MEDICARE PART B

Communiqué

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

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

October 2007

WPS HEALTH INSURANCE

Items of Importance

ALERT REGARDING THE TRANSITION OF THE MEDIGAP CLAIM-BASED CROSSOVER PROCESS

The Centers for Medicare & Medicaid Services (CMS) has made a decision to delay the use of the new Coordination of Benefits Agreement (COBA) Medigap claim-based identifiers on incoming Part B claims or claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) until October 1, 2007. This represents a change from previous CMS direction issued in accordance with Transmittal 283, Change Request (CR) 5662, and the accompanying MLN Matters Article.

Because of the CMS delay, physicians and other suppliers shall inform their billing vendors not to include any newly assigned 5-byte COBA Medigap claim-based identifiers, as referenced at **http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf**, on incoming Medicare claims before October 1, 2007. If participating providers or suppliers include the newly assigned COBA Medigap claim-based ID on incoming claims before October 1, 2007, Medicare will not cross the claims over to the Medigap insurer.

Providers that use PC-Ace or other free billing Medicare software need to ensure this product is updated to reflect the newly assigned 5-byte COBA Medigap claim-based IDs but must ensure that the new identifiers will not be applied on incoming Medicare claims before October 1, 2007.

Effective with October 1, 2007, and as specified in Transmittal 283, CR 5662, physicians and other suppliers that bill using paper forms, i.e., those granted an exception for billing electronically under the Administrative Simplification Compliance Act (ASCA), shall include the newly assigned 5-byte identifier (number will fall in the range 55000 through 59999) within item 9-D of incoming paper CMS-1500 claim forms. These providers should complete items 9A through 9D, in accordance with previous procedures, to ensure they will successfully trigger a Medigap claim-based crossover. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) in field NM109 of the NM1 segment within the 2330B loop. Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier within field 301-C1 of the T04 segment of their incoming NCPDP claims.

ELECTRONIC REMITTANCE ADVICE (ERA) INFORMATION AVAILABLE THROUGH MEDICARE REMIT EASY PRINT (MREP) SOFTWARE

The Centers for Medicare & Medicaid Services (CMS) developed software that gives providers/suppliers a tool to read and print ERAs in a user-friendly format. CMS developed this software in response to comments they received from the provider/supplier community that they needed a paper document for account reconciliation and claim submission for secondary/tertiary payments.

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

Benefits of MREP Software:

- Easy navigation and viewing of the ERA using your personal computer;
- Print the ERA in the Standard Paper Remittance (SPR) format;
- Search capability that allows providers and suppliers the ability to find claims information easily;
- Print and export reports about ERAs including denied, adjusted, and deductible applied claims;
- Easy-to-use method to archive, restore, and delete imported ERAs;
- Providers and suppliers can view and print as many or as few claims as needed. This is especially helpful when you need to print only one claim from the remittance when forwarding the claim to a secondary payer.

CMS and WPS Medicare strongly encourage the use of this software. The software allows you to control the duplication of your remittance advice (RA) information, as necessary. In addition, this alleviates unnecessary requests and costs incurred by Medicare contractors for manual remittance duplications.

For additional information on MREP Software, please refer to our Websites below:
http://www.wpsmedicare.com/provider/mrep.shtml
http://www.wpsic.com/edi/pdf/mrep_overview.pdf

For personal assistance, please contact our Electronic Data Interchange (EDI) Department directly. The telephone numbers follow:
Wisconsin, Illinois, and Michigan – 1-877-567-7261
Minnesota - 952-885-2811, 952-885-2881 or 952-885-2882

The CMS Internet-Only Manual (IOM) Publication 100-4, Chapter 24, Section 60.6.1, also provides information on MREP software. To view a copy of this publication, please refer to the CMS Website below:
http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf

PAYMENT CAPITATION ON THE TECHNICAL COMPONENT (TC) OF DIAGNOSTIC IMAGING PROCEDURES

The Centers for Medicare & Medicaid Services (CMS) recently issued Change Request (CR) 5476, "Revision to the Medicare Physician Fee Schedule (MPFS) Disclosure Format," which pertains to Section 5102(b) of the Deficit Reduction Act of 2005. The Deficit Reduction Act of 2005 required payment capitations to be placed on the TC of specified diagnostic imaging procedures, which includes the TC portion of specified global diagnostic imaging services. The capitation allowance is based on the Outpatient Prospective Payment System (OPPS). When the payment capitation applies to a procedure, Medicare's payment for the TC or global procedure is limited to the OPPS payment amount. CR 5476 required contractors to identify services for which the OPPS Payment capitation applies.

Because of CR 5476, WPS Medicare follows the CMS program manual instruction and places a denotation mark (C) in the Notes column of the MPFS for each state payment locality for which payment has been held to the OPPS cap amount. At the bottom of the PFS page, there is a notation that reads:

C - THE PAYMENT FOR THE TECHNICAL COMPONENT IS CAPPED AT THE OPPS AMOUNT.

Current fee and reimbursement information is available on our Website below:
http://www.wpsmedicare.com/provider/pricing_fees.shtml

To view a copy CR 5476 in its entirety, please refer to the CMS Website below:
http://www.cms.hhs.gov/Transmittals/Downloads/R1171CP.pdf

PROVIDERS RESPONSIBLE FOR KNOWING GUIDELINES

A provider is responsible to know the rules and regulations that apply to all services billed by the provider to the Medicare program.

According to the *Medicare Claims Processing Manual,* Chapter 30, Section 40.1:
"In accordance with regulations at 42 CFR 411.406, evidence that the provider, practitioner, or other supplier did, in fact, know or should have known that Medicare would not pay for a service or item includes:

- A Medicare contractor's prior written notice to the provider, practitioner, or other supplier of Medicare denial of payment for similar or reasonably comparable services or items;
- Medicare's general notices to the medical community of Medicare payment denial of services and items under all or certain circumstances (such notices include, but are not limited to, manual instructions, bulletins, carriers' written guides, and directives); and
- Provision of the services and items was inconsistent with acceptable standards of practice in the local medical community (refer to §40.1.3 and §40.1.4).

  If any of the circumstances described above exists, a provider, practitioner or other supplier is held to have knowledge."

The provider is responsible to know the rules and regulations that are made available through publications from the Medicare carriers and fiscal intermediaries, which include, but are not limited to, the WPS Medicare newsletter (the *Communiqué*), information published on the WPS Medicare Website, and mailings sent periodically to all or individual providers. The WPS Medicare monthly newsletter, the *Communiqué*, is available electronically through the WPS Medicare Website at **http://www.wpsmedicare.com/provider/pub_home.shtml**

For those providers unable to use the electronic *Communiqué*, a quarterly paper copy is available by subscription. Information on the subscription is available in the monthly November *Communiqué* and quarterly Fall *Communiqué*.

To access these publications (**http://www.wpsmedicare.com/provider/pub_home.shtml**), you must first accept the AMA Copyright Statement.

Claim Submission

2008 ANNUAL UPDATE OF HCPCS CODES FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB) FOR THE COMMON WORKING FILE (CWF), MEDICARE CARRIERS AND FISCAL INTERMEDIARIES (FIS)

~CMS MLN Matters~

MLN Matters Number: MM5696
Related CR Release Date: August 17, 2007
Related CR Transmittal #: R1317CP
Related Change Request (CR) #: 5696
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare Administrative Contractors (DME MACs), Part A/B Medicare Administrative Contractors (Part A/B MACs) and fiscal intermediaries (FIs)) for services provided to Medicare beneficiaries in SNFs.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5696, which provides the 2008 annual update of HCPCS Codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

CAUTION – What You Need to Know

CR5696 provides updates to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manual*, Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

GO – What You Need to Do

See the Background and Additional Information sections of this article for further details regarding this update.

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Physicians and providers are advised that, by the first week in December 2007, new code files will be posted to the at **http://www.cms.hhs.gov/SNFConsolidatedBilling/** on the CMS website. Institutional providers note that this site will include new Excel® and PDF format files.

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

Note: It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at **http://www.cms.hhs.gov/SNFConsolidatedBilling/** on the CMS website in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

Additional Information

The official instruction, CR5696, issued to your Medicare contractor regarding this change can be found at **http://www.cms.hhs.gov/Transmittals/downloads/R1317CP.pdf** on the CMS website.

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

DATE OF SERVICE (DOS) FOR LABORATORY SPECIMENS

~CMS MLN Matters~

MLN Matters Number: MM5573
Related CR Release Date: August 17, 2007
Related CR Transmittal #: R1319CP

Related Change Request (CR) #: 5573
Effective Date: January 1, 2007
Implementation Date: January 1, 2008

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5573 which implements revisions to the date of service (DOS) policy for tests performed on laboratory specimens, in accordance with updates to 42CFR414.510 that were published in the Federal Register on December 1, 2006. **Remember when submitting claims that the general rule is that the date of service is the date the specimen is collected. Where a specimen is collected over a period that spans two calendar days, the date of service is the date the collection period ended.**

Background

The general rule for the date of service (DOS) of a test performed on a laboratory specimen is the date that the specimen is collected. If a specimen is collected over a period that spans two calendar days, then the DOS must be the date that the collection period ended.

The current DOS policy allows an exception to the general rule for tests performed on an archived specimen. If a specimen was stored for more than 30 calendar days before testing (otherwise known as "an archived specimen"), the DOS of the test must be the date that the specimen was obtained from storage.

