

# Communiqué

# Part B

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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**Items of Importance****ANNOUNCING PART A MAC ENEWS MESSAGES**

WPS Medicare is pleased to announce the creation of a J5 MAC Part A (IA, KS, MO, NE) General Medicare Messages list. Effective September 8, 2009, Part A MAC information will only be sent out via the new list and the current list will only contain Part B MAC information. To sign up for the new eNews messages, visit us at <http://www.wpsmedicare.com/listserv>

You will continue to receive Part A information on the J5 MAC Part B (IA, KS, MO, NE) General Medicare Messages list until September 8, after which that eNews list will be dedicated to MAC Part B information only.

**CODING FOR BLOOD COLLECTION FROM AN ESTABLISHED ARTERIAL CATHETER**

Wisconsin Physician Services (WPS) has been asked about the proper coding and billing for the service of drawing blood from an arterial catheter. The *2009 CPT Code Book* states (page 175, Professional Edition) "for blood collection from an established arterial catheter, use 37799." This CPT code is defined as "Unlisted procedure, vascular surgery." All "unlisted procedure" codes are manually reviewed and evaluated by Medicare contractors.

One could strongly argue that this blood draw service is analogous to CPT 36591 (collection of blood specimen from a completely implantable venous access device) or CPT 36592 (collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified). In fact, the above instructions "for blood collection from an established arterial catheter, use 37799" is found directly under CPT 36592 in the *2009 CPT Code Book*.

However, both CPT 36591 and 36592 are listed by the Centers for Medicare & Medicaid Services (CMS) in the 2009 Medicare Physician Fee Schedule Database as "T" status. By CMS national requirements, "T" status codes are "only paid when there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made."

There is no "incident to" billing allowed by national Medicare regulations in a hospital setting. Thus, the only allowable place of service would be in an office. However, there are very few arterial lines used in a true outpatient setting.

In summary, CPT 37799 for the purpose of blood collection from an established arterial catheter cannot be paid in an inpatient setting (e.g. POS 21). Similarly an outpatient hospital setting (POS 22), or emergency room-hospital (POS 23) would also not be appropriate for billing this service since the arterial catheter blood drawing in these three locations would be performed by ancillary staff, and not the physician. If CPT 37799 were billed for this purpose, it will be denied as "not a payable service in this POS."

If this service were done in a physician's office (POS 11) and NO OTHER SERVICES PAYABLE UNDER THE PHYSICIAN FEE SCHEDULE BILLED ON THE SAME DATE BY THE

SAME PROVIDER were billed, THEN it could be paid similar to a “T” status CPT code. However, this would be a very rare service.

Stephen D. Boren MD  
Medical Director Medicare B Illinois, Michigan, Minnesota

## **HAVE YOU COMPLETED THE WEBSITE SATISFACTION SURVEY LATELY?**

Your feedback is extremely important to the provider community, WPS Medicare, and the Centers for Medicare & Medicaid Services (CMS). The survey that pops up while you are on our Website is the Website Customer Satisfaction Survey.

This quick survey, sponsored by CMS and conducted by ForeSee, gauges your satisfaction with the WPS Medicare Website. WPS and CMS review the results of the survey regularly, and your feedback directly influences the layout, look and feel, content, and other aspects of the WPS Medicare Website. We encourage you to complete the survey, and appreciate your valuable time.

For more information on the survey, please visit us at:  
[http://www.wpsmedicare.com/sat\\_survey.pdf](http://www.wpsmedicare.com/sat_survey.pdf)

**MAC Providers Only (MO, NE, IA, KS)****CONTRACTOR NUMBER CHANGE FOR J5 PART B EASTERN MISSOURI**

As of 8/1/09, all Jurisdiction 5 (J5) states have been merged into one Part B Multi-Carrier System (MCS) processing system. Please note that the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database (MCD) will reflect both Western Missouri and Eastern Missouri as "MO - Entire State" using the contractor number 05302 (previously just used for Western Missouri). The Eastern Missouri contractor number 05392 will no longer be active.

Beginning 8/1/2009, the CMS MCD will no longer have policies listed by the contractor number 05392. All currently active policies will be searchable by the newly titled "MO - Entire State" 05302 contractor number. To access Eastern Missouri policies for dates of service prior to 8/1/09, please use the CMS MCD SEARCH function. These policies will no longer be accessible via the indexes; they will be available via the SEARCH function only. For more information about the Part B merge of the Eastern Missouri and Iowa MCS systems into the existing Kansas, Nebraska, and Western Missouri MCS system, visit the System Merge Updates page at <http://www.wpsmedicare.com/j5macpartb/publications/news/archived/systemmergeupdate.shtml>

**CUSTOMER SERVICE AFTER-CALL SURVEY**

Have you ever had a Customer Service experience that you wanted to share with us? Did your Customer Service Representative provide you with excellent service that you wanted us to know about? Is there something we could have done differently to make your experience better?

Beginning in September, you will have the chance to provide us with feedback about your Customer Service experience. Starting September 1, many callers to our provider contact center will be presented with the opportunity to complete an automated survey following the call. If your call has been selected for the survey, you will hear a message instructing you to stay on the line after your call if you wish to participate.

This survey is voluntary and will take about five minutes to complete. We encourage you to take advantage of this opportunity whenever it is presented to you. The feedback you provide is valuable to us, and will be evaluated and used to create the best Customer Service experience possible.

**MEDICARE SUMMARY NOTICE (MSN) CROSSWALK**

WPS Medicare is integrating Medicare remark message codes from the Iowa and Eastern Missouri claims processing environment into the new J5 environment in preparation of the August 1, 2009, merge.

The mappings between systems are also referred to as crosswalks, since they provide important information linking codes of one system with codes in the other system. However, with this message integration we have reached the maximum number of Multi-Carrier System (MCS) messages allowed. Remark messages with limited or minimal usage will crosswalk to a generic message for claims finalized prior to August 1, 2009.

***Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)***

Providers requesting duplicate remittance notices may be affected. We anticipate minimal impact, if any, impact to our J5 Providers on these messages due to the limited use of these codes.

**Claim Submission**

**2009 DURABLE MEDICAL EQUIPMENT PROSTHETICS,  
ORTHOTICS, AND SUPPLY (DMEPOS) HEALTHCARE COMMON  
PROCEDURE CODING SYSTEM (HCPCS) CODES JURISDICTION  
LIST  
~CMS MLN Matters~**

MLN Matters® Number: MM6522  
Related CR Release Date: July 10, 2009  
Related CR Transmittal #: R1765CP

Related Change Request (CR) #: 6522  
Effective Date: August 10, 2009  
Implementation Date: August 10, 2009

**Provider Types Affected**

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

**Impact on Providers**

This article is informational and is based on Change Request (CR) 6522 that notifies providers that the spreadsheet containing an updated list of the HCPCS codes for DME MAC, Part B carrier, or A/B MAC jurisdictions is updated annually to reflect codes that have been added or discontinued (deleted) each year. The spreadsheet is helpful to billing staff by showing the appropriate Medicare contractor to be billed for HCPCS appearing on the spreadsheet. The spreadsheet for the 2009 Jurisdiction List is an Excel® spreadsheet and is available at <http://www.cms.hhs.gov/center/dme.asp> on the Centers for Medicare & Medicaid Services (CMS) Website.

**Additional Information**

To see the official instruction (CR6522) issued to your Medicare DME MAC, carrier, or A/B MAC, visit <http://www.cms.hhs.gov/Transmittals/downloads/R1765CP.pdf> on the CMS Website. The 2009 Jurisdiction List is attached to CR 6522.

If you have questions, please contact your Medicare DME MAC, 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.

## APPROPRIATE USE OF MODIFIER 50 AND ADD-ON CURRENT PROCEDURAL TERMINOLOGY CODES (CPT) FOR FACET JOINT INJECTION SERVICES

~CMS MLN Matters~

MLN Matters ® Number: MM6518 **Revised**

Related CR Release Date: July 31, 2009

Related CR Transmittal #: R526OTN

Related Change Request (CR) #: 6518

Effective Date: August 31, 2009

Implementation Date: August 31, 2009

**Note: This article was revised on August 10, 2009, to reflect a revision made to CR6518. The transmittal number (see above) and the Web address for accessing CR6518 have been changed. All other information remains the same.**

### Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FI) and Medicare Administrative Contractors (MAC)) for facet joint injections performed on Medicare beneficiaries.

### Provider Action Needed

This article clarifies the appropriate use of modifier 50 and add-on codes for facet joint injection services. Physicians who perform facet joint injections on **both the right and left sides of one level of the spine must use modifier 50** with the appropriate CPT codes when submitting claims. Physicians who perform facet joint injections **on multiple levels on the same side of the spine must use the CPT add-on codes** to represent these additional levels injected, **instead of using modifier 50**. Physicians should ensure that billing staffs are aware of this clarification.

### Background

Facet joints are joints in the spine that aid stability and allow the spine to bend and twist. Facet joint injections are a type of interventional pain management technique used to diagnose or treat back pain. The CPT codes used for facet joint injections are:

**Table: Facet Joint Injection CPT Codes and Descriptions**

CPT Code	Description
64470	Injection; anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical/thoracic; single level
64472 (add-on)	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; cervical/thoracic; each additional level
64475	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar/sacral; single level
64476 (add-on)	Injection; anesthetic agent and/or steroid; paravertebral facet joint or facet joint nerve; lumbar/sacral; each additional level

The primary codes, 64470 and 64475, are used for a **single** injection in the cervical/thoracic or lumbar/sacral area of the spine, respectively. Each primary code has an associated **add-on code for use when injections are provided at multiple spinal levels**. The add-on codes are 64472 (cervical/thoracic) and 64476 (lumbar/sacral).

