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**Items of Importance****BE READY IN CASE OF EMERGENCY - SIGN UP FOR WPS E-NEWS TODAY!**

CMS is working to strengthen its emergency preparedness. CMS and WPS Medicare will work together to get you any information you might need in the event of an emergency. CMS recommends that you subscribe to the WPS Medicare e-News Listserv in order to remain informed in case of either a regional or national emergency. WPS will ensure that CMS emergency messages are delivered in a timely fashion, and our e-News Listserv is the fastest, most effective means of sharing information with our providers. In addition, CMS also recommends that each provider have an alternate contact subscribe to the WPS e-News Listserv to act as an additional backup to receive urgent emergency information. If you are already registered for our e-News Listserv, please encourage your co-workers and professional associates to sign up as well.

To sign up for the WPS Medicare e-News Listserv, go to:  
<http://www.wpsmedicare.com/listserv>

**IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS**

WPS Medicare Provider Customer Service will be closing for brief periods so our Customer Service Representatives may participate in training sessions. Our representatives are eager to learn more in order to serve you better. During the month of November, we will be closed on:

Thursday November 30, 2006 8:00 a.m. to 10:00 a.m. CT

WPS will also be closed on November 23rd and 24th in observance of Thanksgiving.

At these times, the IVR and CMS Secure Net Access Pilot (C-SNAP) will continue to be available for your use to check eligibility and claim status. For more information regarding C-SNAP, call 1-877-476-8116. Thank you for your patience and for allowing us this chance to serve you better.

**LOOKING FOR THE 2007 FEE SCHEDULE?**

The 2007 fees will be available on the WPS Medicare Website after the 2007 physician fee schedule regulation is on display. We will send a WPS Medicare e-News (Listserv) message out as soon as the fees are available. To sign up to receive your e-News messages, please go to <http://www.wpsmedicare.com/listserv>

## MESSAGE TO MEDICARE PROVIDERS, BILLERS, CLEARINGHOUSE, AND VENDORS

As noted in previous announcements by the agency and our contractors, CMS plans to begin testing the new software that has been developed to use the National Provider Identifier (NPI) in the existing Medicare fee-for-service claims processing systems. Providers have until May 23, 2007, before you are required to submit claims with only an NPI.

Until testing is complete within the Medicare processing systems, CMS urges providers to continue submitting Medicare fee-for-service claims in one of two ways:

- **Use your legacy number**, such as your Provider Identification Number (PIN), NSC number, OSCAR number or UPIN; or
- Use **both** your NPI **and** your legacy number.

Until testing of the new software that uses the NPI in the Medicare systems is complete and until further notice from CMS, the following may occur if you submit Medicare claims with only an NPI:

- Claims may be processed and paid, or
- Claims for which Medicare systems are unable to properly match the incoming NPI with a legacy number (e.g., PIN, OSCAR number) **may** be rejected to the provider, and then you will need to resubmit the claim with the appropriate legacy number.

As always, more information and education on the NPI can be found at the CMS NPI page <http://www.cms.hhs.gov/NationalProidentStand> on the CMS website. Providers can apply for an NPI online at <https://nppes.cms.hhs.gov> or can call the NPI enumerator to request a paper application at 1-800-465-3203.

## **NOVICE KNOW-HOW - HOW CAN YOU RECOGNIZE A SERVICE THAT IS ALWAYS "BUNDLED"?**

One of the most common denials for a new provider's claims is for bundled services. One easy way to check if the service you bill is always bundled is to refer to the Medicare Physician Fee Schedule Database (MPFSDB), also known as the National Physician Fee Schedule Relative Value File. You can view it on the Centers for Medicare & Medicaid Services Website at the following address:

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp#TopOfPage>

The MPFSDB Status Code column contains a letter "B" when the code is always bundled. A bundled service means payment for covered services are always included into payment for other services not specified. Assignment of relative value units, payment amount, and separate payment for the code do not occur. When a bundled service is covered, payment for the service is subsumed by the payment for the services to which it is incident. (An example is a telephone call from a hospital nurse regarding care of a patient). You cannot bill the beneficiary for a bundled service.

Updates occur quarterly to the MPFSDB (October, January, April, and July). Be sure to choose and download the applicable file for the date of service.

### **Claim Submission**

## **2007 ANNUAL UPDATE OF HCPCS CODES FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB)**

~CMS MLN Matters~

**MLN Matters Number:** MM5283

**Related CR Release Date:** September 29, 2006

**Related CR Transmittal #:** R1068CP

**Related Change Request (CR) #:** 5283

**Effective Date:** January 1, 2007

**Implementation Date:** January 2, 2007

### **Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare carriers, durable medical equipment regional carriers (DMERCs) or DME Medicare Administrative Contractors (DME 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) 5283, which provides the 2007 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**

CR5283 provides updated 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* (Publication 100-04), 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, DMERCs/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 carriers and/or FIs.

- For physicians and providers billing carriers: By the first week in December 2006, new code files will be posted at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> on the CMS web site.
- For those providers billing FIs: By the first week in December 2006, new Excel® and PDF files will be posted at <http://www.cms.hhs.gov/SNFConsolidatedBilling/> on the CMS web site.

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 web site in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

**Implementation**

The implementation date for CR5283 is January 2, 2007.

**Additional Information**

For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC or intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1068CP.pdf> on the CMS web site.

