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Items of Importance

NO NEED TO CALL US – JUST SEND US A CHECK

If you receive incorrect payment, take immediate action. Complete the Voluntary Overpayment Refund form at http://www.wpsmedicare.com/part_b/business/vol_refund_new.pdf and refund the incorrect payment.

Providers are responsible for making voluntary/unsolicited refunds to Medicare as soon as possible, without waiting for notification. Do not call Medicare asking us to request the overpayment - simply make the refund.

You can find additional information in the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network brochure “What Physicians and other Suppliers should know about Medicare Overpayment” at the following Web address:
<http://www.cms.hhs.gov/MLNProducts/downloads/Overpaymtbroch07.pdf>

REPORTING WITHHOLDING DUE TO IRS FEDERAL PAYMENT LEVY PROGRAM (FPLP) ON THE REMITTANCE ADVICE

~CMS MLN Matters~

MLN Matters Number: MM6125 Revised
Related CR Release Date: August 15, 2008
Related CR Transmittal #: R367OTN

Related Change Request (CR) #: 6125
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Note: This article was revised on August 21, 2008, to clarify the “Provider Types Affected”. All other information remains the same.

Provider Types Affected

Providers 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

STOP – Impact to You

Your Medicare payments could be reduced if the Internal Revenue Service (IRS) needs to collect overdue taxes that you owe.

CAUTION – What You Need to Know

The Taxpayer Relief Act of 1997, Section 1024, requires the IRS to reduce certain federal payments, including Medicare payments, to allow collection of overdue taxes. Should you owe such taxes and your payments are reduced, your remittance advice will reflect a provider level adjustment code (PLB) of “WU” in the PLB03-1 data field.

GO – What You Need to Do

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

Background

In July 2000, the Treasury Department's Financial Management Service and the IRS started the Federal Payment Levy Program (FPLP) which is authorized by Internal Revenue Code Section 6331 (h), as prescribed by Section 1024 of the Taxpayer Relief Act of 1997.

Through this program, collection of overdue taxes through a continuous levy on certain federal payments is authorized. This includes federal payments made to contractors and vendors, including Medicare providers, doing business with the government.

IRS may reduce federal payments subject to the levy by 15 percent, or the exact amount of tax owed if it is less than 15 percent of the payment. The levy is continuous until the overdue taxes are paid in full, or other arrangements are made to satisfy the debt. Each time the federal payment is levied, the Financial Management Service will send a letter of explanation, including information on which federal payment was levied, and advice on who to contact for resolution.

Effective October 1, 2008, if you owe such taxes to IRS, your Medicare payment may be adjusted accordingly. When such adjustments occur, your Medicare remittance advice will reflect the code of "WU" in the PLB03-1 data field. In addition, a 10 digit toll-free IRS number (1-800-829-3903) will appear in the PLB03-2 data field. **Should this happen to you, note that under current privacy rules and regulations, only the IRS may discuss the tax issue with you. Thus, if you have questions, contact the IRS at the toll-free number just mentioned, instead of contacting your Medicare contractor.**

Additional Information

To view the official instruction (CR6125) issued to your Medicare contractor on this issue, visit <http://www.cms.hhs.gov/Transmittals/downloads/R367OTN.pdf> on the Centers for Medicare & Medicaid Services Website.

Claim Submission**2008 REMINDER FOR ROSTER BILLING AND CENTRALIZED
BILLING FOR INFLUENZA AND PNEUMOCOCCAL VACCINATIONS**
~CMS MLN Matters~

MLN Matters Number: MM6121
Related CR Release Date: August 15, 2008
Related CR Transmittal #: R366OTN

Related Change Request (CR) #: 6121
Effective Date: September 15, 2008
Implementation Date: September 15, 2008

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 influenza and pneumococcal vaccinations provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6121 which reminds the Medicare physician community of the requirements to correctly enroll in order to conduct Mass Immunization Roster Billing and Centralized Billing of Medicare for influenza and pneumococcal immunizations. Remember that centralized billers participation is limited to one year and such billers must reapply each year they wish to be a centralized biller. The yearly reapplication process is not required for Mass Immunizer Roster Billers.

Background

The Centers for Medicare & Medicaid Services (CMS) is issuing Change Request (CR) 6121 as a reminder for Mass Immunization Roster Billing and Centralized Billing for Influenza and Pneumococcal vaccinations.

Mass immunizers are providers and suppliers who enroll in the Medicare program to offer the influenza vaccinations to a large number of individuals, and they must be properly licensed in the States in which they plan to operate influenza (flu) clinics. Enrollment for mass immunizers is ongoing and must be completed through the local A/B MAC or carrier. Mass immunizers submit their claims to the local Medicare contractor.

Centralized billers are mass immunizers who have applied to become centralized billers when they operate in at least three payment localities for which there are three different Medicare contractors processing claims. Individuals and entities must be properly licensed in the States in which they plan to operate influenza (flu) and/or pneumococcal clinics.

Providers who only offer influenza services:

- May enroll as one of two types of providers including a mass immunization roster biller (specialty provider type 73), or a Centralized Biller, and
- Must meet the guidelines for being either a mass immunizer or centralized biller.

Suppliers must enroll as a mass immunization roster biller (specialty provider type 73) with a carrier or A/B MAC to render influenza vaccination services to Medicare beneficiaries.

Mass immunization roster billers and centralized billers must enroll in the Medicare program even if mass influenza and/or pneumococcal immunizations are the only service being provided. They must:

- Accept assignment on both the vaccine and its administration,
- Bill only for influenza and/or pneumococcal vaccinations, and
- Submit claims using the roster billing process.

Participation as a centralized biller is limited to one year and must be renewed annually by contacting the CMS central office by June 1 to request participation for the upcoming year. Claims for centralized billers are processed by one Medicare specialty contractor regardless of the locality where the service was rendered. Centralized billers submit their claims to the designated specialty contractor.

Providers and suppliers must enroll using the appropriate CMS 855 provider enrollment form (See http://www.cms.hhs.gov/MedicareProviderSupEnroll/02_EnrollmentApplications.asp on the CMS Website). Applications are available from the local contractors. Refer to the Medicare Claims Processing Manual, Chapter 18, Sections 10-10.5 at <http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf> on the CMS Website for more information on billing requirements.

Note: Medicare Part B pays 100 percent for pneumococcal vaccines, influenza virus vaccines, and their administration. The Part B deductible and coinsurance do not apply for influenza virus and pneumococcal vaccine.