Bilateral injections are performed on the right and left sides of one joint level. The Centers for Medicare & Medicaid Services (CMS) requires physicians **to indicate a bilateral injection by using billing modifier 50 and the appropriate CPT code**. If a physician performs multiple bilateral injections, modifier 50 should accompany each facet joint injection CPT code.

The Office of the Inspector General (OIG) recently conducted a medical record review of facet joint injection services performed in 2006 and released a final report, entitled, "Medicare Payments for Facet Joint Injection Services," OEI-05-07-00200. **The OIG found that physicians incorrectly billed additional add-on codes to represent bilateral facet joint injections instead of using modifier 50.** This report is viewable at <http://www.oig.hhs.gov/oei/reports/oei-05-07-00200.pdf> on the Internet.

To summarize, when facet joint injections are performed on both the right and left sides of a level of the spine, physicians must use modifier 50 and the appropriate primary CPT code. When facet joint injections are performed at more than one level, physicians must use add-on codes 64472 or 64476 to represent additional levels of the spine injected.

#### Additional Information

If you have questions, please contact your Medicare carrier, FI and/or 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 official instruction issued to your Medicare carrier, FI and/or MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R526OTN.pdf> on the CMS Website.

## FRACTIONAL MILEAGE AMOUNTS SUBMITTED ON AMBULANCE CLAIMS

~CMS MLN Matters~

MLN Matters ® Number: MM6543  
Related CR Release Date: July 31, 2009  
Related CR Transmittal #: R1787CP

Related Change Request (CR) #: 6543  
Effective Date: January 1, 2010  
Implementation Date: January 4, 2010

#### Provider Types Affected

This article is for ambulance suppliers submitting claims to Medicare contractors (carriers and Medicare Administrative Contractors (MAC)) for ambulance services on a CMS-1500 paper claim or ANSI X 12N 837P electronic claim. Hospital-based ambulance services are not affected.

#### Provider Action Needed

This article, based on CR 6543, describes changes to the billing instructions for fractional mileage units. Beginning with dates of services on or after January 1, 2010, ambulance suppliers must report mileage as fractional units for trips totaling up to, but not including, 100 covered miles. Be sure to make billing staff aware of these changes.

**Background**

Currently, ambulance suppliers must round the total mileage up to the nearest whole mile for trips totaling a fractional number of miles or less than one whole mile. For example, if a the total number of round trip miles traveled equals 9.5 miles, the supplier must enter 10 units in Item 24G of the CMS-1500 paper form or the corresponding loop and segment of the ANSI X12N 837P electronic claim.

Medicare fee-for-service systems have been upgraded to process mileage HCPCS codes to a tenth of a mile.

Effective for claims with dates of service on and after January 1, 2010, ambulance suppliers must report fractional mileage units rounded to the nearest tenth of a mile for all claims for mileage totaling up to, but not including, 100 covered miles. Suppliers must submit fractional mileage using a decimal in the appropriate place (e.g., 99.9). For trips totaling 100 covered miles and greater, suppliers should continue to report mileage rounded to the nearest whole number mile (e.g., 999).

For mileage totaling less than 1 mile, suppliers must include a “0” prior to the decimal point (e.g., 0.9). **If you do not supply the mileage on your claim, Medicare will automatically use “0.1” unit as the default.**

The Medicare Claims Processing Manual, Chapters 15 and 26, are revised by CR 6543 to reflect these changes.

**Note:** CR 6543 applies only to ambulances services billed on a CMS-1500 paper claim or ANSI X12N 837P electronic claim and does not apply to hospital-based ambulance services. Mileage is reported in Item 24G of the CMS-1500 claim form or the corresponding loop and segment of the ANSI X12N 837P.

**Additional Information**

Ambulance suppliers might find the Ambulance Fee Schedule Fact Sheet to be helpful. This product is available at [http://www.cms.hhs.gov/MLNProducts/downloads/AmbulanceFeeSched\\_508.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/AmbulanceFeeSched_508.pdf) on the CMS Website.

The official instruction, CR 6543, issued to your Medicare carrier and/or MAC regarding this change, may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1787CP.pdf> on the CMS Website. If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the Centers for Medicare & Medicaid Services (CMS) Website.

**MANUAL UPDATE TO INCLUDE BILLING INSTRUCTIONS FOR  
PROFESSIONAL COMPONENT (PC) AND TECHNICAL COMPONENT  
(TC) IN REGARDS TO ONE LINE GLOBAL BILLING FOR  
PATHOLOGY SERVICES  
~CMS MLN Matters~**

MLN Matters® Number: MM6457  
Related CR Release Date: May 22, 2009  
Related CR Transmittal #: R1744CP

Related Change Request (CR) #: 6457  
Effective Date: August 24, 2009  
Implementation Date: August 24, 2009

This article has been rescinded as the Centers for Medicare & Medicaid Services has rescinded CR 6457.

**MEDICARE CLAIMS PROCESSING MANUAL CLARIFICATIONS FOR  
SKILLED NURSING FACILITY (SNF) AND THERAPY BILLING  
~CMS MLN Matters~**

MLN Matters® Number: MM6407 **Revised**  
Related CR Release Date: May 8, 2009  
Related CR Transmittal #: R1733CP

Related Change Request (CR) #: 6407  
Effective Date: October 1, 2006  
Implementation Date: April 27, 2009

**Note: This article was revised on August 14, 2009, to clarify the CPT codes that physicians (95992) and therapists (97112) are to use for canalith repositioning as noted in CR 6397. All other information is the same.**

**Provider Types Affected**

Skilled Nursing Facilities and other providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries

**Provider Action Needed**

This article is based on Change Request (CR) 6407, which includes clarifications to the *Medicare Claims Processing Manual* for Skilled Nursing Facility (SNF) and therapy billing. Be sure billing staff are aware of the clarifications.

**Background**

Change Request (CR) 6407 provides clarifications and updates to the Medicare Claims Processing Manual, Chapter 5 (Part B Outpatient Rehabilitation Billing), Section 20 (HCPCS Coding Requirements). These clarifications indicate that effective January 1, 2009, the new Current Procedural Terminology (CPT) code 95992 (*Canalith repositioning procedure(s) (eg Epley maneuver, Semont maneuver), per Day*) is bundled under the Medicare Physician Fee Schedule (MPFS).

Regardless of whether CPT code 95992 is billed alone or in conjunction with another therapy code, **separate Medicare payment is never made for this code**. If billed alone, this code will be denied. On remittance advice notices for claims so denied, Medicare contractors will use group code CO and claim adjustment reason code 97 ("Payment is

included in the allowance for another service/procedure.”). Alternatively, reason code B15, which has the same intent, may also be used by your Medicare contractor.

Please note that physicians should use CPT code 95992 for canalith repositioning and therapists must use CPT code 97112 for canalith repositioning, as indicated in Transmittal # 1691, Change Request 6397. The MLN Matters® article related to that transmittal is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6397.pdf> on the CMS Website.

In addition, CR 6407 provides clarifications and updates to the Medicare Claims Processing Manual (Pub 100-04), Chapter 6 (Skilled Nursing Facility (SNF) Inpatient Part A Billing), Section 40 (Special Inpatient Billing Instructions) to indicate that **both full and partial benefits exhaust claims must be submitted by SNFs monthly**. For benefits exhaust bills, an SNF must submit a benefits exhaust bill monthly for those patients who continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insurer, or private payer. There are two types of benefits exhaust claims:

- 1) Full benefits exhaust claims: no benefit days remain in the beneficiary’s applicable benefit period for the submitted statement covers from/through date of the claim; and
- 2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary’s applicable benefit period, remain for the submitted statement covers from/through date of the claim.

Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary’s applicable benefit period. Furthermore, when a change in level of care occurs after exhaustion of a beneficiary’s covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

**Note:** Part B 22x (SNF inpatient part B) bill types **must be submitted after** the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech-language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (SNF inpatient part B) bill type.

**Note:** Unlike with benefits exhaust claims, Part B 22x bill types **may be submitted prior** to the submission of bill type 210 (SNF no-payment **bill type**).

**Additional Information**

The official instruction (CR 6407) issued to your FI and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R1733CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

If you have any questions, please contact your 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.

**QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI)  
EDITS, VERSION 15.3, EFFECTIVE OCTOBER 1, 2009**  
~CMS MLN Matters~

**MLN Matters ® Number: MM6587**  
**Related CR Release Date: July 31, 2009**  
**Related CR Transmittal #: R1785CP**

**Related Change Request (CR) #: 6587**  
**Effective Date: October 1, 2009**  
**Implementation Date: October 5, 2009**

**Provider Types Affected**

Physicians submitting claims to Medicare Carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

**Provider Action Needed**

This article is based on Change Request (CR) 6587, which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in July 2009.

**Background**

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

The coding policies developed are based on coding conventions defined in the:

- American Medical Association's (AMA's) *Current Procedural Terminology (CPT) Manual*;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practice; and by
- Review of current coding practice.

The latest package of CCI edits, Version 15.3, is effective October 1, 2009, and includes all previous versions and updates from January 1, 1996, to the present.