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

**ENDING THE CONTINGENCY PLAN FOR REMITTANCE ADVICE (RA)  
AND CHARGING FOR PC PRINT, MEDICARE REMIT EASY PRINT  
(MREP), AND DUPLICATE RAS  
~CMS MLN Matters~**

**MLN Matters Number:** MM 5308  
**Related CR Release Date:** September 22, 2006  
**Related CR Transmittal #:** R1063CP

**Related Change Request (CR) #:** CR 5308  
**Effective Date:** October 1, 2006  
**Implementation Date:** October 23, 2006

**Provider Types Affected**

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

**Impact on Providers**

This Change Request (CR) updates the *Medicare Claims Processing Manual* (Publication 100-04) for ending the contingency plan for Electronic Remittance Advice (ERA), and instructs contractors about charging for PC Print, Medicare Remit Easy Print (MREP), and duplicate Remittance Advice (RA).

**Background**

This article is based on Change Request (CR) 5308 which

- Updates the *Medicare Claims Processing Manual* (Chapters 22 and 24) to include the end of the contingency period for Electronic Remittance Advice (ERA) effective October 1, 2006; and
- Provides instructions to Medicare contractors (A/B MACs, carriers, DMERCs, DME MACs, FIs, and RHHIs) regarding charging for:
  - Generating and mailing provider requested duplicate remittance advices (RAs). There is no current CMS instruction for contractors to charge for generating duplicate remittance advice (when provider has already been sent a remittance advice – either in electronic or paper format) and mailing in case of paper remittance advice. Therefore, CR 5308 informs Medicare Contractors that they are now allowed to charge to recoup their cost to generate a duplicate RA if the request comes from a provider or any entity working on behalf of the provider.
  - Making PC Print or Medicare Remit Easy Print software available to providers by CD/DVD or any other means when the requested software is available for free to download. Contractors may charge up to \$25.00 for each mailing to cover their cost(s).

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, an ERA sent to a provider on or after October 16, 2003 is required to be a standard HIPAA compliant ERA, and the ERA standard adopted under HIPAA was ANSI ASC X12N transaction 835, Version 004010A1.

CMS implemented a contingency plan (as of October 16, 2003) to continue to accept and send HIPAA-compliant and non HIPAA-compliant transactions from/to trading partners beyond October 16, 2003, for a limited time.

**CMS ended the contingency period for claims in October 2005**, and in a Joint Signature Memorandum (JSM/TDL-06518) issued on June 28, 2006, CMS instructed Medicare contractors that it **is ending the contingency period for ERAs on September 30, 2006**.

CR 5308 instructs Medicare Contractors that, on or after October 1, 2006, all ERAs must be provided in the standard HIPAA (ANSI ASC X12N 835 version 004010A1) format.

**Implementation**

The implementation date for CR5308 is October 23, 2006.

**Additional Information**

For complete details, please see the official instruction issued to your A/B MAC, carrier, intermediary regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1063CP.pdf> on the CMS web site. The revised sections of the Medicare Claims Processing Manual are attached to CR5308.

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

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

**QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI)  
EDITS, VERSION 12.3, EFFECTIVE OCTOBER 1, 2006  
~CMS MLN Matters~**

**MLN Matters Number:** MM5258  
**Related CR Release Date:** September 15, 2006  
**Related CR Transmittal #:** R1056CP

**Related Change Request (CR) #:** 5258  
**Effective Date:** October 1, 2006  
**Implementation Date:** October 2, 2006

### **Provider Types Affected**

Physicians billing Medicare carriers

### **Background**

This article and related CR 5258 provide a reminder for physicians to take note of the quarterly updates to the coding initiatives. The next round of CCI edits will be effective on October 1, 2006. Physicians may view the current CCI edits and the current Mutually Exclusive Code (MEC) edits at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> on the Centers for Medicare & Medicaid Services (CMS) web site. The web site will be updated with the Version 12.3 edits as soon as they are effective.

### **Key Points**

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 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. The latest package of CCI edits, Version 12.3, is effective on October 1, 2006. This version will include 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 table; and
- MEC Edits table.

### **Implementation**

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

### **Additional Information**

The CCI and MEC file formats will be maintained in the Medicare Claims Processing Manual (Publication 100-04), Chapter 23, Section 20.9, which can be found at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS web site.

**TERMINATION OF HEALTHCARE COMMON PROCEDURE CODING  
SYSTEM (HCPCS) CODE G0107, COLORECTAL CANCER  
SCREENING, FECAL-OCCULT BLOOD TESTS (FOBT), 1-3  
SIMULTANEOUS DETERMINATIONS  
~CMS MLN Matters~**

**MLN Matters Number:** MM5292  
**Related CR Release Date:** September 22, 2006  
**Related CR Transmittal #:** R1062CP

**Related Change Request (CR) #:** 5292  
**Effective Date:** January 1, 2007  
**Implementation Date:** January 2, 2007

**Provider Types Affected**

All providers who bill Medicare carriers or fiscal intermediaries (FIs), including Part A/B Medicare Administrative Contractors (A/B MACs) for Fecal Occult Blood Tests administered to Medicare beneficiaries.

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

Do not use HCPCS code G0107 for screening Fecal Occult Blood Tests (FOBT) on or after January 1, 2007. As of that date, that code is being deleted and replaced by CPT code 82270.

**CAUTION – What You Need to Know**

Effective January 1, 2007, HCPCS code G0107 for screening Fecal Occult Blood Tests (FOBT) is being terminated and replaced by CPT code 82270. If you use HCPCS code G0107 for FOBT on or after this date, your reimbursement could be impacted as the claim will be returned as unprocessable.

**GO – What You Need to Do**

Make sure that your billing staffs are aware of this coding change for FOBT.

**Background**

MLN Matters Number: MM5292 Related Change Request Number: 5292  
HCPCS code G0107 will be retired at the next annual release of the clinical diagnostic laboratory fee schedule effective January 1, 2007, and replaced with current procedural terminology (CPT) code 82270.

Prior to January 1, 2007 use G0107 for billing Medicare for screening FOBT; however on or after January 1, 2007 (the effective date of the 2007 clinical diagnostic lab fee schedule) use code 82270 for billing Medicare for screening FOBT.