Remember the following regarding the influenza vaccine:

- Medicare allows one influenza (flu) vaccination per year;
- Medicare does not require for coverage purposes that a doctor of medicine or osteopathy order the influenza vaccine and its administration; and
- The beneficiary may receive the influenza vaccine upon request without a physician's order and without physician supervision.

Remember the following with regard to the pneumococcal vaccine, effective for services furnished on or after July 1, 2000:

- Medicare does not require for coverage purposes, that a doctor of medicine or osteopathy order the pneumococcal vaccine and its administration, and
- The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Typically, the pneumococcal vaccine is administered once in a lifetime. Claims for pneumococcal vaccines are paid for beneficiaries who:

- Are at high risk of pneumococcal disease, and
- Have not received a pneumococcal vaccine within the last five years, or
- Are revaccinated because they are unsure of their vaccination status.

Additional Information

CMS offers a number of free educational products on its Medicare Learning Network (MLN). These products are available on the MLN Preventive Services Educational Products Web page located at

http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS Website.

The official instruction, CR 6121, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R366OTN.pdf> on the CMS Website.

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

BENEFICIARY SUBMITTED CLAIMS

~CMS MLN Matters~

MLN Matters Number: MM5683
Related CR Release Date: September 5, 2008

Related Change Request (CR) #: 5683
Effective Date: Claims received on or after August 18, 2008

Related CR Transmittal #: R1588CP

Implementation Date: August 18, 2008

Note: This article was revised on September 9, 2008, to reflect changes made to CR5683. The CR was revised to emphasize that the changes apply to claims received on or after August 18, 2008, regardless of the date of service. The CR release date, transmittal number and Web address for accessing CR5683 were also changed. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

Background

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

- 1) **Are not covered by Medicare** (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc., in accordance with its normal processing procedures; see 42 CFR 411.15 at http://a257.g.akamaitech.net/7/257/2422/12feb20041500/edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr411.15.pdf for details); and
- 2) **Are covered by Medicare** when the beneficiary has submitted a complete claim (Patient's Request for Medical Payment Form CMS-1490S; <http://www.cms.hhs.gov/CMSForms/CMSForms/>) and all supporting documentation associated with the claim, including an itemized bill with the following information:
 - Date of service,
 - Place of service,
 - Description of illness or injury,
 - Description of each surgical or medical service or supply furnished,
 - Charge for each service,
 - The doctor's or supplier's name, address, and
 - The provider or supplier's National Provider Identifier (NPI).

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

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

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

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

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

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

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

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

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

Contractors will maintain:

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

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

Additional Information

The official instruction, CR5683, issued to your carrier, A/B MAC, and DME MAC regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1588CP.pdf> on the CMS Website.

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

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

IMPLEMENTATION OF A NEW CLAIM ADJUSTMENT REASON CODE (CARC) NO.213. "NON-COMPLIANCE WITH THE PHYSICIAN SELF-REFERRAL PROHIBITION LEGISLATION OR PAYER POLICY"

~ CMS MLN Matters ~

MLN Matters Number: MM6131
Related CR Release Date: August 15, 2008
Related CR Transmittal #: R1578CP

Related Change Request (CR) #: 6131
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), regional home health intermediaries (RHHI), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs (effective January 1, 2009) to use the new Claim Adjustment Reason Code (CARC) #213 when denying claims based on non-compliance with the physician self-referral prohibition.

Make sure that your billing staffs are aware of this new CARC code.

Background

Unless an exception applies (as referenced below), Section 1877 of the Social Security Act (the Act), prohibits a physician from referring a Medicare patient for certain designated health services (DHS) to an entity with which the physician (or his/her immediate family member(s)) has a financial relationship. A “financial relationship” includes both ownership/investment interests and compensation arrangements (for example, contractual arrangements).

The following services are DHS:

- Clinical laboratory services;
- Radiology and certain other imaging services (including MRIs, CT scans and ultrasound);
- Radiation therapy services and supplies;
- Durable medical equipment and supplies;
- Orthotics, prosthetics, and prosthetic devices;
- Parenteral and enteral nutrients, equipment and supplies;
- Physical therapy, occupational therapy, speech-language pathology services;
- Outpatient prescription drugs;
- Home health services and supplies; and
- Inpatient and outpatient hospital services.

Section 1877 of the Act also prohibits the DHS entity from submitting to Medicare, the beneficiary, or any entity for DHS, claims that are furnished as a result of a prohibited referral.

Note: Violations of this statute are punishable by: 1) Denial of payment for all DHS claims; 2) Refunds of amounts collected for DHS claims; and 3) Civil money penalties for knowing violations of the prohibition.

Prior to the publication of the new CARC #213 (“Non-compliance with the physician self-referral prohibition legislation or payer policy”), there was no specific code to describe claims that are denied based on “Stark” (the physician self-referral statute at Section 1877 of the Act). Therefore, so that both the DHS providers and the industry will know that claims are being denied because of non-compliance with the physician self-referral prohibitions; CR 6131, from which this article is taken, instructs carriers, FIs, A/B MACs, RHHIs, and DME MACs to use the new CARC No. 213 (effective January 1, 2009) when denying claims based on non-compliance with the physician self-referral prohibition.

Your Medicare contractors will use this code any time they deny a claim because a physician (or one or more of their immediate family members) has a financial interest in a DHS provider and fails to meet one of the exceptions referenced below.

Exceptions

Please note that the statute enumerates various exceptions, including exceptions for physician ownership or investment interest in hospitals and rural providers. You can read these exceptions in Section 1877 of the Social Security Act Sec. 1877 which you can find at http://www.cms.hhs.gov/PhysicianSelfReferral/Downloads/section_1877.pdf on the CMS Website; and in 42 C.F.R. Part 411, Subpart J.) (42 U.S.C. Section 1395nn).

Additional Information

You can find more information about CARC #213 by going to CR 6131, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1578CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Claims Processing Manual* Chapter 1 (General billing requirements) Section 180 (Denial of Claims Due to Violations of Physician Self-Referral Prohibition) as an attachment to that CR. If you have any questions, please contact DME MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenter> on the CMS Website.

