion is not inclusive to the main procedure; 2) there is more work in putting in the pump; 3) the patient is more uncomfortable without it; and 4) the hospital stay may be lengthened without the device.

1. We agree that there is some additional work in inserting the pump. However, the real issues are whether the procedure is standard, whether it is truly a separate procedure, whether it is allowed by Medicare regulations, and whether it requires a significant amount of additional work. After reviewing many operative reports, manufacturers' Websites, and the medical literature, any additional work appears to be very minimal.

2. Per the National Coverage Provisions (and also found on GSURG-001 on our Website), a global surgery package includes “Postsurgical Pain Management - By the surgeon.” Thus, the insertion of such a pump is included in the overall surgeon’s payment.
3. While the hospital stay may be shortened, this is not an issue.

We have seen these pumps being billed under several CPT and HCPCS codes including A4306, 11981, 23929, and 32999. Billing for these pumps under these or other CPT/HCPCS codes is not appropriate. They should not be billed separately.

CMS-855 TO REPORT NATIONAL PROVIDER IDENTIFIERS

It is not generally required that providers submit a CMS-855 to report their NPIs to us. If, however, claim payment delays or rejections occur because your National Provider Identifier(s) (NPI) is not properly cross-walked to your legacy Medicare provider identification number(s), you may be asked to report your National Provider Identifier(s) to the Provider Enrollment Department as a change of information.

When doing so, be sure to complete each applicable Medicare Identification Number and NPI field on the appropriate CMS-855 enrollment form:

- Individuals and sole proprietors should submit a CMS-855I form, completing Sections 1, 2.A.1., 3, 4.C., 4.F. (if applicable), 13, and 15. (Complete a separate Section 4.C. for each legacy Medicare Identification Number.)
- Individuals who are the sole owner of a professional corporation, professional association, or limited liability company should submit a CMS-855I form, completing Sections 1, 2.A.1., 3, 4.A., 4.C., 13, and 15. (If there are multiple legacy Medicare Identification Numbers, complete Section 4.C. for each legacy Medicare Identification Number.)
- Clinics and other organizations should submit a CMS-855B form, completing Sections 1, 2.B.1, 3, 4.A, and either 15, or 16. (A separate Section 4.A. should be completed for each practice location.)

A copy of each NPI notification must be included with the CMS-855. This may be a copy of an e-mail or letter received from the NPI Enumerator or Electronic File Interchange Organization (EFIO), or it may be a “Welcome to the National Provider System” screen print from the National Plan and Provider Enumeration System (NPPES) Web site.

When you are submitting a CMS-855 to report your NPI because of claims processing issues, please enclose a cover letter explaining that this is the case.

Note: If we do not have current enrollment information on file for you, you may need to submit a complete CMS-855 in order to report your NPI(s). If you have questions about what is needed, please contact our Provider Enrollment Department: (866) 564-0315 for Minnesota and (877) 908-8476 for Illinois, Michigan, and Wisconsin.

HELP US REDUCE CONSULTATION SERVICE ERRORS

Wisconsin Physicians Service (WPS) Medicare identified concerns with provider billing of Consultations services. The Comprehensive Error Rate Testing (CERT) program report shows an increase in payment errors for Consultation services. WPS Medicare created education materials to give you accurate information to determine correct billing. We encourage your office to access this material, compare the instructions to your individual office practices, and decide if you need to make any necessary changes. You can access this information at:

http://www.wpsmedicare.com/provider/pdfs/consultation_presentation.pdf

MAMMOGRAPHY REMINDER FOR IDTF'S

Failure to report the new mammography codes for screening and diagnostic mammography services in the appropriate sections of the 855B will cause your claims to be returned and not processed.

CMS assigned new 2007 Current Procedural Terminology (CPT) mammography codes for screening and diagnostic mammography services.

Effective January 1, 2007, codes were replaced; however, the code descriptors for the services remain unchanged. Failure to report the new codes in the appropriate sections of the 855B will cause your claims to be returned and not processed.

The following table displays the new (and old) replacement codes and their description.

2007 Screening and Diagnostic Mammography CPT codes		
New Code	Old Code	Description
77051	76082	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography. (list separately in addition to code for primary procedure)
77052	76083	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography. (list separately in addition to code for primary procedure)
77055	76090	Diagnostic mammography, unilateral
77056	76091	Diagnostic mammography, bilateral
77057	76092	Screening mammography, bilateral (two view film study of each breast)

MAKE SURE YOUR BILLING STAFF IS AWARE OF THE CPT CODES CHANGES.

To read the Medicare Learning Network Matters articles in its entirety please visit the CMS Website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5327.pdf>

PRIOR AUTHORIZATION, PRIOR APPROVAL, AND PREDETERMINATION OF BENEFITS REQUESTS

WPS Medicare often receives requests for prior authorization, prior approval, or a predetermination of benefits. Unfortunately, while a proposed treatment plan could offer insight into a patient's condition, the actual service and follow-up care provided may differ based on the patient's condition at the time the service is rendered. For this reason, the Original Medicare program does not give prior authorization, prior approval, or a predetermination of benefits for any service.

You can find general coverage guidelines for many services using the Medicare Coverage Database (MCD). This searchable database, which is maintained by the Centers for Medicare & Medicaid Services (CMS), is located on the CMS Website at the following address:

<http://www.cms.hhs.gov/mcd>

Providers can also find WPS Medicare's coverage and billing guidelines for many services using our Local Coverage Determinations (LCDs). You can locate our policies on our Website at the following address:

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

In the absence of a local or national coverage policy, WPS Medicare determines whether coverage is available for a service on a case-by-case basis using the documentation submitted with the claim for payment. WPS Medicare may also request additional medical documentation at the time the claim is processed.

REVISED INFORMATION ON PET SCAN CODING

~CMS MLN Matters~

MLN Matters Number: MM5665 Revised
Related CR Release Date: July 20, 2007

Related Change Request (CR) #: 5665
Effective Date: January 28, 2005 and
January 1, 2008 (per article)
Implementation Date: January 7, 2008

Related CR Transmittal #: R1301CP

Note: This article was revised on August 1, 2007, to correctly list HCPCS code A4641, instead of A4691, in two places within the article and to correct one code shown in Table 2 related to physicians/practitioners billing for CPT 78491 and 78492. All other information remains the same.

Provider Types Affected

Physicians and providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), and Medicare Administrative Contractors (A/B MAC)) for Positron Emission Tomography (PET) Scan services for Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Effective for services on and after January 28, 2005, your carrier, FI, or A/B MAC will deny claims for PET Scan services that contain CPT code 78609 and they will deny claims for PET Scan services on or after January 1, 2008 that contain HCPCS code A4641.

CAUTION – What You Need to Know

CR 5665, from which this article is taken, corrects erroneous information that was originally issued in CR 3741, transmittal 527 (New Coding for FDG PET Scans and Billing Requirements for Specific Indications of Cervical Cancer), dated April 15, 2005. CR5665 updates Medicare Claims Processing Manual, Chapter 13, Sections 60.30.1 and 60.30.2 by removing HCPCS code 78609 from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans.

GO – What You Need to Do

Make sure that your billing staffs are aware of these code changes and submit only covered codes in your claims for PET Scan services.

Background

The Centers for Medicare & Medicaid Services (CMS) recently learned that the Medicare Claims Processing Manual, Chapter 13 (Radiology Services), Sections 60.30.1 (Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005) and 60.30.2 (Tracer Codes Required for PET Scans), and CR 3747 (transmittal 527, dated April 15, 2005), contain incorrect information regarding CPT code 78609 (PET for brain perfusion imaging) and HCPCS code A4641.

- In Section 60.3.1, CPT code 78609 is incorrectly listed as a covered service by Medicare, and in Section 60.3.2 is incorrectly included in terms of the applicability of certain tracer codes. Similarly, Section 60.30.2 incorrectly lists HCPCS code A4641 as an applicable tracer for PET Scans.

CR 5665, from which this article is taken, corrects these errors. It updates the manual by removing HCPCS code 78609 from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans. In so doing, it also corrects the erroneous information that was originally issued in CR 3747.

Notes: 1) All Positron Emission Tomography (PET) Scans services (codes 78459, 78491, 78492, 78608, and 78811-78816) require the use of a radiopharmaceutical diagnostic imaging agent (tracer). Therefore, the applicable tracer code should always be used when billing for a PET scan service.

2) The correct PET Scan CPT codes and tracer HCPCS codes are listed in Tables 1 and 2, below.

Key points in CR 5665

- Effective January 28, 2005, CPT 78609 became a non-covered service for Medicare;
- Carriers, FIs, and A/B MACS will deny claims submitted with CPT code 78609 (effective January 28, 2005);
- When denying these claims, they will use:
- Medicare Summary Notice (MSN) 16.10 “Medicare does not pay for this item or service.”
- Claim Adjustment Reason Code 96: “Non-covered charge.”
- Remittance Advice Remark Codes N386: —“This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to

whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have Web access, you may contact the contractor to request a copy of the NCD.”

- Effective January 1, 2008, HCPCS code A4641 is not an applicable tracer for
- You should not report HCPCS code A4641 when submitting claims for PET Scans for services on or after January 1, 2008. Instead, as of that time, when submitting claims for PET Scans containing CPT code 78491 or 78492 you should use only tracer code A9555 or A9526; and, when submitting claims for PET Scans containing CPT code 78459, 78608, or 78811-78816, you should use only tracer code A9552 (see table 2, below).
- Carriers, FIs, and A/B MACs will not search for, and adjust, claims that have been paid prior to the implementation date, but they will adjust claims brought to their attention.

The following tables list the currently covered PET Scan CPT codes (on or after January 28, 2005) and tracer HCPCS codes, as of January 1, 2008).

Table 1

Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005

CPT Code	Description
78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation
78491	Myocardial imaging, positron emission tomography (PET), perfusion, single study at rest or stress
78492	Myocardial imaging, positron emission tomography (PET), perfusion, multiple studies at rest and/or stress
78608	Brain imaging, positron emission tomography (PET); metabolic evaluation
78811	Tumor imaging, positron emission tomography (PET); limited area (e.g., chest, head/neck)
78812	Tumor imaging, positron emission tomography (PET); skull base to mid thigh
78813	Tumor imaging, positron emission tomography (PET); whole body
78814	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; limited area (e.g., chest, head/neck)
78815	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; skull base to mid thigh
78816	Tumor imaging, positron emission tomography (PET) with concurrently acquired computed tomography (CT) for attenuation correction and anatomical localization; whole body
NOTE: All PET scan services require the use of a radiopharmaceutical diagnostic imaging agent (tracer). The applicable tracer code should be billed when billing for a PET scan service. See Table 2, below, for applicable tracer codes.	