**Additional Information**

The official instruction issued to you carrier, FI, or A/B MAC is CR 5292, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1062CP.pdf> on the CMS web site. Revised Medicare Claims Processing Manual (Publication 100.04), Chapter 18 (Preventive and Screening Services), Section 60 (Colorectal Cancer Screening), Subsections 60.1-60.7 are included as an attachment to that CR.

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

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

## UPDATE TO THE PLACE OF SERVICE (POS) CODE SET TO ADD A CODE FOR PRISON/CORRECTIONAL FACILITY

~CMS MLN Matters~

**MLN Matters Number:** MM4316

**Related CR Release Date:** September 1, 2006

**Related CR Transmittal #:** R1049CP

**Related Change Request (CR) #:** 4316

**Effective Date:** July 1, 2006

**Implementation Date:** January 2, 2007

### Provider Types Affected

Providers, physicians, and suppliers that submit claims to Medicare carriers, for services rendered in a prison/correctional facility.

### Key Points

#### New Place of Service (POS) Code

A new Place of Service (POS) code "09" for prison/correctional facilities was added effective July 1, 2006. This POS code is described in the *Medicare Claims Processing Manual*, Chapter 26, Section 10.5 as:

**"09 Prison/Correctional Facility (July 1, 2006)** - A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders."

#### Claims Paid at Nonfacility Rate

Claims for covered services on the Medicare Physician Fee Schedule in this place of service/setting, if payable by Medicare, will be paid at the nonfacility rate, and Medicare carriers will develop policies as needed to adjudicate claims containing this new code.

#### New Code Does Not Supersede Medicare Policy

The addition of code 09 to the POS code set for a prison/correctional facility setting and Medicare claims processing reflects Medicare's compliance with HIPAA laws and regulations and in no way supersedes existing Medicare policy.

Carriers will continue to abide by current policy that does not allow for payment for Medicare services in a penal institution in most cases. This policy is supplied in the Medicare Claims Processing Manual, Chapter 1, Section 10.4, located at

<http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS site.

### Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set maintained by the Centers for Medicare & Medicaid Services (CMS). As a payer, Medicare must be able to recognize as valid any valid code from the POS code set that appears on the HIPAA standard claim transaction.

### Additional Information

The POS code set provides setting information necessary to appropriately pay Medicare and Medicaid claims. At times, Medicaid has had a greater need for specificity than has Medicare, and many of the new codes developed over the past few years have been developed to meet Medicaid's needs.

While Medicare does not always need this greater specificity to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

**Note:** Medicare's durable medical equipment regional carriers (DMERCs) and durable medical equipment administrative contractors (DME MACs) will implement this change at a later date and a separate notice will be provided when that implementation is scheduled.

CR4316 is the official instruction issued to your carrier, regarding changes mentioned in this article. CR4316 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1049CP.pdf> on the CMS web site.

Please refer to your local carrier if you have questions about this issue. To find their toll free phone number, go to <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS web site.

## Comprehensive Error Rate Testing (CERT)

### CERT ERROR FOCUS – PHYSICAL MEDICINE AND REHABILITATION PROCEDURES AND MODALITIES - CPT 97001- 97546

In our continuing effort to increase the awareness of all Medicare providers regarding issues found as a result of Comprehensive Error Rate Testing (CERT) reviews, we have been focusing on specific services that contribute to our CERT error rate. Our focus this month is on incorrect coding and insufficient documentation issues related to physical medicine and rehabilitation, specifically Current Procedural Terminology (CPT) procedure codes 97035-97140.

Analysis of our current CERT error findings (claims submitted 04/01/05-03/31/06) indicates that insufficient documentation issues are the cause of errors in the majority of these cases, followed by instances of incorrect coding (ex., up coding or down coding). Oftentimes, the CERT contractor is unable to obtain the needed information even after additional follow-up contacts to the provider. Below are examples of actual CERT review comments received for these claims.

#### ***Insufficient Documentation***

- Need copies of physical therapy plan of treatment, physician order/certification/recertification for physical therapy services and notes to include minutes for each billed modality for date of service billed. Per the Social Security Act (SSA) 1833(e) and Internet-Only Manual (IOM) Pub. 100-02, Chapter 15, Section 220, missing physical therapy plan of treatment and physician order/certification/recertification for physical therapy services for date of service. Submitted documentation consists of progress notes without clear notation of modalities and minutes.
- Missing initial physical therapy evaluation and the physician certified treatment plan for care for PT treatment(s) done, per Local Coverage Determination (LCD) for Physical Medicine and Rehabilitation Procedures and Modalities PHYSMED-009 V7 (Rev. Eff. 07/25/2005).
- Need Physician signed order for treatment, and a plan of care with frequency and duration of services provided including goals. Received additional note from provider stating, "Charges have been backed off, no signature on 'Plan of Care'. Refund done to Medicare for all physical therapy dates of service."

**Service Incorrectly Coded**

- Submitted with CPT 97110, therapeutic procedure, one or more areas, each 15 minutes, (2) units of service = 30 minutes. Documentation does not support 30 minutes of therapy provided. Time noted on bottom on progress note dated 03/21/2005 has an entry for 03/24/2005 as 11:20 to 11:30. Change code from CPT 97110, (2) units of service to 97110, (1) unit of service.
- Per SSA 1833(e), CPT 2005 and IOM Pub. 100-4, Chapter 5, Sections 20.2 and 20.3, which states, "For any single CPT code, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes and less than 23 minutes. If the duration of a single modality or procedure is greater than or equal to 23 minutes, to less than 38 minutes, then 2 units should be billed." Submitted with CPT code 97140, manual therapy techniques per 15 minutes, (2) units of service = 30 minutes. Documentation supports 22 minutes of manual therapy technique provided. Change code from 97140(2) units of service to 97140(1) unit of service.

