MEDICARE PART B

Communiqué

Wisconsin Physicians Service Insurance Corporation http://www.wpsmedicare.com

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

September 2008

WPS HEALTH INSURANCE

Items of Importance

ARE YOU MISSING YOUR E-NEWS MESSAGES?

WPS Medicare has been notified that some e-mail service providers are filtering WPS Medicare e-News messages as "junk mail." If you are signed up for WPS Medicare e-News and have not been receiving your weekly messages, please check in your "junk mail" box to see if the messages have been filtered in error.

Still not signed up for e-News? Do so today at **http://www.wpsmedicare.com/listserv**, and get important Medicare news sent straight to your e-mail.

CMS-855 MEDICARE ENROLLMENT APPLICATIONS: 2008 REVISIONS

The Centers for Medicare & Medicaid Services (CMS) revised the CMS-855 Medicare enrollment applications in February 2008. The current versions of the applications are available on the CMS Provider Enrollment Website at **http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage**.

Applications received in our office on and after October 1, 2008 must be submitted on the 2008 versions of the forms. The 2006 versions of the forms will no longer be accepted effective October 1, 2008 and will be returned to the applicant.

IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS

WPS Medicare will close for the following holidays:

Date	Holiday
September 1, 2008	Labor Day
November 27-28, 2008	Thanksgiving

During weekends and evenings, 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. For more information regarding C-SNAP, please call 1-877-476-8116 or visit our Website at the following location: **https://medicareinfo.com/apps/cms/home.do**

For more information regarding the IVR, please check out our Website at the following address: **http://www.wpsmedicare.com/part_b/selfservice/ivr.pdf**

Alternatively, to use the IVR, call:

Illinois (877) 908-9499
Michigan (877) 567-7201
Minnesota (877) 908-8470
Wisconsin (877) 567-7176

NATIONAL PROVIDER IDENTIFIER (NPI) - THINGS TO CONSIDER

Effective May 23, 2008, you were required to submit your claims with a National Provider Identifier (NPI) only. However, the Medicare claims processing system must match the NPI you submitted on your claim to the correct Provider Transaction Access Number (PTAN)/Provider Identification Number (PIN), otherwise known as your legacy number, so payment can be made to the appropriate provider.

If you have one NPI for each of your PTANs/PINs, there should be little disruption to your claims processing timeliness due to the NPI to PTAN/PIN matching process. For purposes of clarification, organizations may have multiple NPIs. An individual person will only have one NPI.

If you choose to have one NPI that corresponds to multiple PTANs/PINs, this may result in additional manual review and development to match your NPI to the correct PTAN/PIN. However, in the situation of one NPI that corresponds to multiple PTANs/PINs, we recommend you bill your corresponding taxonomy code for each rendering provider to reduce the likelihood of delays in processing due to manual review and development. In addition, it may be possible to collapse multiple PTANs/PINS (legacy numbers) into one PTAN/PIN to create a one to one match with your NPI. Additional information on collapsing multiple PTANs/PINs can be found at **http://www.cms.hhs.gov/MLNMattersArticles/01_Overview.asp#TopOfPage** on the Centers for Medicare & Medicaid Services (CMS) Website. From this page, refer to "2008 MLN Matters Articles," article MM5906, "Collapsing Medicare Provider Transaction Access Numbers (PTANs) to Ensure a One-to-One National Provider Identifier (NPI) Match."

The following is additional information to consider on the options for NPI enumeration. We hope you find this information helpful in making informed decisions that are in your best interest.

Enumerating Option #1 - One NPI to one PTAN/PIN

Advantages

- Improved Claims Processing Timeliness, otherwise delayed by the NPI to PTAN/PIN matching process.
- Less risk of matching NPI to wrong PTAN/PIN, resulting in claims being processed and paid incorrectly.
- Fewer claims suspended due to the NPI to PTAN/PIN matching process.
- Fewer claims developed for additional information due to the NPI to PTAN/PIN matching process.
- Fewer denied claims due to the NPI to PTAN/PIN matching process.

Disadvantages

- Applying for and managing multiple NPI numbers

Enumerating Option #2 - One NPI to many PTANs/PINs

Advantages

- Fewer NPI numbers to apply for and manage.

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Disadvantages

- Potential for delays in Claims Processing Timeliness due to the NPI to PTAN/PIN matching process.
- Increased risk of matching NPI to wrong PTAN/PIN, resulting in claims being processed and paid incorrectly.
- Increase in number of claims suspending due to the NPI to PTAN/PIN matching process.
- Increase in number of claims developed for additional information due to the NPI to PTAN/PIN matching process.
- Potential for increased denials on claims due to the NPI to PTAN/PIN matching process.

If you are interested in making changes to your NPI enumeration, you may contact the NPI Enumerator at 1-800-465-3203 or review information on how to apply for an NPI at **https://nppes.cms.hhs.gov/NPPES/Welcome.do**. You may find more information on the NPI through the CMS NPI page **http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp#TopOfPage** on the CMS Website.

If you have questions regarding your Medicare legacy numbers, please contact Provider Enrollment at:
IL/MI/WI: 877-908-8476
MN: 866-564-0315

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our Website at: http://www.wpsmedicare.com

Claim Submission

BENEFICIARY SUBMITTED CLAIMS
~ CMS MLN Matters ~

MLN Matters Number: MM5683
Related CR Release Date: July 18, 2008
Related CR Transmittal #: R1557CP

Related Change Request (CR) #: 5683
Effective Date: August 18, 2008
Implementation Date: August 18, 2008

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 5683 updates the procedures for processing claims submitted by Medicare beneficiaries to carriers and/or A/B MACs and serves as a reminder to providers and suppliers that they are required by law to submit claims to Medicare for services they render to Medicare beneficiaries. These updates do not apply to beneficiary claims submitted to Durable Medical Equipment (DME) MACs.

Background

All providers and suppliers are required to enroll in the Medicare program in order to receive payment. In addition, the Social Security Act (Section 1848 (g)(4)(A); **http://www.ssa.gov/OP_Home/ssact/title18/1848.htm**) requires all providers and suppliers to submit claims for services rendered to Medicare beneficiaries. The current manual requirement instructs Medicare contractors to provide education to the providers and suppliers explaining the statutory requirement, including possible penalties for repeatedly refusing to submit claims for services provided. Medicare contractors are also instructed to process beneficiary submitted claims for services that:

(1) **Are not covered by Medicare** (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc., in accordance with its normal processing procedures; see 42 CFR 411.15 at ***http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr411.15.pdf*** for details); and

(2) **Are covered by Medicare** when the beneficiary has submitted a complete claim (Patient's Request for Medical Payment Form CMS-1490S; **http://www.cms.hhs.gov/CMSForms/CMSForms**) and all supporting documentation associated with the claim, including an itemized bill with the following information:

- Date of service,
- Place of service,
- Description of illness or injury,
- Description of each surgical or medical service or supply furnished,
- Charge for each service,
- The doctor's or supplier's name, address, and
- The provider or supplier's National Provider Identifier (NPI).

If an incomplete claim (or a claim containing invalid information) is submitted, the contractor will return the claim as incomplete with an appropriate letter. The Centers for Medicare & Medicaid Services (CMS) will be providing suggested language for that letter in a later Transmittal. In addition, contractors will manually return (to the beneficiary) beneficiary submitted claims when the beneficiary used Form CMS-1500 with instructions how to complete and return the appropriate beneficiary claims Form CMS-1490S for processing.

Note: CMS will be providing suggested language for the above mentioned letter in a later Transmittal.

When manually returning a beneficiary submitted claim (Form CMS-1490S) for a Medicare-covered service (because the claim is not complete or contains invalid information), the contractor will maintain a record of the beneficiary submitted claim for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.

When returning a beneficiary submitted claim, the contractor will inform the beneficiary by letter that:

- The provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable); and
- In order to submit the claim, the provider must enroll in the Medicare program.

Medicare contractors should encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim on the beneficiary's behalf (for services that would otherwise be payable by Medicare), the beneficiary should:

(1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare, and
(2) Submit a complete Form CMS-1490S with all supporting documentation.

Upon receipt of both the beneficiary's complaint that the provider/supplier refused to submit the claim, and the beneficiary's claim Form CMS-1490S (and all supporting documentation), the contractor will process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider's or supplier's refusal to submit the claim and/or enroll in Medicare.

Contractors will maintain:

(1) Documentation of beneficiary complaints involving violations of the mandatory claims submission policy, and
(2) A list of the top 50 violators (by State) of the mandatory claim submission policy.

The instructions provided in CR 5683 do not apply to foreign claims, and they do not apply to beneficiary claims submitted to DME MACs (for durable medical equipment, prosthetics, orthotics, and supplies). The processing of foreign claims will remain unchanged, and DME MACs should continue to follow procedures that are currently in place.

Additional Information

The official instruction, CR5683, issued to your carrier, A/B MAC, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1557CP.pdf on the CMS Website.