**Additional Information**

Additional information about CCI, including the current CCI and MEC edits, is available at <http://www.cms.hhs.gov/NationalCorrectCodInitEd> on the CMS Website.

The CCI and MEC file formats are defined in the *Medicare Claims Processing Manual*, Chapter 23, Section 20.9, which can be found at

<http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Website. The official instruction (CR 6587) issued to your carrier and A/B MAC, RHHI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1785CP.pdf> on the CMS Website.

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

## THE USE OF THE CR MODIFIER AND THE DR CONDITION CODE ON DISASTER/EMERGENCY-RELATED CLAIMS

~CMS MLN Matters~

MLN Matters ® Number: MM6451  
Related CR Release Date: July 31, 2009  
Related CR Transmittal #: R1784CP

Related Change Request (CR) #: 6451  
Effective Date: August 31, 2009  
Implementation Date: August 31, 2009

### Provider Types Affected

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

### Provider Action Needed

This article is based on CR 6451, which updates and amends claims processing requirements for the use of condition codes and modifiers on Medicare fee-for-service claims when the furnishing of an item or service to a Medicare beneficiary was affected by a disaster or other general public emergency. CR 6451 also establishes a new chapter in the Medicare Claims Processing Manual dedicated to standing policies and procedures applicable to disasters and other public emergencies. Please make sure your billing staff is familiar with these changes, especially if they submit claims affected by emergencies to Medicare.

### Background

As part of its response to the 2005 *Katrina* hurricane emergency, the Centers for Medicare & Medicaid Services (CMS) developed the “DR” condition code and the “CR” modifier to facilitate the processing of claims affected by that emergency. The DR condition code and CR modifier were also authorized for use on claims for items and services affected by subsequent emergencies. Based on that experience, the Medicare fee-for-service program is refining the uses of both the code and the modifier to ensure that program operations are sufficiently flexible to accommodate the emergency health care needs of beneficiaries and the delivery of health care items and services by health care providers/suppliers in emergency situations without adding undue administrative burden associated with claim submission. The use of the “CR” modifier and “DR” condition code indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all of the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.

**Key Points of CR 6451**

**The DR Condition Code:** The title of the DR condition code is “disaster related” and its definition requires it to be “used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.” The DR condition code is used only for institutional billing, i.e., claims submitted by providers on an institutional paper claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I. In previous emergencies, use of the DR condition code was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier’s discretion. Effective August 31, 2009, use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned directly or indirectly on the presence of a “formal waiver.”

**The CR Modifier:** Both the short and long descriptors of the CR modifier are “catastrophe/disaster related.” The CR modifier is used in relation to Part B items and services for both institutional and non-institutional billing. Non-institutional billing, i.e., claims submitted by “physicians and other suppliers”, are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or – for pharmacies – in the NCPDP format. In previous emergencies, use of the CR modifier was entirely discretionary with the billing provider or supplier. It no longer may be used at the provider or supplier’s discretion. Effective August 31, 2009, use of the CR modifier will be mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned directly or indirectly on the presence of a “formal waiver.”

**Formal Waivers:** A “formal waiver” is a waiver of a program requirement that otherwise would apply by statute or regulation. There are two types of formal waivers. One type is a waiver of a requirement specified in Section 1135(b) of the Social Security Act (Act). Although Medicare payment rules themselves are not “waivable” under this statutory provision, the waiver of a Section 1135(b) requirement may permit Medicare payment in a circumstance where such payment would otherwise be barred. The second type of formal waiver is a waiver based on a provision of Title XVIII of the Act or its implementing regulations. The most commonly employed waiver in this latter category is the waiver of the “3-day qualifying hospital stay” requirement that is a precondition for Medicare payment for skilled nursing facility services. This requirement may be waived under Section 1812(f) of the Social Security Act.

**Further Instructions in the Event of a Disaster or Emergency:** In the event of a disaster or emergency, CMS will issue specific guidance to Medicare contractors that will contain a summary of the Secretary’s declaration (if any); specify the geographic areas affected by any declarations of a disaster or emergency; specify what formal waivers and/or informal waivers, if any, have been authorized; specify the beginning and end dates that apply to the use of the DR condition code and/or the CR modifier; and specify what other uses of the condition code and/or modifier, if any, will be mandatory for the particular disaster/emergency.

**Additional Information**

The official instruction, CR 6451, issued to your carrier, FI, and/or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1784CP.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.

**Coverage – General****FDG PET FOR SOLID TUMORS AND MYELOMA AND ADDITIONAL  
MANUAL UPDATES – RESCINDED**

The Centers for Medicare & Medicaid Services (CMS) has rescinded and will not be replacing Change Request (CR) 6464, *FDG PET For Solid Tumors And Myeloma And Additional Manual Updates*.

**PHYSICAL MEDICINE AND REHABILITATION LOCAL COVERAGE  
DETERMINATION (LCD)**

Because of technical problems, LCD PHYSMED 009 (Physical Medicine and Rehabilitation) is being temporarily withdrawn from publication. It will be published at a later date.

**TELEHEALTH SERVICES IN INDIAN HEALTH SERVICE (IHS) OR  
TRIBAL PROVIDERS  
~CMS MLN Matters~**

**MLN Matters ® Number: MM6493**  
**Related CR Release Date: July 24, 2009**  
**Related CR Transmittal #: R1776CP**

**Related Change Request (CR) #: 6493**  
**Effective Date: January 1, 2009**  
**Implementation Date: January 4, 2010**

**Provider Types Affected**

Indian Health Service (IHS) and tribal providers who bill Medicare carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors (A/B MAC) for providing telehealth services to Medicare Beneficiaries.

**What You Need to Know**

CR 6493, from which this article is taken, expands the instructions for telehealth services (effective January 1, 2009) to include Indian Health Service (IHS) and tribal providers as eligible to receive the telehealth originating site facility fee. The CR also clarifies the payment basis to the distant site physician or practitioner. You should make sure that your billing staffs are aware of this new information.

**Background**

CR 6493, from which this article is taken, announces that the Centers for Medicare & Medicaid Services (CMS) is expanding the instructions for telehealth services to include Indian Health Service (IHS) and tribal providers.

Effective January 1, 2009, IHS and tribal providers are included in the telehealth service policies (presented below) and eligible to receive:

- The originating site facility fee (generated from an originating site facility service in which the beneficiary is presented to the distant site practitioner); and
- 2) The payment to the distant site physician or practitioner (usually a professional consultation).

**Telehealth Policies**

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended Section 1834 of the Social Security Act (the Act) to provide for an expansion of Medicare payment for telehealth services. With this amendment, effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous “store and forward” technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. In addition, BIPA does not require that a practitioner present the patient for interactive telehealth services.

**Originating Site Facility and Distant Site Practitioner Services**

The originating site facility fee is equal to \$23.72 for the period January 1, 2009 through December 31, 2009. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased as of the first day of the year by the percentage increase in the Medicare Economic Index (MEI). For CY 2009, the payment amount is 80 percent of the lesser of the actual charge or \$23.72. (No clinic visit is to be billed if this is the only service received.)

The following facility types are authorized by law to be eligible for payment of the telehealth originating site facility fee when a beneficiary is presented to a distant site practitioner:

- The office of a physician or practitioner;
- A hospital (inpatient or outpatient);
- A critical access hospital (CAH);
- A rural health clinic (RHC); and
- A federally qualified health center (FQHC).

*NOTE: Except for the Federal telemedicine demonstration in Alaska and Hawaii, eligibility of originating sites is limited to rural health professional shortage areas (HPSAs) and counties not classified as a metropolitan statistical area (MSA).*

IHS/Tribal facilities should submit claims for the originating site facility fee on Types of Bills (TOB) 12x, 13x, 71x, 73x, or 85x, using HCPCS code Q3014 and revenue code 0780.

Distant site practitioners include only physicians and selected medical practitioners, specifically physician assistants (PA), nurse practitioners (NP), clinical nurse specialists (CNS), certified nurse-midwives, clinical social workers (CSW), clinical psychologists (CP), or registered dietician or nutrition professionals.

Distant site practitioners services are payable as if they were provided face-to-face, using the Medicare Physician Fee Schedule (MPFS); and are based on 80% of the Medicare Physician Fee Schedule (MPFS) payment amount for a physician, and the

appropriate step down percentages for other practitioners. The usual Part B coinsurance and deductible apply, but are waived for IHS/Tribal facilities.

Billing providers should use the following Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes on claims for distant site practitioner services:

- Consultations (CPT codes 99241 - 99255)
- Office or other outpatient visits (CPT codes 99201 - 99215);
- Individual psychotherapy (CPT codes 90804 - 90809);
- Pharmacologic management (CPT code 90862);
- Psychiatric diagnostic interview examination (CPT code 90801);
- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803);
- Neurobehavioral status exam (CPT code 96116); and
- Follow-up inpatient telehealth consultations (HCPCS codes G0406, G0407, and G0408).

You must include either the GT modifier (for interactive telecommunications) on your claims, or the GQ modifier (for the store and forward communication) if used in the Federal Telemedicine Demonstration in Alaska or Hawaii.

#### **Additional Information**

Your Medicare contractor will not search their files to find and adjust claims with dates of service on or after January 1, 2009 that were processed prior to the January 4, 2010 implementation date of CR 6493. However, they will adjust such claims that you bring to their attention.