Providers must be aware of documentation requirements when billing physical therapy services to Medicare Part B. The patient's medical records should be legible, with a plan of care that incorporates the skilled treatment elements that are expected to result in improvement of the patient's physical and functional limitations in a reasonable and generally predictable period of time or the evaluation services must be necessary to establish a safe and effective maintenance regimen required in connection with a specific disease; with clear goals defined. In addition, the type, amount, frequency, and duration of services must be medically necessary for the patient's condition under accepted medical, physical therapy, and occupational therapy practice standards, and relate directly to a written treatment plan.

Proper documentation of services billed to Medicare is crucial in order to meet CMS' error rate reduction expectations, and WPS continues to identify problem areas contributing most significantly to our jurisdiction's error rate. Continued cooperation from providers in proper billing and documentation of services billed to Medicare is essential in order to reach these goals.

For more information regarding the CERT program and other issues related to CERT review findings, please visit our website at <http://www.wpsmedicare.com/provider/cert.shtml>. If you have questions related to the CERT process or a specific CERT sampled claim, you may e-mail us at [medicareadmin@wpsic.com](mailto:medicareadmin@wpsic.com). Be sure to include "CERT Question" in the subject line. Please also include your full name, telephone number, and Provider Identification Number (if available) in the body of the e-mail. This will assure a prompt and accurate reply to your question.

When e-mailing WPS Medicare, please do not include sensitive information. If your question pertains to a specific claim, include the Internal Control Number (ICN), not your patient's Medicare Health Insurance Claim (HIC) Number.

For more information regarding Medicare coverage of physical medicine and rehabilitation services, please refer to LCD PHYSMED-009 and National Coverage Policy (NCP) PHYSMED-001 on our WPS Medicare Website at:

[http://www.wpsmedicare.com/policies/pol\\_home.shtml](http://www.wpsmedicare.com/policies/pol_home.shtml)

**Coverage – General****PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTS****~CMS MLN Matters~****MLN Matters Number:** MM5204**Related CR Release Date:** September 29, 2006**Related CR Transmittal #:** R55BP**Related Change Request (CR) #:** 5204**Effective Date:** January 1, 2006**Implementation Date:** December 28, 2006**Provider Types Affected**

Providers who bill Medicare carriers or fiscal intermediaries (FIs) for the provision of diagnostic psychological and neuropsychological tests.

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

Effective January 1, 2006, carriers and FIs will pay (under the Medicare physician fee schedule (MPFS) database) for diagnostic psychological and neuropsychological tests that are within the CPT code range of 96101 through 96120.

**CAUTION – What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) announces the revision of the CPT codes for psychological and neuropsychological tests (codes 96101 through 96120) to include tests performed by technicians and computers (CPT codes 96102, 96103, 96119 and 96120) in addition to those performed by physicians, clinical psychologists, independently practicing psychologists and other qualified non-physician practitioners (as described in Background, below).

**GO – What You Need to Do**

Make sure that your billing staffs are aware of the CPT code changes.

**Background**

Medicare Part B coverage of psychological tests and neuropsychological tests is authorized under section 1861(s)(2)(C) of the Social Security Act, and payment for these tests is authorized under section 1842(b)(2)(A) of the Social Security Act.

The CPT codes for these tests are included in the range of codes from 96101 to 96120. The appropriate codes when billing for psychological tests are: 96101, 96102, 96103, 96105, 96110, and 96111; and when billing for neuropsychological tests are: 96116, 96118, 96119 and 96120. All of the tests under this CPT code range 96101-96120 are covered and indicated as active codes under the MPFS database.

More specifically, CR 5204, from which this article is taken, provides that (effective January 1, 2006) the CPT codes for psychological and neuropsychological tests include tests performed by technicians and computers (CPT codes 96102, 96103, 96119 and 96120) in addition to tests performed by physicians, clinical psychologists, independently practicing psychologists and other qualified nonphysician practitioners.

These changes, made in accordance with the final physician fee schedule regulation, were published in the Federal Register on November 21, 2005, at 70 FR 70279 and 70280 under

Table 29 (AMA, Relative Value Update Committee (RUC) and Health Care Professional Advisory Committee (HCPAC) Recommendations and CMS Decisions for New and Revised 2006 CPT Codes).

You should be aware of some supervision requirements for diagnostic psychological and neuropsychological tests. First, under the diagnostic tests provision, all diagnostic tests are assigned a certain level of supervision. Generally, regulations governing the diagnostic tests provision allow only physicians to provide the assigned level of supervision for such tests; however, for diagnostic psychological and neuropsychological tests, there is a regulatory exception that allows either a clinical psychologist (CP) or a physician to perform the assigned general supervision.

Moreover, nonphysician practitioners such as nurse practitioners (NPs), clinical nurse specialists (CNSs), and physician assistants (PAs), who personally perform diagnostic psychological and neuropsychological tests are excluded from having to perform these tests under the supervision requirements of the diagnostic psychological and neuropsychological tests benefit, that is, under the general supervision of a physician or a CP.

In fact, rather than providing them under the requirements for diagnostic psychological and neuropsychological tests, NPs and CNSs must perform such tests under the requirements of their respective benefit. Therefore, NPs and CNSs must perform them in collaboration (as defined under Medicare law at section 1861(aa)(6) of the Act) with a physician. Likewise, PAs must perform these tests under the general supervision of a physician as required for services furnished under the PA benefit.

To continue, physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs) are authorized to bill three test codes (96105, 96110, and 96111) as “sometimes therapy” codes. However, when PTs, OTs and SLPs perform these three tests, they must do so under the general supervision of a physician or a CP.