If you have any questions, please contact your Medicare carrier, 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 on the CMS Website.

BILLING FOR COMPOUNDED DRUGS USED IN AN IMPLANTABLE EPIDURAL/SUBARACHNOID PAIN PUMP REFILLS

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

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

Some hospitals and medical centers have the necessary equipment and sterilization facilities to prepare these solutions.

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

Guidelines

1. When these drugs are compounded, they will be paid for by the method described below: baclofen (Lioresal), bupivacaine (Marcaine, Sensorcaine), clonidine (Duraclon), fentanyl (Sublimaze), hydromorphone (Dilaudid), morphine (Astramorph, Duramorph, Infumorph), sufetanil (Sufenta), and ziconotide (Prialt).

2. Use HCPCS code J3490 (Unclassified drugs), with one unit of service, and with the **KD** ("drug or biological infused through DME [durable medical equipment]) Modifier, for the entire compounded drug refill.

3. Drug specific "J" codes **should not be used** for these drug mixtures, for epidural/subarachnoid pain pump refills, as these codes do not specifically describe the actual formulations of the drugs used in this compounding process.

4. An invoice is required for each claim. Electronic submitters should indicate that they have an invoice available upon request by putting "DOCUMENTATION AVAILABLE UPON REQUEST" in the electronic equivalent of Item 19 of the CMS-1500 claim form. The invoice you have, which is needed by Medicare to make its payment determination, will be requested from you by way of a development letter requesting that the invoice be sent to us.

If you do not indicate the availability of the invoice in item 19 or its electronic equivalent, or it is not returned in a timely fashion, the claim will de denied as unprocessable.

5. The correct CPT code for an implantable epidural/subarachnoid pain pump refill and maintenance is 95990 when performed "incident to" a physician's services, or 95991 when administered by a physician **should be billed on the same claim**.

6. The correct CPT code for pump analysis is 62367 and 62368 for analysis with reprogramming.

7. Also in item 19 on the CMS-1500 form, or its electronic equivalent, include:
   a. **Name of the drug**
   b. **Exact total dosage (number of milligrams or micrograms) for that patient**
   c. **Route of administration, i.e., "internal pump" or the brand name of the pump**

8. A4220 (Refill kit for implantable infusion pump) is considered bundled/excluded from Medicare coverage by CMS.

9. An Evaluation and Management (E/M) service is allowed, if performed at the time of pump refill for a significant, separately identifiable reason. The applicable appropriate E/M code should be billed with the -25 modifier.

10. A compounding pharmacy may supply epidural/subarachnoid pain pump refills directly to a patient's home (Place of Service/POS 12). In these circumstances, the Carrier (WPS) reimburses the pharmacy for the compounded drug mixture only.

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

CORRECT BILLING OF THE NUMBER OF SERVICES

WPS Medicare would like to remind providers that it is important to bill the correct numbers of services. Claims may be denied if the incorrect numbers of services are billed.

IT HAS BEEN DETERMINED THE UNITS OF SERVICE ARE IN EXCESS OF THE MEDICALLY REASONABLE DAILY ALLOWABLE FREQUENCY. THE EXCESS CHARGES DUE TO UNITS OF SERVICE GREATER THAN THE MAXIMUM ALLOWABLE MAY NOT BE BILLED TO THE BENEFICIARY AND THIS PROVISION CAN NEITHER BE WAIVED NOR SUBJECT TO AN ADVANCED BENEFICIARY NOTIFICATION (ABN).

This reason code is in response to a line level edit that causes an entire claim to Return to Provider (RTP) until the line(s) in question are within a range that reflects a “reasonable daily allowance.” This range is determined by past claims data, clinical judgment of health care professionals and comments from the medical/provider community. The Centers for Medicare & Medicaid Services (CMS) requires this list (and the associated limits) to remain confidential.

Based on the volume and types of questions received, the issues identified are primarily proper application of the CPT code descriptor for the services, and the medical necessity of the number of services billed.

Example: Psychotherapy Codes
Many psychotherapy codes have a time associated with the CPT descriptors; group psychotherapy, family psychotherapy, and interactive group psychotherapy codes do not. The units for these codes should be reported per session, not incremental units of time.

Example: Infusion Codes
Infusion codes are separated into "initial" and "additional hours" codes, and the concurrent and subsequent services. Pay close attention to the code's descriptors and to documentation supporting the services billed. Many infusions may continue for the duration of a patient's stay in observation or the emergency room to keep the line open, but Medicare allows billing for only the hours supported in the record as medically necessary for the patient's treatment or for diagnostic purposes.

Example: Labs and Diagnostics
Several laboratory and diagnostic tests are done on a "serial" or consecutive basis, and many of these tests have codes for the entire "series." If it is medically necessary to repeat a lab test, modifier -91 may be applied if documentation supports the need for the repeat test.

WPS does not answer questions regarding the limits for billable units.

DO NOT send documentation to the WPS Education Departments or Medical Directors to support additional units. The documentation will be returned to you without review.

For providers who wish to request reconsideration of a value, please request a redetermination by sending the claim and documentation. Part B providers and beneficiaries have 120 days to file a request for a redetermination from the date of receipt of the remittance notice or Medicare Summary Notice (MSN). This is the first level of appeal conducted by Medicare contractors.

Written Redetermination
You may request a redetermination by writing to the following addresses:

WISCONSIN	ILLINOIS
WPS Wisconsin Informal Review P.O. Box 1268 Madison, WI 53701	WPS Illinois Appeals P.O. Box 4433 Marion, IL 62959
MICHIGAN	**MINNESOTA**
WPS Michigan Appeals P.O. Box 5533 Marion, IL 62959	WPS Minnesota Appeals 8120 Penn Ave South, Suite 200 Bloomington, MN 55431-1394

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

~ CMS MLN Matters ~

MLN Matters Number: MM6107
Related CR Release Date: July 29, 2008
Related CR Transmittal #: R1566CP
Related Change Request (CR) #: 6107
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DMACs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs)).

Impact on Providers

This article is based on Change Request (CR) 6107 and reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008). You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the Centers for Medicare & Medicaid Services (CMS) Website at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage** or at the National Center for Health Statistics (NCHS) Website at **http://www.cdc.gov/nchs/icd9.htm** in June of each year.

Background

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing* Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 6107 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2008 (for institutional providers, effective for discharges on or after October 1, 2008).

Remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs)), and for all institutional claims; but is not required for ambulance supplier claims.

Additional Information

The official instruction (CR 6107) issued to your Medicare contractor is available at **http://www.cms.hhs.gov/Transmittals/downloads/R1566CP.pdf** on the CMS Website.

As mentioned, you can find the new, revised, and discontinued ICD-9-CM diagnosis codes at **http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage** on the CMS Website or at the National Center for Health Statistics (NCHS) Website at **http://www.cdc.gov/nchs/icd9.htm** in June of each year. The annual ICD-9-CM code changes

are also included in a CD-ROM, which you can purchase for $25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing* Manual, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage on the CMS Website.

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

NEW REQUIREMENT FOR ORDERING/REFERRING INFORMATION ON AMBULATORY SURGICAL CENTER (ASC) CLAIMS FOR DIAGNOSTIC SERVICES

~ CMS MLN Matters ~

MLN Matters Number: MM6129
Related CR Release Date: August 8, 2008
Related CR Transmittal #: R1572CP
Related Change Request (CR) #: 6129
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

Providers (ASCs) who submit claims to Medicare Administrative Contractors (A/B MACs) or carriers for services provided to Medicare beneficiaries.

Impact on Providers (ASCs)

This article is based on Change Request (CR) 6129 which states that the Centers for Medicare & Medicaid Services (CMS) has determined that beginning January 1, 2009, **the ordering/referring physician needs to be reported on claims for diagnostic radiology services submitted by ASCs,** as it is for other Part B claims for diagnostic services (modifier TC). The name of the ordering/referring physician needs to be present in block 17 and the National Provider Identifier (NPI) of the physician needs to be present in block 17B of the CMS-1500 (or in Data Element Loops 2420E and 2310B of the 837P).

Key Points of CR6129

- Effective for dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, the ordering/referring physician name needs to be included in block 17 and ordering/physician NPI in block 17B of the CMS-1500 for paper claims.

- Effective for dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, the ordering physician name and NPI needs to be present in Loop 2420E NM1 (NM101=DK, NM102=1, NM103=*provider's last name*, NM104=*provider's first name*, NM108=XX, NM109=*provider's NPI*).

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our Website at: http://www.wpsmedicare.com

- Effective January 1, 2009 for allowed ASC claims, if modifier = TC, the referring physician name and NPI needs to be present in Loop 2310A/2420F NM1 (NM101=DN, NM102=1, NM103=*provider's last name*, NM104=*provider's first name*, NM108=XX, NM109=*provider's NPI*).