Table 2

Tracer Codes Required for PET Scans on or after January 1, 2008 (A4641 is allowed for services on or before December 31, 2007)

The following tracer codes are applicable only to CPT 78491 and 78492. They cannot be reported with any other code.	
Institutional providers billing fiscal intermediaries or A/B MACs	
HCPCS Code	Description
*A9555	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium Rb-82, Diagnostic, Per study dose, Up To 60 Millicuries
* Q3000 (Deleted effective 12/31/05)	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium Rb-82
A9526	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13
*NOTE: For claims with dates of service prior to 1/01/06, providers report Q3000 for supply of radiopharmaceutical diagnostic imaging agent, Rubidium Rb-82. For claims with dates of service 1/01/06 and later, providers report A9555 for radiopharmaceutical diagnostic imaging agent, Rubidium Rb-82 in place of Q3000.	
Physicians/practitioners billing carriers or A/B MACs	
*A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified
A9526	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13
A9555	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium Rb-82, Diagnostic, Per study dose, Up To 60 Millicuries
*NOTE: Effective January 1, 2008, tracer code A4641 is not applicable for PET Scans.	
The following tracer codes are applicable only to CPT 78459, 78608, 78811-78816. They cannot be reported with any other code:	
Institutional providers billing fiscal intermediaries or A/B MACs	
* A9552	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18, FDG, Diagnostic, Per study dose, Up to 45 Millicuries
* C1775 (Deleted effective 12/31/05)	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18
**A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified
*NOTE: For claims with dates of service prior to 1/01/06, OPSS hospitals report C1775 for supply of radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F18. For claims with dates of service 1/01/06 and later, providers report A9552 for radiopharmaceutical diagnostic imaging agent, Fluorodeoxyglucose F18 in place of C1775.	
**NOTE: Effective January 1, 2008, tracer code A4641 is not applicable for PET Scans.	

(Table 2 Cont'd)

Physicians/practitioners billing carriers or A/B MACs	
A9552	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18, FDG, Diagnostic, Per study dose, Up to 45 Millicuries
*A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified
*NOTE: Effective January 1, 2008, tracer code A4641 is not applicable for PET Scans.	

Additional Information

You can find more information about PET Scan codes by going to CR 5665, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1301CP.pdf> on the CMS Website. You will find the updated Medicare Claims Processing Manual, Chapter 13 (Radiology Services), Sections 60.30.1 ([Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005](#)) and 60.30.2 ([Tracer Codes Required for PET Scans](#)) as an attachment to that CR.

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

WPS Medicare Tip of the Week

(Published in the 08/27/07 General e-News Listserv)

Where can I find Medicare laws and regulations?

Medicare laws and regulations are located on the Centers for Medicare & Medicaid Services (CMS) Website. Please go to <http://www.cms.hhs.gov/home/regsguidance.asp> to access the CMS laws and regulations page.

To receive our Tips of the Week, sign up to receive our e-News Listserv at:

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

Claim Submission**CLAIM STATUS CATEGORY CODE AND CLAIM STATUS CODE
UPDATE****~CMS MLN Matters~**

MLN Matters Number: MM5687
Related CR Release Date: July 23, 2007
Related CR Transmittal #: R1314CP

Related Change Request (CR) #: 5687
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit Health Care Claim Status Transactions to Medicare contractors (carriers, Medicare administrative contractors (A/B MACs), durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)).

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

This article is based on Change Request (CR) 5687, which provides the January 2008 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, A/B MACs, DME MACs, FIs, and RHHIs)..

CAUTION – What You Need to Know

Effective January 1, 2008, Medicare contractors are to use codes posted on July 9, 2007, at the <http://www.wpc-edi.com/codes> Website. Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277 discusses these codes in more detail. You may review section 20.7 at: <http://www.cms.hhs.gov/manuals/downloads/clm104c31.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

GO – What You Need to Do

See the Background section of this article for further details.

Background

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction. These codes indicate the general category of a claim's status (accepted, rejected, additional information requested, and so on). The national Code Maintenance Committee maintains the Claim Status Category and Claim Status codes. The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at <http://www.wpc-edi.com/content/view/180/223/>. This page has previously been referenced by the following URL address: <http://www.wpc-edi.com/codes>.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2007 committee meeting were posted on that site on July 9, 2007. One of the decisions made during this June meeting by this Maintenance Committee was to allow the industry more lead time for implementation of code changes. At least 6 months lead time will be allowed for industry implementation of all Claim Status-related code changes as well as Claim Adjustment Reason Code changes (the same committee maintains these code sets). As result, changes approved in June 2007 will be effective January 1, 2008.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5687) issued to your Medicare FI, carrier, DME MAC, RHHI or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1314CP.pdf> on the CMS Website.

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

CORRECT REPORTING OF DIAGNOSIS CODES ON SCREENING MAMMOGRAPHY CLAIMS

~CMS MLN Matters~

MLN Matters Number: MM5050 Revised
Related CR Release Date: April 28, 2006
Related CR Transmittal #: R916CP

Related Change Request (CR) #: 5050
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Correct Reporting of Diagnosis Codes on Screening Mammography Claims

This article was revised on July 27, 2007 to add a reference to CR5377. MM5050 erroneously removed TOB 12X as an applicable TOB for diagnostic mammography services (page 1) supplied to Medicare inpatients and billable under Medicare Part B. CR5377 announced that effective April 1, 2007, TOB 12X is acceptable by FIs and A/B MACS as an appropriate bill type for such services.

Provider Types Affected

All providers billing Medicare carriers and fiscal intermediaries (FIs) for screening mammography claims

Providers Action Needed

This article and Change Request (CR) 5050 provide specific information regarding the reporting of diagnostic codes on screening mammography claims. The following are the instructions:

- Continue reporting diagnosis codes V76.11 or V76.12 as the primary or principal diagnosis code (FL 67 of the CMS-1450 or in Loop 2300 of the ANSI-X12 837) on claims that contain ONLY SCREENING mammography services.

- Report diagnosis codes V76.11 or V76.12 as a secondary or other diagnosis (FLs 68-75 of the CMS-1450 or Loop 2300 of the ANSI-X12 837 and field 21 of CMS-1500 or Loop 2300 of the ANSI-X12 837) on claims that contain OTHER services in addition to a screening mammography.

In addition, CR5050 updates Chapter 18, Section 20.4 of the Medicare Claims Processing Manual for FI processed claims as follows:

- It removes 12X type of bill (TOB) from the list of applicable TOBs for diagnostic mammography; (See Note above.)
- It adds HCPCS code G0202 to the list of valid codes for the billing of screening mammography; and
- It adds HCPCS codes G0204 and G0206 to the list of valid codes for the billing of diagnostic mammographies.
- It adds HCPCS codes G0204 and G0206 to the list of valid codes for the billing of diagnostic mammographies.

Background

The Centers for Medicare & Medicaid Services (CMS) is clarifying its reporting requirements to allow other diagnosis codes and a screening mammography submitted on the same claim.

Currently, providers are required to report screening mammography diagnosis codes V76.11 or V76.12 as the primary diagnosis whenever a screening mammography is billed, regardless of whether other services are reported on the same claim. This CR adjusts that requirement.

Implementation

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

Additional Information

The official instructions issued to your Medicare carrier and intermediary regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R916CP.pdf> on the CMS Website. The revised Section 20.4 of Chapter 18 of the Medicare Claims Processing Manual is attached to CR5050.

To view the instruction (CR5377) that reversed the removal of TOB 12x, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1117CP.pdf> on the CMS Website.

The related MLN Matters article maybe found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5377.pdf> on the CMS Website.

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

**LABORATORY AND RADIOLOGY: ADJUSTMENT TO MEDICARE
SYSTEM COMMON WORKING FILE (CWF) DUPLICATE CLAIM EDIT
FOR THE TECHNICAL COMPONENT (TC) OF RADIOLOGY
AND PATHOLOGY LABORATORY SERVICES
PROVIDED TO HOSPITAL PATIENTS**

~CMS MLN Matters~

MLN Matters Number: MM5675
Related CR Release Date: July 13, 2007
Related CR Transmittal #: R1295CP

Related Change Request (CR) #: 5675
Effective Date: April 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected

Radiology suppliers, clinical diagnostic laboratories, and other providers billing Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for the TC of **radiology and pathology** services provided to Medicare fee-for-service hospital inpatients.

Provider Action Needed

STOP – Impact to You

Previously the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5347 that established duplicate claims edits, which included consideration of **the admission and discharge dates of a hospital stay in identifying duplicate claims for radiology and pathology services.**

CAUTION – What You Need to Know

Effective with implementation of CR5675 on October 1, 2007, claims with dates of service on or after April 1, 2007, **will be paid that provide radiology and pathology services to Medicare beneficiaries on the day of admission and the day of discharge during an inpatient hospital stay.**

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes.

Background

This CR is being implemented to avoid denying claims that were legitimately provided to beneficiaries on the admission and discharge dates. The general rule is that the technical component (TC) of radiology services provided during an inpatient stay may be billed only by the admitting hospital. Radiology suppliers that render services to beneficiaries in an inpatient stay may not bill the Medicare carrier for the technical portion of the service.

Also, the TC of physician pathology services provided to a hospital inpatient may be billed only by the admitting hospital. Independent laboratories have been instructed that they may not bill for these services after December 31, 2007 per CR 5468 (Transmittal 1148, issued Jan 5, 2007). The exception is that imaging and pathology services performed on the admission date and discharge date by entities other than the admitting hospital are separately payable.

Also, note that carriers and A/B MACs will not reprocess claims already processed, but they will adjust previously processed claims if affected providers bring such claims to the attention of their carrier or A/B MAC.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5675) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1295CP.pdf> on the CMS Website.

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

CR 5347 implemented a process to prevent payments of the TC of radiology services furnished to an inpatient of a hospital by any entity other than the admitting hospital. This CR may be reviewed by clicking on <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5347.pdf> on the CMS Website

**RESPONSE TO COMPETITIVE ACQUISITION PROGRAM (CAP)
FOR PART B DRUGS AND BIOLOGICALS CLAIMS WHEN THE
MEDICARE SYSTEM COMMON WORKING FILE (CWF) 69XD
ERROR CODE IS RECEIVED**

~CMS MLN Matters~

MLN Matters Number: MM5658
Related CR Release Date: July 23, 2007
Related CR Transmittal #: R1313CP

Related Change Request (CR) #: 5658
Effective Date: August 23, 2007
Implementation Date: August 23, 2007

Provider Types Affected

Participating CAP physicians and other providers billing Medicare carriers or Medicare Administrative Contractors (A/B MAC) for Part B drugs and biologicals under the Competitive Acquisition Program (CAP).

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

If you submit the same prescription order number more than once on a single CAP claim, your carrier or A/B MAC will return the entire claim as unprocessable.

CAUTION – What You Need to Know

CR 5658, from which this article is taken, instructs carriers and A/B MACs to return as unprocessable CAP claims received with duplicate prescription order numbers.

GO – What You Need to Do

Make sure that your billing staffs are aware that they should not submit the same prescription order number more than once on a CAP claim, nor should they use the JW modifier on CAP claims, per CR5658.

Background

Carriers and A/B MACs receive an error code when the same prescription order number is submitted more than once on a CAP claim. This inclusion of duplicate prescription order numbers on a single claim can happen, for example, when:

- The provider is coding wastage of the drug using the JW modifier, and has repeated the prescription order number on the wastage line;
- The units provided for the drug exceed 999 and the balance of the units are coded on an additional line with a repeat of the prescription order number; or
- The provider has submitted more than one line on the same claim with the same or different dates of service using the same prescription order number (even when the units do not exceed 999).