**PNEUMOCOCCAL PNEUMONIA, INFLUENZA VIRUS, AND
HEPATITIS B VACCINES**

~CMS MLN Matters~

MLN Matters Number: MM6079

Related CR Release Date: September 5, 2008

Related CR Transmittal #: R1586CP

Related Change Request (CR) #: 6079

Effective Date: October 6, 2008

Implementation Date: October 6, 2008

Provider Types Affected

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

Impact on Providers

This article is based on Change Request (CR) 6079 and notifies providers that the Centers for Medicare & Medicaid Services (CMS) revised Form CMS-1500 to accommodate the reporting of the National Provider Identifier (NPI). The current Form CMS 1500 (08-05) does not require reporting the NPI for influenza virus and pneumococcal vaccine claims submitted as roster bills. Therefore your Medicare contractor **should NOT return claims as unprocessable** to the supplier/provider of service when the rendering provider does not enter his/her NPI into 24J of Form CMS-1500 for influenza virus and pneumococcal vaccine claims submitted as roster bills.

Key Point of CR6079

The requirement of an NPI for the rendering provider **does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills.**

Additional Information

To see the official instruction (CR6079) issued to your Medicare FI, carrier, or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R1586CP.pdf> on the CMS Website.

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.

REVISIONS TO THE COMPETITIVE ACQUISITION PROGRAM (CAP) FOR PART B DRUGS AND BIOLOGICALS ~CMS MLN Matters~

MLN Matters Number: MM6124
Related CR Release Date: August 15, 2008

Related Change Request (CR) #: 6124
Effective Date: Claims processed on
or after January 5, 2009
Implementation Date: January 5, 2009

Related CR Transmittal #: R1577CP

Provider Types Affected

Physicians and other providers who bill Medicare carriers and Medicare Administrative Contractors (A/B MAC) for competitive acquisition program (CAP) claims for part B drugs and biologicals provided to Medicare beneficiaries.

What You Need to Know

CR 6124, effective with claims processed on or after January 5, 2009, revises Medicare systems to allow individual Competitive Acquisition Program (CAP) claims with different prescription order numbers to not be denied as duplicate claims though they are for the same patient, contain the same date of service, and contain the same Healthcare Common Procedure Coding System (HCPCS) drug code. This will also apply to an individual CAP claim that contains multiple lines that appear to be duplicates except for different prescription order numbers.

Background

Because of a systems error, Medicare carriers and A/B MACs may be denying CAP claims that contain the same beneficiary, date of service, and HCPCS drug code, but have different prescription order numbers.

CR 6124, effective for claims processed on or after January 5, 2009, instructs Medicare carriers, A/B MACs, and the CAP Designated Carrier to revise duplicate claim edits to allow separate CAP claims with different prescription order numbers to be considered as non-duplicative claims even though they are for the same beneficiary, date of service, and HCPCS drug code. This will also apply to an individual claim that contains multiple lines that appear to be duplicates except for different prescription order numbers. If you have claims that were incorrectly denied prior to January 5, 2009, your contractor will adjust those claims if you bring them to their attention.

Additional Information

You can view CR 6124 at <http://www.cms.hhs.gov/Transmittals/downloads/R1577CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

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

Coverage – General

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

~CMS MLN Matters~

MLN Matters Number: MM6048 **Revised**
Related CR Release Date: August 29, 2008
Related CR Transmittal #: R94NCD

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

Note: This article was revised on September 2, 2008, to reflect changes to CR 6048, which CMS revised on August 28, 2008. The CR release date, transmittal number, and the Web address for accessing CR6048 were revised. In addition, some language in item 3 on page 3 was clarified. All other information remains the same.

Provider Types Affected

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

Impact on Providers

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

Background

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

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

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

average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

Key Points of CR6048

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

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

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

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

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

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

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only

when provided in the context of a clinical study and when that study meets the standards outlined in the NCD manual revision attached to CR6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at section 310.1 of the NCD Manual and chapter 32 and sections 69.6-69.7 (Pub 100-04) of the Medicare Claims Processing Manual. These manuals are available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Website.

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

G0398: Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.

G0398 Short Descriptor: Home sleep test/type 2 Porta

G0399: Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation

G0399 Short Descriptor: Home sleep test/type 3 Porta

G0400: Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

G0400 Short Descriptor: Home sleep test/type 4 Porta

Additional Information

To see the official instruction (CR6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R94NCD.pdf> on the CMS Website.

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

**FLUORODEOXYGLUCOSE (FDG) POSITRON EMISSION
TOMOGRAPHY (PET) IMAGING FOR INFECTION AND
INFLAMMATION
~CMS MLN Matters~**

MLN Matters Number: MM6099
Related CR Release Date: June 27, 2008
Related CR Transmittal #: R84NCD

Related Change Request (CR) #: 6099
Effective Date: March 19, 2008
Implementation Date: July 28, 2008

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.

Impact on Providers

This article is based on Change Request (CR) 6099 instructing that the Centers for Medicare & Medicaid Services (CMS) is continuing its national non-coverage policy for the off-label indications of fluorodeoxyglucose (FDG) Positron emission tomography (PET) imaging for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin.

Background

CMS was asked to reconsider the current, de facto non-coverage for FDG PET imaging in the Medicare National Coverage Determinations (NCD) Manual (Section 220.6), for the following off-label uses (instead of bone, leukocyte, and/or gallium scintigraphy):

1. Suspected chronic osteomyelitis in patients with:
 - previously documented osteomyelitis with suspected recurrence, or
 - symptoms of osteomyelitis for more than 6 weeks (including diabetic foot ulcers);
2. Investigation of patients with suspected infection of hip prosthesis; and
3. Fever of unknown origin in patients with:
 - a febrile illness of >3 weeks duration,
 - a temperature of >38.3 degrees Centigrade on at least two occasions, and
 - uncertain diagnosis after a thorough history, physical examination, and 1 week of proper investigation.

Based upon its review, CMS determined that the evidence is inadequate to conclude that FDG PET for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin improves health outcomes in the Medicare populations, and therefore is not reasonable and necessary under the Social Security Act (section 1862(a)(1)(A) (See that provision at http://www.ssa.gov/OP_Home/ssact/title18/1862.htm on the internet.)

Additionally, CMS determined that this request for coverage is not appropriate for the Coverage with Evidence Development (CED) paradigm.

Additional Information

The official instruction, CR 6099, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R84NCD.pdf> on the CMS Website.