You can find more information about the provision of telehealth services by IHS or tribal providers by going to CR 6493, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1776CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Claims Processing Manual*, Chapter 19 (Indian Health Services), Sections 100.16 (Payment for Telehealth Services to Indian Health Service/Tribal Facilities and Practitioners), 100.16.1 (*FI--Payment for Telehealth Services to Indian Health Service/Tribal Facilities and Practitioners*), 100.16.2 (*FI – Telehealth Originating Site Facility Fee – Medicare Part B – Payment Policy*) and (*FI – Telehealth Originating Site Facility Fee – Medicare Part B – Claims Processing*) as an attachment to that CR.

You might also want to review *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Section 190 (Medicare Payment for Telehealth Services); and *Medicare Benefit Policy Manual* Chapter 15 (Covered Medical and Other Health Services), Section 270 (Telehealth Services) for more information on telehealth services. This manual is available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Website.

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

## USUALLY SELF-ADMINISTERED DRUG LIST

The list of Usually Self-Administered Drugs (SAD) has been updated in the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database (MCD) as of September 1, 2009 at <http://www.cms.hhs.gov/mcd/overview.asp>. The list is also available on our Website. To view the entire list, please visit the appropriate Web page for your Medicare contract:

Legacy (IL, MI, MN, WI): [http://www.wpsmedicare.com/part\\_b/policy/sad\\_drugs.shtml](http://www.wpsmedicare.com/part_b/policy/sad_drugs.shtml)  
J5 MAC (IA, KS, MO, NE): [http://www.wpsmedicare.com/j5macpartb/policy/usad\\_listing/](http://www.wpsmedicare.com/j5macpartb/policy/usad_listing/)

## WRONG SURGICAL OR OTHER INVASIVE PROCEDURE PERFORMED ON A PATIENT; SURGERY OR OTHER INVASIVE PROCEDURE PERFORMED ON THE WRONG BODY PART; AND SURGICAL OR OTHER INVASIVE PROCEDURE PERFORMED ON THE WRONG PATIENT

~CMS MLN Matters~

MLN Matters Number: MM6405 Revised  
Related CR Release Date: July 24, 2009  
Related CR Transmittal #: R1778CP and R102NCD

Related Change Request (CR) #: 6405  
Effective Date: January 15, 2009  
Implementation Date: July 6, 2009, for  
those billing carriers and Part B  
MACs; October 5, 2009, for FIs and  
Part A MACs

**Note:** This article was revised on July 27, 2009, to reflect a revised CR6405, which the Centers for Medicare & Medicaid Services issued on July 2, 2009. The third bullet point at the top of page 5 of this article has been added to reflect a similar addition to CR 6405. The CR release date and transmittal numbers (see above) were revised. The Web addresses for accessing the CR6405 transmittals are also changed in this article. All other information remains the same.

### Provider Types Affected

Physicians, other practitioners, and providers billing Medicare contractors (carriers, fiscal intermediaries (FIs) or Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

### Provider Action Needed

#### STOP – Impact to You

Effective January 15, 2009, the Centers for Medicare & Medicaid Services (CMS) does not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient.

Medicare will also not cover hospitalizations and other services related to these non-covered procedures as defined in the Medicare Benefit Policy Manual (BPM) Chapter 1, sections 10 and 180 and Chapter 16, section 120. This is pursuant to the National Coverage Determinations (NCDs) made as part of CR 6405.

**CAUTION – What You Need to Know**

For inpatient claims, hospitals are required to bill two claims when the erroneous surgery related to the NCD is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services/procedures as a no-pay claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS modifiers to all lines related to the erroneous surgery/procedure.

**GO – What You Need to Do**

Make sure that your billing staff are aware of these new billing and claim requirements.

**Background**

In 2002, the National Quality Forum (NQF) published *Serious Reportable Events in Healthcare: A Consensus Report*, which listed 27 adverse events that were “serious, largely preventable and of concern to both the public and health care providers.” (That report is available at

[http://www.qualityforum.org/Publications/2002/Serious\\_Reportable\\_Events\\_in\\_Health\\_care.aspx](http://www.qualityforum.org/Publications/2002/Serious_Reportable_Events_in_Health_care.aspx) on the Internet.) These events and subsequent revisions to the list became

known as “never events.” This concept and need for the proposed reporting led to NQF’s “Consensus Standards Maintenance Committee on Serious Reportable Events,” which maintains and updates the list that currently contains 28 items.

In order to address and reduce the occurrence of these surgeries, CR 6405 establishes three new NCDs that nationally non-cover the three surgical errors and sets billing policy to implement appropriate claims processing.

Effective January 15, 2009, CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. Medicare will also not cover hospitalizations and other services related to these non-covered procedures as defined in the Medicare Benefit Policy Manual (BPM) Chapter 1, sections 10 and 180, and Chapter 16, section 120. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered.

NOTE: Related services do not include performance of the correct procedure.

**Definitions**

- Surgical and other invasive procedures are defined as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry

into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

- A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that patient.
- A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that patient including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

**NOTE:** Emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent are not considered erroneous under this decision. Also, the event is not intended to capture changes in the plan upon surgical entry into the patient due to the discovery of pathology in close proximity to the intended site when the risk of a second surgery outweighs the benefit of patient consultation; or the discovery of an unusual physical configuration (e.g., adhesions, spine level/extra vertebrae).

- A surgical or other invasive procedure is considered to have been performed on the wrong patient if that procedure is not consistent with the correctly documented informed consent for that patient.

#### **Beneficiary Liability**

Generally, a beneficiary liability notice such as an Advance Beneficiary Notice of Non-coverage (ABN) or a Hospital Issued Notice of Non-coverage (HINN) is appropriate when a provider is furnishing an item/service that the provider reasonably believes Medicare will not cover on the basis of Section 1862(a)(1) of the Social Security Act.

- An ABN must include all of the elements described in the Medicare Claims Processing Manual, Chapter 30, Section 50.6.3, in order to be considered valid. For example, the ABN must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include a cost estimate for the non-covered item/service. (The Medicare Claims Processing Manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS Website.)
- Similarly, HINNs must specifically describe the item/service expected to be denied (e.g., a left leg amputation) and must include all of the elements described in the instructions found in the Medicare Claims Processing Manual, Chapter 30, Section 200.

Thus, a provider cannot shift financial liability for the non-covered services to the beneficiary, unless the ABN or the HINN satisfies all of the applicable requirements in Chapter 30, Sections 50.6.3 and 200, respectively, of the Medicare Claims Processing Manual.

Given these requirements, CMS cannot envision a scenario in which HINNs or ABNs could be validly delivered in these NCD cases. However, an ABN or a HINN could be validly delivered prior to furnishing follow-up care for the non-covered surgical error that

would not be considered a related service to the non-covered surgical error (see Chapter 1, Sections 10 and 180, and Chapter 16, Section 120, of the Benefit Policy Manual).

## Implementation

### *Inpatient Claims*

Effective for inpatient discharges on or after January 15, 2009, hospitals are required to bill two claims when the erroneous surgery(s) related to the NCD is reported:

- One claim with covered service(s)/procedure(s) unrelated to the erroneous surgery(s) on a Type of Bill (TOB) 11X (with the exception of 110), and,
- The other claim with the non-covered service(s)/procedure(s) related to the erroneous surgery(s) on a TOB 110 (no-pay claim).
- Both the covered and non-covered claim must have a matching Statement Covers Period.

The non-covered TOB 110 will be required to be submitted via the UB-04 (hard copy) claim form, clearly indicating in Form Locator (FL) 80 (Remarks), or the 837i (electronic) claim form, Loop 2300, one of the applicable 2-digit surgical error codes as follows:

- MX – for a wrong surgery on patient;
- MY – for surgery on the wrong body part; or
- MZ – for surgery on the wrong patient.

The claim for the non-covered services will be denied using:

- **Claim adjustment reason code (CARC) 50** - These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- **Group Code CO** - Contractual Obligation.

### *Outpatient, Ambulatory Surgical Centers (ASCs), Other Appropriate Bill Types and Practitioner Claims*

Hospital outpatient departments, ASCs, practitioners and those submitting other appropriate TOBs are required to append one of the following applicable NCD modifiers to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009:

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

Contractors shall suspend claims with dates of service on and after January 15, 2009, with surgical errors identified by one of the above HCPCS modifiers.

Contractors shall create/maintain a list that includes the beneficiary health information code and the surgical error date of service. Each new surgical error occurrence shall be added to the list, and an MPP event or a system control facility (SCF) rule shall be implemented so that all claims for that beneficiary for that date of service will be suspended. Contractors shall then continue to process the claim.

Claim lines submitted with one of the above HCPCS modifiers will be line-item denied using the following:

- **CARC 50** – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

- **Group Code - CO** – Contractual Obligation

**Related Claims**

Within 5 days of receiving a claim for a surgical error, contractors shall begin to review beneficiary history for related claims as appropriate (both claims already received and processed and those received subsequent to the notification of the surgical error). Also, contractors shall review any claims applied to SCF rules and MPP events to identify incoming claims that have the potential to be related. When Medicare identifies such claims, it will take appropriate action to deny such claims and to recover any overpayments on claims already processed.

Every 30 days for an 18-month period from the date of the surgical error, contractors shall continue to review beneficiary history for related claims and take appropriate action as necessary.