You should also note that expenses for diagnostic psychological and neuropsychological tests are not subject to the outpatient mental health treatment limitation, which is the payment limitation on treatment services for mental, psychoneurotic and personality disorders as authorized under Section 1833(c) of the Social Security Act. Further, the payment amounts that are billed for tests performed by a technician or a computer reflect a site of service payment differential for the facility and non-facility settings.

Remember that CPs, NPs, CNSs and PAs are required by law to accept assigned payment for psychological and neuropsychological tests. And although Independently Practicing Psychologists (IPPs) are not required to accept assigned payment for these tests, they must report the name and address of the physician who ordered the test on the claim form when billing for tests. (An IPP is any psychologist who is licensed (or certified) to practice psychology in the State or jurisdiction where furnishing services or, if the jurisdiction does not issue licenses, if provided by any practicing psychologist. Examples of psychologists (other than CPs) whose psychological and neuropsychological tests are covered under the diagnostic tests provision include, but are not limited to, educational psychologists and counseling psychologists.) Additionally, there is no authorization under Medicare law for payment for diagnostic tests when performed on an “incident to” basis.

Following is a summary of who may bill for diagnostic psychological and neuropsychological tests, and references for the review of qualifications, when appropriate.

**Providers that May Bill for Diagnostic Psychological and Neuropsychological Tests**

CPs	See qualifications under Chapter 15, section 160 of the Medicare Benefits Policy Manual.
NPs –to the extent authorized under State scope of practice.	See qualifications under Chapter 15, section 200 of the Medicare Benefits Policy Manual.
CNSs –to the extent authorized under State scope of practice.	See qualifications under Chapter 15, section 210 of the Medicare Benefits Policy Manual.
PAs – to the extent authorized under State scope of practice.	See qualifications under Chapter 15, section 190 of the Medicare Benefits Policy Manual.
Independently Practicing Psychologists (IPPs)	
PTs, OTs and SLPs	See qualifications under Chapter 15, sections 220-230.6 of the Medicare Benefits Policy Manual.

The Medicare Benefits Policy Manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS website.

**Here are some other important things that you should know.**

- The technician and computer CPT codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Therefore, CPT psychological test code 96101 will not be paid if you include it in the bill for the same tests or services performed under psychological test codes 96102 or 96103. Similarly, CPT neuropsychological test code 96118 will not be paid when included in the bill for the same tests or services performed under neuropsychological test codes 96119 or 96120. Note, however, CPT codes 96101 and 96118 can sometimes be paid separately, when billed on the same date of service for different and separate tests from 96102, 96103, 96119 and 96120.
- Under the MPFS, there is no payment for services performed by students or trainees. Accordingly, Medicare does not pay for services represented by CPT codes 96102 and 96119, when performed by a student or a trainee. However, the presence of a student or a trainee while the test is being administered does not prevent a physician, CP, IPP, NP, CNS or PA from performing and being paid for the psychological test under 96102 or the neuropsychological test under 96119.
- Fiscal intermediaries will continue to pay claims from providers of outpatient Part B therapy services (including physical therapy, occupational therapy, and speech-language pathology) for CPT codes 96105, 96110 and 96111 with revenue codes and corresponding therapy modifiers (42X with GP, 43X with GO, and 44X with GN, respectively).

- Finally, your carriers and fiscal intermediaries do not have to search their files to either retract payment for claims already paid, or to retroactively pay claims to January 1, 2006; they will adjust claims that you bring to their attention.

### Additional Information

You can find more information about Psychological and Neuropsychological Tests by reading CR 5204, located at <http://www.cms.hhs.gov/Transmittals/downloads/R55BP.pdf> on the CMS website. As an attachment to this CR, you will find updated relevant portions of Publication 100.02 (Medicare Benefit Policy Manual), Chapter 15 (Covered Medical and Other Health Services), Section 80.2 (Psychological Tests and Neuropsychological Tests)

If you have any questions, please contact your carrier or fiscal intermediary at their toll-free number, which may be found at

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

## REMINDER NOTICE OF THE IMPLEMENTATION OF THE AMBULANCE TRANSITION SCHEDULE

On April 1, 2002, the Centers for Medicare & Medicaid Services (CMS) implemented a new fee schedule that applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers, i.e., hospitals, critical access hospitals, and skilled nursing facilities. The fee schedule was effective for claims with dates of services on or after April 1, 2002. Under the fee schedule, ambulance services covered under Medicare will be paid based on the lower of the actual billed amount or the ambulance fee schedule amount.

As discussed in previous Program Memoranda (PMs), the fee schedule will be phased in over a 5-year period. When fully implemented, the fee schedule will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers.

This article is a reminder of the transition schedule, which is subject to a 5-year transition period as follows (Calendar Years (CY) run January 1 - December 31):

Year	Fee Schedule Percentage	Cost/Charge Percentage
Year 1 (4/1/02 - 12/31/02)*	20%	80%
Year 2 (CY 2003)*	40%	60%
Year 3 (CY 2004)	60%	40%
Year 4 (CY 2005)	80%	20%
Year 5 (CY 2006 and thereafter)	100%	0%

\* Previous and current year percentages

## **ZOSTER VACCINE - ZOSTAVAX™**

Zostavax is a new vaccine that helps reduce the risk of contracting herpes zoster (shingles) in patients 60 years and older. This vaccine is currently not a covered Medicare benefit, even though the Food and Drug Administration approved it on May 25, 2006. Congress would need to amend Medicare law to expand preventive benefits coverage in order for Zostavax to become a Medicare benefit.