In the final physician fee schedule regulation published in the Federal Register on December 1, 2006 (**http://www.access.gpo.gov/su_docs/fedreg/a061201c.html**), the Centers for Medicare & Medicaid Services (CMS) revised the DOS policy for laboratory specimens to allow additional exceptions to the general rule and the DOS rule for tests performed on an archived specimen.

CR 5573 implements the revisions to the DOS policy for tests performed on laboratory specimens specified in the final rule, in accordance with the updates to 42 CFR §414.510 (**http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/06-9086.htm**).

As already mentioned, under the revised DOS policy for laboratory specimens, the **General Rule** is that the DOS of the test must be the date the specimen was collected. However, there is a **variation:** If a specimen is collected over a period that spans two calendar days, then the DOS must be the date the collection ended.

The following exceptions apply to the DOS policy for laboratory tests:

DOS for Tests Performed on Stored Specimens:
In the case of a test performed on a stored specimen, if a specimen was stored for less than or equal to 30 calendar days from the date it was collected, **the DOS of the test must be the date the test was performed only if:**

- The test is ordered by the patient's physician at least 14 days following the date of the patient's discharge from the hospital;
- The specimen was collected while the patient was undergoing a hospital surgical procedure;
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
- The results of the test do not guide treatment provided during the hospital stay; and
- The test was reasonable and medically necessary for treatment of an illness.

Note: If the specimen was stored for more than 30 calendar days before testing, the specimen is considered to have been archived, and the DOS of the test must be the date the specimen was obtained from storage.

DOS for Chemotherapy Sensitivity Tests Performed on Live Tissue:
In the case of a chemotherapy sensitivity test performed on live tissue, **the DOS of the test must be the date the test was performed only if**:

- The decision regarding the specific chemotherapeutic agents to test is made at least 14 days after discharge;
- The specimen was collected while the patient was undergoing a hospital surgical procedure;
- It would be medically inappropriate to have collected the sample other than during the hospital procedure for which the patient was admitted;
- The results of the test do not guide treatment provided during the hospital stay; and
- The test was reasonable and medically necessary for treatment of an illness.

Note: For purposes of applying the above exception, a "chemotherapy sensitivity test" is

defined as a test that requires a fresh tissue sample to test the sensitivity of tumor cells to various chemotherapeutic agents.

Additional Information

The official instruction, CR5573, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1319CP.pdf** on the CMS website.

If you have any 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.

DELETE REFERENCES TO REQUIRED REPORTING OF THE NATIONAL PROVIDER IDENTIFIER (NPI) ON OR AFTER MAY 23, 2007 AND REVISE TO A "WHEN EFFECTIVE" DATE

~CMS MLN Matters~

MLN Matters Number: MM5678
Related CR Release Date: August 31, 2007
Related CR Transmittal #: R1328CP

Related Change Request (CR) #: 5678
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected

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

Provider Action Needed

This article is informational in nature and is based on Change Request (CR) 5678 which updates Chapter 80 of the *Medicare Claims Processing Manual* to delete references to the May 23, 2007 mandatory date for entry of the National Provider Identifier (NPI) on claims. The effective date for providers to use only the NPI on Medicare claims will be officially announced at a later date, as previously communicated to providers in the MLN Matters article corresponding to CR5595. That article is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf** on the CMS website.

Background

The National Provider Identifier (NPI) final rule, published in the Federal Register on January 23, 2004 (**http://www.access.gpo.gov/su_docs/fedreg/a040123c.html**; Health and Human Services Department Rules), established the standard for a unique identifier for each health care provider for use in health care transactions. Medicare contractors were to be required to enter NPI in certain items and fields of paper claim forms and electronic equivalents on or after May 23, 2007.

However, on April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance regarding contingency planning for the implementation of the NPI. For some time after May 23, 2007, Medicare Fee for Service (FFS) will allow continued

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use of legacy numbers (Unique Physician Identification Numbers (UPINs) and Provider Identification Numbers (PINs)), as well as accepting transactions with only NPIs. The effective date for providers to use only the NPI only on claims and to cease entering UPINs and PINs will be officially announced at a later date, as previously communicated to providers in the MLN Matters article corresponding to CR5595. That article is available at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf** on the CMS website. This article reflects CR5678, which simply amends Chapter 80 of the *Medicare Claims Processing Manual* to reflect that the use of the NPI will be mandated for Medicare FFS claims at a future date.

Additional Information

The official instruction, CR5678, issued to your carrier, A/B MAC, or DME MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1328CP.pdf** on the CMS website.

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

QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI) EDITS, VERSION 13.3, EFFECTIVE OCTOBER 1, 2007

~CMS MLN Matters~

MLN Matters Number: MM5703
Related CR Release Date: August 31, 2007
Related CR Transmittal #: R1330CP
Related Change Request (CR) #: 5703
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected

Physicians who submit claims to Medicare carriers and Part A/B Medicare Administrative Contractors (A/B MACs)

Background

This article is based on Change Request (CR) 5703 which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The latest package of CCI edits, Version 13.3, effective October 1, 2007, and the current Mutually Exclusive Code (MEC) edits will be available at **http://www.cms.hhs.gov/NationalCorrectCodInitEd/** on the Centers for Medicare & Medicaid Services (CMS) website.

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. 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
- Review of current coding practice.

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The latest package of CCI edits, Version 13.3, includes all previous versions and updates from January 1, 1996, to the present and will be organized in two tables:

- Column 1/ Column 2 Correct Coding Edits, and
- Mutually Exclusive Code (MEC) Edits.

Additional Information

The CCI and MEC file formats will be maintained in the Medicare Claims Processing Manual (Chapter 23, Section 20.9) which can be found at **http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage** on the CMS website.

The official instruction, CR 5703, issued to your carrier and A/B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1330CP.pdf** on the CMS website.

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

WPS Medicare Tip of the Week

(Published in the 09/17/07 General e-News Listserv)

WPS Medicare requests that providers not send unsolicited medical records to support a recently submitted claim. Due to the large number of claims we process, it is difficult for us to match unsolicited medical records with a Medicare claim currently in process. Providers wishing to submit documentation to support a claim should indicate in the narrative section of their electronic claim that documentation is available upon request. WPS Medicare will send the provider a request for the information only if we need it to process the claim. Providers who submit paper claims should continue to include their documentation with their CMS-1500 claim form.

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

Coverage – General

CLARIFICATION OF PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY (PTA) BILLING REQUIREMENTS ISSUED IN CR 3811

~CMS MLN Matters~

MLN Matters Number: MM5667 Revised
Related CR Release Date: August 10, 2007
Related CR Transmittal #: R1315CP
Related Change Request (CR) #: 5667
Effective Date: March 17, 2005
Implementation Date: October 1, 2007

Note: This article was revised on August 30, 2007, to correct the link to MLN Matters article MM3811 on page 2. A link was also added in the Additional Information section to another PTA-related article, MM5022, which provided clarification of MM3811. All other information remains unchanged.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), 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) 5667, which adds ICD-9-CM diagnosis code 433.11, occlusion of the carotid artery with infarct, to the list of payable claims for PTA to ensure all eligible Medicare beneficiaries are covered.

Background

On March 17, 2005, the Centers for Medicare & Medicaid Services (CMS) issued a National Coverage Determination (NCD) providing Medicare coverage for Percutaneous Transluminal Angioplasty (PTA) of the carotid artery concurrent with placement of an FDA-approved carotid stent when beneficiaries are at high risk for carotid endarterectomy (CEA). (This was announced in CR 3811, effective March 17, 2005; see related *MLN Matters* article at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf.**) The NCD provides coverage for patients with symptomatic carotid artery stenosis who meet the coverage criteria specified in the policy. As stated in the NCD,

- Patients who experience non-disabling strokes (modified Rankin scale < 3) are considered to be symptomatic and therefore **are** eligible for coverage; however,
- Patients who experience disabling strokes (modified Rankin scale ≥ 3) **are not** eligible for coverage.

Currently, there are no codes that distinguish between non-disabling and disabling strokes. In order to ensure that claims for all eligible patients can be paid, CR5667 adds the following International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code of 433.11 (Occlusion and stenosis of carotid artery, with cerebral infarction) to the list of payable claims for carotid artery stenting (CAS).

Patients who experience disabling strokes remain ineligible for coverage.

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Note that Medicare contractors will not search their files to reprocess claims already processed. However, they will adjust such claims if you bring the claims to their attention. Also, since the Centers for Medicare & Medicaid Services (CMS) considers this an administrative error, your Medicare contractor will follow the guidelines in the *Medicare Claims Processing Manual* (Chapter 1, Section 70.7.1) for allowing an extension to the timely filing limits. In essence, this allows your contractor to accept claims with 433.11 outside the timely filing limitations, since such claims were not previously payable due to the administrative error. Medicare manuals are available at **http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage** on the CMS website.

CR5667 also advises providers that they can correctly bill covered bilateral carotid services by coding both 433.30 (Occlusion and stenosis of multiple and bilateral arteries, without mention of cerebral infarction) or 433.31 (Occlusion and stenosis of multiple and bilateral arteries, with cerebral infarction) and 433.10 (Occlusion and stenosis of carotid artery, without mention of cerebral infarction) or 433.11 in any order on the same claim. Providers would code 433.30 with 433.10 or 433.31 with 433.11 to identify the multiple and bilateral condition and 433.10 or 433.11 to specifically identify the carotid artery.