If you have any questions, please contact your carrier, FI, or A/B MAC at their toll-free numbers, 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/part_b/policy/index.shtml

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

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



New Policies for October 2008

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
AN-030	<i>* Moderate (Conscious) Sedation</i>	LCD	Click here to view	18
GSURG-050	<i>Stereotactic Computer Assisted Volumetric Navigational Procedure</i>	LCD	Click here to view	18

Revised Policies for October 2008

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
NA	<i>2009 ICD-9-CM Coverage – Policy Revisions For Wisconsin, Illinois, Michigan, Minnesota</i>	NA	Click here to view	19
CV-004	<i>Cardiac Stress Testing</i>	LCD	Click here to view	23
NA	<i>Injection List</i>	NA	Click here to view	24
OPHTH-015	<i>Optical Coherence Tomography</i>	LCD	Click here to view	24

Coverage – New Policies

LCD Policy New

Contractor’s Policy Number:

AN-030

LCD Title:

* Moderate (Conscious) Sedation

Primary Geographic Jurisdiction:

Wisconsin, Illinois, Michigan, Minnesota

Note: This LCD is scheduled to become final 11/16/2008. Please view this LCD in its entirety at http://www.wpsmedicare.com/part_b/policy/index.shtml

* The draft version of this LCD was posted on the draft Website and presented at both the Open Meeting and to the CAC members entitled Sedation and Analgesia by Non-anesthesiologists. The title was found to be misleading and not in agreement with the CPT Code Book. Therefore, a decision to change the title was made.



Contractor’s Policy Number:

GSURG-050

LCD Title:

Stereotactic Computer Assisted Volumetric Navigational Procedure

Primary Geographic Jurisdiction

Wisconsin, Illinois, Michigan, Minnesota

Notice: This LCD is scheduled to become final 11/16/2008. Please visit http://www.wpsmedicare.com/part_b/policy/index.shtml to read this LCD in its entirety.

Coverage – Revised Policies

2009 ICD-9-CM COVERAGE - POLICY REVISIONS FOR WISCONSIN, ILLINOIS, MICHIGAN, MINNESOTA

Effective for claims submitted with dates of service on or after 10/01/2008, WPS will cover the new 2009 ICD-9-CM codes for the policies and procedures listed below. The listed changes to these affected policies will be posted to the Website after 10/01/2008.

Policy Name/Number	Policy Procedure Code	2009 ICD-9-CM Changes
Antineoplastics and their Adjuncts HONC-010	J9001	203.02
	J9010	204.12
	J9015	205.02
	J9017	205.02, 205.12, 203.02
	J9020	204.02, 204.12, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02
	J9040	078.12
	J9041	203.02
	J9065	204.12
	J9150	204.02, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02
	J9185	204.12, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02
J9190	078.12	
	J9211	204.02, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02
	J9214	078.12, 203.02, 204.12, 205.12
	J9215	078.12, 203.02, 203.12, 205.12
	J9245	203.02, 203.12, 203.82, 205.12
	J9261	204.02
	J9266	204.02
	J9268	204.02, 204.12, 204.92,
	J9293	203.02, 203.12, 204.02, 204.12, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12,

Policy Name/Number	Policy Procedure Code	2009 ICD-9-CM Changes
		206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02
	J9300	205.02
	J9310	204.12
	J9320	204.02
	J9350	205.12
	J9999 for Teniposide	204.02
	J9999 for Bendamustine hydrochloride	204.12
Cardiac Stress Testing CV-004	93015, 93016, 93017, 93018, 93350, 93799,	249.00- 249.91
Computerized Tomography (CAT Scans) RAD-033	70450-70498	199.2, 208.92, 337.00, 337.01, 337.09, 339.00-339.89, 346.92, 346.93, 349.31, 349.39, 780.60-780.65,
	71250-71270	199.2, 208.92, 780.60-780.65, 997.31, 997.39
	72191-72194, 74150-74175, 75635	199.2, 208.92, 209.00-209.69, 599.70, 599.71, 599.72, 780.60-780.65
	72125-72127	199.2, 203.02
	72128-72130	199.2, 203.02
	72131-72133	199.2, 203.02
Cosmetic and Reconstructive Surgery GSURG-032	11920, 11921, 11922	V51.0, V51.8
	19316, 19318, 19324, 19325, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19396	V51.0
Cytogenetic Studies PATH-027	88237, 88239, 88262, 88271, 88272, 88273, 88274, 88275, 88283	203.02, 203.12, 203.82 204.02, 204.12, 204.22, 204.82, 204.92, 205.02 205.12, 205.22, 205.32 205.82, 205.92, 206.02 206.12, 206.22, 206.82 206.92, 207.02, 207.22 207.82, 208.02, 208.12 208.22, 208.82, 208.92

Policy Name/Number	Policy Procedure Code	2009 ICD-9-CM Changes
Diagnostic Mammogram RAD-005	77051, 77055, 77056, G0204, G0206	611.83, 611.89, 612.0, 612.1
Diagnostic Sigmoidoscopy and Colonoscopy GI-006	44388, 44389, 44390- 44394, 44397, 45330- 45335, 45337-45342, 45345, 45355, 45378- 45387, 45391, 45392	558.42
Flow Cytometry PATH-016	88184-88189	203.02, 203.12, 203.82 204.02, 204.12, 204.22, 204.82, 204.92, 205.02 205.12, 205.22, 205.32 205.82, 205.92, 206.02 206.12, 206.22, 206.82 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 279.51, 279.52 279.53
Foot Care FT-001	G0127, 11055, 11056, 11057, 11719-11721	249.00 - 249.91
Human Granulocyte /Macrophage Colony Stimulating Factors INJ-019	J1440, J1441 J2820	205.02 204.02, 205.02
Hyperbaric Oxygen Therapy (HBO) PHYS-056	99183	249.70-249.71; 707.20-707.25
Immune Globulins INJ-012	J1561, J1566, J1568, J1569, J1572, Q4097	203.02, 203.12, 203.82, 204.12, 204.22, 695.13-695.15
Magnetic Resonance Imaging (MRI) RAD-024	70336, 70540-70543, 70551-70553 71550-71552 72195-72197, 74181- 74183 72141, 72142, 72156 72146, 72147, 72157 72148, 72149, 72158	199.2, 208.92, 337.00, 337.01, 337.09, 339.00-339.89, 346.92, 346.93, 349.31, 349.39, 780.60- 780.65. 199.2, 208.92, 780.60-780.65, 997.31, 997.39 199.2, 208.92, 209.00-209.69, 599.70, 599.71, 599.72, 780.60- 780.65 199.2, 203.02 199.2, 203.02 199.2, 203.02
Myocardial Perfusion Imaging CV-017	78460-78465, 78478, 78480	249.00-249.91
Nerve Conduction Studies	95860-95874, 95900-	249.60 - 249.61