The Centers for Medicare & Medicaid Services' Medicare Benefit Policy Manual, Publication 100-02, Section 50.4.4.2, states that vaccinations or inoculations are excluded from coverage as immunizations unless they are directly related to the treatment of an injury or direct exposure to a disease or condition, such as anti-rabies treatment, tetanus antitoxin or booster vaccine, botulin antitoxin, antivenin sera, or immune globulin. In the absence of injury or direct exposure, preventive immunization (vaccination or inoculation) against such diseases as smallpox, polio, diphtheria, etc., is not covered. However, pneumococcal, hepatitis B, and influenza virus vaccines are exceptions to this rule. In cases where a vaccination or inoculation is excluded from coverage, related charges are also not covered. Therefore, the administration of Zostavax is not a covered Part B benefit.

### **Coverage – Policies**

#### **OPEN MEETING ON DRAFT LOCAL COVERAGE DECISIONS (LCD)**

In order to assure that development of Local Coverage Decisions (LCD) occurs through a public and open process, WPS, the Medicare Part B Carrier for Wisconsin, Illinois, Michigan, and Minnesota, sponsors open meetings to allow the submission of scientific evidence and other information from members of the general public relating to draft policies:

The next Open Policy Meeting will be held on **Wednesday, December 13, 2006**, at 1:00 p.m. CST, 2:00 p.m. EST. The local coverage decisions that will be discussed at the meeting will be available on the WPS website:

[http://www.wpsmedicare.com/policies/open\\_mtg\\_on\\_draftpol.shtml](http://www.wpsmedicare.com/policies/open_mtg_on_draftpol.shtml)

#### **UPDATE CONCERNING PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTS (PSYCH-014)**

LCD PSYCH-014 Psychiatry and Psychology Services describes Psychological tests and Neuropsychological testing.

CMS transmittal Change Request 5204 revises CMS Manual System Pub 100-2 Medicare Benefit Policy 80.2. LCD Psych-014 is based on this national manual.

The updated policy is on WPS' website

<http://www.wpsmedicare.com/policies/wisconsin/psych014.pdf>

**Summary**

CPT codes for psychological and neuropsychological tests have been revised to include tests performed by technicians and computers in addition to tests performed by physicians, clinical psychologists, independently practicing psychologists and other qualified nonphysician practitioners. Effective January 1, 2006, diagnostic psychological and neuropsychological tests under the CPT code range 96101-96120 are indicated as active codes that are paid under the Physician Fee Schedule. Since this revision by CMS is so important to this LCD, we have included below so that Medicare providers can easily reference it. Our policy of will reflect the required CMS changes.

**80.2 – Psychological Tests and Neuropsychological Tests  
(Rev. 55, Issued: 09-29-06, Effective: 01-01-06, Implementation: 12-28-06)**

*Medicare Part B coverage of psychological tests and neuropsychological tests is authorized under section 1861(s)(2)(C) of the Social Security Act. Payment for psychological and neuropsychological tests is authorized under section 1842(b)(2)(A) of the Social Security Act. The payment amounts for the new psychological and neuropsychological tests (CPT codes 96102, 96103, 96119 and 96120) that are effective January 1, 2006, and are billed for tests administered by a technician or a computer reflect a site of service payment differential for the facility and non-facility settings. Additionally, there is no authorization for payment for diagnostic tests when performed on an “incident to” basis.*

*Under the diagnostic tests provision, all diagnostic tests are assigned a certain level of supervision. Generally, regulations governing the diagnostic tests provision require that only physicians can provide the assigned level of supervision for diagnostic tests. However, there is a regulatory exception to the supervision requirement for diagnostic psychological and neuropsychological tests in terms of who can provide the supervision. That is, regulations allow a clinical psychologist (CP) or a physician to perform the general supervision assigned to diagnostic psychological and neuropsychological tests.*

*In addition, nonphysician practitioners such as nurse practitioners (NPs), clinical nurse specialists (CNSs) and physician assistants (PAs) who personally perform diagnostic psychological and neuropsychological tests are excluded from having to perform these tests under the general supervision of a physician or a CP. Rather, NPs and CNSs must perform such tests under the requirements of their respective benefit instead of the requirements for diagnostic psychological and neuropsychological tests. Accordingly, NPs and CNSs must perform tests in collaboration (as defined under Medicare law at section 1861(aa)(6) of the Act) with a physician. PAs perform tests under the general supervision of a physician as required for services furnished under the PA benefit.*

*Furthermore, physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs) are authorized to bill three test codes as “sometimes therapy” codes. Specifically, CPT codes 96105, 96110 and 96111 may be performed by these therapists. However, when PTs, OTs and SLPs perform these three tests, they must be performed under the general supervision of a physician or a CP.*

**Who May Bill for Diagnostic Psychological and Neuropsychological Tests**

- CPs – see qualifications under chapter 15, section 160 of the Benefits Policy Manual, Pub. 100-02.
- NPs –to the extent authorized under State scope of practice. See qualifications under chapter 15, section 200 of the Benefits Policy Manual, Pub. 100-02.

- CNSs –to the extent authorized under State scope of practice. See qualifications under chapter 15, section 210 of the Benefits Policy Manual, Pub. 100-02.
- PAs – to the extent authorized under State scope of practice. See qualifications under chapter 15, section 190 of the Benefits Policy Manual, Pub. 100-02.
- Independently Practicing Psychologists (IPPs)
- PTs, OTs and SLPs – see qualifications under chapter 15, sections 220-230.6 of the Benefits Policy Manual, Pub. 100-02.