- Claims will be returned as **unprocessable (using Claim Adjustment Reason Code 16-Claim/service lacks information which is needed for adjudication)** for the above services without the ordering/referring physician name or NPI on the claim.

- When returning claims as unprocessable, your Medicare Carrier or A/B MAC will use Remittance Advice Remark codes:
  - N264 - Missing/incomplete/invalid ordering provider name;
  - N265 - Missing/incomplete/invalid ordering provider primary identifier;
  - N285 - Missing/incomplete/invalid referring provider name; or
  - N286 - Missing/incomplete/invalid referring provider primary identifier.

- If the NPI of the ordering/referring provider cannot be obtained by the billing provider and it cannot be found on the NPI Registry, the billing provider (in X12N 837 transactions) or the service provider (in NCPDP 5.1 transactions) may be used in the ordering/referring field on a temporary basis and such use is subject to postpayment review.

Background

Prior to January 1, 2008, ASCs could not be paid for diagnostic radiology services since these services were not included on the list of ASC-approved procedures. Effective for services on or after January 1, 2008 several radiology codes were added to the list of payable ASC procedures. Since ASCs can now bill for these services with the TC modifier, claims from ASCs for these services must be in compliance with Section 1883 (q) of the Social Security Act, which requires that physician ordering/referring information be included on all claims for payable services when there had been a referral by a referring physician.

Additional Information

To see the official instruction (CR6129) issued to your Medicare Carrier or AB/MAC, refer to **http://www.cms.hhs.gov/Transmittals/downloads/R1572CP.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.

REMITTANCE ADVICE REMARK CODE AND CLAIM ADJUSTMENT REASON CODE UPDATE

~ CMS MLN Matters ~

MLN Matters Number: MM6109
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1563CP

Related Change Request (CR) #: 6109
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Impact on Providers

CR 6109, from which this article is taken, announces the latest update of Remittance Advice Remark Codes (RARC) used in electronic and paper remittance advice, and Claim Adjustment Reason Codes (CARC) used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective October 1, 2008.

Be sure that your billing staffs are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in coordination-of-benefits (COB) transactions.

The RARC list is maintained by the Centers for Medicare & Medicaid Services (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by any health care organization. The CARC list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year and are posted on the Washington Publishing Company (WPC) Website at http://www.wpc-edi.com/Codes on the Internet. The tables at the end of this article (right after the “Additional Information” section) summarize the latest changes to these lists, as announced in CR6109.

CMS has also developed a tool to help you search for a specific category of RARC code and that tool is available at http://www.cmsremarkcodes.info on the Internet. Note that this Website does not replace the WPC site and, should there be any discrepancies in what is posted at this site and the WPC site, consider the WPC site to be correct.

Additional Information

To see the official instruction (CR 6109) issued to your Medicare Carrier, RHHI, DME/MAC, FI and/or A/B MAC refer to http://www.cms.hhs.gov/Transmittals/downloads/R1563CP.pdf on the CMS Website.

This bulletin should be shared with all health care practitioners and managerial members of the provider staff. Bulletins are available at no cost from our Website at: http://www.wpsmedicare.com

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* at **http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf** on *the* CMS Website.

If you have questions, please contact your Medicare Carrier, RHHI, DME/MAC, FI, and/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. The changes that are effective on October 1, 2008 are as follows:

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N433	Resubmit this claim using only your National Provider Identifier (NPI)	Y

Modified Codes

Code	Current Modified Narrative	Last Modified
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.	2/29/08
N175	Missing review organization approval.	2/29/08
N241	Incomplete/invalid review organization approval.	2/29/08
N421	Claim payment was the result of a payer's retroactive adjustment due to a review organization decision.	2/29/08

Deactivated Codes

Code	Current Narrative	Last Modified
None		

Health Care Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Effective Date (per WPC Website)
213	Non-compliance with the physician self referral prohibition legislation or payer policy.	1/27/2008
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only)	1/27/2008
215	Based on subrogation of a third party settlement	1/27/2008
216	Based on the findings of a review organization	1/27/2008
217	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note: To be used for Workers' Compensation only)	1/27/2008
218	Based on entitlement to benefits (Note: To be used for Workers' Compensation only)	1/27/2008

Code	Current Narrative	Effective Date (per WPC Website)
219	Based on extent of injury (Note: To be used for Workers' Compensation only)	1/27/2008
220	The applicable fee schedule does not contain the billed code. Please resubmit a bill with the appropriate fee schedule code(s) that best describe the service(s) provided and supporting documentation if required. (Note: To be used for Workers' Compensation only)	1/27/2008
221	Workers' Compensation claim is under investigation. (Note: To be used for Workers' Compensation only. Claim pending final resolution)	1/27/2008
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/27/2008

Modified Codes

Code	Modified Narrative	Effective Date (per WPC Website)
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	1/27/2008

Deactivated Codes

Code	Current Narrative	Effective Date (per WPC Website)
D22	Reimbursement was adjusted for the reasons to be provided in separate correspondence. (Note: To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to replace or strategy to use another existing code	1/1/2009

Coverage – General

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY FOR OBSTRUCTIVE SLEEP APNEA (OSA)

~ Revised CMS MLN Matters ~

MLN Matters Number: MM6048 Revised
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R91NCD

Related Change Request (CR) #: 6048
Effective Date: March 13, 2008
Implementation Date: August 4, 2008

Note: This article was revised on July 28, 2008, to reflect changes to CR 6048, which CMS revised on July 25, 2008. The CR release date, transmittal number, and the Web address for accessing CR6048 were revised. All other information remains the same.

Provider Types Affected

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

Impact on Providers

Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of CPAP therapy based upon a positive diagnosis of OSA by home sleep testing (HST), subject to the requirements of CR6048.

Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered its 2005 National Coverage Determination (NCD) for CPAP Therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with section 240.4 of the Medicare NCD Manual (see the *Additional Information* section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR6048. (Note that billing guidelines for capped rental equipment are contained in the Medicare Claims Processing Manual, Chapter 20, Section 30.5, which is available at http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf on the CMS Website.)

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation. The apnea hypopnea index (AHI) is equal to the average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

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Key Points of CR6048

1. Coverage of CPAP is initially limited to a 12-week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12-week period.

NOTE: DME Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively. 42 CFR 424.57(c)(12). Failure to meet this standard may result in revocation of the DMEPOS supplier's billing privileges. 42 CFR 424.57(d).

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:
   - Polysomnography (PSG) performed in a sleep laboratory; or
   - Unattended home sleep monitoring device of Type II; or
   - Unattended home sleep monitoring device of Type III; or
   - Unattended home sleep monitoring device of Type IV, measuring at least 3 channels.

NOTE: In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

3. A positive test for OSA is established if either of the following criteria using the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) is met:
   - AHI or RDI greater than or equal to 15 events per hour, or
   - AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

Note: The AHI is equal to the average number of episodes of apnea and hypopnea per hour. The RDI is equal to the average number of respiratory disturbances per hour.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.

5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.

6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the NCD manual revision attached to CR6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at section 310.1 of the NCD Manual and chapter 32 and sections 69.6-69.7 (Pub 100-04) of the Medicare Claims Processing Manual. These manuals are available at http://www.cms.hhs.gov/manuals/IOM/list.asp on the CMS Website.

Note: The following <u>HST portable monitoring G codes effective March 13, 2008, are provided for your information only, are not included in the CPAP for OSA NCD at section 240.4 of the NCD Manual, and do not necessarily convey coverage, which is determined at local contractor discretion.</u>

G0398: Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.
G0398 Short Descriptor: Home sleep test/type 2 Porta
G0399: Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
G0399 Short Descriptor: Home sleep test/type 3 Porta
G0400: Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels
G0400 Short Descriptor: Home sleep test/type 4 Porta

Additional Information

To see the official instruction (CR6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC, visit **http://www.cms.hhs.gov/Transmittals/downloads/R91NCD.pdf** on the CMS Website.

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

CRITICAL CARE VISITS AND NEONATAL INTENSIVE CARE (CODES 99291 - 99292)

~ Revised CMS MLN Matters ~

MLN Matters Number: MM5993 Revised
Related CR Release Date: July 9, 2008
Related CR Transmittal #: R1548CP

Related Change Request (CR) #: 5993
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Note: This article was revised on July 23, 2008, to reflect additional changes made to CR5993 on July 9. CR5993 was revised to correctly state the payment policy regarding emergency department visits on the same day as critical care services for the same patient by the same physician, to clarify reporting of services supplied to neonates, infants, and children by referring providers to consult the American Medical Association's Current Procedural Terminology, and to correct the information on how to calculate critical care time from the paragraph before the table on page 6 of this article. There are additional minor clarifications.

Provider Types Affected

Physicians and Qualified Non-Physician Practitioners (NPP) who bill Medicare carriers and Medicare Administrative Contractors (A/B MAC) for critical care services provided to Medicare beneficiaries.