**Additional Information**

For complete details regarding this Change Request (CR) please see the official instruction (CR 6405) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction was issued in two transmittals. The first transmittal presents the National Coverage Determination related to this issue and that transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R102NCD.pdf> on the CMS Website. The other transmittal presents the Medicare Claims Processing Manual revision and instructions. That transmittal is at <http://www.cms.hhs.gov/Transmittals/downloads/R1778CP.pdf> on the CMS Website.

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

## Coverage – Policies

### INFORMATION ON WEBSITE

WPS Medicare publishes Local Coverage Determinations (LCDs), National Coverage Provisions (NCPs), and National Coverage Determinations (NCDs), as well as retired LCDs for Medicare Part B, on its Website:

Legacy (IL, MI, MN, WI): [http://www.wpsmedicare.com/part\\_b/policy/index.shtml](http://www.wpsmedicare.com/part_b/policy/index.shtml)

MAC (IA, KS, MO, NE): <http://www.wpsmedicare.com/j5macpartb/policy/active/local/>

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.

#### Part B Legacy and MAC (IL, MI, MN, WI and IA, KS, MO, NE)

WPS Medicare  
Attn: Freedom of Information Act (FOIA)  
PO Box 8810  
Marion, IL 62959



### New Policies for September 2009

Policy Title	Policy Number	Contract	LCD/ NCD	Communiqué Page
Bisphosphonate Drug Therapy	L30139	Leg/MAC	LCD	26
Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring)	L29584	Leg/MAC	LCD	26
Helicobacter Pylori Testing	L30163	Leg/MAC	LCD	27
Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma	L30153	Leg/MAC	LCD	28
Intra-articular Injections of Hyaluronan	L30149	Leg/MAC	LCD	28
Optical Coherence Tomography (OCT)	L29971	Leg/MAC	LCD	29
Selective Internal Radiation Therapy (SIRT) for Primary and Secondary Hepatic Malignancy (90Y-Microsphere Hepatic Brachytherapy)	L30137	Leg/MAC	LCD	30
Trigger Points, Local Injections	L30155	Leg/MAC	LCD	30

## Retired Policies for September 2009

Policy Title	Policy Number	Contract	LCD/ NCD	Communiqué Page
Extended Ophthalmoscopy	L26666	MAC	LCD	33
Fundus Photography	L26712	MAC	LCD	33
Helicobacter Pylori Testing	L16834 L16835 L16836 L16837	Leg	LCD	32
Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma	L26661	MAC	LCD	33
Intra-articular Injections of Hyaluronate for Treatment of Osteoarthritis of the Knee	L18093 L18095 L18097 L18099	Leg	LCD	32
Transrectal Echography	L26648	MAC	LCD	33
Trigger Point Local Injections	L26662	MAC	LCD	33
Yag Capsulotomy	L26673	MAC	LCD	33

## Revised Policies for September 2009

Policy Title	Policy Number	Contract	LCD/ NCD	Communiqué Page
Application of Bioengineered Skin Substitutes	L30135	MAC	LCD	34
Chemotherapy Drugs and their Adjuncts	L28576	Leg/MAC	LCD	34

**Coverage – New Policies****LCD Title**

Bisphosphonate Drug Therapy

**Contractor's Determination Number**

INJ-025

**Contractor Name**

Wisconsin Physicians Service (WPS)

**Contractor Number**

00951, 00952, 00953, 00954  
05101, 05201, 05301, 05401,  
05102, 05202, 05302, 05402, 52280

**Contractor Type**

Carrier B  
Fiscal Intermediary A  
MAC A  
MAC B

**LCD Database ID Number**

L30139

**Original Determination Effective Date**

10/16/2009

**New Local Coverage Determination (LCD)****Contractor Number**

00951, 00952, 00953, 00954  
05101, 05201, 05301, 05401  
05102, 05202, 05302, 05402, 52280

**Contractor Type**

Carrier  
Fiscal Intermediary (FI)  
MAC A  
MAC B

**LCD Database ID Number**

L29584

**LCD Version Number**

**LCD Title**

Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring)

**Contractor's Determination Number**

CV-016

**Original Determination Effective Date**

10/16/2009

This is a new WPS Medicare LCD for our Fiscal Intermediary (FI), MAC A, and MAC B contracts. This LCD replaces the following WPS versions on this topic:

Wisconsin	L7040
Illinois	L10892
Michigan	L11068
Minnesota	L10820
Iowa, Kansas,	L26625
Missouri and Nebraska	Cardiac Monitoring (Long Term and Holter)

L29584 is effective 10/16/2009. This policy can be read in its entirety at <http://www.cms.hhs.gov/mcd/overview.asp>

**LCD Title**

Helicobacter Pylori Testing

**LCD Number**

L30163

**Contractor's Determination Number**

PATH-026

**Contractor Type**

Carrier  
Fiscal Intermediary (FI)  
MAC A  
MAC B

**Effective Date**

10/16/2009

This is a new policy for all Legacy A/B and MAC A/B jurisdictions with effective date of 10/16/2009. This policy replaces all previous policies for Helicobacter Pylori Testing by Wisconsin Physicians Service (WPS). This policy replaces Wisconsin L16834, Illinois L16835 Michigan L16836, and Minnesota L16837.

Please read this policy in its entirety at the following Website:

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

**New Local Coverage Determination (LCD)****Contractor Name**

Wisconsin Physicians Service (WPS)

**Contractor Number**

00951, 00952, 00953, 00954  
05101, 05201, 05301, 05401,  
05102, 05202, 05302, 05402,  
52280

**Contractor Type**

Carrier B  
Fiscal Intermediary A  
MAC A  
MAC B

**LCD Database ID Number**

L30153

**LCD Title**

Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma

**Contractor's Determination Number**

MS-007

**Original Determination Effective Date**

10/16/2009

This is a new policy and can be read in its entirety on the CMS Website. It will replace the former Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma policy. See the "Coverage – Retired Policies" section of the *Communiqué* for this information.

**New Local Coverage Determination (LCD)****Contractor Name**

Wisconsin Physicians Service (WPS)

**Contractor Number**

00951, 00952, 00953, 00954  
05101, 05201, 05301, 05401,  
05102, 05202, 05302, 05402,  
52280

**Contractor Type**

Carrier B

Fiscal Intermediary A  
MAC A  
MAC B

**LCD Database ID Number**  
L30149

**LCD Title**  
Intra-articular Injections of Hyaluronan

**Contractor's Determination Number**  
INJ-033

**Original Determination Effective Date**  
10/16/09

This is a new policy and can be read in its entirety on the CMS Website. This policy replaces all previous policies by Wisconsin Physicians Service (WPS) on this topic. See the "Coverage – Retired Policies" section of the *Communiqué* for the LCDs this policy will replace.



**Contractor Number**  
00951, 00952, 00953, 00954  
05101, 05201, 05301, 05401,  
05102, 05202, 05302,  
05402, 52280

**Contractor Type**  
Carrier  
Fiscal Intermediary (FI)  
MAC – A  
MAC - B

**LCD Database ID Number**  
L29971

**LCD Title**  
Optical Coherence Tomography (OCT)

**Contractor's Determination Number**  
OPHTH-015

This is a new WPS Medicare LCD for all WPS Medicare contracts. This LCD is an adaptation of the WPS Carrier policy on this topic. Policy L29971 will become effective for all WPS Medicare contracts 10/16/2009. This new policy can be read in its entirety on the CMS Website.

The following WPS Medicare policies on this topic will retire 10/15/2009: L7436, L17821, L17822, L17823 and L26676.



**LCD Title**

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

**Contractor's Determination Number**

RAD-038

**LCD Database ID Number**

L30137

**Contractor Name**

Wisconsin Physicians Service (WPS)

**Contractor Number**

00951, 00952, 00953, 00954  
05101, 05201, 05301, 05401,  
05102, 05202, 05302, 05402,  
52280

**Contractor Type**

Carrier B  
Fiscal Intermediary A  
MAC A  
MAC B

**Original Determination Effective Date**

10/16/2009



**New Local Coverage Determination (LCD)**

**Contractor Name**

Wisconsin Physicians Service (WPS)

**Contractor Number**

00951, 00952, 00953, 00954  
05101, 05201, 05301, 05401,  
05102, 05202, 05302, 05402,  
52280

**Contractor Type**

Carrier B  
Fiscal Intermediary A  
MAC A  
MAC B

**LCD Database ID Number**

L30155

**LCD Title**

Trigger Points, Local Injections

**Contractor's Determination Number**

MS-008

**Original Determination Effective Date**

10/16/2009

This is a new policy and can be read in its entirety on the CMS Website. It will replace the former Trigger Points, Local Injections. See the "Coverage – Retired Policies" section of the *Communiqué* for this information.

**Coverage – Retired Policies****Legacy Providers Only****LCD Title**

Helicobacter Pylori Testing

**LCD Number Retiring**

Wisconsin L16834

Illinois L16835

Michigan L16836

Minnesota L16837

**Contractor's Determination Number**

PATH-026

**Contractor Type**

Carrier

**Effective Date**

10/16/2009

Helicobacter Pylori Testing (PATH-026) is being retired effective 10/16/2009 for the Carrier states of Illinois, Michigan, Wisconsin, and Minnesota. These policies are being replaced with a new jurisdictional policy L30163 titled Helicobacter Pylori Testing (PATH-026) with effective date 10/16/2009.