Claims submitted by physicians to carriers or MACs may also contain a CPT code of 37215 (Transcatheter placement of intravascular stent(s), cervical carotid artery, Percutaneous; with distal embolic protection), 0075T (Transcatheter placement of extracranial vertebral or intrathoracic carotid artery stent(s), including radiologic supervision and interpretation, percutaneous; initial vessel), or 0076T (Each additional vessel). Claims submitted by institutional providers to FIs or MACs should contain the appropriate procedure codes of 00.61 (Percutaneous angioplasty or atherectomy of precerebral (extracranial) vessels) and 00.63 (Percutaneous insertion of carotid artery stent(s)).

Additional Information

MM3489, Percutaneous Transluminal Angioplasty (PTA), can be found at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3489.pdf** on the CMS website.

MM3811, Expansion of Coverage for Percutaneous Transluminal Angioplasty (PTA), is located at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3811.pdf** on the CMS website.

MM5022, Clarification on Billing Requirements for Percutaneous Transluminal Angioplasty (PTA) Concurrent with the Placement of an FDA-approved Carotid Stent, is located at **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5022.pdf** on the CMS website.

The official instruction, CR5667, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at **http://www.cms.hhs.gov/Transmittals/downloads/R1315CP.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 is at **http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip** on the CMS website.

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MEDICARE CLINICAL TRIAL POLICY (CTP)

~CMS MLN Matters~

MLN Matters Number: MM5719
Related CR Release Date: September 7, 2007
Related CR Transmittal #: R74NCD

Related Change Request (CR) #: 5719
Effective Date: July 9, 2007
Implementation Date: October 9, 2007

Provider Types Affected

All physicians, providers, and suppliers who submit claims related to clinical trials to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), durable medical equipment Medicare Administrative Contractors (DME/MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)).

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5719, which implements two changes to the 2000 clinical trial policy by: (1) modifying for clarity the language describing coverage of an investigational item/service in the context of a clinical trial, and, (2) adopting coverage with evidence development (CED). The remainder of the 2000 clinical trials policy continues without change.

CR 5719 states that for items and services furnished on and after July 9, 2007, the routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries (i.e., there exists a benefit category, it is not statutorily excluded, and there is not a national non-coverage decision) that are provided in either the experimental or the control arms of a clinical trial. The investigational item or service itself is excluded, *unless otherwise covered outside of the clinical trial.*

CAUTION – What You Need to Know

In addition, the National Coverage Determination (NCD) is revised to add coverage with evidence development (CED). CED is for items and services in clinical research trials for which there is some evidence of significant medical benefit, but for which there is insufficient evidence to support a “reasonable and necessary” determination. CED is determined through the NCD process, and conditional upon meeting standards of patient safety and clinical evidence, items and services not otherwise covered would be considered "reasonable and necessary" in the context of a clinical trial. Coverage determined under CED is implemented via subsequent NCDs, CRs, and *MLN Matters* articles specific to the coverage issue.

GO – What You Need to Do

Make certain your billing staffs are aware of these changes. Medicare contractors will adjust claims processed prior to the implementation date of this change if you bring such claims to their attention.

Background

On June 7, 2000, the President of the United States issued an executive memorandum directing the Secretary of Health and Human Services to "explicitly authorize [Medicare] payment for routine patient care costs and costs due to medical complications associated with participation in clinical trials." In keeping with the President's directive, the Centers for Medicare & Medicaid Services (CMS) engaged in defining the routine

costs of clinical trials and identifying the clinical trials for which payment for such routine costs should be made. On September 19, 2000, CMS implemented its initial Clinical Trial Policy through the NCD process. On July 10, 2006, CMS opened a reconsideration of its NCD on clinical trials in the NCD Manual, section 310.1. CR5719 communicates the findings resulting from that analysis.

Additional Information

To see the official instruction (CR5719) issued to your Medicare FI, carrier, DME/MAC, RHHI or A/B MAC, visit **http://www.cms.hhs.gov/transmittals/downloads/R74NCD.pdf** on the CMS website.

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

ULTRASOUND DIAGNOSTIC PROCEDURES

~CMS MLN Matters~

MLN Matters Number: MM5608
Related Change Request (CR) #: 5608
Related CR Release Date: September 12, 2007
Effective Date: May 22, 2007
Related CR Transmittal #: R76NCD
Implementation Date: September 28, 2007

Provider Types Affected

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FIs), and Medicare Administrative Contractors (MACs) for ultrasound diagnostic procedures.

What Providers Need to Know

CR 5608, from which this article is taken, announces that effective on and after May 22, 2007, the Centers for Medicare & Medicaid Services (CMS) will allow payment for the monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the intensive care unit (ICU) and for operative patients with a need for intra-operative fluid optimization.

Make sure that your billing staffs are aware of this change in the ***National Coverage Determinations (NCD) Manual***, Chapter 1 (Coverage Determinations), Section 220.5 (Ultrasound Diagnostic Procedures) to allow coverage for this procedure.

Background

CR 5608, from which this article is taken, announces:

- Effective for claims with dates of service on and after May 22, 2007, CMS has determined that esophageal Doppler monitoring of cardiac output for ventilated patients in the ICU and for operative patients with a need for intra-operative fluid optimization is reasonable and necessary; and
- The previous national non-coverage of cardiac output Doppler monitoring is therefore removed.

Specifically, in CR 5608, CMS amends the Medicare *NCD Manual,* Chapter 1 (Coverage Determinations), Section 220.5 (Ultrasound Diagnostic Procedures), by adding:

"Monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization" to Category I (covered procedures), and deleting "Monitoring of cardiac output (Doppler)" from Category II (non-covered procedures).

Notes:

There is no specific CPT code for this service. CPT code 76999 is for unlisted ultrasound procedures.

When performed in a hospital setting for ventilated patients in the ICU or for operative patients with a need for ultrasound diagnostic procedures, the professional services only are separately payable when billed using CPT code 76999 with the modifier -26 to show professional component.

Such services, when globally billed in a hospital setting with code 76999, will be returned as unprocessable to the provider with a reason code such as 58 denoting "Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service."

When such services are billed in a hospital setting as technical services with the code 76999-TC, Medicare will deny the services with the 58 reason code and an M77 remark code to show "Missing/Incomplete/Invalid place of service."

When performed in an ambulatory surgery center (ASC), ultrasound diagnostic procedures are covered when performed by an entity other than the ASC if globally billed using code 76999, or the technical and professional components may be separately billed using codes 76999-TC and 76999-26, respectively.

Ultrasound diagnostic procedures professional services billed using codes 76999, 76999-T, and 76999-26 are carrier-priced.

Medicare contractors will not search their files to identify and adjust claims processed prior to the implementation of this change, which are for services rendered on or after May 22, 2007. However, they will adjust such claims when you bring the claims to their attention.

Additional Information

You can find more information about the coverage of esophageal Doppler monitoring of cardiac output by going to CR 5608, located at **http://www.cms.hhs.gov/Transmittals/downloads/R76NCD.pdf** on the CMS website. You will find the amended *Medicare NCD Manual*, Chapter 1 (Coverage Determinations), Section 220.05 (Ultrasound Diagnostic Procedures), as an attachment to that CR.

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.

Coverage – Policies

INFORMATION ON WEBSITE

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

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

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

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

Revised Policies for October 2007

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
AN-001	*Anesthesia Services*	NCP	Click here to view	18
INJ-025	*Bisphosphonate Drug Therapy*	LCD	Click here to view	18
PHYS-077	*Clinical Trials*	NCD	Click here to view	20
RAD-004	*Coding and Billing Guidelines for Radiologic Examination of the Chest, Including Portable (RAD-004)*	LCD	Click here to view	20

Coverage – Revised Policies

National Coverage Provision

Subject:
Anesthesia Services

Subject Number:
AN-001

Effective Date:
January 1, 2006

Implementation Date:
October 1, 2007

Anesthesia Services Furnished by the Same Physician Providing the Medical and Surgical Service

WPS Medicare is updating our National Coverage Provision (NCP) AN-001 *Anesthesia Services,* per the Centers for Medicare & Medicaid Services (CMS) Change Request (CR) 5618, Transmittal 1324.

The CMS is revising the anesthesia policy in the CMS Internet Only Manual (IOM) Publication 100-04, Chapter 12, Section 50. The revision makes this section of the IOM consistent with the pricing of the conscious sedation codes under the Medicare physician fee schedule and the *Current Procedural Terminology* CPT coding guidelines. CR 5816 applies to CPT codes 99143 through 99150. CMS added new language explaining the payment policy if the same physician performs the medical/surgical service and the conscious sedation service.

In addition, CMS is deleting Exhibit 1 that lists the base units by anesthesia code. This exhibit is out of date and CMS communicates the material to the carriers annually via the HCPCS file.

Please refer to our updated NCP AN-001 *Anesthesia Services* in its entirety on the WPS Medicare Website.
http://www.wpsmedicare.com/policies/wisconsin/an001.pdf
The asterisked (*) text indicates changes made since the last publication date.

You may locate the official instructions issued to your Medicare carrier and intermediary regarding this change on the following on the CMS Website.
http://www.cms.hhs.gov/transmittals/downloads/R1324CP.pdf

LCD Title
Bisphosphonate Drug Therapy

Contractor's Determination Number
INJ-025

***Revision Effective Date**
08/17/2007

Indications and Limitations of Coverage and/or Medical Necessity

*C. Ibandronate [Boniva] (effective with FDA approval 01/06/2006); Pamidronate: or Zolendronic acid (05/01/2006, off-label) *Reclast® (August 17, 2007 – FDA approval) are covered for:

1. Treatment of osteoporosis (733.00 -733.09) when;

   Bisphosphonates remain the most appropriate anti-osteoporosis intervention, and there is no class contraindication or hypersensitivity to bisphosphonates, and there exists either:

   - Demonstrated intolerance or contraindication for FDA approved oral bisphosphonates and oral dosing regimens, or insurmountable issues related to absorption, compliance or dosing posture, or
   - When adequate trials of FDA-approved oral bisphosphonates result in fallen BMD and/or failure to suppress bone turnover (e.g. persisting high bone -turnover marker measurements.)