Policy Name/Number	Policy Procedure Code	2009 ICD-9-CM Changes
and Electromyography NEURO-005	95904, 95933-95937, 95999, 51785, 92265	337.00-337.09
Non-Coronary Vascular Stents/Endovascular Graft Placement CV-028	34833, 34834, 34900, 37205-37208, 75960	249.70, 249.71, 707.20, 707.21, 707.22, 707.23 707.24, 707.25
Noninvasive Vascular Testing CV-033	90940	V45.11
Nutrition Training Benefits PHYS-041	G0108, G0109 (DSMT) 97802, 97803, 97804, G0270, G0271 (MNT)	249.00 -249.91
Optical Coherence Tomography (OCT) OPHTH- 015	92135	362.20-326.27, 364.82
Physical Medicine and Rehabilitation Procedures PHYSMED-009	97022, 97036	707.20-707.25
Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) RAD-014	77301, 77418, 0073T (IMRT)	199.2, 203.02, 203.12, 203.82, 204.02, 204.12, 204.22, 204.82, 204.92, 205.02, 205.12, 205.22, 205.32, 205.82, 205.92, 206.02, 206.12, 206.22, 206.82, 206.92, 207.02, 207.12, 207.22, 207.82, 208.02, 208.12, 208.22, 208.82, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30
Radiologic Exam of the Chest , Including Portable; RAD-004	71010, 71015, 71020, 71021, 71022, 71023, 71030, 71034, 71035	199.2, 204.92, 205.92, 208.92, 238.77, 289.84, 780.60- 780.65, 997.31, 997.39, 999.81, 999.82, 999.88, 999.89, V12.04
Transthoracic Echocardiogram; CV-026	93303, 93304, 93307, 93308, 93320, 93321, 93325	780.60-780.65
Vertebroplasty (Percutaneous) and Kyphoplasty RAD-032	22520-22525, 22899, 72291-72292, 70612- 70613, 76499	205.02-209.69



LCD Title

Cardiac Stress Testing

Contractor's Determination Number

CV-004

- E. Pharmacologic ECG stress testing is indicated only when the patient is unable to exercise adequately. Documentation in the patient's record must clearly indicate that the patient is unable to exercise, as well as the reason(s) why the patient cannot undergo exercise stress testing. (A review of records may be performed to determine if drugs are being used appropriately.) The drugs used in cardiovascular testing are potent drugs with many side effects, and must be used with appropriate caution.
1. Dobutamine
 - HCPCS code J1250 - per 250 mg
 - Dosage is calculated according to the patient's weight (beginning at 5-10 mcg/kg/min) and increased (titrated) to reach the maximum heart rate for 2-5 minutes (for a 200-lb person, the total dose is not to exceed 35 mg).
 2. Dipyridamole (Persantine)
 - HCPCS code J1245 - per 10 mg
 - Dosage is calculated according to the patient's weight (0.142 mg/kg/minute) and infused IV over approximately 4 minutes. The maximum dose is not to exceed 60 mg.
 3. Adenosine (Adenoscan)
 - HCPCS code J0152 - per 30mg
 - Dosage is calculated according to the patient's weight (140 mcg/kg/minute) for 6 minutes. The total dose is not to exceed 0.84 mg/kg (for a 200-lb person, the total maximum dose would equal 76 mg).

Note: Code J0150 – Adenosine (Adenocard) 6mg. It is inappropriate to use this code when billing Medicare Part B in conjunction with a stress test. This drug is indicated for treatment of supraventricular tachycardia (SVT) 427.0, 427.31, 427.32 and will be denied as not medically necessary when billed in conjunction with cardiac stress testing.
 4. Arbutamine
 - HCPCS code J0395 - 1 mg
 - The maximum infusion rate delivered by its accompanying device is 0.8 mg/kg/min and the maximum total dose is 10mcg/kg.
 - *5. Regadenoson (Lexiscan)
 - HCPCS code J3490 – Unclassified Drug (06/24/2008)
 - Recommended dose of Regadenoson (Lexiscan) is 5mL (0.4 mg Regadenoson) by rapid (approximately 10 seconds) injection; followed immediately by saline flush and radiopharmaceutical. Regadenoson (Lexiscan) is indicated for radionuclide myocardial perfusion imaging (MPI) in patients unable to undergo adequate exercise stress.



Injection List

Effective: 08/22/08 FDA approval Date

Romiplostim (Nplate™) will be covered for the treatment of thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who have had an insufficient response to corticosteroids, immunoglobulins or splenectomy (287.31).

J3490 should be used with the name of the drug, dosage and the route of administration listed in line 19.

The therapeutic administration code (90772) should be used with this drug.

**LCD Policy Revision****Contractor's Policy number**

OPHTH-015

LCD Title

Optical Coherence Tomography

Primary Geographic Location

Wisconsin, Illinois, Michigan, Minnesota

Revision Effective Date

10/01/2008

ICD-9 Codes that Support Medical Necessity

Note: ICD-9 codes must be coded to the highest level of specificity.

Degenerative Disorders of the Globe

*360.21

Retinoschisis, Retinal Cysts/Defects/Retinopathy and Vascular Changes

*361.00-361.07, 361.10-361.19, 361.2, 361.81, 362.01, 362.02-362.07, 362.12, 362.15,

*362.20-362.27, 362.35, 362.36, 362.37, 362.41, 362.43, *362.50-362.57, 362.83, 362.85,

Note: Addition of ICD-9-CM codes 360.21, 361.00-361.07 and completed range 362.50-362.57 with the addition of 362.50, 362.51, 362.52, 362.55 and 362.57. This version also includes the 2009 ICD-9 updates; effective 10/01/2008

Electronic Data Interchange (EDI)**CLAIMS ADJUSTMENT REASON CODES AND REMITTANCE ADVICE
REMARK CODES**

The claims adjustment reason codes and remittance advice remark codes are updated quarterly and are available on the Washington Publishing Company's (WPC) Website at: <http://www.wpc-edi.com/codes>

The WPC Website lists the latest descriptions for the Remittance Advice reason and Remark Codes found on the Medicare Electronic Remittance Advice (ERA).

PC-ACE PRO32 BILLING SOFTWARE FOR VACCINATION BILLING

WPS Medicare has a HIPAA-compliant software product, PC-Ace Pro32, available for vaccination billing. This software has the ability to submit roster billing and will allow you to submit your Medicare claims electronically.