**Legacy Providers Only****Legacy Part B LCD Retirement**

These LCDs are being retired **effective** 10/15/2009

**Title:** Intra-articular Injections of Hyaluronate for Treatment of Osteoarthritis of the Knee

**LCD Database ID Numbers**

Wisconsin L18093

Illinois L18095

Michigan L18097

Minnesota L18099

This LCD will be retired 10/15/2009 and replaced with the new LCD Intra-articular Injections of Hyaluronan. The LCD Database ID for the new LCD will be L30149



**MAC Providers Only****MAC Part B LCD Retirement**

The following LCDs are being retired **effective** 09/1/2009:

**LCD ID Number Title**

L26648	Transrectal Echography
L26666	Extended Ophthalmoscopy
L26712	Fundus Photography
L26673	Yag Capsulotomy

The following LCDs are being retired **effective** 10/15/2009

**LCD ID Number Title**

L26662	Trigger Point Local Injections
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This LCD will be retired 10/15/2009 and replaced with a new LCD of the same name that will be in effect of all WPS Medicare contracts. The LCD Database ID for the new LCD will be L30155.

**LCD ID Number Title**

L26661	Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma
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This LCD will be retired 10/15/2009 and replaced with a new LCD of the same name that will be in effect of all WPS Medicare contracts. The LCD Database ID for the new LCD will be L30153.

**Coverage – Revised Policies****MAC Providers Only****LCD Policy Revision****Contractor Type.**

Carrier  
Intermediary  
MAC A  
MAC B

**LCD Version Number**

L30135

**LCD Title**

Application of Bioengineered Skin Substitutes

**Contractor's Determination Number**

GSURG-052

**Effective Date**

08/16/2009

ICD-9-CM codes 250.80 and 250.83 were inadvertently omitted from this policy

**List 1B Secondary Diagnoses**

- \*250.82 Diabetes with other specified manifestations; type II or unspecified type, uncontrolled
- \*250.83 Diabetes with other specified manifestations; type I [juvenile type] uncontrolled

**Contractor Name**

Wisconsin Physicians Service (WPS)

**Contractor Type**

Carrier  
MAC A  
MAC B

**LCD Database ID Number**

L28576

**LCD Title**

Chemotherapy Drugs and their Adjuncts

**Contractor's Determination Number**

HONC-010

**Effective Date**

05/16/09

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

The following coverage has been added to this document.

Section B:

9. Bortezomib (Velcade™) (J9041), 0.1mg

Anaplastic large cell lymphoma	200.60-200.68
Peripheral T-cell lymphoma	202.70-202.78
Other Lymphomas	202.80-202.88

**Electronic Data Interchange (EDI)****AM I REQUIRED TO RECEIVE MEDICARE PAYMENT VIA ELECTRONIC FUNDS TRANSFER (EFT)?**

All applications for initial provider enrollment require that Form CMS-588, "Electronic Funds Transfer (EFT) Authorization Agreement," be included with the application.

Established providers who are not already receiving payment via EFT, and who are reporting any change to their 855 enrollment information, must submit Form CMS-588 to initiate payment via EFT.

All Medicare providers receiving EFTs currently cannot go back to receiving paper checks. However, they can change their current banking information by completing a new EFT form at [http://www.wpsic.com/edi/pdf/cms588\\_elec\\_funds.pdf](http://www.wpsic.com/edi/pdf/cms588_elec_funds.pdf). Please mark the EFT as a **revision** and provide the required information to change your banking information. An EFT power point presentation is available to your answer questions regarding the CMS-588 EFT Agreement at <http://www.wpsic.com/edi/tools.shtml>. Scroll down to EFT Funds Transfers and go to the EFT Presentation.

If you have any questions, please call 866-380-4742, Option 2.

**ELECTRONIC DATA INTERCHANGE (EDI) ASK-THE-CONTRACTOR TELECONFERENCES (ACTS)**

WPS Medicare is pleased to announce the 2009 schedule for our Electronic Data Interchange (EDI) Ask-the-Contractor Teleconferences (ACT).

We have scheduled our EDI ACTs for 2009. These teleconferences will last one and one-half hours. We encourage providers, billing staff, vendors, and clearinghouses to call with any Medicare EDI questions they deem appropriate.

We will approach the call much in the same way CMS approaches their valuable Open Door Forums, promoting a forum that is less structured, and encourages participants to ask whatever they choose, as long as it pertains to Medicare EDI. We look forward to your participation in these calls!

**What are Ask-the-Contractor Teleconferences (ACTs)?**

The Medicare Modernization Act (MMA) requires Medicare contractors to hold Ask-the-Contractor Teleconferences (ACTs). This requirement is based on CMS' goal of giving those who provide service to beneficiaries the information they need to understand the Medicare program; be informed often and early about changes; and, in the end, bill correctly.

The ACT promotes valuable interaction between the Medicare Contractor (WPS Medicare) and EDI customers. As stated previously, we modeled our ACTs after CMS Open Door Forums. **Participants are encouraged to ask questions and raise concerns.** EDI staff is available during the call to provide education, program updates, answer questions, and take feedback. In

addition, we will provide necessary follow-up to any issues that cannot be resolved during the call time.

WPS Medicare encourages providers to participate in this important educational activity. You can access a recording of the EDI ACT teleconference on this Website approximately one week following the event.

*Please Note: No Registration is Necessary*

Date	Time	Dial-In Number	Conference ID
September 10, 2009	1 pm CT	800-305-2862	70746156
November 12, 2009	1 pm CT	800-305-2862	70746399

\* Remember you can access a recording of this session on our Website approximately one week following the teleconference.

## **PC-ACE PRO32 BILLING SOFTWARE UPGRADE VERSION 2.14 NOW AVAILABLE ONLINE**

If you are currently using the PC-Ace Pro32 billing software, you can now download the latest upgrade online. You can download this information from the WPS EDI Website:

<http://www.wpsic.com/edi/pcacepro32.shtml>

Now available on-line are:

- The upgrade to the latest version of PC-Ace, version 2.14
- Instructions related to the upgrade
- User guides/manuals

**If you are not using the version listed above, it is very important that you update your software immediately.**

### **Eastern Missouri PC-Ace Users ONLY**

There will be a change in Contract Code from 05392 to 05302. The effective date of this change is July 31, 2009. This change will be automatic when you upgrade to version 2.14 of the PC-Ace Pro32 billing program. Please upgrade to version 2.14 on or after July 31, 2009.

It is important that each user updates their software program in a timely manner. As software upgrades are received, please download/install the upgrades to update your program.

If you have any questions, please contact the EDI Hotline:

Illinois, Michigan, Minnesota, Wisconsin      877-567-7261  
Iowa, Kansas, Missouri, Nebraska              866-503-9670

**If you are NOT currently using this program but you are interested in using this HIPAA-compliant software, please contact our EDI Hotline or download the PC-Ace request form from <http://www.wpsic.com/edi/pdf/medbpcace.pdf>.**

**General Information**

**ADDITIONAL INSTRUCTIONS ON PROCESSING CLAIMS FOR  
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND  
SUPPLIES (DMEPOS) ITEMS SUBMITTED UNDER THE GUIDELINES  
ESTABLISHED IN CHANGE REQUEST (CR) 5917  
~CMS MLN Matters~**

MLN Matters ® Number: MM6573  
Related CR Release Date: August 14, 2009  
Related CR Transmittal #: R531OTN

Related Change Request (CR) #: 6573  
Effective Date: January 1, 2010  
Implementation Date: January 4, 2010

**Provider Types Affected**

Providers and suppliers billing Medicare Carriers and Medicare Administrative Contractors (A/B MACs) for certain DME products provided to Medicare beneficiaries.

**Provider Action Needed**

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6573 in order to augment previously issued CR 5917. In CR 5917 CMS instructed Medicare contractors to process and pay claims for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME when submitted by suppliers that are enrolled with both the National Supplier Clearinghouse (NSC) and with their local carrier/MAC. Although CR 5917 reinstated the local carrier/A/B MAC jurisdiction for claims for these items, the **instruction was not clear about the jurisdiction or payment rules to apply when the beneficiary resides outside of the local carrier/A/B Medicare Administrative Contractor's (A/B MAC) jurisdiction.** Be sure billing staff are aware of the changes.

**Background**

CR 6573 clarifies the claims filing jurisdiction and payment policies for claims submitted under the guidelines established in CR 5917 when the beneficiary is located outside of the local carrier/A/B Mac's jurisdiction. Payment of DMEPOS items is based on the fee schedule amount for the State where the beneficiary maintains their permanent residence.

CR 6573 also makes a correction to CR 5917 to replace the list of codes that may be billed, originally included as Attachment A to CR 5917, with the revised list of HCPCS codes attached to CR6573 and available at <http://www.cms.hhs.gov/Transmittals/downloads/R531OTN.pdf> on the CMS Website. (In CR 5917 this list included codes for implanted devices, which may not be separately billed to the carrier/MAC by DMEPOS suppliers.)

**Key Points of CR 6573**

- Suppliers that are enrolled with the NSC as a DMEPOS supplier may enroll with and bill claims to their local carrier/A/B MAC for any of the attached list of DMEPOS items when billed under the guidelines established in CR 5917, including items furnished to beneficiaries who reside in other States.