     The World Health Organization (WHO) defines osteoporosis as spine, hip, or wrist bone mineral density (BMD) T-score <-2.5 **or** prevalent fragility fracture; and severe osteoporosis as T-score <-2.5 **and** prevalent fragility fracture

   Evidence in the medical record should clearly support the need for the intravenous administration of bisphosphonates for the treatment of osteoporosis.

   The recommended dose of Boniva Injection for the treatment of postmenopausal osteoporosis is 3 mg every 3 months.

   *The recommended dose of Reclast® for treatment of postmenopausal osteoporosis is a single 5 mg infusion once a year given intravenously over no less than 15 minutes. (5 mg in a 100 mL ready to infuse solution)

Precautions
Hypocalcemia may occur with Reclast therapy. To reduce the risk of hypocalcemia, all patients should receive 1500 mg elemental calcium daily in divided doses (750 mg two times a day, or 500 mg three times a day) and 800 IU vitamin D daily, particularly in the 2 weeks following Reclast administration.

Reclast may cause fetal harm when administered to a pregnant woman. Reclast should not be used during pregnancy.

Reclast is not recommended for use in patients with severe renal impairment (creatinine clearance <35mL/min) due to lack of adequate clinical experience in this population.

Reclast has been associated with heart arrhythmia problems in the form of atrial fibrillation.

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

National Coverage Decision

Subject Name: Clinical Trials

Subject Number: PHYS 077

CMS National Coverage Policy:
Effective for items and services furnished on or after July 9, 2007, Medicare covers the National Coverage Decision Manual - 310.1 - Routine Costs in Clinical Trails (Rev. 74, Issued: 09-07-07, Effective: 07-09-07, Implementation: 10-09-07) Formerly: CIM 30-1

This policy has been revised in accordance with NCD-REV-74, CR 5719, "Medicare Clinical Trial Policy (CTP)." Please read the revised policy on the WPS Medicare Website

Companion Document
Revision Article

Coding and Billing Guidelines for Radiologic Examination of the Chest, Including Portable (RAD-004)

Contractor Name:
Wisconsin Physician Service (WPS)

Contractor Number:
00951, 00952, 00953, 00954

Coding Guidelines
4. *When billing for a non-covered service, use one of the ICD-9 codes listed below and report the service with the modifier GY.

Note: Corrected direction from “use one of the ICD-9 codes listed above…” to “use one of the ICD-9 codes listed below…” Deleted from same sentence (items statutorily excluded or does not match the definition of any Medicare benefit).

WPS Medicare Tip of the Week
(Published in the 08/27/07 General e-News Listserv)

Where can I find Medicare laws and regulations?

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

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

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Electronic Data Interchange (EDI)

CLAIMS ARE BEING REJECTED—ARE YOUR CLAIMS AFFECTED?—REVIEW YOUR CLAIM FILE PRE-PASS REPORTS

WPS Medicare has begun editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. If you are sending the NPI and the legacy ID, we will verify for a match on the Medicare crosswalk file. If they do not appear as a match, your claims will reject. You will not get a remittance on claims that have rejected. The only notification that you will receive will be the claim file pre-pass report. If you submit claims directly to Medicare and are not currently reviewing this report, you need to begin doing so immediately. If you submit through a clearinghouse and are not currently receiving this report from them, you will need to contact them to obtain it.

For a complete list of the current pre-pass edits you can go to the following Website:
http://www.wpsic.com/edi/pdf/hipaa_mcs837.pdf

What should you do if you fail a pre-pass edit?
Read your report. Make sure that the provider/NPI combination is valid. Go to NPPES; add your legacy.

Failing M379, 381 or M382?
Make sure you are sending the correct qualifier with your social security number or EIN.

Watch for the following Medicare Part B Pre-pass report NPI error messages:

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

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

WPS Medicare Tip of the Week

(Published in the 05/04/07 General e-News Listserv)

Are you still using the old http://www.wpsic.com/medicare address to get to the WPS Medicare Website? Check your bookmarks and change them to ***http://www.wpsmedicare.com*** *if necessary. While the older address still works, it will no longer be valid in the near future, so change your bookmarks now to avoid missing out on any vital Medicare information.*

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

General Information

CLAIMS INVOLVING BENEFICIARIES WHO HAVE ELECTED HOSPICE COVERAGE

Medicare beneficiaries entitled to Hospital Insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare-certified hospice is covered under the hospice benefit provisions. Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the hospice patient's lifetime.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of the terminal illness during any period the beneficiary's hospice benefit election is in force, except for professional services of an "attending physician." For purposes of administering the hospice benefit provisions, an "attending physician" means a physician who:

- Is a doctor of medicine or osteopathy; and
- Is identified by the individual, at the time the individual elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.
- Is a nurse practitioner. (For further explanation, see the CMS MLN Matters article at: **http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3226.pdf**

The beneficiary may designate and use an attending physician, who is not employed by the hospice, for professional services furnished in addition to the services of hospice-employed physicians. The professional services of an attending physician that are reasonable and necessary for the treatment and management of a hospice patient's terminal illness are not considered hospice services. Provided he or she does not furnish the services under a payment arrangement with the hospice, the services of the attending physician are billed to Medicare Part B with **modifier GV,** *Attending physician not employed or paid under agreement by the patient's hospice provider*. If a substitute or locum tenens physician provides services, the services are billed by the designated attending physician under the reciprocal or locum tenens billing instructions by use of **modifier GV** in conjunction with either the **Q5** or the **Q6 modifier**. Payment is made to the attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service. Services not related to the hospice patient's terminal condition are coded with the **GW modifier,** *Service not related to the hospice patient's terminal condition*.

If a private attending physician furnishes services related to a hospice patient's terminal condition under a payment arrangement with the hospice, such services are considered "hospice services" and are billed by the hospice to Medicare Part A. Hospice physician services are paid by the hospice intermediary, Part A, at 100 percent of Medicare-approved charges.

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

NEW REMARK CODE FOR DENYING SEPARATELY BILLED SERVICES

~CMS MLN Matters~

MLN Matters Number: MM5659 Revised
Related CR Release Date: August 17, 2007
Related CR Transmittal #: R1333CP

Related Change Request (CR) #: 5659
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Note: This article was revised on September 10, 2007, to reflect that CR5659 was revised. The CR transmittal number (see above) and the Web address for accessing CR5659 were revised. All other information remains the same.

Provider Types Affected

Medicare providers who submit claims to Medicare Part A/B Medicare Administrative Contractors (A/B MACs) or carriers for ambulance services rendered to Medicare beneficiaries.

Provider Action Needed

Be aware that contractors will use a new Remittance Advice Remark Code (RARC) message when denying ambulance claims submitted with a code(s) that is not separately billable and already included in the base rate. For claims submitted by ambulance suppliers that Medicare processes on or after October 1, 2007, and which Medicare denies because the code for the service does not appear on the Ambulance Fee Schedule, Medicare will return the RARC of N390 to show "This service cannot be billed separately." See the remainder of this article for further details.

Key Points of CR5659

- Effective October 1, 2007, the new Remittance Advice Remark Code N390 and N185 with Claim Adjustment Reason Code 97, group code CO, will be used when denying any codes on the ambulance claims that does not appear on the Ambulance Fee Schedule.
- For such claims processed and denied on or after October 1, 2007, the following Medicare Summary Notice (MSN) message will be sent to Medicare beneficiaries: "16.45 - You cannot be billed separately for this item or service. You do not have to pay this amount."

Background

CR5659 is the official document that announces these changes in Medicare processes and states that effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when the Centers for Medicare & Medicaid Services (CMS) fully implemented the Ambulance Fee Schedule. Therefore, payment is based solely on the Ambulance Fee Schedule amount as cited in 42 CFR § 414.615 (e) and such payment represents payment in full for all services, supplies, and other costs for an ambulance service furnished to a Medicare beneficiary. CMS was made aware that some providers are submitting claims with ancillary services that are included in the base rate.

CMS decided that a clearer denial message was needed to explain the reason for the denial and that this service is not separately billable and as a result, these claims/services should not be resubmitted. This is true whether the primary transportation service is allowed or denied. Remember that when these services are denied, the services are not separately billable to the beneficiaries.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5659) issued to your Medicare carrier or A/B MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1333CP.pdf** on the CMS website.

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

NURSE PRACTITIONER (NP) SERVICES AND CLINICAL NURSE SPECIALIST (CNS) SERVICES

~CMS MLN Matters~

MLN Matters Number: MM5639
Related CR Release Date: August 17, 2007
Related CR Transmittal #: R75BP and R219PI
Related Change Request (CR) #: 5639
Effective Date: November 19, 2007
Implementation Date: November 19, 2007

Provider Types Affected

Nurse practitioners (NP) and clinical nurse specialist (CNS) who bill Medicare Carriers and Medicare Administrative Contractors (A/B MACs) for services provided to Medicare Beneficiaries.

What You Need to Know

In CR 5639, from which this article is taken, the Centers for Medicare & Medicaid Services (CMS) announces that their manuals are being updated by adding the National Board on Certification of Hospice and Palliative Nurses (NBCHPN) to the list of recognized national certifying bodies for NPs. This list will also provide the new name for the National Certification Board of Pediatric Nurse Practitioners and Nurses and provide the correct reference for the Critical Care Certification Corporation. This same list of recognized national certifying bodies for advanced practice nurses will be included under the manual instruction on CNS services.