Please review the minimum requirements to ensure you will be able to use PC-Ace.

PC-Ace Pro32 for Windows***Minimum System Requirements***

Before you install PC-Ace Pro32 software, your computer must meet these minimum requirements.

- IBM-compatible Pentium 133 MHz processor
- Windows 95, 98, 2000, ME, XP, or NT 4.0 Operating System
- CD-ROM drive
- 64 MB system memory
- Hayes-compatible modem with minimum speed (baud) of 9600
- SVGA monitor with minimum resolution of 800 X 600 (VERY IMPORTANT)
- Adobe Acrobat Reader Version 4.0 or later

Software Cost

PC-Ace Pro32 is free to use for Medicare billers. WPS will provide:

- Telephone support by WPS Electronic Data Services staff
- User Manual updates
- Periodic software updates

PC-Ace Pro32 software can now be downloaded from our Website.

If you are interested in using PC-Ace Pro32, download the PC-Ace request form at: <http://www.wpsic.com/edi/pdf/medbpcace.pdf> or call the EDI Hotline at 877-567-7261

If you are currently using the PC-Ace Pro32 billing software, you can now download the most current upgrade at: <http://www.wpsic.com/edi/pcacepro32.shtml>

PC-ACE PRO32 BILLING SOFTWARE UPGRADE VERSION 1.94 NOW AVAILABLE ONLINE

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

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

Now available online is:

- The upgrade to the latest version of PC-Ace, version 1.94
- Instructions related to the upgrade
- Users Guides/Manuals

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

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

If you are NOT currently using this program but you are interested in using this HIPAA-compliant software, please contact our EDI Hotline at 877-567-7261 or download the PC-Ace request form at: <http://www.wpsic.com/edi/pdf/medbpcace.pdf>

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% of Medicare-approved charges.

**PART B DRUG COMPETITIVE ACQUISITION PROGRAM (CAP)
QUARTERLY DRUG UPDATE
~CMS MLN Matters~**

MLN Matters Number: MM6158
Related CR Release Date: August 15, 2008
Related CR Transmittal #: R1576CP

Related Change Request (CR) #: 6158
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians billing Medicare Administrative Contractors (A/B MAC) and carriers for Medicare Part B drugs, and approved CAP vendors billing the CAP designated carrier.

What Providers Need to Know

This article is based on Change Request (CR) 6158, which provides notice that there will be a Part B CAP Quarterly Drug List Update effective October 1, 2008. When available, the October 2008 list of drugs supplied under the CAP will be posted at http://www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp#TopofPage on the Centers for Medicare & Medicaid Services (CMS) Website.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Section 303 (d), which can be found at <http://www.cms.hhs.gov/MMAUpdate> on the Centers for Medicare & Medicaid Services (CMS) Website) required the implementation of a CAP for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians were given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process.

Key Points of CR6158

- A quarterly update of the CAP drug list will become effective on October 1, 2008.
- Payment amounts for drugs added to the CAP drug list as a result of the update will be implemented for claims with dates of service beginning October 1, 2008 per the new file.

Additional Information

To see the official instruction (CR6158) issued to your Medicare A/B MACs and carriers visit <http://www.cms.hhs.gov/Transmittals/downloads/R1576CP.pdf> on the CMS Website.

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

For more information about the Competitive Acquisition for Part B Drugs & Biologicals, refer to <http://www.cms.hhs.gov/CompetitiveAcquisforBios> on the CMS Website.

PHYSICIAN SIGNATURE REQUIREMENTS FOR DIAGNOSTIC TESTS ~CMS MLN Matters~

MLN Matters Number: MM6100
Related CR Release Date: August 29, 2008
Related CR Transmittal #: R94BP

Related Change Request (CR) #: 6100
Effective Date: January 1, 2003
Implementation Date: September 30, 2008

Provider Types Affected

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors (A/B MAC)) for diagnostic laboratory services provided to Medicare beneficiaries.

What You Need to Know

CR 6100, from which this article is taken, updates the *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests) Subsection 80.6.1 (Definitions); to incorporate language previously contained in Section 15021 of the *Medicare Carriers Manual*, but inadvertently omitted when the *Medicare Benefit Policy Manual* was published.

Specifically, it notes that a physician's signature is not required on orders for clinical diagnostic tests (including x-ray, laboratory, and other diagnostic tests) that are paid on the basis of the clinical laboratory fee schedule, the Medicare physician fee schedule, or for physician pathology services. While a physician order is not required to be signed, the physician must clearly document in the medical record his or her intent that the test be performed.

Make sure that your office, billing, and/or laboratory staffs are aware of this updated guidance regarding the signature requirement for diagnostic tests.

Additional Information

You can find more information about physician signature requirements for diagnostic tests by going to CR 6100, located at <http://www.cms.hhs.gov/Transmittals/downloads/R94BP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website. You will find the updated *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Section 80 (Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests), Subsection 80.6.1 (Definitions) as an attachment to CR6100.

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

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/part_b/publications/newsletter.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 September *Communiqué*.

To access these publications

(http://www.wpsmedicare.com/part_b/publications/newsletter.shtml), you must first accept the AMA Copyright Statement.

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 at:

http://subscriptions.cms.hhs.gov/service/subscribe.html?code=USCMS_460

REVISED FORM CMS-R-131 ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE ~CMS MLN Matters~

MLN Matters Number: MM6136
Related CR Release Date: September 5, 2008
Related CR Transmittal #: R1587CP

Related Change Request (CR) #: 6136
Effective Date: March 3, 2008
Implementation Date: March 1, 2009

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services provided to Medicare beneficiaries.

What You Need to Know

CR 6136, from which this article is taken announces that, effective March 3, 2008, the Centers for Medicare & Medicaid Services (CMS) implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN); which combines the general Advance Beneficiary Notice (ABN-G) and laboratory Advance Beneficiary Notice (ABN-L) into a single form, with form number (CMS R-131).

You should be aware that beginning March 3, 2008 and prior to March 1, 2009, your contractors will accept either the current ABN-G and ABN-L or the revised ABN as valid notification. **However, beginning March 1, 2009, Medicare contractors will accept only a properly executed revised ABN (CMS R-131) as valid notification.**

Make sure that your billing staffs are aware of these ABN form changes.