In response to this error code, carriers and A/B MACs will return the claims as unprocessable, using the following Remittance Advice Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) messages:

- CARC 16: Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. This change to be effective 4/1/2007. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
- Message MA130: Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- RARC M16: Please see our Website, mailings, or bulletins for more details concerning this policy/procedure/decision.

In order to resolve the issue of units that exceed 999, the Centers for Medicare & Medicaid Services (CMS) will be working with the approved CAP vendor to issue additional prescription order numbers when the units of the drug exceed 999.

Finally, CR 5658 rescinds (from CR 4309, issued on February 17, 2006) the instructions that addressed applying the unused drug modifier (JW) to indicate billing for the unused portion of a single-use drug product under the CAP. Claims for drugs provided under CAP submitted with the JW modifier will be treated as unprocessable. This CR does not affect the use of the JW modifier for non CAP claims.

Additional Information

You can find the official instruction, CR5658, issued to your carrier or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1313CP.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/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

Coverage – General
2008 ICD-9-CM COVERAGE - POLICY REVISIONS

Effective for claims submitted with dates of service on or after 10/01/2007, WPS will cover the new 2008 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 10/01/2007.

Policy Name/Number	Policy Procedure Code	2008 ICD-9-CM Changes
CV-006 Cardiac Catheterization and Coronary Angiography	93501, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529	414.2, 415.12, 423.3
CV-007 Transesophageal Echocardiography (TEE)	93312-93317	414.2, 415.12.
CV-026 Transthoracic Echocardiography (TTE)	93303, 93304, 93307, 93308, 93320, 93321, 93325	359.21-359.24, 359.29, 414.2, 415.12, 423.3, 440.4, 999.31, 999.34 Delete: 359.2, 999.3
CV-033 Noninvasive Vascular Testing	93922-93931 93965-93971, G0365	440.4; 449 415.12
CV-034 Intraoperative Transesophageal Echocardiography	93312-93317	414.2, 415.12
HONC-010 Antineoplastics and their Adjuncts	J0640, J9000, J9015, J9020, J9040, J9045, J9050, J9060, J9062, J9065, J9070, J9080, J9090-J9097, J9100, J9110, J9120, J9130, J9140, J9150, J9165, J9178, J9181, J9182, J9185, J9190, J9200, J9201, J9208, J9209, J9213, J9214, J9215, J9230, J9250, J9260, J9270, J9280, J9290, J9291, J9293, J9310, J9320, J9340, J9360, J9370, J9375, J9380 J9999 (Teniposide)	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78
	J9160	202.70-202.78
	J9041	200.40-200.48 replaces non- specific code range 202.80- 202.88 for Mantle cell lymphoma

Policy Name/Number	Policy Procedure Code	2008 ICD-9-CM Changes
GU-020 Diagnostic PAP Tests	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175	233.30-233.39 Delete: 233.3
INJ-012 Immune Globulins	J1566, Q4087, Q4088, Q4091, Q4092	284.81 Delete: 284.8
INJ-019 Human Granulocyte/Macrophage Colony Stimulating Factors	J1440, J1441, J2820	284.89 Delete: 284.8
NEUR0-005 Nerve Conduction Studies and Electromyography	All Code Listed	359.21-359.29
PATH-016 Flow Cytometry	88184, 88185, 88187, 88188, 88189	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78
PATH-027 Cytogenetic Studies	88237, 88239, 88262, 88271, 88272, 88273, 88274, 88275, 88283	233.30-233.39 Delete: 233.3
PATH-031 Syphilis Tests	86592, 86593, 86781	331.5
PSYCH-014 Psychiatry and Psychology Services	90802, 90810-90815, 90823, 90824, 90826-90829, 90857 90804-90809, 90816-90819, 90821, 90822, 90846, 90847, 90849, 90853, 90862, 90865, 90870, M0064	315.34 315.34
PSYCH-015 Health and Behavior Assessment/ Intervention	96150-96154	315.34
RAD-004 Chest X-Ray	71010, 71015, 71020-71023, 71030, 71034, 71035	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 255.41, 255.42, 414.2, 423.3, 449, 488, 787.20-787.24, 787.29, 789.51, 789.59, 999.31, 999.39, V12.53 Delete: 787.2, 789.5, 999.3 Coding Article Non-Covered: V68.01 Coding Article Non-Covered Delete: V68.0

Policy Name/Number	Policy Procedure Code	2008 ICD-9-CM Changes
RAD-014 Radiation Oncology Including Modulated Radiation Therapy (IMRT)	77301, 77418, 0073T	200.30-200.78; 202.70-202.78
RAD-023 MRA	71555 73725	415.12 440.4
RAD-024 Magnetic Resonance Imaging (MRI)	70336, 70540, 70542, 70543, 70551-70553	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 331.5, 359.21-359.24, 359.29, 388.45, 389.05, 389.06, 389.13, 389.17, 389.20- 389.22, 787.20-787.24, 787.29, 999.31, 999.39 Delete: 359.2, 389.2, 787.2, 999.3
	71550-71552	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 423.3
	72195-72197, 74181-74183	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 233.30-233.32, 233.39, 255.41, 255.42, 449, 569.43, 789.51, 789.59 Delete: 233.3, 255.4, 789.5
	73218-73223	359.21-359.24, 359.29 Delete: 359.2
	73718-73723	359.21-359.24, 359.29 Delete: 359.2
RAD-032 Vertebroplasty (Percutaneous) and Kyphoplasty	22520-22525, 72291, 72292,	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78,

Policy Name/Number	Policy Procedure Code	2008 ICD-9-CM Changes
RAD-033 Computerized Tomography (CAT Scans)	70450-70489	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 331.5, 359.21-359.24, 359.29, 388.45, 389.05, 389.06, 389.13, 389.17, 389.20- 389.22, 787.20-787.24, 787.29, 999.31, 999.39 Delete: 359.2, 389.2, 787.2, 999.3
	71250-71270	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 415.12, 423.3
	72191-72194, 74150-74175, 75635	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70- 202.78, 233.30-233.32, 233.39, 255.41, 255.42, 449, 569.43, 789.51, 789.59 Delete: 233.3, 255.4, 789.5
	73200-73206	359.21-359.24, 359.29 Delete: 359.2
	73700-73706	359.21-359.24, 359.29 Delete: 359.2
PHYSMED-009 Physical Medicine and Rehabilitation	97022, 97036, 97110, 97112, 97113, 97116, 97535	359.21, 359.22, 359.29 Delete: 359.2
DENT-002 Dental Services	Any	200.31, 200.41, 200.51, 200.61, 200.71, 202.71 Non-Covered Services 525.71, 525.72, 525.73, 525.79

**CLARIFICATION OF PERCUTANEOUS TRANSLUMINAL
ANGIOPLASTY (PTA) BILLING REQUIREMENTS
ISSUED IN CR 3811
~CMS MLN Matters~**

MLN Matters Number: MM3811 Revised
Related CR Release Date: April 22, 2005
Related CR Transmittal #: R33NCD and R531C

Related Change Request (CR) #: 3811
Effective Date: March 17, 2005
Implementation Date: July 5, 2005

Expansion of Coverage for Percutaneous Transluminal Angioplasty (PTA)

Note: This article was revised on April 3, 2006, to clarify that reporting of both 433.30 and 433.10, in either diagnosis position, needs to be done in the same claim as noted in the "Note" box at the top of page 5 of this article. All other information remains the same.

Provider Types Affected

Hospitals, physicians, and suppliers billing Medicare carriers or fiscal intermediaries (FIs) for Percutaneous Transluminal Angioplasty (PTA) services provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

MM3811 and related CR3811 announce the expansion of Medicare coverage for PTA of the carotid artery.

CAUTION – What You Need to Know

Effective March 17, 2005, Medicare revised its coverage of PTA of the carotid artery as detailed in this article and CR 3811.

GO – What You Need to Do

If you are a provider of PTA services, be aware of the coverage changes and make certain that your billing staff is aware of the expanded national coverage allowed to Medicare beneficiaries receiving PTA services

Background

Medicare covers PTA of the carotid artery concurrent with carotid stent placement when all the requirements stipulated by the Food and Drug Administration (FDA)-approved policies for Category B Investigational Device Exemption (IDE) clinical trials are met, effective for dates of service on or after July 1, 2001.

PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent for an FDA-approved indication is covered, when all the requirements stipulated by the FDA-approved policies for post-approval studies are met, for dates of service on or after October 12, 2004.

Expanded Coverage

Effective March 17, 2005, The Centers for Medicare & Medicaid Services (CMS) expanded the coverage of PTA of the carotid artery concurrent with placement of an FDA-approved carotid stent with embolic protection for the following:

- Patients who are at high risk for carotid endarterectomy (CEA) and who also have symptomatic carotid artery stenosis $\geq 70\%$. Coverage is limited to procedures performed using FDA-approved carotid artery stenting systems and embolic protection devices;
- Patients who are at high risk for CEA and have symptomatic carotid artery stenosis between 50% and 70% in accordance to the Category B IDE clinical trials regulation (42 CFR 405.201), as a routine cost under the clinical trials policy (Medicare National Coverage Determination (NCD) Manual, Section 310.1), or according to the NCD on carotid artery stenting (CAS) post-approval studies (Medicare NCD Manual, Section 20.7); and
- Patients who are at high risk for CEA and have asymptomatic carotid artery stenosis $\geq 80\%$ (according to the Category B IDE clinical trials regulation (42 CFR 405.201)), as a routine cost under the clinical trials policy (Medicare NCD Manual 310.1), or according to the NCD on CAS post-approval studies (Medicare NCD Manual, Section 20.7).

Significant Comorbidities

CMS defines high risk patients as those having significant comorbidities and/or anatomic risk factors and are considered by a surgeon to be poor candidates for CEA. The significant comorbidities, include, but are not limited to, those listed in Section 20.7 of the Medicare NCD Manual as follows:

- Congestive heart failure (CHF) class III/IV;
- Left ventricular ejection fraction (LVEF) $< 30\%$;
- Unstable angina;
- Contralateral carotid occlusion;
- Recent myocardial infarction (MI);
- Previous CEA with recurrent stenosis ;
- Prior radiation treatment to the neck; and

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

- Other conditions that were used to determine patients at high risk for CEA in the prior CAS trials and studies, such as ARCHER, CABERNET, SAPPHIRE, BEACH, and MAVERIC II.

Carotid Artery Stenosis

Symptoms of carotid artery stenosis include carotid transient ischemic attack (distinct focal neurologic dysfunction persisting less than 24 hours), focal cerebral ischemia producing a non-disabling stroke (modified Rankin scale < 3 with symptoms for 24 hours or more), and transient molecular blindness (amaurosis fugax). Patients who have had a disabling stroke (modified Rankin > 3) would be excluded from coverage.

The appropriate documentation confirming that a patient is at high risk for CEA and records of the patient's symptoms of carotid artery stenosis should be available in the patient medical records prior to performing any procedure.