Carriers and A/B MACs will enroll nurses, under the NP and CNS benefits, who meet all of the other NP or CNS qualifications; and are certified as advanced practice nurses by any of the recognized national certifying bodies listed below, effective November 19, 2007.

Background

Federal regulations that govern nurse practitioner (NP) services at 42 CFR 410.75 and those governing the clinical nurse specialists (CNS) services at 42 CFR 410.76 require

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that these advanced practice nurses be certified by a national certifying body that has established standards for NPs and CNSs.

CR 5639, from which this article is taken, announces that CMS is adding the National Board on Certification of Hospice and Palliative Nurses (NBCHPN) to the list of recognized national certifying bodies for NPs at the advanced practice level, located in the ***Medicare Benefit Policy Manual,*** Chapter 15 (Covered Medical and Other Health Services), Section 200 (Nurse Practitioner (NP) Services). CR5639 also announces the addition of this same list of recognized national certifying bodies for advanced practice CNSs in Section 210 (Clinical Nurse Specialist (CNS) Services) and in Chapter 10, Sections 12.4.5 and 12.4.8 of the ***Medicare Program Integrity Manual***.

Effective November 19, 2007, the list of recognized national certifying bodies for NPs and CNSs at the advanced practice level is as follows:

- American Academy of Nurse Practitioners;
- American Nurses Credentialing Center;
- National Certification Corporation for Obstetric, Gynecologic and Neonatal Nursing Specialties;
- Pediatric Nursing Certification Board (previously named the National Certification Board of Pediatric Nurse Practitioners and Nurses);
- Oncology Nurses Certification Corporation;
- AACN Certification Corporation; and
- National Board on Certification of Hospice and Palliative Nurses.

Additional Information

You can find more information about NP and CNS services by going to CR 5639, which is in two transmittals located on the CMS website. As an attachment to transmittal R75BP (**http://www.cms.hhs.gov/Transmittals/downloads/R75BP.pdf**), you will find updated ***Medicare Benefit Policy*** manual, Chapter 15 (Covered Medical and Other Health Services), Sections 200 (Nurse Practitioner (NP) Services) and 210 (Clinical Nurse Specialist (CNS) Services). As an attachment to transmittal R219PI (**http://www.cms.hhs.gov/Transmittals/downloads/R219PI.pdf**), you will find updated Chapter 10, Sections 12.4.5 and 12.4.8 of the ***Medicare Program Integrity Manual***.

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

QUARTERLY PROVIDER UPDATE

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare, including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at:
http://www.cms.hhs.gov/QuarterlyProviderUpdates/

We encourage you to bookmark this Website and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update Listserv (electronic mailing list) at:
http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1

REVISION TO CERTIFICATION FOR HOSPITAL SERVICES COVERED BY THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM AS IT PERTAINS TO AMBULANCE SERVICES

~CMS MLN Matters~

MLN Matters Number: MM5684
Related CR Release Date: August 17, 2007
Related CR Transmittal #: R47GI
Related Change Request (CR) #: 5684
Effective Date: September 17, 2007
Implementation Date: September 17, 2007

Provider Types Affected

Physicians and hospitals who bill Medicare Fiscal Intermediaries (FIs), Carriers, and A/B Medicare Administrative Contractors (MAC) for ambulance services for Medicare patients.

Background

CR5684 furnishes the revised Certification for Hospital Services by the Supplementary Medical Insurance Program as those requirements pertain to physician certification of ambulance services in Chapter 4, Section 20 of the *Medicare General Information, Eligibility, and Entitlement Manual.*

Key Points of CR5684

- Prior to the effective date (September 17, 2007) of CR5684, certification by a physician in connection with ambulance services furnished by a participating hospital was required.

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

- As of the effective date of CR5684, language requiring physician certification for ambulance services furnished by a participating hospital is deleted from the above mentioned Medicare manual.
- Your Medicare FI, Carrier or A/B MAC has been instructed to comply with this revision.

Additional Information

To view the official instruction (CR5684) issued to your Medicare FI, Carrier or A/B MAC, visit **http://www.cms.hhs.gov/Transmittals/downloads/R47GI.pdf** on the CMS website. The revised manual section is attached to CR5684.If you have questions, please contact your Medicare FI, 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.

TRANSITIONING THE MANDATORY MEDIGAP ("CLAIM-BASED") CROSSOVER PROCESS TO THE COORDINATION OF BENEFITS CONTRACTOR (COBC)

~CMS MLN Matters~

MLN Matters Number: MM5601 Revised
Related CR Release Date: August 31, 2007
Related CR Transmittal #: R1332CP

Related Change Request (CR) #: 5601
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Note: This article was revised on September 3, 2007, to reflect changes CMS made to CR5601, which was re-issued on August 31, 2007. The CR transmittal number, release date, and the web address for accessing CR5601 were revised in this article. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5601, which outlines the Centers for Medicare & Medicaid Services (CMS) systematic requirements for the transitioning of its mandatory Medigap (“claim-based”) crossover process from its Part B contractors to the COBC. During the period from June through September 2007, CMS’ Coordination of Benefits Contractor (COBC) will sign national crossover agreements with Medigap claim-based crossover insurers and will assign new 5-digit Coordination of Benefits (COBA) Medigap claim-based crossover identifiers to these entities for inclusion on incoming Medicare claims. CMS is also preparing a separate change request (CR 5662) that includes the website where provider billing staffs may go to obtain the listing of new COBA Medigap claim-based identifiers for purposes of initiating Medigap claim-based crossovers. Within the next few weeks, following the issuance of CR 5662, providers will

also receive more detailed information regarding this change via their Medicare contractors' provider newsletters/bulletins and websites.

CAUTION – What You Need to Know

October 1, 2007 is the effective date for completing the transition of the Medigap crossover process to the COBC. At that time, CMS will then only support the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X-12N 837 professional COB (version 4010-A1) claim format **and National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claim format for such crossovers.** As CMS' COBC assigns the new COBA Medigap claim-based ID to the Medigap insurers, it will populate this information on its COB website so that provider billing staffs may access it for purposes of including the new identifiers on incoming Medicare Part B claims, claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and NCPDP Part B drug claims. By October 1, 2007, providers will exclusively be including the new identifiers on incoming claims to initiate Medigap claim-based crossovers.

GO – What You Need to Do

During June through September, 2007, CMS will gradually be moving Medigap insurers to the new process. Be certain that your billing staffs are aware of these changes and that claims are sent to Medicare contractors in a timely and correct manner.

Background

Currently, in accordance with §1842(h)(3)(B) of the Social Security Act and §4081(a)(B) of Public Law 100-203 (the Omnibus Budget Reconciliation Act of 1987), Part B contractors, including carriers and Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs) transfer participating provider claims to Medigap insurers if the beneficiary has assigned rights to payment to the provider and if other claims filing requirements are met. This form of claims transfer is commonly termed "Medigap claims-based crossover." One of the "other" claims filing requirements for Medigap claim-based crossover is that the participating provider must include an Other Carrier Name and Address (OCNA) or N-key identification number on the incoming electronic claim to trigger the crossing over of the claim.

Key Points of CR5601

- Be aware that during the transition period from June through September 2007 the COBC will assign new 5-byte claim-based Coordination of Benefits Agreement (COBA) IDs to the Medigap insurers on a graduated basis throughout the three month period prior to the actual transition. Until CMS' COBC assigns a new 5-digit COBA Medigap claim-based ID to a Medigap insurer, Medicare will continue to accept the older contractor-assigned OCNA or N-key identifiers for purposes of initiating Medigap claim-based crossovers. During June through September 2007, the affected contractors will also continue to cross claims over as normal to their Medigap claim-based crossover recipients. CMS will be regularly apprising the affected Medicare contractors when -the COBC has assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB website so that contractors **may direct providers to that link for purposes of obtaining regular updates.**

- Effective with claims filed to Medicare on October 1, 2007:
  - All participating providers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) should enter CMS' newly assigned COBA Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers.
  - All other participating providers shall enter the newly assigned COBA Medigap claim-based ID, left-justified and followed by spaces, within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim **and** within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers.
- Providers will need to make certain that claims are submitted with the appropriate identifier that begins with a "5" and contains "5" numeric digits.
- Be mindful that claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. If your claim does not follow the appropriate format, Medicare will continue to adjudicate your claim as normal but will notify you via the Electronic Remittance Advice (ERA) and the beneficiary via the Medicare Summary Notice (MSN) that the information reported was insufficient to cause the claim to be crossed over.
- Your Medicare contractor's screening process will also -continue to verify that you participate with Medicare and that the beneficiary has assigned benefits to you as the provider.
- If the claim submitted to the Medicare contractor indicates that (1) the claim contained an invalid claim-based Medigap crossover ID, **the Medicare contractor** will send the following standard message to you, the provider.
  - "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. **Please verify your information and submit your secondary claim directly to that insurer."**
- In addition, in these cases, if CMS' Common Working File (CWF) system determines that the beneficiary was identified for crossover on a Medigap insurer's eligibility file, the CWF system will suppress crossover to the Medigap insurer whose information was entered on the incoming claim.
- Also, the Medicare contractor will include the following message on the beneficiary's MSN in association with the claim: (MSN #35.3):
  - "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."