*Psychological and neuropsychological tests performed by a psychologist (who is not a CP) practicing independently of an institution, agency, or physician's office are covered when a physician orders such tests. An IPP is any psychologist who is licensed or certified to practice psychology in the State or jurisdiction where furnishing services or, if the jurisdiction does not issue licenses, if provided by any practicing psychologist. (It is CMS' understanding that all States, the District of Columbia, and Puerto Rico license psychologists, but that some trust territories do not. Examples of psychologists, other than CPs, whose *psychological and neuropsychological tests* are covered under *the diagnostic tests* provision include, but are not limited to, educational psychologists and counseling psychologists.)*

*The carrier must secure from the appropriate State agency a current listing of psychologists holding the required credentials to determine whether the tests of a particular IPP are covered under Part B in States that have statutory licensure or certification. In States or territories that lack statutory licensing or certification, the carrier checks individual qualifications before provider numbers are issued. Possible reference sources are the national directory of membership of the American Psychological Association, which provides data about the educational background of individuals and indicates which members are board-certified, the records and directories of the State or territorial psychological association, and the National Register of Health Service Providers. If qualification is dependent on a doctoral degree from a currently accredited program, the carrier verifies the date of accreditation of the school involved, since such accreditation is not retroactive. If the listed reference sources do not provide enough information (e.g., the psychologist is not a member of one of these sources), the carrier contacts the psychologist personally for the required information. Generally, carriers maintain a continuing list of psychologists whose qualifications have been verified.*

**NOTE:** *When diagnostic psychological tests are performed by a psychologist who is not practicing independently, but is on the staff of an institution, agency, or clinic, that entity bills for the *psychological tests*.*

The carrier considers psychologists as practicing independently when:

- They render services on their own responsibility, free of the administrative and professional control of an employer such as a physician, institution or agency;
- The persons they treat are their own patients; and
- They have the right to bill directly, collect, and retain the fee for their services.

A psychologist practicing in an office located in an institution may be considered an independently practicing psychologist when both of the following conditions exist:

- The office is confined to a separately-identified part of the facility which is used solely as the psychologist's office and cannot be construed as extending throughout the entire institution; and
- The psychologist conducts a private practice, i.e., services are rendered to patients from outside the institution as well as to institutional patients.

**Payment for Diagnostic Psychological and Neuropsychological Tests**

Expenses for *diagnostic psychological and neuropsychological tests* are not subject to the *outpatient mental health treatment limitation*, that is, the payment limitation on treatment services for mental, psychoneurotic and personality disorders as *authorized under Section 1833(c) of the Act*. The payment amount for the new psychological and neuropsychological tests (CPT codes 96102, 96103, 96119 and 96120) that are billed for tests performed by a technician or a computer reflect a site of service payment differential for the facility and non-facility settings. CPs, NPs, CNSs and PAs are required by law to accept assigned payment for psychological and neuropsychological tests. However, while IPPs are not required by law to accept assigned payment for these tests, they must report the name and address of the physician who ordered the test on the claim form when billing for tests.

**CPT Codes for Diagnostic Psychological and Neuropsychological Tests**

The range of CPT codes used to report psychological and neuropsychological tests is 96101-96120. CPT codes 96101, 96102, 96103, 96105, 96110, and 96111 are appropriate for use when billing for psychological tests. CPT codes 96116, 96118, 96119 and 96120 are appropriate for use when billing for neuropsychological tests.

All of the tests under this CPT code range 96101-96120 are indicated as active codes under the physician fee schedule database and are covered if medically necessary.

**Payment and Billing Guidelines for Psychological and Neuropsychological Tests**

The technician and computer CPT codes for psychological and neuropsychological tests include practice expense, malpractice expense and professional work relative value units. Accordingly, CPT psychological test code 96101 should not be paid when billed for the same tests or services performed under psychological test codes 96102 or 96103. CPT neuropsychological test code 96118 should not be paid when billed for the same tests or services performed under neuropsychological test codes 96119 or 96120. However, CPT codes 96101 and 96118 can be paid separately on the rare occasion when billed on the same date of service for different and separate tests from 96102, 96103, 96119, and 96120.

Under the physician fee schedule, there is no payment for services performed by students or trainees. Accordingly, Medicare does not pay for services represented by CPT codes 96102 and 96119 when performed by a student or a trainee. However, the presence of a student or a trainee while the test is being administered does not prevent a physician, CP, IPP, NP, CNS or PA from performing and being paid for the psychological test under 96102 or the neuropsychological test under 96119.

## 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](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.

<b>Illinois</b>	<b>Michigan</b>
WPS Medicare Freedom of Information PO Box 4433, Marion, IL 62959	WPS Medicare Freedom of Information PO Box 5533, Marion, IL 62959
<b>Minnesota</b>	<b>Wisconsin</b>
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 November 2006

<b>Policy</b>	<b>Title</b>	<b>NCD/NCP/LCD</b>	<b>Web</b>	<b>Communiqué Page</b>
ALRG-001	Allergy Testing and Allergy Immunotherapy	LCD	Click here to view	Page 21
ENT-012	Surgical Treatment of Obstructive Sleep Apnea (OSA)	LCD	Click here to view	Page 21
GI-008	Colorectal Cancer Screening Benefit	NCD	Click here to view	Page 21
GSURG-032	Cosmetic and Reconstructive Surgery	LCD	Click here to view	Page 22
GSURG-033	Cryosurgery for Liver Tumors	LCD	Click here to view	Page 23
HONC-010	Antineoplastics and their Adjuncts	LCD	Click here to view	Page 23
Injection List			Click here to view	Page 24
OPHTH-025	Corneal Pachymetry	LCD	Click here to view	Page 24
PHYS-006	Consultations	NCP	Click here to view	Page 24
PSYCH-014	Psychiatry and Psychology Services	LCD	Click here to view	Page 25
RAD-034	Computed Coronary Tomography Angiography	LCD	Click here to view	Page 26

**Coverage – Revised Policies****LCD Title**

Allergy Testing and Allergy Immunotherapy

**Contractor's Determination Number**

ALRG-001

**Indications and Limitations of Coverage and/or Medical Necessity****I. Allergy sensitivity tests:****J. The following tests are considered not medically necessary:**

Leukocyte Toxic – 86021 has been removed from this policy because this test is used to detect other diseases..