The degree of carotid artery stenosis should be measured by duplex Doppler ultrasound or carotid artery angiography and recorded in the patient medical records. If the stenosis is measured by ultrasound prior to the procedure, then the degree of stenosis must be confirmed by angiography at the start of the procedure. If the stenosis is determined to be less than 70% by angiography, the CAS should not proceed.

- Carotid artery stenting with embolic protection is reasonable and necessary only if performed in facilities that have been determined to be competent in performing the evaluation, procedure, and follow-up necessary to ensure optimal patient outcomes.
- All facilities must at least meet the minimum standards outlined in Pub 100-03, Section 20.7 of the NCD Manual in order to receive coverage for CAS for highrisk patients. Briefly, facilities must have high quality X-ray imaging equipment, device inventory, staffing, and infrastructure to support a dedicated CAS program.
- Advanced physiologic monitoring, including real time and archived physiologic, hemodynamic, and cardiac rhythm monitoring equipment, and associated support staff capable of interpreting findings and responding appropriately.
- Readily available emergency management equipment and systems, such as resuscitation equipment, a defibrillator, vasocative and antiarrhythmic drugs, endotracheal intubation capability, and anesthesia support.
- A clearly delineated program for granting CAS privileges and for monitoring the quality of the individual interventionists and the program as a whole. The oversight committee for this program is encouraged to apply published standards from national specialty societies recognized by the American Board of Medical Specialties to determine appropriate physician qualifications.

Examples of standards and clinical competence guidelines include those published in the December 2004 edition of the American Journal of Neuroradiology and those published in the August 18, 2004, Journal of the American College of Cardiology.

- A data collection system maintained by the facility or its contractor on all CAS procedures done at that facility. The data must be analyzed routinely to ensure patient safety (to be determined by the facility but should not be less frequent than 6-month intervals), will be used in re-credentialing the facility, and must be made available to CMS upon request.

Written Documentation

For evaluation purposes, all facilities must provide written documentation to CMS indicating it meets one of the following criteria:

- Was an FDA-approved site that enrolled patients in prior CAS IDE trials, such as SAPPHIRE, and ARCHER;

- Is a FDA-approved site that is participating and enrolling patients in ongoing CAS IDE trials, such as CREST;
- Is a FDA-approved site for one or more FDA post-approval studies; or
- Has provided a written affidavit to CMS affirming that the facility meets the minimum facility standards. The affidavit must include the facility's name and complete address, Medicare provider number, point-of-contact name and telephone number, CAS procedure data collection mechanism, and a senior facility administrative official's signature. (Note that a new affidavit is required every two years.)

The affidavit should be sent to:

Director, Coverage and Analysis Group
7500 Security Boulevard, Mail-stop C1-09-06
Baltimore, MD 21244

Note: Performance of PTA to treat obstructive lesions of the vertebral and cerebral arteries remains non-covered. All other indications of PTA for which CMS has not specifically indicated coverage remain non-covered.

Additional Information

All providers should note that the following relate to services on or after March 17, 2005:

- FIs and carriers will only pay CAS claims from providers who are listed on the approved facility list which is at <http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp#TopOfPage> on the CMS Website.

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

- Carriers will pay claims containing ICD-9 CM 433.10 and any of the following procedure codes: 37215, 37216, 0075T, or 0076T, for beneficiaries meeting the high risk criteria previously specified.
- FIs will pay claims containing ICD-9 CM 433.10 and both procedure codes 00.61 and 00.63.
- FIs will reject claims that do not have both procedure codes 00.61 and 00.63.
- FIs and carriers will deny CAS services for patients at high risk if the appropriate diagnosis code is not on the claim and use the appropriate Medicare Summary Notice (MSN) message and claim adjustment reason code in doing so.
- FIs and carriers will deny claims where the service was performed in an unapproved facility and use the appropriate MSN message and claim adjustment reason code in doing so.

Note: Providers must also bill V70.7 (Exam – clinical trial) as a secondary diagnosis for claims with “From” dates before October 1, 2005. Providers must bill V70.7 in order to avoid unintentional Medicare Code Editor (MCE) editing. For claims that have “From” dates on or after October 1, 2005, hospitals are not required to bill V70.7 as the unintentional MCE editing will be corrected.

Coding for Carotid Artery Stents

In the American Hospital Association’s (AHA’s) publication Coding Clinic for ICD-9-CM, First Quarter 2002, page 10 (and corrected in Second Quarter 2002, page 19), there is a Q&A regarding coding of bilateral carotid artery stenosis. The answer said, “Assign only code 433.10, (Occlusion and stenosis of precerebral arteries, Carotid artery, without mention of cerebral infarction) as the principal diagnosis.” The correction notice changed that advice to use code 433.30 (Occlusion and stenosis of precerebral arteries, multiple and bilateral, without mention of cerebral infarction) instead of 433.10. In an effort to reduce the confusion, CMS has decided to allow hospitals to be able to code both 433.30 and 433.10, in any diagnosis positions, on the same claim. Code 433.30 will identify the bilateral condition, while 433.10 will specifically identify the carotid vessel.

You may also want to review the following MLN Matters article MM3489 and CR3489 for additional information relating to Medicare coverage of PTA. They are available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf> and <http://www.cms.hhs.gov/Transmittals/downloads/R314CP.pdf> on the CMS Website.

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

The official instruction issued to your carrier/FI regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R33NCD.pdf> on the CMS Website. That site contains the NCD manual revision. The changes to the Medicare Claims Processing Manual are at <http://www.cms.hhs.gov/Transmittals/downloads/R531CP.pdf> on the CMS Website.

If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at <http://www.cms.hhs.gov/apps/contacts/> on the CMS Website.

**INSTRUCTIONS FOR IMPLEMENTING THE
CENTERS FOR MEDICARE & MEDICAID (CMS) RULING
CMS 1536-R; ASTIGMATISM-CORRECTING
INTRAOCULAR LENS (A-C IOLS)
~CMS MLN Matters~**

MLN Matters Number: MM5527 Revised
Related CR Release Date: April 27, 2007
Related CR Transmittal #: R1228CP

Related Change Request (CR) #: 5527
Effective Date: January 22, 2007
Implementation Date: May 29, 2007

Note: This article was revised on July 18, 2007, to correct a typo in the sentence at the end of paragraph 1 on page 3 and to provide new Web addresses for accessing the Notices of Exclusion from Medicare Benefits. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5527 which discusses a recent Administrator Ruling from the Centers for Medicare & Medicaid Services (CMS) regarding astigmatism-correcting intraocular lenses (A-C IOLs) following cataract surgery (CMS-1536-R). **The new policy is effective for dates of service on and after January 22, 2007. Physicians and providers need to be aware that effective January 22, 2007:**

- Medicare will pay the same amount for cataract extraction with A-C IOL insertion that it pays for cataract extraction with conventional IOL insertion.
- **The beneficiary is responsible for payment of that portion of the hospital or ambulatory surgery center (ASC) charge for the procedure that exceeds the facility's usual charge for cataract extraction and insertion of a conventional IOL following cataract surgery, as well as any fees that exceed the physician's usual charge to perform a cataract extraction with insertion of a conventional IOL.**

In addition, CMS reminds physicians that they can be reimbursed for the conventional or A-C IOL (V2632) only when the service is performed in a physician's office. Also, when physicians perform cataract surgery in an ASC or hospital outpatient setting, the physician may only bill for the professional service because payment for the lens is bundled into the facility payment for the cataract extraction.

Background

The Centers for Medicare & Medicaid Services (CMS) Administrator rulings serve as 1) precedent final opinions and orders and 2) statements of policy and interpretation. The Administrator rulings provide clarification and interpretation of complex or ambiguous provisions of the law or regulations relating to Medicare, Medicaid, utilization and peer review by Quality Improvement Organizations, private health insurance, and related matters. These rulings also promote consistency in interpretation of policy and

adjudication of disputes, and they are binding on all CMS components, Medicare contractors, the Provider Reimbursement Review Board, the Medicare Geographic Classification Review Board, and Administrative Law Judges who hear Medicare appeals.

CR5527 discusses a recent CMS Administrator Ruling concerning requirements for determining payment for insertion of intraocular lenses (IOLs) that replace beneficiaries' natural lenses and correct pre-existing astigmatism following cataract surgery under the Social Security Act:

Note that CR5527 basically restates CMS policy provided in CR3927 (MLN Matters article MM3927), except that CR3927 focused on presbyopia-correcting IOLs and this article focuses on A-C IOLs.

Coverage Policy

In general, an item or service covered by Medicare must satisfy the following three basic requirements:

- Fall within a statutorily-defined benefit category;
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body part;
- Not be excluded from coverage.

The Social Security Act specifically excludes eyeglasses and contact lenses from coverage, with an exception for one pair of eyeglasses or contact lenses covered as a prosthetic device furnished after each cataract surgery with insertion of an IOL. In addition, there is no Medicare benefit category to allow payment for the surgical correction or cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for the imperfect curvature of the cornea (astigmatism).

An A-C IOL is intended to provide what is otherwise achieved by two separate items:

- An implantable conventional IOL (one that is not astigmatism -correcting) that is covered by Medicare, and
- The surgical correction, eyeglasses, or contact lenses that are not covered by Medicare.

Although A-C IOLs may serve the same function as eyeglasses or contact lenses furnished following removal of a cataract, A-C IOLs are neither eyeglasses nor contact lenses. The following table is a summary of benefits for which Medicare makes payment, and services for which Medicare does not pay (no benefit category):

Benefits for Which Medicare Makes Payment	Services for Which Medicare Does NOT Pay – No Benefit Category
A conventional intraocular lens (IOL) implanted following cataract surgery.	The astigmatism-correcting functionality of an IOL implanted following cataract surgery.

Benefits for Which Medicare Makes Payment	Services for Which Medicare Does NOT Pay – No Benefit Category
Facility or physician services and supplies required to insert a conventional IOL following cataract surgery.	Facility or physician services and resources required to insert and adjust an AC-IOL following cataract surgery that exceeds the services and resources furnished for insertion of a conventional IOL.
One pair of eyeglasses or contact lenses as a prosthetic device furnished after each cataract surgery with insertion of an IOL.	The surgical correction of cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for imperfect curvature of the cornea (astigmatism)
	Eye examinations performed to determine the refractive state of the eyes specifically associated with insertion of an AC-IOL (including subsequent monitoring services), that exceed the one-time eye examination following cataract surgery with insertion of a conventional IOL.

Currently, there is one NTIOL class approved for special payment when furnished by an ASC, and this currently active NTIOL category for “Reduced Spherical Aberration” was established on February 27, 2006 and expires on February 26, 2011. Effective for services furnished on or after January 22, 2007, CMS now recognizes the following as A-C IOLs:

- Acrysof® Toric IOL (models: SN60T3, SN60T4, and SN60T5), manufactured by Alcon Laboratories, Inc; and
- Silicon 1P Toric IOL (models: AA4203TF and AA4203TL), manufactured by STAAR Surgical.