Background

Prior to March 3, 2008, physicians, providers, practitioners, and suppliers paid under Part B, and hospice providers and religious non-medical health care institutions paid under Part A; were instructed to use the general Advance Beneficiary Notice (ABN-G) or laboratory Advance Beneficiary Notice (ABN-L) to inform beneficiaries of their potential liability in accordance with the limitation on liability provisions set forth in Section 1879 of the Social Security Act.

Beginning on March 3, 2008, however, CMS implemented use of the revised Advance Beneficiary Notice of Noncoverage (ABN). This revised ABN combines the ABN-G and the ABN-L into a single notice, with the same form number (CMS R-131).

The *Medicare Claims Processing Manual* Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) has been substantially updated to reflect these changes. 85 subsections have been deleted from this chapter, and 47 are either new or have been revised. Attached to CR6136 is the updated Chapter 30 and the Web address for viewing CR6136 is contained in the "Additional Information" section of this article.

Some key points from the updated Chapter 30 are as follows:

1. The revised ABN is the new CMS-approved written notice that physicians, providers, practitioners, suppliers, and laboratories issue to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program for items and services that they provide under Medicare Part A (hospice and religious non-medical healthcare institutions only) and Part B. It may not be used for items or services provided under the Medicare Advantage (MA) Program, or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).
2. The revised ABN (which replaces the ABN-G (CMS-R-131-G), ABN-L (CMS-R-131-L), and Notice of Exclusion from Medicare Benefits (NEMB) (CMS-20007)) will now be used to fulfill both mandatory and voluntary notice functions.

Note: Once the revised SNFABN is implemented, Skilled Nursing Facilities must use the revised SNFABN for all items and services billed to Part A and Part B.

3. The following situations require by statute that an ABN be issued:
 - Care is not reasonable and necessary;
 - There was a violation of the prohibition on unsolicited telephone contacts;
 - Medical equipment and supplies supplier number requirements not met;
 - Medical equipment and/or supplies denied in advance;
 - Custodial care; and
 - A hospice patient who is not terminally ill.
4. In the following situations ABN use is voluntary

ABNs are not required for care that is either statutorily excluded from coverage under Medicare (i.e. care that is never covered) or fails to meet a technical benefit requirement (i.e. lacks required certification).

Additionally, the ABN can also be issued voluntarily in place of the Notice of Exclusion from Medicare Benefits (NEMB) for care that is never covered such as:

- Care that fails to meet the definition of a Medicare benefit as defined in Section 1861 of the Social Security Act;
- Care that is explicitly excluded from coverage under Section 1862 of the Social Security Act. Examples include:
 - Services for which there is no legal obligation to pay;

- Services paid for by a government entity other than Medicare (this exclusion does not include services paid for by Medicaid on behalf of dual-eligibles);
 - Services required as a result of war;
 - Personal comfort items;
 - Routine physicals (except the initial preventive physical or “Welcome to Medicare” physical examination) and most screening tests;
 - Routine eye care;
 - Dental care; and
 - Routine foot care.
5. ABN issuers (who may be physicians, practitioners, providers (including laboratories), suppliers, Medicare contractors, or utilization review committees for the care provider) are collectively known as “**notifiers**”. Be aware that the notifier may direct an employee or a subcontractor to actually deliver an ABN, however, the notifier remains ultimately responsible for its effective delivery.

Notifiers are required to issue ABNs whenever limitation on liability applies. This typically occurs at three “**triggering events**” during a course of treatment (initiation, reduction, and termination).

Notifiers must give an ABN to “**recipients**” (FFS Medicare beneficiaries or their representatives), including beneficiaries who have Medicaid coverage in addition to Medicare (i.e. dual-eligible). You should note that notifiers’ inability to give notice to a beneficiary or his/her representative does not allow them to shift financial liability to the beneficiary, unless they have exhausted all attempts to issue the notice and such attempts are clearly documented in the patient’s record and undisputed by the beneficiary.

Medicare Claims Processing Manual Chapter 30 (Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) also contains specific information about ABN Preparation Requirements such as the number of pages, fonts and form reproduction, completion and retention of the form, delivery requirements; and what to do in particular situations such as emergencies, or if a beneficiary changes his/her mind or refuses to complete or sign the notice.

It also discusses potential beneficiary and provider liability; requirements for advance coverage determinations; the collection of funds and refunds; and issues specific to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), hospice, and Comprehensive Outpatient Rehabilitation Facility (CORF).

Additional Information

You can find more information about the revised ABN Form (CMS-R-131) by going to CR 6136, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1587CP.pdf> on the CMS Website. There you will find the updated *Medicare Claims Processing Manual* Chapter 30(Financial Liability Protections), Section 50 (Form CMS-R-131 Advance Beneficiary Notice of Noncoverage (ABN)) as an attachment to that CR.

If you have any questions, please contact your carrier, FI, RHHI, A/B MAC or DME MAC at their toll-free number, which may be found at

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

Additional information on the revised ABN and other limitation of liability notices can be found on the Beneficiary Notice Initiatives Website at <http://www.cms.hhs.gov/bni> on the CMS Website. Questions regarding the revised ABN can be emailed to RevisedABN_ODF@cms.hhs.gov.

Provider Education**EDUCATION SCHEDULE**

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

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

Reimbursement

**2009 ANNUAL UPDATE FOR THE HEALTH PROFESSIONAL
SHORTAGE AREA (HPSA) BONUS PAYMENTS**
~CMS MLN Matters~

MLN Matters Number: MM6150
Related CR Release Date: August 29, 2008
Related CR Transmittal #: R1582CP

Related Change Request (CR) #: 6150
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

Physicians and other providers who bill Medicare Carriers, Fiscal Intermediaries (FI), or Medicare Administrative Contractors (A/B MAC) for services provided to Medicare beneficiaries in Health Professional Shortage Areas (HPSA).

What You Need to Know

CR 6150, from which this article is taken provides your carriers, FIs, and A/B MACs with the names of the test and final files for the Health Professional Shortage Area (HPSA) bonus payments for 2009 and alerts providers that the 2009 file will be posted to the Centers for Medicare & Medicaid Services (CMS) Website when it is available.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) (Section 413(b)) mandated that the automated HPSA bonus payment files be updated annually. CMS creates a new automated HPSA bonus payment file and provides it to your Medicare contractors in early December of each year. CR 6150, from which this article is taken, provides them the names of the test and final 2009 HPSA bonus payment files which contractors will use for the automated bonus payment for claims with dates of service on or after January 1, 2009, through December 31, 2009.

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

Additional Information

You can find the official instruction, CR 6150, issued to your carrier, FI, or A/B MAC by visiting <http://www.cms.hhs.gov/Transmittals/downloads/R1582CP.pdf> on the CMS Website.