- **REMEMBER:** As CMS's COBC assigns new 5-digit COBA Medigap claim-based identifiers to Medigap insurers, participating providers will be expected to include the new 5 digit identifier on incoming crossover claims for purposes of triggering claim-based Medigap crossovers. Additionally, effective with **October 1, 2007, Medigap claim-based crossovers will occur exclusively through the COBC in the HIPAA ANSI X12-N 837 professional claim format (version 4010A1 or more current standard) and NCPDP claim format**.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5601) issued to your Medicare carrier, A/B MAC, or DME MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1332CP.pdf** on the CMS website.

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

WPS Medicare Tip of the Week

(Published in the 09/24/07 General e-News Listserv)

Who processes charges for services provided to Medicare patients?

The services provided determine the contractor that will process the claim.

- *Providers submit claims for physician services, independent laboratory services, ambulance services and other Part B services to WPS Medicare Part B.*
- *Providers should submit claims for patients with Railroad Medicare (the HICN begins with a letter) to Palmetto GBA Railroad Medicare.*
- *National Government Services (DME MAC, formerly AdminaStar Federal) processes claims for durable medical equipment.*

Your Fiscal Intermediary processes claims for hospital charges.

- *In Wisconsin, Illinois, and Michigan – National Government Services (formerly United Government Services and AdminaStar Federal)*
- *In Minnesota – Noridian Administrative Services*

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http://www.wpsmedicare.com/listserv

Program Safeguards

SANCTIONED AND REINSTATED PROVIDERS

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

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

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

WPS will not issue payments for services performed, ordered, or referred by these providers after the indicated dates. All providers are excluded as of August 20, 2007, unless otherwise indicated after their name.

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

Illinois Sanctioned Providers

Name/Specialty/Address/Date of Birth
Cheryl Jean Apollo, S.W. Social Worker 844 East Jackson Morton, IL 61550 02-09-1947
Midwest Medical Laboratory Laboratory 1915 N. Harlem Chicago, IL 60707 N/A **EXCLUDED: 01/19/2007**

Name/Specialty/Address/Date of Birth
John A. Petrovich, Jr., M.D. Surgeon 29 Flower Hill Ct. St. Louis, MO 63122 07/01/1959

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Illinois Reinstated Providers

Name/Specialty/Address/Date of Birth	Name/Specialty/Address/Date of Birth
Nicholas C. Atkins Owner/Operator 1340 Beacon Lane Bartlett, IL 60103 07/16/1970 **REINSTATED: 07/26/2007**	Susan Charow Sherman, M.D. Medical Doctor 749 Elm Street Flossmoor, IL 60422 04/30/1948 **REINSTATED: 08/02/2007**
Jane N. Buikema Nurse/Nurses Aide 504 S. Orange St. Morrison, IL 61270 08/27/1961 **REINSTATED: 07/13/2007**	

Michigan Sanctioned Providers

Name/Specialty/Address/Date of Birth	Name/Specialty/Address/Date of Birth
Eric A. Anderson, P.A. Physician Assistant 1701 Oswego St., NW Grand Rapids, MI 49504 03/01/1972	Marie Jo Mellon Officer/Execut/Board 50807 Lenox New Baltimore, MI 48047 12/11/1941
Lisa Carol Coney Nurse/Nurses Aide 182 Garfield Ave. Battle Creek, MI 49017 12/08/1968	Mukunda Dev Mukherjee, M.D. Family Practice P O Box 12015, #32278-039 Terre Haute, IN 47801 07/05/1942
Jeffery Scott Cooke, D.P.M. Podiatrist 2581 Pebble Beach Oakland, MI 48363 06/01/1956	Igor Murin Owner/Operator 100 E. 2nd St., #A098708635 Monroe, MI 48161 12/16/1963
Wendy Ann Hoogterp Nurse/Nurses Aide 1928 Hollow Creek Dr., SE Caledonia, MI 49316 11/15/1965	John Joseph Oliver, D.O. Doctor of Osteopathy 215 Maple St. Manistee, MI 49660 12/20/1938
Horizon Residential Centers Inter Care Facility 36355 Main Street New Baltimore, MI 48047 N/A	Gloria Ann Rayourriego Nurse/Nurses Aide 2133 Fordney St. Saginaw, MI 48601 11/08/1946

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Name/Specialty/Address/Date of Birth	Name/Specialty/Address/Date of Birth
Thomas Paul Johnson, D.C. Chiropractor 1936 Edgwood Dr. Defiance, OH 43512 07/13/1966 Brenda Kay Luther Nurse/Nurses Aide 1009 Oaklawn St. NE Grand Rapids, MI 49505 03/30/1957	Richard Charles Sprague Nurse/Nurses Aide 69091 W. 92nd St. Fremont, MI 49412 12/07/1952

Minnesota Sanctioned Providers

Name/Specialty/Address/Date of Birth	Name/Specialty/Address/Date of Birth
Barry Jay Meringdol Owner/Operator 297 S. Century Ave. Maplewood, MN 55119 04/30/1962 Daniel Sarpong Owner/Operator 4516 104th Avenue North Brooklyn Park, MN 55443 07/02/1955	Margaret Sarpong Owner/Operator 4516 104th Avenue North Brooklyn Park, MN 55443 10/16/1958

Minnesota Reinstated Providers

Name/Specialty/Address/Date of Birth
Lyle G. Elenkiwich, S.W. Social Worker 2311 146th Ave., NE Ham Lake, MN 55304 07/06/1949 **REINSTATED: 07/17/2007**

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Wisconsin Sanctioned Providers

Name/Specialty/Address/Date of Birth	Name/Specialty/Address/Date of Birth
Darnell Adkins Owner/Operator 2344 W. Oliver St. Milwaukee, WI 53209 08/12/1968 Thubten Dargyel Nurse/Nurses Aide 100 Corrections Dr., #480916 Stanley, WI 54768 03/25/1951	James George Doeslaere Nurse/Nurses Aide 2925 Columbia Dr, P O Box 900 Portage, WI 53901 01/28/1958

WPS Medicare Tip of the Week

(Published in the 09/04/07 General e-News Listserv)

How do I know when I can charge the patient for services that Medicare denied?

Included in the information on the Provider Remittance Notice (PRN) is an ANSI (American National Standards Institute) message that either starts with PR (Patient Responsibility) or CO (Contractor Obligation). You may charge the patient for anything that is denied as a PR.

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http://www.wpsmedicare.com/listserv

Provider Education

EDUCATION SCHEDULE FOR FISCAL YEAR 2008

Wisconsin Physicians Service (WPS) Medicare Provider Outreach staff is currently planning programs for this coming fiscal year. As always, WPS Medicare and the Centers for Medicare & Medicaid Services are firmly committed to providing the education that meets a provider's or partner's need to understand and work successfully with Medicare. Our goal is to continue to provide high quality education that will offer a broad base of Medicare knowledge, as well as provide specific programs on special topics of interest. Thank you for your continuing interest in our educational offerings. We will notify you of the finalization of our schedule via WPS Medicare e-News (Listserv) messages, and our educational schedules and subsequent updates will be available at **http://wpsmedicare.com/provider/proved_seminar.shtml**

PLACE OF SERVICE (POS) 34 – HOSPICE

WPS Medicare recognizes that Current Procedural Terminology (CPT) codes for 2007 do not have specific codes for hospice care. Providers who are not employed by or under a financial arrangement with a hospice may need to bill for evaluation and management services for a hospice patient who is receiving respite care in a facility. Due to that fact, we would like to provide the following guidance for billing CPT codes and POS 34.

The WPS Medicare system recognizes POS 34 with three types of inpatient codes. The codes are inpatient CPT codes (99221 – 99239), nursing facility CPT codes (99304 – 99318), or inpatient consultation codes (99251-99255). WPS Medicare's system does not recognize other outpatient and observation CPT codes with POS 34.

A provider needs to determine the type of facility in order to determine the correct CPT code and POS 34 to submit. If the hospice is certified by Medicare and is part of a hospital or facility, then it may be appropriate to bill the inpatient hospital CPT codes in POS 34. If the hospice is a free-standing hospice, or located in a skilled nursing facility, or a domiciliary care facility the provider may want to bill the nursing facility codes in POS 34.

If the patient is receiving hospice services in the home, the correct POS is 12 – Home, not POS 34. The Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM) 100-04, Chapter 26, Section 10.5 defines POS 34 as "A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided." WPS Medicare does not accept CPT codes 99341 – 99350 when billed with POS 34 based on the definition in the IOM manual.

WPS Medicare's system does not recognize Domiciliary Care CPT codes 99324 – 99340 to be billable in POS 34, as the certification from Part A changes the bed from a domiciliary care bed to a hospice care bed. This type of certification from Part A is for a free-standing hospice facility and should follow the guidelines for that type of a facility.

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Reimbursement

ANESTHESIA SERVICES FURNISHED BY THE SAME PHYSICIAN PROVIDING THE MEDICAL AND SURGICAL SERVICE

~CMS MLN Matters~

MLN Matters Number: MM5618 Revised
Related CR Release Date: August 27, 2007
Related CR Transmittal #: R1324CP
Related Change Request (CR) #: 5618
Effective Date: January 1, 2006
Implementation Date: October 1, 2007

Note: This article was revised on August 28, 2007, to reflect changes made to CR5618 on August 27, 2007. CR5618 was modified to include the correct Medicare Summary Notice message number for notifying beneficiaries when they are not liable for payment. The CR transmittal number, release date, and the Web address for accessing CR5618 were also changed. All other information remains the same. Physicians are reminded to follow the coding guidelines in CPT, including those in Appendix G, for reporting the conscious sedation codes.