Payment Policy for Facility Services and Supplies

The following applies to an IOL inserted following removal of a cataract in a hospital (on either an outpatient or inpatient basis) that is paid under 1) the hospital Outpatient Prospective Payment System (OPPS) or 2) the Inpatient Prospective Payment System (IPPS), respectively (or in a Medicare-approved ASC that is paid under the ASC fee schedule):

- Medicare does not make separate payment to the hospital or the ASC for an IOL inserted subsequent to extraction of a cataract. Payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure; and

Any person or ASC, who presents or causes to be presented a bill or request for payment for an IOL inserted during or subsequent to cataract surgery for which payment is made under the ASC fee schedule, is subject to a civil money penalty.

For an A-C IOL inserted subsequent to removal of a cataract in a hospital (on either an outpatient or inpatient basis) that is paid under the OPPOS or the IPPS, respectively (or in a Medicare-approved ASC that is paid under the ASC fee schedule):

- The facility should bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional or A-C IOL is inserted. When a beneficiary receives an A-C IOL following removal of a cataract, hospitals and ASCs should report the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL (see “Coding” below);
- There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL; and
- There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services and supplies required to examine and monitor the beneficiary who receives an AC-IOL following removal of a cataract that exceed the facility charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary after cataract surgery followed by insertion of a conventional IOL.

Payment Policy for Physician Services and Supplies

For an IOL inserted following removal of a cataract in a physician’s office Medicare makes separate payment, based on reasonable charges, for an IOL inserted subsequent to extraction of a cataract that is performed at a physician’s office.

For an A-C IOL inserted following removal of a cataract in a physician’s office:

- A physician should bill for a conventional IOL, regardless of whether a conventional or A-C IOL is inserted (see “Coding,” below);
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed the physician charges for services and supplies for the insertion and adjustment of a conventional IOL; and
- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of an AC-IOL that exceed the physician charges for services and supplies to examine and monitor a beneficiary following removal of a cataract with insertion of a conventional IOL.

For an A-C IOL inserted following removal of a cataract in a hospital or ASC:

- A physician may not bill Medicare for the A-C IOL inserted during a cataract procedure performed in those settings because payment for the lens is included in the payment made to the facility for the entire procedure;
- There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust an A-C IOL following removal of a cataract that exceed physician charges for services and supplies required for the insertion of a conventional IOL; and

- There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services, and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of an A-C IOL that exceed the physician charges for services and supplies required to examine and monitor a beneficiary following cataract surgery with insertion of a conventional IOL.

Coding

No new codes are being established at this time to identify an A-C IOL or procedures and services related to an A-C IOL, and hospitals, ASCs, and physicians should report one of the following CPT codes to bill Medicare for removal of a cataract with IOL insertion:

- CPT Code 66982 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage,
- CPT Code 66983 - Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure), or
- CPT Code 66984 - Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification).

Physicians inserting an IOL or an A-C IOL in an office setting may bill code V2632 (posterior chamber intraocular lens) for the IOL or the A-C IOL, which is paid on a reasonable charge basis.

If appropriate, hospitals and physicians may use the proper CPT code(s) to bill Medicare for evaluation and management services usually associated with services following cataract extraction surgery, if appropriate.

Beneficiary Liability

When a beneficiary requests insertion of an A-C IOL instead of a conventional IOL following removal of a cataract and that procedure is performed, the beneficiary is responsible for payment of facility charges for services and supplies attributable to the astigmatism-correcting functionality of the A-C IOL:

- In determining the beneficiary's liability, the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the AC-IOL that exceeds the work and resources attributable to insertion of a conventional IOL;
- The physician and the facility may not charge for cataract extraction with insertion of an A-C IOL unless the beneficiary requests this service; and
- The physician and the facility may not require the beneficiary to request an A-C IOL as a condition of performing a cataract extraction with IOL insertion.

Provider Notification Requirements

When a beneficiary requests insertion of an A-C IOL instead of a conventional IOL following removal of a cataract:

Prior to the procedure to remove a cataractous lens and insert an A-C IOL, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment, or other subsequent treatments related to the astigmatism-correcting functionality of the IOL. The correcting functionality of an A-C IOL does not fall into a Medicare benefit category and, therefore, is not covered. Therefore, the facility and physician are not required to provide an Advanced Beneficiary Notice to beneficiaries who request an A-C IOL.

Although not required, CMS strongly encourages facilities and physicians to issue a Notice of Exclusion from Medicare Benefits to beneficiaries in order to identify clearly the non-payable aspects of an A-C IOL insertion. This notice may be found on the CMS Website at:

<http://www.cms.hhs.gov/BNI/downloads/CMS20007English.pdf> for the English language version and

<http://www.cms.hhs.gov/BNI/downloads/CMS20007Spanish.pdf> for the Spanish language version.

Additional Information

The official instruction, CR5527, issued to your Medicare carrier, intermediary, and A/B MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1228CP.pdf> on the CMS Website.

If you have any questions, please contact your Medicare carrier, intermediary, or A/B MAC at their toll-free number, which may be found on the CMS Website at:

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

RETIRED LCD/NCDS

The following LCD and NCD policy documents will be retired effective 10/01/2007.

- GU-019 - Non-Implantable Pelvic Floor Electrical Stimulator
- OPHTH-021 - Visual Rehabilitation Program
- PHYSMED-011 - Neuromuscular Electrical Stimulators (NMES)

Selected information and/or CMS manual references from these policies have been incorporated into the PHYSMED-009 PM&R policy. The national coverage criteria and Medicare regulations for these services remain in place. Reference and note the following Medicare Internet Only Manual section for these services at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>

Non-Implantable Pelvic Floor Electrical Stimulator, CMS Pub.100-03 Part 4 §230.8
Neuromuscular Electrical Stimulators (NMES), CMS Pub.100-03 Part 3 §160.12

Coverage – Policies

INFORMATION ON WEBSITE

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

http://www.wpsmedicare.com/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 2007

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
RAD-018	<i>Cranial Stereotactic Radiosurgery (SRS) and Cranial Stereotactic Radiotherapy (SRT)</i>	LCD	Click here to view	33
RAD-038	<i>Selective Internal Radiation Therapy (SIRT) for Primary and Secondary Hepatic Malignancy (90Y-Microsphere Hepatic Brachytherapy)</i>	LCD	Click here to view	33

Revised Policies for September 2007

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
CV-007	<i>Transesophageal Echocardiography</i>	LCD	Click here to view	34
CV-026	<i>Transthoracic Echocardiography</i>	LCD	Click here to view	34
CV-039	<i>Percutaneous Transluminal Angioplasty (PTA) (Carotid and Intracranial Stents)</i>	NCD	Click here to view	35
HONC-002	<i>Chemotherapy and Drug Administration</i>	NCP	Click here to view	36
HONC-010	<i>Antineoplastics and their Adjuncts</i>	LCD	Click here to view	36
OPHTH-003	<i>Optometrist Services</i>	LCD	Click here to view	37
PHYS-031	<i>Prolonged Evaluation and Management Services and Standby Services</i>	NCP	Click here to view	37
PHYS-078	<i>Independent Diagnostic Testing Facilities (IDTFs)</i>	LCD	Click here to view	37
PHYSMED-009	<i>Physical Medicine Rehabilitation Procedures and Modalities</i>	LCD	Click here to view	38

WPS Medicare Tip of the Week
(Published in the 08/13/07 General e-News Listserv)

Does the Physician Quality Reporting Initiative apply to services provided to Railroad Medicare beneficiaries?

The Physician Quality Reporting Initiative (PQRI) includes all Physician Fee Schedule reimbursed services for which a provider or other eligible professional successfully reports quality related data, including services provided for Railroad Medicare beneficiaries.

To receive our Tips of the Week, sign up to receive our e-News Listserv at:

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

Coverage – New Policies**Contractor Name**

Wisconsin Physicians Service (WPS)

Contractor Number

00951, 00952, 00953, 00954

Contractor Type

Carrier

LCD Title

Cranial Stereotactic Radiosurgery (SRS) and Cranial Stereotactic Radiotherapy (SRT)

Contractor's Determination Number

RAD-018

This is a new policy. Please read this policy in its entirety on our Website at:
<http://www.wpsmedicare.com/policies/wisconsin/index.shtml>

Look for policy RAD-018 on the table and click on the policy number or name to access the policy.

**Contractor Name**

Wisconsin Physicians Service (WPS)

Contractor Number

00951, 00952, 00953, 00954

Contractor Type

Carrier

LCD Title

Selective Internal Radiation Therapy (SIRT) for Primary and Secondary Hepatic Malignancy (90Y-Microsphere Hepatic Brachytherapy)

Contractor's Determination Number

RAD-038

This is a new policy. Please read this policy in its entirety on our Website at:
<http://www.wpsmedicare.com/policies/wisconsin/index.shtml>

Look for policy RAD-038 on the table and click on the policy number or name to access the policy.

Coverage – Revised Policies**Local Coverage Determination (LCD) Companion Article Revision****Contractor's Policy Number**

CV-007

Article Title

Transesophageal Echocardiography

Revision Effective Date

NA

Coding Guidelines

6. Submit services for the contrast material on the same claim as the echocardiogram, using procedure codes *Q9955, *Q9956, *Q9957 or A9700. In the narrative record of the electronic format list the name of the contrast imaging agent and dosage.

Note: For the purpose of providing clear and consistent directions added Q9955, Q9956 and Q9957 to sentence number six.

**Local Coverage Determination (LCD) Companion Article Revision****Contractor's Policy Number**

CV-026

Article Title

Transthoracic Echocardiography

Revision Effective Date

NA

Coding Guidelines

5. If using *Q9955, *Q9956, *Q9957 or A9700 (supply of injectable contrast material for use in echocardiography, per study) identify the contrast agent in the narrative record of the electronic format. List the name of the contrast imaging agent, route of administration and dosage.

Note: For the purpose of providing clear and consistent directions added Q9955, Q9956 and Q9957 to sentence number five.



National Coverage Determination (NCD)

Subject:

*Percutaneous Transluminal Angioplasty (PTA) (Carotid and Intracranial Stents)

Subject No:

CV-039

Coding Guidelines

CMS National Coverage Policy:

- *11. Medicare Claims Processing Pub 100-04; Transmittal 1315; Date: AUGUST 10, 2007
Change Request 5667; Subject: Clarification of Percutaneous Transluminal Angioplasty (PTA)
Billing Requirements Issued in CR 3811; New / Revised Material
Effective Date: March 17, 2005; Implementation Date: October 1, 2007

Coding Guidelines

I. Carotid Arteries

- D. **Effective for dates of service performed on and after March 17, 2005**, carriers shall pay claims that contain the following for beneficiaries that meet the high risk criteria listed under the Policy section of this instruction and in the Pub 100-03, chapter 1, section 20.7.

*ICD-9 codes:

For any of the following **procedure codes**: 37215, 0075T, 0076T

433.10	Occlusion and stenosis of carotid artery without mention of cerebral infarction
*433.11	Occlusion of the carotid artery with infarct
*433.30	Occlusion and stenosis of carotid artery, multiple and bilateral, without mention of cerebral infarction
*433.33	Occlusion and stenosis of carotid artery, multiple and bilateral, with infarct

*Bilateral Services

To correctly bill covered bilateral carotid services, providers can code both 433.30 or 433.31 and 433.10 or 433.11 in any order on the same claim. Code 433.30 with 433.10, or 433.31 with 433.11 to identify the multiple and bilateral condition and 433.10 or 433.11 to specifically identify the carotid artery.