- Medicare contractors will determine the claims filing jurisdiction for items billed under the guidelines established in CR 5917 based on the location of the supplier, in accordance with Chapter 1, section 10 of the *Medicare Claims Processing Manual* available at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> on the CMS Website.
- Medicare contractors will pay claims for items submitted under the guidelines established in CR 5917 by applying the appropriate fee schedule amount for the State where the beneficiary maintains his or her permanent residence.
- Under no circumstances may any entity enrolled as a DMEPOS supplier with the NSC, that is not the physician or provider that implants the device, bill the carrier/A/B MAC for an implanted device. However, DMEPOS suppliers may bill for any of the replacement parts, accessories or supplies for prosthetic implants and surgically implanted DME included in the attached revised list of HCPCS codes, under the guidelines established in CR 5917.

#### Additional Information

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.

The official instruction (CR 6573) issued to your Medicare Carrier or A/B MAC is available at <http://www.cms.hhs.gov/Transmittals/downloads/R531OTN.pdf> on the CMS Website. CR 6573 contains the ***DMEPOS Fee Schedule HCPCS Codes Payable as a Replacement Part, Accessory or Supply for Prosthetic Implants and Surgically Implanted DME*** (Rev. March 2009) and that list is an attachment to CR 6573.

To review MM5917, the MLN Matters® article related to CR 5917, go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5917.pdf> on the CMS Website.

## DIABETES SELF-MANAGEMENT TRAINING (DSMT) CERTIFIED DIABETIC EDUCATOR

~CMS MLN Matters~

MLN Matters® Number: MM6510  
Related CR Release Date: August 7, 2009  
Related CR Transmittal #: R109CP

Related Change Request (CR) #: 6510  
Effective Date: March 30, 2009  
Implementation Date: September 8, 2009

#### Provider Types Affected

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

#### Impact on Providers

This article is based on Change Request (CR) 6510 which recognizes the American Association of Diabetes Educators (AADE) as an approved Diabetes Self-Management Training (DSMT) national accreditation organization. CR 6510 also implements the following

exception for DSMT in rural areas: an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by the Centers for Medicare & Medicaid Services (CMS) may furnish training and is deemed to meet the multidisciplinary team requirement.

### Background

The Centers for Medicare & Medicaid Services (CMS) announced in their Final Notice published in the Federal Register (Volume 74, February 27, 2009) that the American Association of Diabetes Educators (AADE) is approved as a national accreditation organization to furnish DSMT and is recognized as a national accrediting organization for accrediting entities to furnish outpatient DSMT to Medicare beneficiaries. See the Federal Register (V74, February 27, 2009) at <http://edocket.access.gpo.gov/2009/pdf/E9-3287.pdf> on the Internet.

Providers and suppliers of DSMT services may submit requests for accreditation through the AADE, and Medicare contractors shall recognize the AADE as an approving entity for the DSMT program billable through Medicare.

In addition, if providers/suppliers had a valid AADE certificate disapproved by their Medicare contractor, they may ask their contractor to reprocess that application.

CR 6510 also amended the Medicare Benefit Policy Manual (Chapter 15 (Covered Medical and Other Health Services)) to clarify that there is an exception for who can provide DSMT in a rural area as follows:

*“...Registered dietitians are eligible to bill on behalf of an entire DSMT program on or after January 1, 2002, as long as the provider has obtained a Medicare provider number. A dietitian may not be the sole provider of the DSMT service. **There is an exception for rural areas. In a rural area, an individual who is qualified as a registered dietitian and as a certified diabetic educator who is currently certified by an organization approved by CMS may furnish training and is deemed to meet the multidisciplinary team requirement.**”*

See the Code of Federal Regulations (CFR), Title 42, Chapter IV, Section 410.144(a)(4)(C)(ii) which describes the exception for DSMT in rural areas at [http://edocket.access.gpo.gov/cfr\\_2008/octqtr/pdf/42cfr410.144.pdf](http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr410.144.pdf) on the Internet.

### Additional Information

The official instruction, CR 6510, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R109BP.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.

## REPORTING NON-TAX WITHHOLDING DUE TO FEDERAL PAYMENT LEVY PROGRAM (FPLP) ~CMS MLN Matters~

MLN Matters ® Number: MM6228  
Related CR Release Date: June 12, 2008  
Related CR Transmittal #: R503OTN

Related Change Request (CR) #: 6228  
Effective Date: January 1, 2009  
Implementation Date: October 5, 2009

### Provider Types Affected

Physicians and providers who bill Medicare carriers, fiscal intermediaries (FI), and Medicare Administrative Contractors (MAC) for services provided to Medicare beneficiaries.

### What You Need to Know

CR 6228, from which this article is taken, notifies providers that (effective October 1, 2009) in addition to collecting for overdue taxes (effective October 1, 2008), the Centers for Medicare & Medicaid Services (CMS) will also levy non-tax debt offsets against Medicare providers to repay unpaid debts owed to other Federal agencies, such as educational loans.

Make sure that your billing staffs are aware that both tax and non-tax debt, subject to FPLP, will be withheld from Medicare payments.

If you have a question about the **non-tax** payment reduction, call the Treasury Department's Financial Management Service (FMS) at 1-800-304-3107.

### Background

The Taxpayer Relief Act of 1997 authorized the Federal Payment Levy Program (FPLP), which the Internal Revenue Service (IRS) and the Treasury Department's Financial Management Service implemented in July 2000. This program gives CMS the authority to collect overdue taxes through a levy on certain federal payments; including those made to providers, contractors, and vendors doing business with the government.

The Medicare Improvements for Patients and Providers Act of 2008 requires CMS to fully implement the FPLP for Medicare payments for overdue taxes, and extends it to also include a levy for non-tax debt.

CR 6125 ([Reporting Withholding Due to IRS Federal Payment Levy Program \(FPLP\) on the Remittance Advice](#)) issued on August 15, 2008, covers the implementation of the debt levy for overdue taxes, effective October 2008. (A related MLN Matters article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf> on the CMS Website.) CR 6228, from which this article is taken, notifies providers that (effective October 1, 2009) non-tax debt offsets will also be levied against Medicare providers to repay unpaid debts owed to other Federal agencies, such as from educational loans.

Should you owe such taxes and/or debt, and your payments are reduced:

- For tax levy (effective October 1, 2008), your Medicare remittance advice will reflect the provider level adjustment code (PLB) of "WU" in the PLB03-1 data field (however, in the HIPAA 835, PLB reason code "LE" will replace currently used WU for: Third Party Payment (TPP) - Garnishments, including attorneys, Child Support, Alimony, Secondary

Corporation, and Change of Ownership). In addition, the toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field.

- For non-tax debt levy (effective October 1, 2009), your Medicare remittance advice will reflect the PLB code of "ZZ" in the PLB03-1 data field, and the amount of the withholding can be found in the PLB04 field. In addition, the toll-free FMS number will appear in the PLB03-2 data field.

*Notes:*

- 1) *Due to current privacy rules and regulations, the IRS is the only agency that can discuss the tax-related debt question with you, and FMS/Treasury is the only agency that can discuss the non-tax debt issue with you. Thus, if you have questions, contact them at the toll-free numbers just mentioned, instead of contacting your Medicare contractor.*
- 2) *Please observe that the toll-free IRS telephone number for questions regarding tax-related withholding is **not** the same as the toll-free FMS/Treasury toll-free telephone number for non-tax withholding questions.*

You may find the following details about non-tax FPLP withholding of interest:

- CMS may reduce federal payments subject to the non-tax levy by 100 percent, (or the exact amount of the non-tax debt owed if it is less than 100 percent of the payment); and this levy is continuous until the non-tax debt is paid in full, or other arrangements are made to satisfy the debt.
- The Medicare Provider Payment Offset priority order is: 1) Medicare accounts receivable (AR) debt, 2) FPLP Offsets for Federal Tax debt at 15% maximum of the payable amount, 3) Administrative Offsets for Federal Non-Tax debt at 100% of the payable amount, and 4) Third-Party Payments (TPP).
- Within each payment offset priority category, CMS will collect the oldest debts first, namely the FPLP Offsets for Federal Tax debt and the Administrative Offsets for Federal Non-Tax debt.
- CMS will implement a minimum \$25 threshold for tax and non-tax debt offsets.
- The Treasury Department will process refunds to providers from CMS over-collections of FPLP Federal Tax debt or Administrative Offsets for Federal Non-Tax debt.

### **Additional Information**

You can find the official instruction, CR6228, issued to your carrier, FI, or MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R503OTN.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. You may also want to review the article related to CR 6125 ([Reporting Withholding Due to IRS Federal Payment Levy Program \(FPLP\) on the Remittance Advice](#)), which you can find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6125.pdf> on the CMS Website.

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

**Provider Education****EDUCATION SCHEDULE**

If you are a Legacy Part B provider in Illinois, Michigan, Minnesota, or Wisconsin, please be sure to visit the WPS Medicare Education Schedule at [http://www.wpsmedicare.com/part\\_b/education/education\\_schedule.shtml](http://www.wpsmedicare.com/part_b/education/education_schedule.shtml) to learn more about the educational events we have scheduled for the upcoming months.

If you are a MAC J5 Part B provider in Iowa, Kansas, Missouri, or Nebraska, please be sure to visit the WPS Medicare Education Schedule at [http://www.wpsmedicare.com/j5macpartb/training/training\\_programs/](http://www.wpsmedicare.com/j5macpartb/training/training_programs/) to learn more about the educational events we have scheduled for the upcoming months.