Provider Types Affected

Physicians and other practitioners who bill Medicare carriers and/or Medicare Administrative Contractors (A/B MACs) for anesthesia services provided in conjunction with the performance of medical/surgical services.

Provider Action Needed

STOP – Impact to You

Physicians who both perform, and provide moderate sedation for, medical/surgical services will be paid for the conscious sedation consistent with CPT guidelines. However, physicians who perform, and provide local or minimal sedation for, these procedures will not be paid separately for the sedation services.

CAUTION – What You Need to Know

The *Medicare Claims Processing Manual* (Publication 100-04) Chapter 12 (Physicians/Nonphysician Practitioners) Section 50A (General Payment) is being revised to be consistent with the pricing of the conscious sedation codes under the Medicare physician fee schedule payment system and CPT coding guidelines. In addition, a new section, 50L, explains the payment policy when the same physician performs both the medical/surgical service and the conscious sedation service, is added. Finally, Exhibit 1, that listed the base units by anesthesia code is deleted, because it is out of date and the material is communicated to carriers and Medicare Administrative Contractors (known as A/B MACs) annually via the HCPCS tape.

GO – What You Need to Do

Make sure that your billing staffs are aware of these new payment policies that address the same physician performing both the medical/surgical service and the conscious sedation service.

Background

The continuum of complexity in anesthesia services (from least intense to most intense) ranges from 1) local or topical anesthesia, 2) moderate (conscious) sedation, 3) regional anesthesia, to 4) general anesthesia. Moderate sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care.

CR 5618, from which this article is taken announces the revision of the anesthesia policy in the *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 50A (General Payment), to be consistent with the pricing of conscious sedation codes under the Medicare physician fee schedule and CPT coding guidelines. It further announces:

1) The addition of a new Section (50L), that explains the payment policy if the same physician performs the medical/surgical service and the conscious sedation service; and
2) The deletion of Exhibit 1, that lists the base units by anesthesia code because it is out of date and the material is communicated to the carriers annually via the HCPCS tape.

Currently, section 50A instructs carriers and MACs not to allow separate payment for the anesthesia service performed by the same physician who furnishes the medical or surgical services (for example, there is no separate payment allowed for a surgeon's performance of a local or surgical anesthesia if the surgeon also performs the surgical procedure; or a psychiatrist's performance of the anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs the electroconvulsive therapy).

The revised policy is: If the physician performing the procedure also provides moderate sedation for the procedure, then payment may be made for conscious sedation consistent with CPT guidelines; however, if the physician performing the procedure provides local or minimal sedation for the procedure, then no separate payment is made for the local or minimal sedation service.

Carriers and A/B MACS will not allow payment for codes 99148-99150 if any of these codes are performed on the same day with a medical/surgical service listed in Appendix G of CPT and the service is provided in a non-facility setting. A facility is defined in Chapter 23 Addendum of the *Medicare Claims Processing Manual* as one with a place of service code of 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, or 61.

Prior to 2006, Medicare did not recognize separate payment if the same physician both performed the medical or surgical procedure and provided the anesthesia needed for the procedure. The final physician fee schedule published in the Federal Register on November 21, 2005 included newly created codes (99143 to 99150) for moderate (conscious) sedation, which the CPT added in 2006.

Note: These codes have been assigned a status indicator of "C" under the Medicare physician fee schedule designating that these services are carrier priced. CMS has not established relative value units for these services.

Three of these codes (99143, 99144, and 99145) describe the scenario in which the same physician performing the diagnostic or therapeutic procedure provides the moderate sedation, and an independent trained observer's presence is required to assist in the monitoring of the patient's level of consciousness and physiological status. The other three codes (99148, 99149, and 99150) describe the scenario in which the moderate sedation is provided by a physician other than the one performing the diagnostic or therapeutic procedure.

CR 5618 presents some specific points that you should be aware of*:*

- CPT coding guidelines for conscious sedation codes instruct practices not to report Codes 99143 to 99145 in conjunction with the codes listed in CPT Appendix G. Your carrier or A/B MAC will follow the National Correct Coding Initiative, which added edits in April 2006 that bundled CPT codes 99143 and 99144 into the procedures listed in Appendix G (There are no edits for code 99145; it is an add-on-code and it is not paid if the primary code is not paid.)

- In the unusual event that a second physician (other than the one performing the diagnostic or therapeutic services) provides moderate sedation in the facility setting for the procedures listed in CPT Appendix G, the second physician can bill 99148 to 99150, but cannot report these codes when the second physician performs these services (on the same day as a medical/surgical service) in the non-facility setting.

- If an anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections, and a different provider performs the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using CPT code 01991. In this case, the service must meet the criteria for monitored anesthesia care. If the anesthesiologist or CRNA provides both the anesthesia service and the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using the conscious sedation code and the injection or block. However, the anesthesia service must meet the requirements for conscious sedation and if a lower level complexity anesthesia service is provided, then the conscious sedation code should not be reported.

- There is no CPT code for the performance of local anesthesia, and as such, payment for this service is considered to be part of the payment for the underlying medical or surgical service. Therefore, if the physician performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation (such as a local or topical anesthesia), then the conscious sedation code should not be reported and the carrier or A/B MAC will allow no payment.

- When denying claims, as appropriate under this policy, carriers and A/B MACs will use:

    - Medicare Summary Notice (MSN) message 16.8 when the service is bundled into the other service: "Payment is included in another service received on the same day;" In addition, the MSN (via MSN message 16.45) will note to the

beneficiary that "You cannot be billed separately for this item or service. You do not have to pay this amount."

- Claim adjustment reason code (CARC) 97: "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated;"

- Remittance advice remark code (RARC) M80: "We cannot pay for this when performed during the same session as another approved service for this beneficiary." Carriers and A/B MACs will note that the beneficiary is not liable for payment for claims denied as noted in the above MSN message.

- Finally, carriers and A/B MACs will adjust claims, brought to their attention, that were not processed in accordance with the Medicare physician fee schedule data base indicators assigned to the conscious sedation codes.

Additional Information

You can find the official instruction, CR 5618, issued to your carrier or A/B MAC by visiting **http://www.cms.hhs.gov/Transmittals/downloads/R1324CP.pdf** on the CMS website. You will find updated *Medicare Claims Processing Manual* (100-04), Chapter 12 (Physicians/Non-physician Practitioners) as an attachment to that CR.

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**

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) UPDATES

The following changes to HPSA designations have occurred:

Illinois

Primary Care HPSA

Eligible for dates of service on and after March 30, 2007

Douglas County – Entire County

Eligible for dates of service on and after January 22, 2007

LaSalle County – Mendota Service Area

Adams Township
Dimmick Township
Earl Township
Freedom Township
Mendota Township
Meriden Township
Ophir Township
Serena Township
Troy Grove Township

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Eligible for dates of service on and after March 30, 2007
Cook County –
North Lawndale/Garfield Park Service Area
Census Tracts:
2601 – 2610 2701 – 2719
2901 – 2927
Chicago Heights Service Area
Census Tracts:
8289
8292
8293.01

Eligible for dates of service on and after January 22, 2007
Ford County - Artesia/Loda/Pigeon Grove Service Area
Button Township
Dix Township
Lyman Township
Patton Township
Peach Orchard Township
Wall Township

Eligible for dates of service on and after January 22, 2007
Iroquois County - Artesia/Loda/Pigeon Grove Service Area
Artesia Township
Loda Township
Pigeon Grove Township

Eligible for dates of service on and after September 22, 2006
Ogle County – Entire County

**Changes to St. Clair County – East St. Louis Service Area
The previously listed census tracts have been replaced by these townships.
Canteen Township
Centreville Township
East St. Louis Township
Stites Township

*No longer eligible for dates of service on and after October 1, 2007
Lake County – Entire County

The following areas are eligible for dates of service prior to October 1, 2007
Waukegan/N. Chicago Area
Census Tracts:
8623 8627
8624 8628
8625 8629

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Mental Health HPSA

Eligible for dates of service on and after May 19, 2007

Monroe County – Entire County

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

Will County – East Joliet Area

Census Tracts:

8812 8813

8819 – 8825

8830 8831

Minnesota

Primary Care HPSA

Eligible for dates of service on and after March 30, 2007

Roseau County – West Roseau Area

Badger City
Barnett Township
Barto Township
Deer Township
Dewey Township
Greenbush City
Hereim Township
Huss Township
Lind Township
Moose Township
Northwest Roseau UT
Pohlitz Township
Polonia Township
Skagen Township
Soler Township
Strathcona City

**Changes to Hennepin County – Near North-Minneapolis Service Area

The previously listed census tracts have been replaced with the following

Census Tracts:

22 1021
27 1023
32 1028
33 1029
35.02 1034
1020 1041

Mental Health HPSA

No Changes

Michigan

Primary Care HPSA

No longer eligible for dates of service on and after October 1, 2007

Montmorency County – Entire County

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No longer eligible for dates of services on and after October 1, 2007
Wayne County – Inkster Service Area 5701 – 5702

Note: The following Wayne County census tracts no longer exist:
Census tracts 5155, 5703, and 5707 have been incorporated into other census tracts

Mental Health HPSA
Chippewa County was previously reported as no longer eligible. However, until further notice, Chippewa County is a designated mental health HPSA.