E. CPT and ICD-9 coding of carotid stenting (a time line)

*5. **CR 5667 (Effective March 17, 2005)**

As stated in the NCD, patients who experience non-disabling strokes (modified Rankin scale <3) are considered to be symptomatic and therefore eligible for coverage; however, patients who experience disabling strokes (modified Rankin scale ≥3) are not eligible for coverage. Prior to the implementation of CR 5667, there are no codes that distinguish between non-disabling and disabling strokes. To ensure claims for all eligible patients can be paid, CR 5667 adds the ICD-9-CM diagnosis code 433.11, occlusion of the carotid artery with infarct, to the list of payable claims for CAS. Patients who experience disabling strokes remain ineligible for coverage.

Contractors shall allow claims that contain any of the following ICD-9-CM diagnosis codes: 433.10; 433.10 and 433.30; 433.11; 433.11 and 433.31; Along with any of the following CPT procedure codes: 37215 , 0075T, 0076T

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

Chemotherapy and Drug Administration

Subject Number

HONC-002

Revision Effective Date

NA -Clarification

F. Billing Examples:

- *8. **Example:** Is J1642 injection, Heparin sodium, (heparin lock flush) per 10 units payable when I administer it to flush an IV line?

Response: No, it is not separately payable. A flush is included in an infusion service or an evaluation and management service that is performed on the same day.

**LCD Title**

Antineoplastics and their Adjuncts

Contractor's Determination Number

HONC-010

Revision Effective Date:

*05/30/2007 FDA approval date

Indications and Limitations:

Temsirolimus has been added to this LCD.

Temsirolimus (Torisel) J9999

Advanced Renal Cell Carcinoma (189.0, 189.1)



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

OPHTH-003 Optometrist Services

Contractor Policy Number

OPHTH-003

Revision Effective Date

*10/01/2007

CPT/HCPCS CodesTHERAPEUTIC/EXPANDED LICENSURE:All States:

CPT code 66180-55 is added to this policy effective for services performed on or after 10/01/2007.

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

Prolonged Evaluation and Management Services and Standby Services

Subject Number:

PHYS-031

WPS Medicare is updating the PHYS-031 *Prolonged Evaluation and Management Services and Standby Services* National Coverage Provision. Italicized text in the NCP is the wording of the Centers for Medicare & Medicaid Services (CMS). The text is published from CMS documentation and is subject to change. The asterisked (*) text indicates changes made since the last publication date.

Please refer to the revised PHYS-031 *Prolonged Evaluation and Management Services and Standby Services* National Coverage Provision in its entirety on the following WPS Medicare Website:

<http://www.wpsmedicare.com/policies/wisconsin/phys031.pdf>

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

Independent Diagnostic Testing Facilities (IDTFs)

Subject Number:

PHYS-078

Billing and Enrollment Guideline for PHYS-078 Independent Diagnostic Testing Facilities (IDTF)**Revision:**

The new compliance standards for Independent Diagnostic Testing Facilities (IDTFs) have been added to the Program Integrity Manual (PUB 100-08) chapter 10. This information has been incorporated into the Billing and Enrollment Guideline associated with our LCD PHYS-078.

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

PHYSMED-009 Physical Medicine Rehabilitation Procedures and Modalities

Contractor's Determination Number

PHYSMED-009

Revision Effective Date

10/01/2007

The following revisions have been made to this LCD and the Companion Article.

Indications and Limitations of Coverage and/or Medical Necessity**IV. Specific Modality Clinical Guidelines:****G0283: Electrical Stimulation Therapy (unattended):**

- *1. Non-implantable pelvic floor electrical stimulators are used in the treatment of stress and/or urge urinary incontinence. One or two office treatments may be medically necessary to determine the effectiveness of treatment and for patient education in use of the home equipment. This device is covered for home use by the DMERC and is governed under their jurisdiction. *(See CMS National Coverage Determination Manual CMS Pub.100-03 Part 4 §230.8)

V. General Guidelines for Therapeutic Procedures 97110-97546:***Visual Rehabilitation (VR)**

***A Medicare beneficiary with vision loss may be eligible for rehabilitation services designed to improve functioning, by therapy, to improve performance of activities of daily living, including self-care and home management skills. Evaluation of the patient's level of functioning in activities of daily living, followed by implementation of a therapeutic plan of care aimed at safe and independent living, is critical and should be performed by an occupational or physical therapist. (Physical Therapy and Occupational Therapy assistants cannot perform such evaluations.)**

*In accordance with established conditions, all rehabilitation services to beneficiaries with a primary vision impairment diagnosis must be provided under a written treatment plan (See PHYSMED-001) established by a Medicare physician or qualified NPP, and

implemented by approved Medicare providers (occupational or physical therapists) or incident to physician services. Some of the following rehabilitation programs/services for beneficiaries with vision impairment may include Medicare covered therapeutic services:

Mobility;

Activities of Daily Living; and

Other rehabilitation goals that are medically necessary.

*The patient must have a potential for restoration or improvement of lost functions, and must be expected to improve significantly within a reasonable and generally predictable amount of time.

*Rehabilitation services are not medically reasonable or necessary if the patient is unable to cooperate in the treatment program and if clear goals are not definable.

*The usual duration of a visual rehabilitation program is a three-month period of time with session intervals appropriate to the patient's rehabilitation needs. Additional time may be considered when a change in the patients' condition or circumstance is documented and the treatment plan is revised accordingly.

*Rehabilitation programs are usually short-term and intensive. The visual rehabilitation program will be considered completed when the treatment goals have been attained. Subsequent physical medicine and rehabilitation services, to sustain the level of function would be regarded as maintenance and not reasonable and necessary. In some situations the specialized knowledge, judgment and skill of a qualified therapist may be required to establish a maintenance program following completion of the visual rehabilitation program. Periodic evaluation of a patient in a maintenance program may be considered reasonable and necessary.

*Services may be provided by a physician as defined in §1861(r)(1) and (4) of the Social Security Act, a qualified occupational therapist, or a qualified physical therapist. Services furnished by an employee of the physician may only be provided incident to the physician's professional services, must be furnished under the physician's direct personal supervision, and must meet other incident to requirements provided in CMS Benefit Policy Manual Pub.100-04 §§60.1-60.4. Certified occupational therapy and physical therapy assistants must perform under the appropriate level of supervision as other therapy services.

*Definition of Levels of Vision Impairment:

moderate = best corrected visual acuity is less than 20/60

severe = best corrected visual acuity is less than 20/160, or
(*legal blindness*) visual field is 20 degrees or less

profound = best corrected visual acuity is less than 20/400, or
(*moderate blindness*) visual field is 10 degrees or less

near-total = best corrected visual acuity is less than 20/1000, or
(*severe blindness*) visual field is 5 degrees or less

total = no light perception
(*total blindness*)

97116: Gait Training:

- *5. For Spinal Cord Injury (SCI) patients using a neuromuscular electrical stimulator to enhance the ability to walk see CMS Pub.100-03 Part 3 §160.12.

ICD-9 Codes that DO NOT Support Medical Necessity

* For Spinal Cord Injury (SCI) patients using a neuromuscular electrical stimulator to enhance the ability to walk Gait Training (97116) is **not** covered for the following.

337.3, 733.00-733.09, 736.00-736.09, 736.30-736.39, 736.9, 736.7-736.79, 736.81, 736.89, 737.30-737.39, 737.40, 737.43, 738.4, 738.5, 754.2; V45.00, V45.01, V45.02, V45.09, V45.89, V53.31.

Companion Article**Article Title**

Physical Medicine Rehabilitation Procedures and Modalities – PHYSMED-009: Billing and Coding Guidelines

Article Effective Date

*0/01/2007

Article Text

This article contains the claim coding information and reasons for denial ***(Denial Summary)** for PM&R services. *The Denial Summary section is revised to include additional reasons for denial previously contained in the retired GU-019, OPHTH-021, and PHYSMED-011 policies. The Exception statement regarding Chiropractors participating in the Chiropractic Service Demonstration is removed. This article should be used in conjunction with the PHYSMED-009 LCD.

Other Information**Denial Summary**

*Chiropractors and doctors of dental medicine/surgery are not considered physicians for PM&R services; they may not refer patients for treatment or establish/certify therapy care plans.

Medical Necessity:

Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section excludes coverage and payment for items and services that are not considered reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the function of a malformed body member.

- *17. Lack of documentation for the trial pelvic muscle training (*Non-Implantable Pelvic Floor Electrical Stimulators*) will result in the ES services being denied as not medically necessary.

Non-Covered:

Title XVIII of the Social Security Act section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

- *8. PM&R services performed or ordered/referred by chiropractors and doctors of dental medicine/surgery will be denied as not-covered.

Electronic Data Interchange (EDI)**CLAIMS NOT SHOWING UP ON C-SNAP OR THE
MEDICARE IVR SYSTEM?**

Have you submitted an electronic claim more than once because it did not appear on C-SNAP, or the Medicare IVR system? The claim might be rejecting/deleting at the Medicare pre-pass edit level. This rejection/deletion will not be reflected on an EOB or ERA file and will only be found on this pre-pass edit report. This report might also be known as: “the batch detail control listing report”; “the H99 report”; “the 04 report”; “the Medicare payer report”; “the Med B report”; and even “the Payer delete report.” If you are not receiving this report contact your vendor or clearinghouse to find out how to obtain this report.

Some of the most common pre-pass errors that occur are claims with invalid diagnosis codes (all diagnosis codes submitted on the claim must be valid for all dates of service submitted on the claim); Provider/NPI number problems (i.e. sending the wrong provider number/NPI number in the wrong electronic location); missing required information (such as special dates, codes, or other specialty information) and many others. For a complete list of the current pre-pass edits you can go to the following Website: http://www.wpsic.com/edi/pdf/hipaa_mcs837.pdf

For further information, and an example of the pre-pass edit report, please refer to the June *Communiqué* on the WPS Website at:

<http://www.wpsmedicare.com/provider/pdfs/0607comm.pdf>

If you have questions about pre-pass rejections you can call the EDI hotline for IL, MI, and WI at 877-567-7261 for MN 952-885-2882 or 952-885-2881 or 952-885-2811.

EDI HOTLINE HAS HIGH CALL VOLUME

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

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

If you have tested with us and wish confirmation of your test file, the analyst assigned to the test will contact you with the results. You do not need to call us unless more than 3 workdays have passed since you submitted the test file.

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

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

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

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

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

ELECTRONIC FUNDS TRANSFER STANDARDIZATIONS AND REVISIONS TO THE MEDICARE CLAIMS PROCESSING MANUAL (CHAPTER 24)

~CMS MLN Matters~

MLN Matters Number: MM5586
Related CR Release Date: July 9, 2007
Related CR Transmittal #: R1284CP

Related Change Request (CR) #: 5586
Effective Date: July 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5586 which revises the *Medicare Claims*

Processing Manual, Chapter 24 (General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims).