What You Need to Know

CR 5993, from which this article is taken, revises the *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.12. (Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)), replacing all previous critical care payment policy language in the section and adding general Medicare evaluation and management (E/M) payment policies that impact payment for critical care services.

Specifically, CR 5993:

- Explains the definition of, and how to bill for, critical care services, and includes the American Medical Association (AMA) Current Procedural Terminology (CPT) definitions of critical care and critical care services.
- **Adds a new CPT code for 2008 (36591) which replaces code 36540**. Code 36591 identifies a bundled vascular access procedure when performed with a critical care service.

Make sure that your billing staffs are aware of these revisions.

Background

CR 5993, from which this article is taken, explains the definition of critical care services and how to correctly bill for these services. It discusses medically necessary services, full physician attention, counting the hours of critical care billing, performance of other evaluation and management (E/M) services on the same day as critical care services, group practice issues, services by a qualified nonphysician practitioner (NPP), bundled procedures, global surgery issues, ventilation management, teaching physician issues, physician services off the unit/floor, split/shared services, unbundled procedures, and inappropriate use of time and family counseling and discussions.

The following summarizes the information contained in CR 5993 and in *Medicare Claims Processing Manual* Chapter 12, Section 30.6.12, which is an attachment to CR5993.

Use of Critical Care Codes (CPT codes 99291-99292)

Critical care is defined as a physician's (or physicians') direct delivery of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

Critical care involves high complexity decision making to assess, manipulate, and support vital system functions to treat single, or multiple, vital organ system failure; and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include (but are not limited to):

- Central nervous system failure;
- Circulatory failure;
- Shock;
- Renal, hepatic, metabolic, and/or respiratory failure.

Although it typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.

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You should remember that providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. While critical care is usually given in a critical care area such as a coronary care unit, intensive care unit, respiratory care unit, or the emergency department, payment may also be made for critical care services that you provide in any location as long as this care meets the critical care definition.

When all these criteria are met, Medicare contractors (carriers and A/B MACs) will pay for critical care and critical care services that you report with CPT codes 99291 and 99292 (described below).

Critical Care Services and Medical Necessity

Critical care services must be reasonable and medically necessary. As explained above, critical care services encompass both the treatment of "vital organ failure" and "prevention of further life threatening deterioration in the patient's condition." Therefore, delivering critical care in a moment of crisis, or upon being called to the patient's bedside emergently, is not the only requirement for providing critical care service. Treatment and management of a patient's condition, in the threat of imminent deterioration; while not necessarily emergent, is required.

In this context, examples of patients whose medical conditions may warrant critical care services would include:

1. An 81-year-old male patient is admitted to the intensive care unit following abdominal aortic aneurysm resection. Two days after surgery he requires fluids and vasopressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
2. A 67-year-old female patient is three days status post mitral valve repair. She develops petechiae, hypotension, and hypoxia requiring respiratory and circulatory support.
3. A 70-year-old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive two days after admission.
4. A 68-year-old admitted for an acute anterior wall myocardial infarction continues to have symptomatic ventricular tachycardia that is marginally responsive to antiarrhythmic therapy.

You should not consider that the provision of care to a critically ill patient is automatically a critical care service just because the patient is critically ill or injured. To this point, each physician providing critical care services to a patient during the critical care episode of an illness or injury must be managing one or more of the critical illness(es) or injury(ies) in whole, or in part.

In this context, examples of scenarios in which a patient's medical condition may not warrant critical care services would include:

1. A dermatologist evaluating and treating a rash on an ICU patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist.
2. Daily management of a patient on chronic ventilator therapy unless the critical care is separately identifiable from the chronic long term management of the ventilator dependence.
3. Management of dialysis or care related to dialysis for a patient receiving End Stage Renal Disease (ESRD) hemodialysis, unless the critical care is separately identifiable from the chronic long term management of the dialysis dependence (Refer to *Medicare*

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Claims Processing Manual, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section160.4 (Requirements for Payment).

Note: When a separately identifiable condition (e.g., management of seizures or pericardial tamponade related to renal failure) is being managed it may be billed as critical care, if critical care requirements are met. Modifier –25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) should be appended to the critical care code when applicable in this situation.

Similarly, examples of patients who may not satisfy Medicare medical necessity criteria for critical care payment would include:

- Patients admitted to a critical care unit because no other hospital beds were available,
- Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose), or
- Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

You should consult the American Medical Association (AMA) CPT Manual for the applicable codes and guidance for critical care services provided to neonates, infants and children.

Critical Care Services and Full Attention of the Physician

The duration of critical care services that physicians should report is the time you actually spend evaluating, managing, and providing the critically ill, or injured, patient's care. Be aware that during this time, you cannot provide services to any other patient, but rather must devote your full attention to this particular critically ill patient.

This time must be spent at the patient's immediate bedside or elsewhere on the floor, or unit, so long as you are immediately available to the patient. For example, time spent reviewing laboratory test results or discussing the critically ill patient's care with other medical staff in the unit or at the nursing station on the floor would be reported as critical care, even when it does not occur at the bedside; if this time represents your full attention to the management of the critically ill/injured patient.

Note: Time spent off the unit or floor where the critically ill/injured patient is located (i.e., telephone calls, whether taken at home, in the office, or elsewhere in the hospital) floor may not be reported as critical care time because the physician is not immediately available to the patient. This time is regarded as pre- and post service work bundled in evaluation and management services.

Critical Care Services and Qualified Non-Physician Practitioners (NPP)

Qualified NPPs may provide critical care services (and report for payment under their National Provider Identifier (NPI)), when these services meet the above **critical care services definition and requirements.**

Notes: 1) The critical care services that NPPs provide must be within the scope of practice and licensure requirements for the State in which they practice and provide the services; and 2) NPPs must meet the collaboration, physician supervision requirements, and billing requirements; and physician assistants (PA) must meet the general physician supervision requirements.

Critical Care Services and Physician Time

Critical care is a time- based service. Payment for critical care services is not restricted to a fixed number of hours, days, or physicians (on a per-patient basis) when such services meet medical necessity; and time counted toward critical care services may be continuous clock time or intermittent in aggregated time increments (e.g. 50 minutes of continuous clock time or five ten minute blocks of time spread over a given calendar date). Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient. For each medical encounter, the physician's progress notes must document the total time that critical care services are provided.

For Medicare Part B physician services, paid under the physician fee schedule, critical care is not a service that is paid on a "shift" basis or a "per day" basis. Documentation may be requested for any claim to determine medical necessity. Examples of critical care billing that may require further review could include:

- Claims from several physicians submitting multiple units of critical care for a single patient; and
- Submitting claims for more than 12 hours of critical care time by a physician for one or more patients on the same given calendar date.

Physicians assigned to a critical care unit (e.g., hospitalist, intensivist etc.) may not report critical care for patients based on a 'per shift" basis. You should use CPT code 99291 (evaluation and management of the critically ill or critically injured patient, first 30-74 minutes) to report the first 30-74 minutes of critical care on a given calendar date of service. You can only use this code once per calendar date to bill for care provided for a particular patient by the same physician or physician group of the same specialty.

CPT code 99292 (critical care, each additional 30 minutes) is used to report additional block(s) of time, of up to 30 minutes each beyond the first 74 minutes of critical care. Critical care of less than 30 minutes total duration on a given calendar date is not reported separately using the critical care codes. This service should be reported using another appropriate E/M code such as subsequent hospital care.

Table 1 (below) illustrates the correct reporting of critical care services, followed by a clinical example.

Table 1: Reporting of Critical Care Services

Total Duration of Critical Care	Appropriate CPT Codes
Less than 30 minutes	99232 or 99233 or other appropriate E/M code
30 - 74 minutes	99291 x 1
75 - 104 minutes	99291 x 1 and 99292 x 1
105 - 134 minutes	99291 x1 and 99292 x 2
135 - 164 minutes	99291 x 1 and 99292 x 3
165 - 194 minutes	99291 x 1 and 99292 x 4
194 minutes or longer	99291 – 99292 as appropriate (per the above illustrations)

Clinical Example of Correct Billing of Time:

A patient arrives in the emergency department (ED) in cardiac arrest. The emergency department physician provides 40 minutes of critical care services. A cardiologist is called to the ED and assumes responsibility for the patient, providing 35 minutes of critical care

services. The patient stabilizes and is transferred to the CCU. In this instance, the ED physician provided 40 minutes of critical care services and reports only the critical care code (CPT code 99291) and not also codes for emergency department services. Using CPT code 99291, the cardiologist may also report the 35 minutes of critical care services provided in the ED. Additional critical care services by the cardiologist in the CCU (on the same calendar date) using 99292 or another appropriate E/M code depending on the clock time involved.

Other Critical Care Issues

There are some specific rules about physician services and time that you should know:

1. Only one physician can bill for critical care during any one single period of time. Unlike other E/M services, critical care services reflect one physician's (or qualified non-physician practitioner's) care and management of a critically ill or critically injured patient for the specified reportable period of time. You cannot report a split/shared E/M service performed by a physician and a qualified NPP of the same group practice (or employed by the same employer) as a critical care service. The critical care service reported should reflect the evaluation, treatment, and management of the patient by the individual physician or qualified non-physician practitioner and not representative of a combined service between a physician and a qualified NPP.