Wisconsin
Primary Care HPSA
Dane County - South Madison Service Area
Census Tract 14.98 has been changed to 14.02

Mental Health HPSA
New eligibility for dates of service on and after December 18, 2006:
Dodge County – Entire County

MPFSDB - 2007 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) OCTOBER QUARTERLY UPDATE

For a complete listing of the 2007 fees, please visit the Wisconsin Physicians Service (WPS) website at: **http://www.wpsmedicare.com/provider/pricing_fees.shtml**

To access the 2007 Relative Value Units (RVUs) and other indicators associated with each procedure code on the MPFSDB, please see the Centers for Medicare & Medicaid Services (CMS) website at:
http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage

The following changes will be made to the 2007 Medicare Physician Fee Schedule. These changes apply to claims processed on or after October 1, 2007, for dates of service January 1, 2007 and after.

MPFSDB Fee Changes Effective 01/01/07

CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
54150	IL-12	$195.65	$185.87	$213.75	$101.25	$96.19	$110.62
54150	IL-15	$218.91	$207.96	$239.15	$106.73	$101.39	$116.60
54150	IL-16	$222.05	$210.95	$242.59	$108.77	$103.33	$118.83
54150	IL-99	$183.88	$174.69	$200.89	$96.10	$91.30	$105.00
54150	MI-01	$218.84	$207.90	$239.09	$112.79	$107.15	$123.22
54150	MI-99	$191.97	$182.37	$209.73	$99.37	$94.40	$108.56

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CODE/ MOD	LOC	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	Facility Setting PAR Amount	Facility Setting NON-PAR Amount	Facility Setting Limiting Charge
54150	MN	$196.12	$186.31	$214.26	$95.09	$90.34	$103.89
54150	WI	$187.36	$177.99	$204.69	$94.97	$90.22	$103.75

MPFSDB - OCTOBER UPDATE TO THE 2007 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE

~CMS MLN Matters~

MLN Matters Number: MM5714
Related CR Release Date: August 30, 2007
Related CR Transmittal #: R1326CP
Related Change Request (CR) #: 5714
Effective Date: January 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries, or Medicare Administrative Contractors (MACs)) for professional services paid under the MPFS.

What You Need to Know

CR5714, from which this article was taken, amends the payment files previously issued to your Medicare contractor (based upon the December 1, 2006, Medicare Physician Fee Schedule (MPFS) Final Rule); and includes new codes for the Physician Quality Reporting Initiative.

Background

Section 1848(c)(4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. Medicare contractors, in accordance with the *Medicare Claims Processing Manual*, Chapter 23, Section 30.1, give providers 30 days notice before implementing the revised payment amounts and the changes identified in CR5714, which (unless otherwise stated in the CR5714) will be retroactive to January 1, 2007.

You should be aware that carriers will adjust claims that you bring to their attention, but are not required to search their files to either retract payment for claims already paid or to retroactively pay claims. The changes made as a result of CR5714 are as follows: Changes included in the October Update to the 2007 Medicare Physician Fee Schedule Database are as follows:

The following changes are retroactive to January 1, 2007:

CPT/HCPCS	ACTION
16035	Global Period = 000 Pre Op = 0.00 Intra Op = 0.00 Post Op = 0.00

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CPT/HCPCS	ACTION
20690	Bilateral Indicator = 0
38740	Bilateral Indicator = 1
38745	Bilateral Indicator = 1
54150	Transitional Non-Facility PE RVU = 3.38 Transitional Facility PE RVU = 0.73
64412	Bilateral Indicator = 1
64418	Bilateral Indicator = 1
64613	Bilateral Indicator = 1

As stated in Transmittal 1301, dated July 20, 2007, (Change Request 5665 -- Revised Information on PET Scan Coding), effective January 28, 2005, CPT code 78609 became a non-covered service for Medicare purposes.

CPT Code	Procedure Status Indicator*
78609	N
78609 – TC (Technical Component)	N
78609 – 26 (Professional Component)	N

*Effective for dates of service on or after January 28, 2005

New Category II codes for the Physician Quality Reporting Initiative (PQRI)
Effective for dates of service on or after October 1, 2007, the following Category II codes will be added to the MPFS with a status indicator of "M".

Code	Long Descriptor	Short Descriptor
1116F	Auricular or periauricular pain assessed	Auric/peri pain assessed
2035F	Tympanic membrane mobility assessed with pneumatic otoscopy or tympanometry	Tymp memb motion exam'd
3215F	Patient has documented immunity to Hepatitis A	Pt immunity to hep a doc'd
3216F	Patient has documented immunity to Hepatitis B	Pt immunity to hep b doc'd
3219F	Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for Hepatitis C	Hep c geno tstng doc'd - done
3220F	Hepatitis C quantitative RNA testing documented as performed at 12 weeks from initiation of antiviral treatment	Hep c quant rna tstng doc'd
3230F	Documentation that hearing test was performed within 6 months prior to tympanostomy tube insertion	Note hring tst w/in 6 mon
3260F	pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report	Pt cat/pn cat/hist grd doc'd

Code	Long Descriptor	Short Descriptor
4130F	Topical preparations (including OTC) prescribed for acute otitis externa	Topical prep rx, aoe
4131F	Systemic antimicrobial therapy prescribed	Syst antimicrobial thx rx
4132F	Systemic antimicrobial therapy not prescribed	No syst antimicrobial thx rx
4133F	Antihistamines or decongestants prescribed or recommended	Antihist/decong rx/recom
4134F	Antihistamines or decongestants neither prescribed nor recommended	No antihist/decong rx/recom
4135F	Systemic corticosteroids prescribed	Systemic corticosteroids rx
4136F	Systemic corticosteroids not prescribed	Syst corticosteroids not rx
4150F	Patient receiving antiviral treatment for Hepatitis C	Pt recvng antivir txmnt hepc
4151F	Patient not receiving antiviral treatment for Hepatitis C	Pt not recvng antiv hep c
4152F	Documentation that combination peginterferon and ribavirin therapy considered	Doc’d pegintf/rib thxy consd
4153F	Combination peginterferon and ribavirin therapy prescribed	Combo pegintf/rib rx
4154F	Hepatitis A vaccine series recommended	Hep a vac series recommended
4155F	Hepatitis A vaccine series previously received	Hep a vac series prev recvd
4156F	Hepatitis B vaccine series recommended	Hep b vac series recommended
4157F	Hepatitis B vaccine series previously received	Hep b vac series prev recvd
4158F	Patient education regarding risk of alcohol consumption performed	Pt edu re: alcoh drnkng done
4159F	Counseling regarding contraception received prior to initiation of antiviral treatment	Contrcp talk b/4 antiv txmnt

The payment indicators are identical for all of the above PQRI CPT codes and those indicators are as follows:

Procedure Status:	M
WRVU:	0.00
Non-Facility PE RVU:	0.00
Facility PE RVU:	0.00
Malpractice RVU:	0.00
PC/TC:	9
Site of Service:	9
Global Surgery:	XXX
Multiple Procedure Indicator:	9
Bilateral Surgery Indicator:	9
Assistant at Surgery Indicator:	9

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Co-Surgery Indicator:	9
Team Surgery Indicator:	9
Physician Supervision Diagnostic Indicator:	9
Type of Service:	1
Diagnostic Family Imaging Indicator:	99

**Effective for services performed on or after October 1, 2007*

The short descriptor for G8370 was listed incorrectly in Transmittal 1258, dated May 29, 2007 (Change Request 5614 – July Update to the 2007 Medicare Physician Fee Schedule Database). The short descriptor has been corrected to read:

HCPCS	Revised Short Descriptor
G8370	Asthma pt w survey not docum

Additional Information

You can find the official instruction about the October update to the 2007 Medicare Physician Fee Schedule Database by going to CR5714, located at **http://www.cms.hhs.gov/Transmittals/downloads/R1326CP.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.

SUNSET OF THE PHYSICIAN SCARCITY AREA (PSA) BONUS PAYMENT

~CMS MLN Matters~

MLN Matters Number: MM5711
Related CR Release Date: August 24, 2007
Related CR Transmittal #: R1321CP

Related Change Request (CR) #: 5711
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Providers billing a Medicare carrier, fiscal intermediary (FI), or Medicare Administrative Contractor (A/B MAC) for services provided to Medicare beneficiaries in physician scarcity areas.

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5711 that reminds physicians that the PSA bonus under Section 413(a) of the Medicare Modernization Act (MMA) will sunset after December 31, 2007.

CAUTION – What You Need to Know

The PSA bonus is payable for dates of service January 1, 2005 through December 31, 2007. The PSA bonus is **not payable for dates of service after December 31, 2007.**

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GO – What You Need to Do

Make certain that your billing staffs are aware of these changes as listed in the Background section below and in the revisions to the *Medicare Claims Processing Manual* chapter 4, sections 250.2.1, 250.2.2 and 250.3.2. The revised manual sections are attached to the official instruction in CR5711. The Web address for accessing CR5711 is in the *Additional Information* section of this article.

Background

Section 413(a) of the Medicare Modernization Act (MMA) requires Medicare to pay an additional 5 percent bonus to physicians rendering service in a designated PSA. Physician scarcity designations are based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in every county or the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in each identified rural census tract. The bonus payment is based on the amount actually paid, not the amount Medicare approved for each service. **The Key Point of CR5711 is that** the PSA termination date is December 31, 2007 and is not payable for dates of service after that date.

Additional Information

For complete details regarding this issue, see the official instruction (CR5711) issued to your Medicare carrier, FI, or A/B MAC. That instruction may be viewed by going to **http://www.cms.hhs.gov/Transmittals/downloads/R1321CP.pdf** on the CMS website. For the CMS website with information about HPSA/PSA (Physician Bonuses) and zip code downloadable files you may visit **http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/** 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.

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