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

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

MLN Matters Number: MM6195
Related CR Release Date: September 5, 2008
Related CR Transmittal #: R1584CP

Related Change Request (CR) #: 6195
Effective Date: July 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Clinical laboratories submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for clinical laboratory services provided to Medicare beneficiaries.

Provider Action Needed STOP – Impact to You

This article is based on Change Request (CR) 6195, which **revises and clarifies payment** of travel allowances that are based on either a per mileage basis (P9603) or on a flat rate basis (P9604) for calendar year (CY) 2008. The new rates are \$1.035 per mile (P9603) and \$9.55 per flat-rate trip (P9604).

CAUTION – What You Need to Know

Note that Medicare contractors will not re-process claims that were processed before the new rates were implemented unless you bring such claims to their attention.

GO – What You Need to Do

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

Background

Medicare, under Part B, covers a specimen collection fee and travel allowance for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient under Section 1833(h)(3) of the Social Security Act and payment is made based on the clinical laboratory fee schedule. (See Section 1833(h)(3) of the Social Security Act at http://www.ssa.gov/OP_Home/ssact/title18/1833.htm on the Internet.) Furthermore, the travel codes allow for payment of the travel allowance either on a per mileage basis (P9603) or on a flat rate per trip basis (P9604), and payment of the travel allowance is made only if a specimen collection fee is also payable.

The travel allowance is intended to cover estimated travel costs of collecting the specimen (including the laboratory technician's salary and travel expenses), and Medicare contractors have the discretion to choose:

- Either a flat rate or a mileage basis, and
- How to set each type of allowance.

The per flat rate trip basis travel allowance (P9604) is \$9.55, and the per mile travel allowance (P9603) is \$1.035 cents per mile and is used in situations where the average trip to the patients' homes is:

- Longer than 20 miles round trip, and

- To be pro-rated in situations where specimens are drawn or picked up from non-Medicare patients in the same trip.

As of August 1, 2008, the per mile allowance rate of \$1.035 cents per mile was computed using the Federal mileage rate of \$0.585 cents per mile for automobile expenses plus an additional \$0.45 cents per mile to cover the technician's time and travel costs. Medicare contractors have the option of establishing a higher per mile rate in excess of the minimum of \$1.035 cents per mile if local conditions warrant it.

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

The following are examples to further clarify the new allowances:

Example 1: On August 2, 2008, a laboratory technician travels 60 miles round trip from a lab in a city to a remote rural location, and back to the lab to draw a single Medicare patient's blood. The total reimbursement would be \$62.10 (60 miles x 1.035 cents a mile), plus the specimen collection fee.

Example 2: On August 2, 2008, a laboratory technician travels 40 miles from the lab to a Medicare patient's home to draw blood, and then travels an additional 10 miles to a non-Medicare patient's home and then travels 30 miles to return to the lab. The total miles traveled would be 80 miles. The claim submitted would be for one half of the miles traveled or \$41.40 (40 x 1.035), plus the specimen collection fee.

Note: Some Medicare contractors have established local policy to pay based on a flat rate basis only.

Example 3: A laboratory technician travels from the laboratory to a single Medicare patient's home and returns to the laboratory without making any other stops. The flat rate would be calculated as follows: 2 x \$9.55 for a total trip reimbursement of \$19.10, plus the specimen collection fee.

Example 4: A laboratory technician travels from the laboratory to the homes of five patients to draw blood, four of the patients are Medicare patients and one is not. An additional flat rate would be charged to cover the 5 stops and the return trip to the lab (6 x \$9.55 = \$57.30). Each of the claims submitted would be for \$11.46 (\$57.30 / 5 = \$11.46). Since one of the patients is non-Medicare, four claims would be submitted for \$11.46 each, plus the specimen collection fee for each.

Example 5: A laboratory technician travels from a laboratory to a nursing home and draws blood from 5 patients and returns to the laboratory. Four of the patients are on Medicare and one is not. The \$9.55 flat rate is multiplied by two to cover the return trip to the laboratory (2 x \$9.55 = \$19.10) and then divided by five (1/5 of \$19.10 = \$3.82). Since one of the patients is non-Medicare, four claims would be submitted for \$3.82 each, plus the specimen collection fee.

At no time will a laboratory be allowed to bill for more miles than are reasonable or for miles not actually traveled by the laboratory technician.

Additional Information

To see the official instruction (CR6195) issued to your Medicare A/B MACs and carriers visit <http://www.cms.hhs.gov/Transmittals/downloads/R1584CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website.

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

OCTOBER UPDATE TO THE 2008 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE (MPFSDB) ~ CMS MLN Matters ~

MLN Matters Number: MM6180
Related CR Release Date: August 22, 2008
Related CR Transmittal #: R1580CP

Related Change Request (CR) #: 6180
Effective Date: January 1, 2008
Implementation Date: October 6, 2008

Provider Types Affected

Physicians and providers who submit claims to Medicare Carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for services rendered to Medicare beneficiaries paid based on the MPFSDB.

Key Points of CR 6180

- Changes in the October Update to the 2008 MPFSDB are as follows:

CPT/HCPCS Codes	Action
15878 and 15879	Bilateral indicator = 1
92557 and 92567	PC/TC Indicator = 9
93660—26	Multiple Procedure Indicator= 2
G0398, G0399, and G0400	PC/TC Indicator = 1

- Changes effective March 13, 2008 for G0398–TC, G0398–26, G0399-TC, G0399-26, G0400-TC, and G0400-26 are as described in Attachment 1 of CR 6180.
- An editorial change was made to the long descriptor of G0250 as noted in Attachment 1 of CR6180.

Make certain your billing staffs are aware of these changes. Your Medicare contractor will retroactively adjust claims if you bring such claims to their attention.

Background

This article is based on CR 6180, which states that payment files were issued to contractors based upon the 2008 MPFS Final Rule. CR 6180 amends those payment files.

Additional Information

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

You may see the official instruction (CR6180) issued to your Medicare Carrier or A/B MAC, by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1580CP.pdf> on the CMS Website.

WPS MEDICARE PROVIDER SERVICES

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

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Michigan WPS Medicare Customer Service PO Box 5533 Marion, IL 62959 (866) 234-7331	Minnesota WPS Medicare Customer Service 8120 Penn Avenue South, Ste. 200 Bloomington, MN 55431-1394 (866) 359-1598

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