**HARD COPY COMMUNIQUÉ SUBSCRIPTION**

WPS will offer *Communiqué* subscriptions in hard copy format for Fiscal Year 2010 (which runs from October 2009 through September 2010) **for those providers without Internet access**. The cost for the subscription to the Fiscal Year 2010 hard copy *Communiqué* is \$60.00. You will receive your hardcopies at the end of each quarter (December 2009, March 2010, June 2010, and September 2010).

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.

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:

WPS Medicare  
Medicare Publications  
P.O. Box 81909  
Madison, WI 53708

**Reimbursement****2010 ANNUAL UPDATE FOR THE HEALTH PROFESSIONAL  
SHORTAGE AREA (HPSA) BONUS PAYMENTS**  
~CMS MLN Matters~

MLN Matters ® Number: MM6581  
Related CR Release Date: August 7, 2009  
Related CR Transmittal #: R1789CP

Related Change Request (CR) #: 6581  
Effective Date: January 1, 2010  
Implementation Date: January 4, 2010

**Provider Types Affected**

Physicians and other providers who bill Medicare Carriers, Fiscal Intermediaries (FI), or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries in HPSAs.

**What You Need to Know**

Change Request (CR) 6581, from which this article is taken, alerts providers that the 2010 file will be posted to the Centers for Medicare & Medicaid Services (CMS) Website.

**Background**

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS will create a new automated HPSA bonus payment file for claims with dates of service on or after January 1, 2010, through December 31, 2010 and post it to the Website in early December of 2009.

You will find the annual HPSA bonus payment file and other important HPSA information at <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/> on the CMS Website. You should also review the CMS Website to determine whether a HPSA bonus will automatically be paid for services provided in your ZIP code area or whether a modifier must be submitted. You can determine if you are eligible for the automated payment by going to <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/Downloads/instructions.pdf> on the CMS Website and following the instructions on the page.

**Additional Information**

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

The official instruction (CR6581) issued to your MAC, carrier, and/or FI may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1789CP.pdf> on the CMS Website.

## CLINICAL LABORATORY FEE SCHEDULE – MEDICARE TRAVEL ALLOWANCE FEES FOR COLLECTION OF SPECIMENS ~CMS MLN Matters~

MLN Matters® Number: MM6524  
Related CR Release Date: August 7, 2009  
Related CR Transmittal #: R1790CP

Related Change Request (CR) #: 6524  
Effective Date: January 1, 2009  
Implementation Date: October 5, 2009

### Provider Types Affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for clinical laboratory specimen collection services provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on Change Request (CR) 6524 which updates the Medicare travel allowance fees for collection of specimens for Calendar Year (CY) 2009. Subsequent updated travel allowance amounts will be issued by the Centers for Medicare & Medicaid Services (CMS) on an annual basis via a recurring update CR.

### Background

Change Request (CR) 6524 clarifies payment of travel allowances, either on a per mileage basis (Healthcare Common Procedure Coding System (HCPCS) code P9603) or on a flat rate basis (HCPCS code P9604) for Calendar Year (CY) 2009. Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under the Social Security Act (Section 1833(h)(3); see [http://www.ssa.gov/OP\\_Home/ssact/title18/1833.htm](http://www.ssa.gov/OP_Home/ssact/title18/1833.htm) on the Internet), and payment is made based on the clinical laboratory fee schedule.

### Travel Allowance for 2009

The travel codes allow for payment either on a per mileage basis (HCPCS code P9603) or on a flat rate per trip basis (HCPCS code P9604). Payment of the travel allowance is made only if a specimen collection fee is also payable. The travel allowance is intended to cover the estimated travel costs of collecting a specimen including the laboratory technician's salary and travel expenses. Medicare allows contractor discretion to choose either a mileage basis or a flat rate, and how to set each type of allowance.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip, for both Medicare and non-Medicare patients, either at the time the claim is submitted by the laboratory or when the flat rate is set by the contractor.

### Per Mile Travel Allowance (HCPCS Code P9603)

The per mile travel allowance is to be used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is to be prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

CR 6524 instructs that Medicare contractors will pay for **HCPCS code P9603**, where the average trip to the patients' homes exceeds 20 miles round trip, at a total of **\$1.00 per mile**. This includes:

- The Federal mileage rate of \$0.55 per mile **plus**
- An additional \$0.45 per mile to cover the technician's time and travel costs.

Contractors shall have the option of establishing a higher per mile rate for HCPCS code P9603, in excess of the minimum \$1.00 per mile, if local conditions warrant it.

The minimum mileage rate will be reviewed and updated in conjunction with the Clinical Laboratory Fee Schedule (CLFS) as needed. At no time will the laboratory be allowed to bill for more miles than are reasonable or for miles that are not actually traveled by the laboratory technician.

#### **Per Flat-Rate Trip Basis Travel Allowance (HCPCS Code P9604)**

CR 6524 also instructs that Medicare contractors shall pay for **HCPCS code P9604** on a flat-rate trip basis travel allowance of **\$10.00 per trip**.

#### **Additional Information**

The official instruction, CR 6524, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1790CP.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.

## **OCTOBER 2009 QUARTERLY AVERAGE SALES PRICE (ASP) MEDICARE PART B DRUG PRICING FILES AND REVISIONS TO PRIOR QUARTERLY PRICING FILES ~CMS MLN Matters~**

MLN Matters® Number: MM6585  
Related CR Release Date: August 14, 2009  
Related CR Transmittal #: R1795CP

Related Change Request (CR) #: 6585  
Effective Date: October 1, 2009  
Implementation Date: October 5, 2009

#### **Provider Types Affected**

All physicians, providers and suppliers who submit claims to Medicare contractors (Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs), carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs) or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

#### **Provider Action Needed**

This article is based on Change Request (CR) 6585 and instructs Medicare contractors to download and implement the October 2009 ASP drug pricing file for Medicare Part B drugs; and if released by the Centers for Medicare & Medicaid Services (CMS), also the revised July 2009, April 2009, January 2009, and October 2008, files. Medicare will use the October

2009 ASP and not otherwise classified (NOC) drug pricing files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after October 5, 2009 with dates of service October 1, 2009, through December 31, 2009. See the Background and Additional Information Sections of this article for further details regarding these changes.

### **Background**

Section 303(c) of the Medicare Modernization Act of 2003 revised the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Beginning January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis are paid based on the ASP methodology, and pricing for compounded drugs has been performed by the local contractor.

### **ASP Methodology**

In general, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. Further, beginning January 1, 2006, payment allowance limits are paid based on 106 percent of the ASP for:

- End Stage Renal Disease (ESRD) drugs (when separately billed by freestanding and hospital-based ESRD facilities); and
- Specified covered outpatient drugs and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS).

Beginning January 1, 2008, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+5 percent. Beginning January 1, 2009, under the OPPS, payment allowance limits for specified covered outpatient drugs are paid at ASP+4 percent. Drugs and biologicals with pass-through status under the OPPS continue to have a payment allowance limit of 106 percent of the ASP. CMS will update the payment allowance limits quarterly. There are exceptions to this general rule and they are stated in the Medicare Claims Processing Manual, Chapter 17, Section 20.1.3 and may be reviewed at

<http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf> on the CMS Website.

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

Physicians (or a practitioner described in Section 1842(b) (18) (C) of the Social Security Act) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above, except that pricing for compounded drugs is done by your local Medicare contractor.

**Use of Quarterly Payment Files**

The following table shows how the quarterly payment files will be applied:

Files	Effective Dates of Service
October 2009 ASP and ASP NOC files	October 1, 2009, through December 31, 2009
July 2009 ASP and ASP NOC files	July 1, 2009, through September 30, 2009
April 2009 ASP and ASP NOC files	April 1, 2009, through June 30, 2009
January 2009 ASP and NOC Files	January 1, 2009, through March 31, 2009
October 2008 ASP and NOC Files	October 1, 2008, through December 31, 2008

**NOTE:** The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

**Additional Information**

The official instruction (CR6585) issued to your Medicare carrier, FI, RHHI, MAC, or DME MAC is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1795CP.pdf> on the CMS Website.

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

CMS would like providers to be aware that the following MLN products are available through the MLN Catalogue:

1. The guide at [http://www.cms.hhs.gov/MLNProducts/downloads/RA\\_Guide\\_Full\\_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf) describes topics such as: types of Remittance Advice (RA), the purpose of the RA and types of codes that appear on the RA.
2. A fact sheet at <http://www.cms.hhs.gov/PQRI/Downloads/PQRIEPrescribingFactSheet.pdf> introduces the E-Prescribing Incentive Program as authorized by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).
3. The brochure at <http://www.cms.hhs.gov/MLNProducts/downloads/Protectingpracbroch508-09.pdf> highlights some the steps providers can employ to protect their practices from inappropriate Medicare business interactions.

## WPS MEDICARE PROVIDER SERVICES

For additional information on the content of this newsletter, changes in policy or procedures, how to obtain a hardcopy of a Local Coverage Determination (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.

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## VISIT THE WPS MEDICARE WEBSITE FOR ALL YOUR MEDICARE NEEDS

WPS Medicare would like to remind providers that the *Communiqué* does not include all the information needed by Medicare providers. While the publication does include general information, articles, and updates, the most comprehensive source of WPS Medicare information is the WPS Medicare Website (<http://www.wpsmedicare.com/>), which we update at least twice weekly. For weekly Medicare updates delivered straight to your e-mail inbox, sign up for WPS Medicare eNews at <http://www.wpsmedicare.com/listserv>.

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