   When CPT code requirements for time and critical care requirements are met for a medically necessary visit by a qualified NPP, the service shall be billed using the appropriate individual NPI number. Medically necessary visit(s) that do not meet these requirements shall be reported as subsequent hospital care services.

   Please note that medically necessary service(s) that do not meet critical care criteria may be reported as subsequent hospital care services.

   In denying a claim for a critical care service that is a split/shared service, carriers and A/B MACS will use the following messages:

   Claims Adjustment Reason Code:
   150 – Payment adjusted because the payer deems the information submitted does not support this level of service.

   Remittance Advice Reason Code:
   N180 – This item or service does not meet the criteria for the category under which it was billed.

   Medicare Summary Notice:
   17.11 – This item or service cannot be paid as billed.

   For unassigned claims, Medicare contractors will use add-on message 16.34 – You should not be billed for this service. You are only responsible for any deductible and coinsurance amounts listed in the 'you may be billed' column; or

   For assigned claims, Medicare contractors will use add-on message 16.35 – You do not have to pay this amount.

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2. When performed on the day a physician bills for critical care, the following services are included in the critical care service, and should not be reported separately:
   - the interpretation of cardiac output measurements (CPT 93561, 93562)
   - chest x-rays, professional component (CPT 71010, 71015, 71020)
   - blood draw for specimen (CPT 36415)
   - blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data (CPT 99090))
   - gastric intubation (CPT 43752, 91105)
   - pulse oximetry (CPT 94760, 94761, 94762)
   - temporary transcutaneous pacing (CPT 92953)
   - ventilator management (CPT 94002 – 94004, 94660, 94662)
   - vascular access procedures (CPT 36000, 36410, 36415, 36591, 36600)

   No other procedure codes are bundled into the critical care services. Therefore, other medically necessary procedure codes may be billed separately.

3. Concurrent care by more than one physician (generally representing different physician specialties) is payable if the services all meet critical care requirements, are medically necessary, and are not duplicative (refer to *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 30 (Physician Services) for concurrent care policy discussion).

   Critically ill or injured patients may require the care of more than one physician medical specialty, but keep in mind that the critical care services provided by each physician must be medically necessary. Medicare will pay for non-duplicative, medically necessary critical care services provided by 1) physicians from the same group practice; or 2) from different group practices to the same patient.

   Note: Physician specialty means the self-designated primary specialty by which the physician bills Medicare and is known to the Medicare contractor who adjudicates the claims. Physicians in the same group practice who have different medical specialties may bill and be paid without regard to their membership in the same group. For example, if a cardiologist and an endocrinologist are group partners and the critical care services of each are medically necessary and not duplicative the critical care services may be reported by each regardless of their group practice relationship.

   Your medical record documentation must support that the critical care services each physician provided were necessary for treating and managing the patient's critical illness(es) or critical injury(ies). Each physician must accurately report the service(s) he/she provided to the patient in accordance with any applicable global surgery rules or concurrent care rules. (Refer to *Medicare Claims Processing Manual,* Chapter 12 (Physicians/Nonphysician Practitioners), and Section 40 (Surgeons and Global Surgery); and *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), and Section30 (Physician Services)).

   You will need to follow these specific coding requirements.
   - The initial critical care time (billed as CPT code 99291) must be met by a single physician or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician on the same calendar date. A history or physical

examination performed by one group partner for another group partner in order for the second group partner to make a medical decision would not represent critical care services.

- Subsequent critical care visits performed on the same calendar date are reported using CPT code 99292. The service may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty in order to meet the duration of minutes required for CPT code 99292. The aggregated critical care visits must be medically necessary and each aggregated visit must meet the definition of critical care in order to combine the times.
- Physicians in the same group practice who have the same specialty may not each report CPT initial critical care code 99291 for critical care services to the same patient on the same calendar date. Medicare payment policy states that physicians in the same group practice who are in the same specialty must bill and be paid as though each were the single physician. (Refer to *Medicare Claims Processing Manual,* Chapter 12 (Physicians/Nonphysician Practitioners.)
- Physicians in the same group practice, with different specialties, who provide critical care to a critically ill or critically injured patient may not always each report the initial critical care code (CPT 99291) on the same date. When these physicians are providing care that is unique to his/her individual medical specialty, and are managing at least one of the patient's critical illness(es) or critical injury(ies); then the initial critical care service may be payable to each. However, if a physician (or qualified NPP) within a group provides "staff coverage" or "follow-up" for each other after another group physician provided the first hour of critical care services on that same calendar date but has left the case; the second group physician (or qualified NPP) should report the CPT critical care add-on code 99292, or another appropriate E/M code.

Clinical Examples of Critical Care Services

a) Two pulmonary specialists, who share a group practice, each provide critical care services (at different times during the same day) to a patient who has multiple organ dysfunction (including cerebral hematoma, flail chest and pulmonary contusion), is comatose, and has been in the intensive care unit for 4 days following a motor vehicle accident. Both physicians may report medically necessary critical care services provided at the different time periods. One physician would report CPT code 99291 for the initial visit and the second, as part of the same group practice, would report CPT code 99292 on the same calendar date if the appropriate time requirements are met.

b) A 79 year old male comes to the emergency room with vague joint pains and lethargy. The ED physician evaluates him and phones his primary care physician to discuss his medical evaluation. His primary care physician visits the ER and admits him to the observation unit for monitoring, and diagnostic and laboratory tests; during which time he has a cardiac arrest. His primary care physician provides 50 minutes of critical care services, and admits him to the intensive care unit. On the same calendar day, his condition deteriorates and he requires intermittent critical care services. In this scenario, the ED physician should report an emergency department visit and the primary care physician should report both an initial hospital visit and critical care services.

4. When a patient requires critical care services upon presentation to a hospital emergency department, you may only report critical care codes 99291 - 99292. You may not also report an emergency department visit code.

   However, when critical care services are provided on a day during which an inpatient hospital, or office/outpatient evaluation and management service was furnished earlier on the same date at which time the patient did not require critical care, both the critical care and the previous evaluation and management service may be paid. Hospital emergency department services are not payable for the same calendar date as critical care services when provided by the same physician to the same patient. Physicians are advised to submit documentation to support a claim when critical care is additionally reported on the same calendar date as when other evaluation and management services are provided to a patient by the same physician or physicians of the same specialty in a group practice.

5. Critical care services will not be paid on the same calendar date that the physician also reports a procedure code with a global surgical period, unless the critical care is billed with CPT modifier -25 to indicate that the critical care is a significant, separately identifiable, evaluation and management service that is above and beyond the usual pre and post operative care associated with the procedure that is performed.

   Services such as endotracheal intubation (CPT code 31500) and the insertion and placement of a flow directed catheter e.g., Swan-Ganz (CPT code 93503) are not bundled into the critical care codes. Therefore, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing the pre, intra, and post procedure work of these unbundled services, e.g., endotracheal intubation, should be excluded from the determination of the time spent providing critical care.

   This policy applies to any procedure with a 0, 10, or 90 day global period including cardiopulmonary resuscitation (CPR -- CPT code 92950). CPR has a global period of 0 days and is not bundled into critical care codes. Therefore, critical care maybe billed in addition to CPR if critical care was a significant, separately identifiable service and it was reported with modifier -25. The time spent performing CPR should be excluded from the determination of the time spent providing critical care. In this instance the physician who performs the resuscitation must bill for this service. Members of a code team cannot each bill Medicare Part B for this service.

   When a physician, other than the surgeon, provides postoperative critical care services (for procedures with a global surgical period); no modifier is required unless all surgical postoperative care has been officially transferred from the surgeon to the physician performing the critical care services. In this situation, both the surgeon and intensivist, who are submitting claim, must use CPT modifiers "-54" (surgical care only) and "-55"(postoperative management only). Critical care services must meet all the conditions previously described, and the medical record documentation of the surgeon and physician who assumes a transfer (e.g., intensivist's), must both support claims for services when CPT modifiers -54 and -55 are used indicating the transfer of care from the surgeon to the intensivist.

6. In addition to a global fee, critical care services provided during the preoperative portion and postoperative portions of the global period of procedures with 90 day global period in trauma and burn cases may be paid if the patient is critically ill and requires the full attention of the physician; and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed.

   Such patients may meet the definition of being critically ill and criteria for conditions where there is a high probability of imminent or life threatening deterioration in the patient's condition. Preoperatively, in order for these services to be paid, two reporting requirements must be met. Codes 99291 - 99292 and modifier -25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) must be used, and documentation identifying that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

   Postoperatively, in order for these services to be paid, two reporting requirements must also be met. Codes 99291 - 99292 and modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) must be used, and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted.