CAUTION – What You Need to Know

Effective July 1, 2007, your Medicare contractor will conduct Administrative Simplification Compliance Act (ASCA) reviews annually of at least 20% of providers submitting CMS 1500 paper claims who were not already reviewed in the past 2 years and found to have fewer than 10 FTEs employed by the practice. In addition, contractors will insure that the addenda record is sent with the Medicare claim payment when an ACH format is used to transmit an EFT payment to a financial institution but the remittance advice is separately transmitted to a provider. This will assist with reconciliation of the payment and the information that explains the payment. The EFT format will be the National Automated Clearinghouse Association (NACHA) format CCP - Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) as mentioned in the X12N 835 version 004010A1 implementation guide.

GO – What You Need to Do

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

Background

Change Request (CR) 5586 provides the following revisions to the Medicare Claims Processing Manual (Chapter 24, Sections 40.7 and Section 90.5.3) regarding electronic funds transfer (EFT) and the identification of providers to be reviewed.

Contractor Roles in Administrative Simplification Compliance Act (ASCA) Reviews and Identification of Providers to be Reviewed

Each carrier, DME MAC and B MAC (not FIs or RHHs at this time) conducts an ASCA review annually of 20% of those providers still submitting CMS 1500 paper claims.

Medicare contractors will not select a provider for a quarterly review if:

- A prior quarter review is underway and has not yet been completed for that provider;
- The provider has been reviewed within the past two years, determined to be a “small” provider as fewer than 10 FTEs are employed in that practice and there is no reason to expect the provider’s “small” status will change within two years of the start of the prior review; or
- Fewer than 30 paper claims were submitted by the provider to Medicare during the prior quarter.

Electronic Funds Transfer (EFT)

Although EFT is not mandated by the Health Insurance Portability and Accountability Act (HIPAA), EFT is the required method of Medicare payment for all providers entering the Medicare program for the first time and any existing providers, not currently receiving payments by EFT, who are submitting a change to their existing enrollment data. Providers must submit a signed copy of Form CMS-588 (Electronic Funds Transfer Authorization Agreement) to their Carriers, DME MACs, A/B MACs, FIs, and/or RHHs. For

changes of information, DME MACs will verify the authorized official on the CMS-855 form. In addition, Medicare contractors will not approve any requests to change the payment method from EFT to check.

Carriers, DME MACs, A/B MACs, FIs and RHHIs must use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an X12 835 transaction, then the NACHA format CCP (Cash Concentration/Disbursement plus Addenda –CCD+) is used to make sure that the addenda record is sent with the EFT, because providers need the addenda record to re-associate dollars with data. Carriers, DME MACs, A/B MACs, FIs, and RHHIs must:

- Transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim, and
- Designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

Note: Medicare contractors will not approve any requests to change payment method from EFT to check.

Additional Information

The official instruction, CR5586, issued to your carrier, intermediary, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1284CP.pdf> on the CMS Website.

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

HEALTHCARE PROVIDER TAXONOMY CODE (HPTC) UPDATE

Change Requests (CR) 5436 and 5673 advise your carrier to use the most cost effective means to obtain the Healthcare Provider Taxonomy Code (HPTC) lists for April and October 2007 and update their HPTC tables as necessary.

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim. Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. Although the NUCC generally posts their updates on the Washington Publishing Company (WPC) Web page 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider

type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs.

The HPTC list is available from the Washington Publishing Company (WPC) at <http://www.wpc-edi.com/codes/taxonomy> in two forms. The first form is a free Adobe PDF download. The second form, available for purchase, is an electronic representation of the code set that facilitates automatic loading of the codes.

NPI: CLAIMS WILL BEGIN TO REJECT

BEGINNING 8/27/07, ELECTRONIC CLAIMS WILL BE REJECTED IF NPI PREPASS EDIT OCCURS.

BELOW ARE THE DATES WHICH NPI EDITS WILL BE TURNED TO DELETE. ALL CLAIMS RECEIVING THESE EDITS ON OR AFTER THE FOLLOWING DATES WILL BE DELETED. THAT MEANS THAT IT WILL NOT BE SUBMITTED TO THE PROCESSING SYSTEM. IF DELETED, THE CLAIMS MUST BE CORRECTED AND RESUBMITTED FOR PROCESSING.

EDIT	WI/MN	IL/MI
M340	9/17/07	9/24/07
M379	9/17/07	9/24/07
M341	9/17/07	9/24/07
M380	9/17/07	9/24/07
M343	8/27/07	9/4/07
M381	8/27/07	9/4/07
M347	8/27/07	9/4/07
M382	8/27/07	9/4/07

What should you do if you fail a prepass edit? Read your report. Make sure that the provider/NPI combination is valid. Go to NPPES; add your legacy. Failing M379, 381, or M382? Make sure you are sending the correct qualifier with your Social Security Number or EIN.

Watch for the following Medicare Part B Prepass report NPI error messages:

- Billing Provider level (2010AA)– M340 & M379
- Pay To Provider level (2010AB) – M341 & M380
- Rendering Provider level (2310B) – M343 & M381
- Rendering Provider level (2420A) – M347 & M382

Edits M340, M341, M343, and M347 occur when the NPI submitted with legacy number does not match the crosswalk; that is the NPI legacy is not on the crosswalk or is invalid. Edits M379, M380, M381, and M382 will fail if you are sending NPI only and the NPI is not on the crosswalk or you are sending an EIN/SSN with the incorrect qualifier.

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

NPI: LIFTING THE NATIONAL PROVIDER IDENTIFIER (NPI) CROSSWALK BYPASS LOGIC

Since October 2, 2006, providers have been encouraged to submit both the NPI and Medicare legacy identifier (PIN) on their claims. During this timeframe providers were **not** penalized for invalid NPI/legacy ID combinations.

Effective **August 27, 2007 for Minnesota and Wisconsin and September 4, 2007 for Illinois and Michigan**, WPS Part B, will begin editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. Where a match cannot be located on the crosswalk, claims will be rejected or returned to the provider.

When the claim is returned, a provider should first verify that the correct NPI was submitted. If correct, you will need to verify that your legacy identifier (PIN or NSC) number corresponds with the information on file with the National Plan and Provider Enumeration System (NPPES). NPPES data may be checked on line at <https://nppes.cms.hhs.gov>

If your NPPES information is correct and you have included and matched ALL Medicare legacy identifiers with a corresponding NPI in NPPES, but you are experiencing provider identifier problems with your claims that contain an NPI, you may need to submit a Medicare enrollment application (i.e., the CMS-855). Please contact your contractor if you need more information.

More information and education on the NPI may be found at the CMS NPI page, <http://www.cms.hhs.gov/NationalProviderStand> on the CMS Website. Also, providers can apply for an NPI online at <https://nppes.cms.hhs.gov>

Additional NPI information may be found at:
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf>

NPI: WPS ANNOUNCES SCHEDULE FOR TURNING ON NPI PREPASS EDITS: WHY NPI PREPASS EDITS OCCUR AND HOW TO CORRECT

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

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

When a provider is not on crosswalk, an EDI prepass edit message will appear. Once the provider has been loaded to crosswalk, message should disappear. If message continues, you should verify the information you are sending is correct. If correct, access NPPES and correct any errors if any found. Make sure all Medicare legacy numbers are loaded correctly (e.g. Michigan provider

number containing leading zero(s), not the letter O; Wisconsin providers include all leading zeros). Updates to NPPES typically update the crosswalk in 8-10 business days.

BELOW ARE THE DATES WHICH NPI EDITS WILL BE TURNED TO DELETE. ALL CLAIMS RECEIVING THESE EDITS ON OR AFTER THE FOLLOWING DATES WILL BE DELETED. THAT MEANS THAT IT WILL NOT BE SUBMITTED TO THE PROCESSING SYSTEM. IF DELETED, THE CLAIMS MUST BE CORRECTED AND RESUBMITTED FOR PROCESSING.

EDIT	WI/MN	IL/MI
M340	9/17/07	9/24/07
M379	9/17/07	9/24/07
M341	9/17/07	9/24/07
M380	9/17/07	9/24/07
M343	8/27/07	9/4/07
M381	8/27/07	9/4/07
M347	8/27/07	9/4/07
M382	8/27/07	9/4/07

Recommendations for providers: Begin dual strategy immediately! Pay close attention to your prepass reports. Send NPI only on a small percentage of claims (recommended 25 claims). Track claims with NPI throughout the claim process (e.g. compare to your remittance). If results are as you expected, increase your volume of NPI only claims.

Medicare Part B Prepass report NPI error messages Important NPI error messages to watch for:

- Billing Provider level (2010AA) – M340 & M379
- Pay To Provider level (2010AB) – M341 & M380
- Rendering Provider level (2310B) – M343 & M381
- Rendering Provider level (2420A) – M347 & M382

Edits M340, M341, M343, and M347 occur when the NPI submitted with legacy number does not match the crosswalk; that is the NPI legacy is not on the crosswalk or is invalid. Edits M379, M380, M381, and M382 will fail if you are sending NPI only and the NPI is not on the crosswalk or you are sending an EIN/SSN with the incorrect qualifier.

What should you do? Verify that the provider number NPI combination is valid. Validate that legacy numbers are entered in NPPES. If legacy numbers are added and you continue to receive the informational errors on your report contact your carrier. Updates to NPPES typically update the crosswalk in 8-10 business days. If the error persists, contact EDI department. A new 855 may be required or the carrier may need to contact crosswalk team to have problem corrected manually. <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

All NPI prepass edits will be turned on by September 24, 2007. It is important that you act now. If you fail to take action, your claims may reject which will impact your claim processing.

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: 4010_401.doc) or on the WPS Website:

http://www.wpsic.com/edi/pdf/hipaa_mcs837.pdf

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

General Information

REVISION TO MEDICARE PUBLICATION 100-09, CHAPTER 3 – PROVIDER INQUIRIES AND CHAPTER 6 - PROVIDER CUSTOMER SERVICE PROGRAM UPDATES

~CMS MLN Matters~

MLN Matters Number: MM5597 Revised
Related CR Release Date: July 13, 2007
Related CR Transmittal #: R20COM

Related Change Request (CR) #: 5597
Effective Date: May 23, 2007
Implementation Date: July 30, 2007

Note: This article was revised on July 16, 2007, to reflect changes that CMS made to CR5597. The transmittal number, CR release date, and the Web address for accessing CR5597 were changed. All other information remains the same.

Provider Types Affected

All physicians, suppliers, and providers who submit written inquiries to, or contact the toll-free lines at, their Medicare contractors [fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative Contractors (DME/MACs), and/or regional home health intermediaries (RHHIs).]

Provider Action Needed

CR5597 contains a number of revisions to the Medicare Contractor Beneficiary and Provider Communications Manual, including changes for authenticating providers who make inquiries of Medicare contractors. Due to the Medicare fee-for-service contingency plan for the National Provider Identifier (NPI), the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare fee-for-service provider contact centers (PCCs), will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and written inquiry units. While the authentication rules are part of CR5597, for complete details about these rules under the Medicare NPI contingency plan, see MLN Matters article SE0721, which you will find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf> on the CMS Website.

The remainder of this article provides information on the highlights of changes announced in CR5597.