   An ICD-9-CM code in the range 800.0 through 959.9 (except 930.0 – 939.9), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

   Note: Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

7. Critical care CPT codes 99291 and 99292 include pre and post service work. Routine daily updates or reports to family members and or surrogates are considered part of this service.

   However, time involved with family members or other surrogate decision makers, whether to obtain a history or to discuss treatment options (as described in CPT), may be counted toward critical care time when these specific criteria are met:
   - The patient is unable or incompetent to participate in giving a history and/or making treatment decisions; and
   - The discussion is necessary for determining treatment decisions.

   For such family discussions, the physician should document:
   - The medically necessary treatment decisions for which the discussion was needed;
   - That the patient is unable or incompetent to participate in giving history and/or making treatment decisions;

- The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family"; and
- A summary in the medical record that supports this medical necessity.

Telephone calls to family members and or surrogate decision-makers may be counted towards critical care time, only if they meet the same criteria as described in the aforementioned paragraph. Further, no other family discussions (no matter how lengthy) may be additionally counted towards critical care.

8. A teaching physician, to bill for critical care services, must meet the requirements for critical care described above. For procedure codes determined on the basis of time, such as critical care, the teaching physician must be present for the entire period of time for which the claim is submitted. For example, payment will be made for 35 minutes of critical care services only if the teaching physician is present for the full 35 minutes. (See *Medicare Claims Processing Manual,* Chapter 12 (Physicians/Nonphysician Practitioners), Section 100.1.4 (Time-Based Codes).

   Time spent teaching may not be counted towards critical care time. Nor, can the teaching physician bill, as critical care or other time-based services, for time spent by the resident (in the teaching physician's absence). Only time that the teaching physician spends alone with the patient (and that he/she and the resident spend together with the patient), can be counted toward critical care time.

   A combination of the teaching physician's documentation and the resident's documentation may support critical care services. Provided that all requirements for critical care services are met, the teaching physician documentation may tie into the resident's documentation. The teaching physician may refer to the resident's documentation for specific patient history, physical findings and medical assessment.

   However, the teaching physician medical record documentation must provide substantive information including:
   - Time the teaching physician spent providing critical care;
   - That the patient was critically ill during the time the teaching physician saw the patient;
   - What made the patient critically ill; and
   - The nature of the treatment and management provided by the teaching physician.

   The medical review criteria are the same for the teaching physician as for all physicians. (See *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 100.1.1 (Evaluation and Management (E/M) Services) for teaching physician documentation guidance).

   The following is an example of acceptable teaching physician documentation:
   "Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."
   Conversely, the following is an example of unacceptable documentation from a teaching physician: *"I came and saw (the patient) and agree with (the resident)".*

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9. Medicare recognizes ventilator codes (CPT codes 94002 - 94004, 94660 and 94662) as physician services payable under the physician fee schedule. Medicare Part B under the physician fee schedule does not pay for ventilator management services in addition to an E/M service (e.g., critical care services, CPT codes 99291 - 99292) on the same day for the patient even when the E/M service is billed with CPT modifier -25.

Additional Information

You can find more information about critical care visits and neonatal intensive care (codes 99291 - 99292) by going to CR 5993, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1548CP.pdf** on the Centers for Medicare & Medicaid Services (CMS) Website. Updated *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.12. (Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292) is an attachment to that CR.

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.

MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 - LEGISLATIVE CHANGE TO INDEPENDENT LABORATORY BILLING FOR THE TECHNICAL COMPONENT (TC) OF PHYSICIAN PATHOLOGY SERVICES

~ CMS MLN Matters ~

MLN Matters Number: MM6042
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R1561CP

Related Change Request (CR) #: 6042
Effective Date: July 1, 2008
Implementation Date: August 25, 2008

Provider Types Affected

Independent laboratories billing Medicare Carriers or Medicare Administrative Contractors (MACs) for services rendered to hospitalized Medicare beneficiaries.

Impact on Providers

Qualifying independent laboratories may continue to bill Medicare directly for the TC of certain physician pathology services provided to patients as part of a covered hospital inpatient stay or outpatient hospital service, through December 31, 2009 regardless of the beneficiary's hospitalization status, in accordance with the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

CR6042 also instructs the carriers/MACs not to implement the business requirements of CR 5347 with respect to action for physician pathology services. (See MLN Matters article MM5347 at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5347.pdf** on the Centers for Medicare & Medicaid Services (CMS) Website. (CR5347 prevents payment by a carrier for a TC of a pathology service rendered during an inpatient stay or for the same date of service (DOS) as an outpatient service. CR 6042 negates that directive to carriers/MACs.))

Background

As a result of MIPPA, CR6042 instructs the carriers/MACs to notify the independent laboratories that those that qualify to bill under the Section 542 of the Benefits Improvement and Protection Act of 2000 (BIPA)/Section 732 of the Medicare Modernization Act (MMA)/ Section 104 of the Tax Relief and Health Care Act of 2006 (TRHCA)/ Section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) for the TC of the physician pathology services may continue to do so effective with DOS July 1, 2008 through December 31, 2009. This is an additional eighteen (18) months beyond the expiration date in the MMSEA.

Additional Information

To see the official instruction (CR6042) issued to your Medicare Carrier or A/B MAC visit **http://www.cms.hhs.gov/Transmittals/downloads/R1561CP.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.

PROTHROMBIN TIME (PT/INR) MONITORING FOR HOME ANTICOAGULATION MANAGEMENT

~ CMS MLN Matters ~

MLN Matters Number: MM6138 **Related Change Request (CR) #: 6138**
Related CR Release Date: July 25, 2008 **Effective Date: March 19, 2008**
Related CR Transmittal #: R1562CP and R90NCD **Implementation Date: August 25, 2008**

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 home PT and International Normalized Ratio (INR) anticoagulation management monitoring services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 6138, and alerts providers that effective for claims with dates of service on and after March 19, 2008 the Centers for Medicare & Medicaid Services (CMS) revised its National Coverage Determination (NCD) limits and will expand the population eligible for home coverage of PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin. See the *Key Points* section of this article for details.

Background

The prothrombin time (PT) test is an in-vitro test to assess coagulation. PT testing and its normalized correlate, the International Normalized Ratio (INR), are the standard measurements for therapeutic effectiveness of warfarin therapy. Warfarin, Coumadin®, and others, are self-administered, oral anticoagulant, or blood thinner, medications that affect a person's Vitamin K-dependent clotting factors.

Currently, Medicare's national coverage determination (NCD) at 190.11 of the NCD Manual limits coverage of home PT/INR monitoring to anticoagulation management for patients with mechanical heart valves who are on warfarin. The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) (See http://www.cms.hhs.gov/ClinicalLabFeeSched/downloads/410_32.pdf on the CMS Website) and the following requirements must be met:

1. The patient must have been anticoagulated for at least 3 months prior to use of the home INR device;
2. The patient must undergo an educational program on anticoagulation management and the use of the device prior to its use in the home; and
3. Self-testing with the device should not occur more frequently than once a week.

CMS received a formal, complete, written request for reconsideration to expand the population eligible for coverage of home PT/INR monitoring to patients on warfarin. CR6138 is a result of that request.

Key Points of CR 6138

Effective for claims with dates of service on and after March 19, 2008, CMS revised its NCD to provide for home coverage of PT/INR monitoring for chronic, oral anticoagulation management for patients with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive of deep venous thrombosis and pulmonary embolism) on warfarin.

The monitor and the home testing must be prescribed by a treating physician as provided at 42 CFR 410.32(a) and all of the following requirements must be met:

1. The patient must have been anticoagulated for at least 3 months prior to use of the home INR device; and,
2. The patient must undergo a face-to-face educational program on anticoagulation management and must have demonstrated the correct use of the device prior to its use in the home; and,
3. The patient continues to correctly use the device in the context of the management of the anticoagulation therapy following the initiation of home monitoring; and,
4. Self-testing with the device should not occur more frequently than once a week.

NOTE: Applicable HCPCS Codes G0248, G0249, and G0250 will continue to be used for claims processing purposes for PT/INR. With the July 2008 Outpatient Code Editor (OCE) and Medicare Physician Fee Schedule updates, the descriptors of these codes will change to reflect the revised coverage policy.

The following revised descriptors reflect the expanded NCD criteria and are effective for services on or after March 19, 2008 as follows:

- **Long Descriptor G0248:** Demonstration, prior to initial use, of home INR monitoring for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing prior to its use.
- **Short Descriptor G0248**: Demonstrate use home INR mon
- **Long Descriptor G0249:** Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or

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venous thromboembolism who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; not occurring more frequently than once a week

- **Short Descriptor G0249:** Provide INR test mater/equipm
- **Long Descriptor G0250**: Physician review, interpretation, and patient management of home INR testing for a patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes face-to-face verification by the physician that the patient uses the device in the context of the management of the anticoagulation therapy following initiation of the home INR monitoring; not occurring more frequently than once a week.
- **Short Descriptor G0250**: MD INR test revie inter mgmt

NOTE: Test materials continue to include 4 tests. Frequency of reporting requirements shall remain the same.

NOTE: Porcine valves are not included in this NCD, so Medicare will not make payment on Home INR Monitoring for patients with porcine valves unless covered by local Medicare contractors.

NOTE: This NCD is distinct from, and makes no changes to, the PT clinical laboratory NCD at section 190.17, of the NCD Manual.

The following are applicable diagnosis codes to be used when submitting claims to Medicare contractors:

- For services furnished on or after March 19, 2008, the applicable ICD-9-CM diagnosis codes for this benefit are:
  - V43.3 (organ or tissue replaced by other means; heart valve);
  - 289.81 (primary hypercoagulable state);
  - 451.0-451.9 (phlebitis & thrombophlebitis);
  - 453.0-453.3 (other venous embolism & thrombosis);
  - 415.11-415.19 (pulmonary embolism & infarction); or
  - 427.31 (atrial fibrillation (established) (paroxysmal))

Medicare contractors will deny claims for PT/INR monitoring services that are not delivered in accordance with CR6138. Denied claims are subject to appeal. When denying such claims, your Medicare carrier, FI or A/B MAC will use the following codes:

- Remittance Advice Remark Code 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** on the CMS Website. If you do not have Web access, you may contact the contractor to request a copy of the NCD."
- Claim Adjustment Reason Code 50 will be used: "These are non-covered services because this is not deemed a 'medical necessity' by the payer."

Providers should be aware that your Medicare Contractor will assign liability for the denied charges to you unless documentation of an Advance Beneficiary Notice (ABN) is present on the claim. Also, your contractor will not search for claims but will adjust inappropriately denied claims with dates of service March 19, 2008, through the implementation date of CR6138, that are brought to their attention.

Additional Information

CR6138 was issued in two transmittals, i.e., one for the NCD Manual and one for the Medicare Claims Processing Manual. These transmittals are available at http://www.cms.hhs.gov/Transmittals/downloads/R90NCD.pdf and http://www.cms.hhs.gov/Transmittals/downloads/R1562CP.pdf, respectively, on the CMS Website.

If you have questions, please contact your Medicare A/B MAC, FI, 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.

SCREENING DNA STOOL TEST FOR COLORECTAL CANCER

~ Revised CMS MLN Matters ~

MLN Matters Number: MM6145 Revised
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R93BP and R92NCD

Related Change Request (CR) #: 6145
Effective Date: April 28, 2008
Implementation Date: August 25, 2008

Note: This article was revised on August 11, 2008, to reflect changes made to CR6145. The transmittal number, release date, and Web address for accessing the NCD portion of CR6145 were revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6145 which announces the Centers for Medicare & Medicaid Services (CMS) decision regarding a request for reconsideration of the current national coverage determination (NCD) for colorectal cancer screening.

CAUTION – What You Need to Know

CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test; because the Food and Drug Administration (FDA) determines that this test requires pre-market review and approval. A subsequent request for reconsideration will be considered once FDA approval is obtained.

GO – What You Need to Do

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

Background

Congress specifically authorized coverage of certain screening tests under Part B of the Medicare program and made necessary conforming changes in order to ensure that payments are made. As a result, CMS currently covers colorectal cancer screening for

average-risk individuals ages 50 years and older using fecal occult blood testing, sigmoidoscopy, colonoscopy, and barium enema.

Neither the law nor regulations identify screening DNA stool tests as a possible coverage option under the colorectal cancer screening benefit. However, under the Code of Federal Regulations (42 CFR 410.37(a)(1)(v)) at **http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr410_02.html** and the Social Security Act (section 1861(pp)(1)(D)) **http://www.ssa.gov/OP_Home/ssact/title18/1861.htm** on the internet), CMS is allowed to use the NCD process to determine coverage of other types of colorectal cancer screening tests not specifically identified in the law or regulations as it determines to be appropriate, and in consultation with appropriate organizations.

Following a request for reconsideration of the current NCD at Section 210.3 of the Medicare NCD Manual for colorectal cancer screening, CMS will not expand the colorectal cancer screening benefit to include coverage of PreGen-Plus™, a commercially available screening DNA stool test, as an alternative to a screening colonoscopy or a screening flexible sigmoidoscopy.

The FDA determined that this test is a medical device that requires pre-market review and approval prior to marketing, which, to date, has not been obtained. In the absence of an FDA determination, CMS believes that there may be unresolved questions regarding the safety and effectiveness of the stool DNA test. Therefore, CMS does not believe that identification of stool DNA mutations is an appropriate colorectal cancer screening test at this time.

Additional Information

The official instruction, CR 6145, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change, is reflected in two transmittals, one for the Medicare Benefit Policy Manual and one for the National Coverage Determinations Manual. These two transmittals are at **http://www.cms.hhs.gov/Transmittals/downloads/R93BP.pdf** and **http://www.cms.hhs.gov/Transmittals/downloads/R92NCD.pdf**, respectively, on the CMS Website.

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

USUALLY SELF-ADMINISTERED DRUG LIST

The list of Usually Self-Administered Drugs (SAD) has been revised to include codes J3590 Pegvisomant and J3355 Urofollitropin.

To view the entire list, please go to the following Web address:
http://www.wpsmedicare.com/part_b/policy/sad_drugs.shtml

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Coverage – Policies

INFORMATION ON WEBSITE

WPS Medicare publishes Local Coverage Decision (LCDs), National Coverage Provisions (NCPs), and National Coverage Decisions (NCDs), as well as retired LCDs/Local Medical Review Policies (LMRPs) for Medicare Part B on its Website:
http://www.wpsmedicare.com/part_b/policy/index.shtml

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

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

Revised Policies for September 2008

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
Injection List	*Injection List*	NA	Click here to view	36
Podiatry Code List	*Podiatry Code List*	NA	NA	36

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Coverage – Revised Policies

Injection List

Effective: 10/15/08

Bevacizumab (Avastin™) should be billed with **J3590** when used for the treatment of "wet" macular degeneration (362.52).

Coding Guidelines:
When using the NOC code J3590 indicate the **name of the drug, the total dosage administered, and the method of administration** in the electronic narrative that is equivalent to item 19 of the CMS 1500 form. List the units of service as **one** in 2400/SV1-04 data element of the ANSI X12 4010A1 or in item 24G of the CMS 1500 form.

Podiatry Code List

Policy Name & Number	**Added Codes**
Podiatry Code List	*99238*

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Electronic Data Interchange (EDI)

HEALTH CARE CLAIM STATUS REQUEST AND RESPONSE (276/277)

Wisconsin Physicians Service (WPS) has added a 276/277(Health Care Claim Status Request and Response) request form to the EDI Forms Website:
http://www.wpsic.com/edi/tools.shtml

The 276 transaction is an electronic request for the current status of a claim within the adjudication process. This can be requested at the claim and/or line level.

The 277 transaction is an electronic response to the 276 request. This transaction is a Batch process and requires the requester to have access to the Bulletin Board System. To request a submitter ID, go to the following Web page:
https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do

The implementation guide for this transaction set (276/277) is located at the following Website:
http://www.wpc-edi.com

General Information

IMPLEMENTATION OF NEW PROVIDER AUTHENTICATION REQUIREMENTS FOR MEDICARE CONTRACTOR INTERACTIVE VOICE RESPONSE (IVR) SYSTEMS

~ Revised CMS MLN Matters ~

MLN Matters Number: MM6139 Revised
Related CR Release Date: August 8, 2008
Related CR Transmittal #: R22COM
Related Change Request (CR) #: 6139
Effective Date: March 1, 2009
Implementation Date: January 5, 2009

Note: This article was revised on August 13, 2008, to change the title to more accurately reflect the Change Request requirements. Additionally, changes were made to further clarify the authentication requirements. In particular, the note on page 2 was changed to show that you will only be allowed three attempts to correctly provide your NPI, PTAN, **AND** last 5-digits of your TIN.

Provider Types Affected

CR 6139 impacts all physicians, providers, and suppliers (or their staffs) who make inquiries to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs)). Inquiries include written inquiries or calls made to Medicare contractor provider contact centers, including calls to Interactive Voice Response (IVR) systems.

What You Need to Know

CR 6139, from which this article is taken, addresses the necessary provider authentication requirements to complete IVR transactions and calls with a Customer Service Representative (CSR).

Effective March 1, 2009, when you call either the IVR system, or a CSR, the Centers for Medicare & Medicaid Services (CMS) will require you to provide three data elements for authentication: 1) Your National Provider Identifier (NPI); 2) Your Provider Transaction Access Number (PTAN); and 3) The last 5-digits of your tax identification number (TIN).

Make sure that your staffs are aware of this requirement for provider authentication.

Background

In order to comply with the requirements of the Privacy Act of 1974 and of the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee-for-service provider contact centers must properly authenticate callers and writers before disclosing protected health information.