Background

CR5597 modifies Medicare Contractor Beneficiary and Provider Communications Manual, Publication 100-09. These changes are summarized as follows:

Overlapping Claims—New Rules

- Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing

period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.

- When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/ legacy number or NPI, beneficiary name, Health Insurance Claim Number (HICN), and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.
- Contractors shall release overlapping claim information whether a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.
- For specific information regarding the resolution of claims rejected by Medicare's Common Working File (CWF) system, refer to the Medicare Claims Processing Manual, Chapter 27, §50 at <http://www.cms.hhs.gov/manuals/downloads/clm104c27.pdf> on the CMS Website.

Information Available on the IVR

- **USE THE IVR whenever possible.** Providers should be aware that if a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information is available on the IVR, the CSR/correspondent will probably encourage you to use the self-service options that are available.
- If at any time during a telephone inquiry, you request information that can be found on the IVR the CSR will most likely refer you back to the IVR.

Information Available on the Remittance Advice (RA)

- USE THE RA whenever possible. If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.
- To make your job easier you may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available at: http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS Website.
- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers, which is available at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS Website.

There is a Web-based training course, Understanding the Remittance Advice for Professional Providers, which is available at:
http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS Website. The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

Authentication of Beneficiary Elements—additions to current rules.

CR5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR5597 is available at
<http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf> on the CMS Website.

Additional Key Points of CR5597

- Medicare's CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the Report of Contact made during a telephone response to a written inquiry, Medicare contractors will send you a letter detailing the discussion. This letter may be sent to you by e-mail or fax, if you request, unless the details include specific beneficiary or claim related information.
- When your Medicare contractor schedules a training event for which there is a charge for attendance and you register and pay, but are unable to attend, you may be entitled to a refund of some or all of your payment. But, to receive such a refund, you must notify the contractor before the event.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5597) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to
<http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf> on the CMS Website.

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

THE 2007 MEDICARE CONTRACTOR PROVIDER SATISFACTION SURVEY (MCPSS) SHOWS POSITIVE RESULTS FOR MEDICARE'S FEE-FOR-SERVICE CONTRACTORS
~CMS MLN Matters~

MLN Matters Number: SE0733
Related CR Release Date: N/A
Related CR Transmittal #: N/A

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

Provider Types Affected

All Medicare physicians, providers, and suppliers billing the Medicare program.

Provider Action Needed

No action is needed. This article is informational only and provides a summary of the findings from the second annual survey by Medicare to assess provider satisfaction with service from Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Background

The Centers for Medicare & Medicaid Services (CMS) reports that most Medicare health care providers continue to find satisfaction with the services provided by Medicare contractors.

The Medicare Contractor Provider Satisfaction Survey (MCPSS), recently conducted by CMS for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The survey revealed that 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale, with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The national average score for 2007 is 4.56.

Contractors received an overall composite score for the seven business functions of the provider-contractor relationship: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. For all contractor types, a contractor's handling of provider inquiries surpassed claims processing as the key predictor of a provider's satisfaction. CMS has provided contractors information for process improvement based on individual MCPSS results.

The MCPSS was sent early this year to more than 36,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. The survey was expanded this year to include hospice locations and federally qualified health centers.

The full results of the 2007 survey are now available at <http://www.cms.hhs.gov/MCPSS> on the CMS Website.

In January 2008, the next MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2008 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

Additional Information

Remember, your Medicare contractor is available to assist you in providing services to Medicare beneficiaries and in being reimbursed timely for those services. Whenever you have questions, contact your contractor at their toll free number, which is available at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

WPS Medicare Tip of the Week

(Published in the 03/19/07 General e-News Listserv)

Is there any prohibition against writing-off the beneficiary coinsurance when he/she does not have a Medicare supplement plan and cannot afford the coinsurance?

A provider, practitioner or supplier may not routinely waive Medicare deductibles or co-payments. One important exception to the prohibition against waiving co-payments and deductibles is that providers, practitioners, or suppliers may forgive the co-payment in consideration of a particular patient's financial hardship. Any exception must address the special needs of a particular patient. For additional information, please refer to the article entitled "Fraud and Abuse," located on our Website at the following address: http://www.wpsmedicare.com/provider/fraud_abuse.shtml

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

Program Safeguards

SANCTIONED AND REINSTATED PROVIDERS

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

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

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

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

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

Illinois Sanctioned Providers

Name/Specialty/Address/Date of Birth
Edward Orleans, PhD. Psychologist 482 Pinehurst Glenview, IL 60025 01/04/1941 EXCLUDED: 08/31/2006

Illinois Reinstated Providers

Name/Specialty/Address/Date of Birth
Bryan G. Barrish Owner/Operator 4160 Walter's Ave. Northbrook, IL 60062 09/17/1955 REINSTATED: 06/12/2007

Name/Specialty/Address/Date of Birth
Patricia F. Nicosia Nurse/Nurses Aide 7106 West 16 th Street Berwyn, IL 60402 04/05/1957 REINSTATED: 06/13/2007

Illinois Reinstated Providers (Cont'd)

Name/Specialty/Address/Date of Birth
Michael Raymond Giannini Owner/Operator 1062 S. Saddle Ridge Ct. Palatine, IL 60067 01/27/1952 REINSTATED: 06/12/2007

Michigan Sanctioned Providers

Name/Specialty/Address/Date of Birth
Wendy M. Dyer Health Care Aide 1456 Larchmont St. Erie, MI 48133 04/14/1980
Susan Lee Goodell Nurse/ Nurses Aide 21227 Alexander St. St. Clair Shores, MI 48081 07/16/1954
John Frederick Hildebrandt, M.D. Physician 2687 W. Lincoln Ave. Ionia, MI 48846 03/11/1955

Name/Specialty/Address/Date of Birth
John F. Hildebrandt, M.D. PC Clinic 330 Lovell St. Ionia, MI 48846 N/A
Susan M. Zielonka, D.O. Doctor of Osteopathy 850 W. Fisher Freeway Detroit, MI 48201 06/04/1961

Michigan Reinstated Providers

Name/Specialty/Address/Date of Birth
Eulalia Marie Jones Nurse/Nurses Aide 16255 Westmoreland Rd. Detroit, MI 48219 09/15/1962 REINSTATED: 06/13/2007

Minnesota Sanctioned Providers

Name/Specialty/Address/Date of Birth
Arthur E. Krontz, S.W. Social Worker P O Box 4000, #33066-083 Rochester, MN 55903 11/19/1949
Timothy Hugh McIntyre Nurse/Nurses Aide 1481 Woodview St., E. Eagan, MN 55122 11/06/1951

Name/Specialty/Address/Date of Birth
Steven R. Pierson, D.C. Chiropractor 4041 Linden Hills Blvd. Minneapolis, MN 55410 02/13/1951
Michael Todd Pitts Nurse/Nursing Aide 1107 Sanders Rd. Sandy, UT 84094 12/16/1963

Minnesota Reinstated Providers**Name/Specialty/Address/Date of Birth**

Lyle G. Elenkiwich, S.W.
Social Worker
231 146th Avenue, NE
Ham Lake, MN 55304
07/06/1949

REINSTATED: 07/17/2007

Wisconsin Sanctioned Providers**Name/Specialty/Address/Date of Birth**

Mary Teckla Johnson
Nurse/Nurses Aide
1821 N. Rapids Rd.
Manitowoc, WI 54220
06/15/1957

Provider Education

EDUCATION SCHEDULE

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

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

Seminars

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

Basic Principles of Medicare

Date/Time	Course Number	Address
9/11/2007 8:00am - 12:00 pm CT	IL101 FULL	Four Points by Sheraton 319 Fountains Parkway Fairview Heights, IL 62208

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

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

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

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

Save Dollars, Avoid Denials

Date/Time	Course Number	Address
9/11/2007 1:00pm - 5:00 pm CT	ILSD2 FULL	Four Points by Sheraton 319 Fountains Parkway Fairview Heights, IL 62208

Are you having trouble with Medicare payments? Are you trying to avoid unprocessable denials? Are you struggling to understand duplicates?

Attend this four-hour workshop to get a better understanding of all these things and more. WPS designed this workshop as an interactive learning session containing, exercise, questions, and answers. The focus is to teach providers what resources are available and how to use them. We will cover:

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

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

Beyond the Basics

Date/Time	Course Number	Address
09/06/07 9:00am - 3:00 pm ET	M2080 FULL	DoubleTree Hotel Dearborn 5801 Southfield Service Drive Detroit, MI 48228
09/12/07 9:00am - 3:00 pm ET	I2068 FULL	Hawthorne Suites 101 Trade Centre Drive Champaign, IL 61820-
09/12/07 9:00am - 3:00 pm ET	MN2012 FULL	Comfort Inn (Outback Catering & Event Center) 1321 East 78 th Street Bloomington, MN 54425
09/13/07 9:00am - 3:00 pm ET	MN2013 FULL	Comfort Inn (Outback Catering & Event Center) 1321 East 78th Street Bloomington, MN 54425

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

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

- Top Unprocessable Claim Denials
- National Provider Identifier
- Medical Review Process
- Comprehensive Error Rate Testing (CERT) Program
- Advance Beneficiary Notice Initiative
- Physician Quality Reporting Initiative
- Documentation
- Non-covered versus Not Medically Necessary Services
- Medical Policy (includes overview and exercise for Policy PHYS-001)

Due to time limitations, the “Beyond the Basics” program does not include detailed information about specialty claims (i.e. Chiropractic, Ambulance, Physical Therapy, etc.). Information on the training day schedule, and other workshop details, including steps for the easy on-line registration process is available at the bottom of this page. Sign up today!

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

How to Register

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. Go to the schedule on-line at
http://www.wpsmedicare.com/provider/proved_seminar.shtml
2. Select a course near you
3. Register online:
 - a. Click on the appropriate course number (this can be found in the second column of the appropriate table(s) above).
 - b. Fill out the form accordingly.
 - c. You will receive a message back from our Website stating we have received your request. This is NOT a confirmation of your registration. You will however receive a confirmation via telephone or e-mail.
PLEASE NOTE: When a confirmation e-mail for this seminar is sent from WPS it will come from a mailbox named **Medsemin**.

*If you experience technical difficulty registering online, or 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

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) DESIGNATION CHANGES

The following changes to HPSA designations have occurred:

Illinois

Mental Health

Eligible for dates of service on and after April 26, 2007

Bureau County	Entire County
Logan County	Entire County
Marshall County	Entire County
Mason County	Entire County
Menard County	Entire County
Putnam County	Entire County
Stark County	Entire County

Minnesota

Mental Health

Eligible for dates of service on and after May 8, 2007

Carlton County	Entire County
Cook County	Entire County
Lake County	Entire County
St. Louis County	Entire County

Michigan

Primary Care

Eligible for dates of service on and after April 26, 2007

Saginaw County – East Side Service Area	
Census Tracts	
1 – 2	6 – 11
4	110

Eligible for dates of service on and after April 26, 2007

Oakland County – Pontiac City Service Area
Pontiac City

WPS MEDICARE PROVIDER SERVICES

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

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

WPS MEDICARE e-NEWS MESSAGES

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

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

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