Because of issues with the public availability of previous authentication elements, CMS has addressed the current provider authentication process for providers who use the IVR system or call a CSR. To better safeguard providers' information before sharing information on claims status, beneficiary eligibility, and other provider related questions, CR 6139, from which this article is taken, announces that CMS has added the last 5-digits of the provider's

TIN as an additional element in the provider authentication process. Your Medicare contractor's system will verify that the NPI, PTAN, and last 5-digits of the TIN are correct and belong to you before providing the information you request.

Note: You will only be allowed three attempts to correctly provide your NPI, PTAN, and last 5-digits of your TIN.

As a result of CR 6139, the *Disclosure Desk Reference* for Provider Contact Centers, which contains the information Medicare contractors use to authenticate the identity of callers and writers, is updated in the *Medicare Contractor Beneficiary and Provider Communications Manual,* Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information) and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information) to reflect these changes.

New information in these manual chapters also addresses other authentication issues. This new information is summarized as follows:

- **Authentication of Providers with No NPI**
  Occasionally, providers will never be assigned an NPI (for example providers who are retired/terminated), or inquiries may be made about claims submitted by a provider who has since deceased.

  Most IVRs use the NPI crosswalk to authenticate the NPI and PTAN. The NPI is updated on a daily basis and does not maintain any history about deactivated NPIs or NPI/PTAN pairs. Therefore, if a provider enters an NPI or NPI/PTAN pair that is no longer recognized by the crosswalk, the IVRs may be unable to authenticate them; or if the claim was processed using a different NPI/PTAN pair that has since been deactivated, the IVR may not be able to find the claim and return claims status information.

  Since these types of inquiries are likely to result in additional CSR inquiries, before releasing information to the provider, CSRs will authenticate using at least two other data elements available in the provider's record, such as provider name, TIN, remittance address, and provider master address.

- **Beneficiary Authentication**
  Before disclosing beneficiary information (whether from either an IVR or CSR telephone inquiry), and regardless of the date of the call, four beneficiary data elements are required for authentication: 1) last name, 2) first name or initial, Health Insurance Claim Number (HICN), 3) and either date of birth (eligibility, next eligible date), and 4) Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim) **or** date of service (claim status, CMN/DIF (post-claim.)).

- **Written Inquiries**
  In general, three data elements (NPI, PTAN, and last 5-digits of the TIN) are required for authenticating providers' written inquiries. This includes inquiries received without letterhead (including hardcopy, fax, email, pre-formatted inquiry forms or inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs)),

  The exception to this requirement is written inquiries received on the provider's official letterhead (including emails with an attachment on letterhead). In this case, provider

authentication will be met if the provider's name and address are included in the letterhead and clearly establish their identity. Therefore, the provider's practice location and name on the letterhead must match the contractor's file for this provider. (However, your Medicare contractor may use discretion if the file does not exactly match the letterhead, but it is clear that the provider is one and the same.) In addition, the letterhead information on the letter or email needs to match either, the NPI, PTAN, or last 5-digits of the TIN. Providers will also include on the letterhead either the NPI, PTAN, or last 5-digits of the TIN. Medicare contractors will ask you for additional information, if necessary.

- **Overlapping Claims**
  When claims overlap (that is, multiple claims with the same or similar dates of service or billing periods), the contractor that the provider initially contacts will authenticate that provider by verifying his/her name, NPI, PTAN, last 5-digits of the TIN, beneficiary name, HICN, and date of service for post-claim information, or date of birth for pre-claim information.

Additional Information

You can find more information about the new provider authentication requirements for Medicare inquiries by going to CR 6139, located at http://www.cms.hhs.gov/Transmittals/downloads/R22COM.pdf on the CMS Website.

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

REVISIONS TO THE CHAPTER 14 OF THE MEDICARE PROGRAM INTEGRITY MANUAL

~ CMS MLN Matters ~

MLN Matters Number: MM6036
Related CR Release Date: July 25, 2008
Related CR Transmittal #: R263PI

Related Change Request (CR) #: 6036
Effective Date: May 23, 2008
Implementation Date: August 8, 2008

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs and DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is informational only and is based on Change Request (CR) 6036 which reminds providers that the Centers for Medicare & Medicaid Services (CMS) no longer issues, updates, or uses the Unique Physician Identification Number (UPIN) in claims processing. CR 6036 also provides information on how to access the National Plan and Provider Enumeration System (NPPES) and UPIN data.

Background

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. CMS published the National Provider Identifier (NPI) final rule, which established the NPI as this standard.

CR 6036 updates Medicare's Program Integrity Manual, Chapter 14, Sections 14.1 -14.4) by removing information related to the issuance and maintenance of UPINs and replacing this information with information about obtaining NPI and UPIN data. CR 6036 includes the updated Chapter 14 as an attachment.

Information about the NPI can be found on the National Provider Identifier Standard Web page at **http://www.cms.hhs.gov/NationalProvIdentStand/** on the CMS Website.

Since the UPIN Registry is no longer available, a copy of the UPIN file can be obtained by writing to:

CMS Public Use Files
7500 Security Boulevard, N1-15-03
Baltimore, MD 21244-1850

The following information is releasable for physicians and non-physician practitioners:

- Full name,
- Credentials (e.g., MD),
- UPIN,
- State,
- ZIP Code, and
- Specialty code.

Additional Information

The official instruction, CR 6036, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R263PI.pdf** on the CMS Website.

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

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 June 19, 2008 unless otherwise indicated after their name.

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

Michigan Sanctioned Providers

Name/Specialty/Address/Date of Birth
Michael Jay Andrews Nurse/Nurses Aide 257 Ionia Street #196 Mulliken, MI 48861 04-22-1965
Thomas Andre Endicott, D.D.S. Dentist 3500 N. Elm Rd., #579321 Jackson, MI 49201 08-28-1953

Name/Specialty/Address/Date of Birth
David Harold Harding, S.W. Social Worker 7505 11 Mile Road, NE Rockford, MI 49341 08-25-1960
Terrence Gene Hickman, Ph.D. Psychologist 8045 Crablake Rd. Presque Isle, WI 54557 03-22-1945

Minnesota Sanctioned Providers

Name/Specialty/Address/Date of Birth	Name/Specialty/Address/Date of Birth
David Demaret Chube, II, M.D. Family Practice Physician P O Box 1731, #08106-027 Waseca, MN 56093 08-28-1958	Shayne Norman Pound Health Care Aide 14070 Forest Drive Baxter, MN 56425 04-03-1972

Wisconsin Sanctioned Providers

Name/Specialty/Address/Date of Birth	Name/Specialty/Address/Date of Birth
Charles Randall Chube, M.D. Family Practice Physician P O Box 1000, #08107-027 Oxford, WI 53952 05-27-1962	Terrance Gene Hickman, Ph.D. Psychologist 8045 Crablake Rd. Presque Isle, WI 54557 03-22-1945

Wisconsin Reinstated Providers

Name/Specialty/Address/Date of Birth	Name/Specialty/Address/Date of Birth
Vicki S. DeBolt, D.O. Doctor of Osteopath 809 Gilead Lake Road Bronson, MI 49028 06-08-1966 **REINSTATED: 07-16-2008**	Mark H. Radandt, D.C. Chiropractor 710 N. 1060 E Lehi, UT 84043 09-19-1954 **REINSTATED: 05-05-2008**

Provider Education

EDUCATION SCHEDULE

Be sure to visit the WPS Medicare Education Schedule at http://www.wpsmedicare.com/part_b/education/education_schedule.shtml to learn more about the educational events we have scheduled for the upcoming months.

Coming up, we will host events such as:
- Basic Principles of Medicare seminar
- Save Dollars, Avoid Denials seminar
- Ask-the-Contractor Teleconference (ACT)

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

HARD COPY COMMUNIQUÉ SUBSCRIPTION

WPS will offer *Communiqué* subscriptions in hard copy format for Fiscal Year 2009 (which runs from October 2008 through September 2009) **for those providers without Internet access**. The cost for the subscription to the Fiscal Year 2009 hard copy *Communiqué* is $60.00. You will receive your hardcopies at the end of each quarter (December 2008, March 2009, June 2009, and September 2009).

WPS Medicare would like to take this opportunity to remind you that you can avoid additional costs by finding all the information in the hard copy newsletter free on our Website: http://www.wpsmedicare.com/part_b/publications/newsletter.shtml

If you would like to receive the *Communiqué* newsletter in hard copy format, please complete and return the following order form along with your check to "WPS Medicare."

Provider Name: ____
Attn: ____
Address: ____ PO Box/Suite: ___________
City: _______________________________________ State: _____ Zip: ______________
Telephone: ______________________________

Orders must be pre-paid and check made payable to **WPS Medicare**.
Send check or money order to:

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Medicare Publications
P.O. Box 8190
Madison, WI 53708

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

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http://www.wpsmedicare.com/listserv

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