**LCD-Revision****LCD Title**

Surgical Treatment of Obstructive Sleep Apnea (OSA)

**Contractor's Determination Number**

ENT-012

**Revision Effective Date**

\*10/01/2006

The Surgical Treatment of Obstructive Sleep Apnea (OSA) LCD and Companion Article have been revised. This revision included coverage and billing instruction for Palatal Implants (Pillar System). Please read this LCD in its entirety on our website.

**National Coverage Decision****Subject:**

Colorectal Cancer Screening Benefit

**Subject Number:**

GI-008

**Effective Date:** 01/01/2007

\*8. *Prior to January 1, 2007, deductible and coinsurance applied to codes (G0104, G0105, G0106, G0120 and G0121). Beginning with services provided on or after January 1, 2007, Section 5113 of the Deficit Reduction Act of 2005 waives the requirement of the annual Part B deductible for these services. Coinsurance still applies.*

Effective 01/01/2007 CPT code 82270 replaces G0107 for Colorectal cancer screening; fecal-occult blood test, 1-3 simultaneous determinations;

The following changes were made to the section 3a:

*High risk for colorectal cancer is an individual with one or more of the following:*

- \*- a close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyp (V16.0, V19.8);
- a family history of familial adenomatous polyposis (V19.8);
- \*- A family history of hereditary nonpolyposis colorectal cancer (V16.0 & V19.8)
- a personal history of adenomatous polyps (V12.72); or
- a personal history of malignant neoplasm of the large intestine (V10.05)
- \*- a personal history of colorectal cancer (V10.06); or
- a personal history of gastrointestinal cancer (V10.00, V10.03, V10.04, V10.07)
- Inflammatory bowel disease, including Crohn's Disease, and ulcerative colitis (555.0-555.2, 555.9-556.3, 556.8, 556.9, 558.2, 558.9).

**\*Covered ICD-9 Codes for G0105: Colorectal cancer screening; colonoscopy on individual at high risk**

555.0-555.2, 555.9, 556.0-556.3, 556.8, 556.9, 558.2, 558.9, V10.00, V10.03, V10.04, V10.05, V10.06, V10.07, V12.72, V16.0, V19.8

**Coding Guidelines**

- \*1. The ICD-9 codes listed in this policy are for identifying individuals eligible to receive a high risk screening colonoscopy every 24 months (G0105).



**LCD Title**

Cosmetic and Reconstructive Surgery

**Contractor's Determination Number**

GSURG-032

**\*Revision Effective Date**

\*11/01/2006

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

ICD-9 code 724.5 has been added to the section on Reduction Mammoplasty (CPT 19318).

\*3. Reduction Mammoplasty (CPT 19318) is the surgical reshaping of the breasts to reduce or lift enlarged or sagging breasts. When bilateral reduction mammoplasty is performed on the basis of medical necessity, it is considered reasonable and necessary.

- \*A. At least **two** of the following symptoms:
  - \*1. Back/neck/shoulder pain (\*724.5, 719.41,723.1). \*Pain in the back, neck or shoulder is considered one symptom.
  - 2. Breast pain (611.71)
  - 3. Paresthesias of hands/arms (782.0)
  - 4. Permanent shoulder grooving from bra straps (709.9)
  - 5. Intertrigo (695.89)
- B. Greater than 350g (estimated) excess breast tissue per breast to be removed
- C. Macromastia by physical exam



**LCD Policy Revision**

**Contractor's Policy Number:**

GSURG-033

**LCD Title:**

Cryosurgery for Liver Tumors

**Primary Geographic Jurisdiction:**

Wisconsin, Illinois, Michigan, Minnesota

**Effective Date:**

11/01/2006

**CPT/HCPCS Codes**

47371	Laprosopy, surgical ablation of one or more liver tumor(s); cryosurgical
47381	Ablation, open, of one or more liver tumor(s); cryosurgical
*76940	Ultrasound guidance for, and monitoring of, visceral tissue ablation

CPT code 76940 replaces CPT code 76986.



**LCD Title**

Antineoplastics and their Adjuncts

**Contractor's Determination Number**

HONC-010

**Revision Effective Date:**

09/27/2006-FDA approval date

**Indications and Limitations:**

\*D. Not otherwise Classified Agents (NOC) (J9999):

- \*4. Panitumumab (Vectibix™) (J9999) effective 09/27/06  
Colorectal cancer 153.0-154.8

Panitumumab (Vectibix™) is indicated for the treatment of EGFR expressing, metastatic colorectal carcinoma with disease progression on or following fluoropyrimidine-, oxaliplatin-, and irinotecan-containing chemotherapy regimens.

**Injection List**

**Effective:** 09/26/06 FDA approval Date

Infliximab (Remicade™) 10 mg (J1745) received FDA approval for the treatment of chronic severe plaque psoriasis (696.1).

**LCD-Revision****LCD Title**

Corneal Pachymetry

**Contractor's Determination Number**

OPHTH-025

**Revision Effective Date**

\*11/01/2006

The Corneal Pachymetry LCD and Companion Article have been revised. Please read this LCD in its entirety on our website.

**National Coverage Provision Correction****Subject**

*Consultations*

**NCP Number**

PHYS-006

**Effective Date**

\*01/01/2006

**Coding Information**

- \*4. Follow-up inpatient consultation codes (99261-99263) are deleted effective 12/31/2005. If the attending or original requesting physician requests a subsequent visit to monitor or evaluate the patient's progress on the treatment recommended in the original consultation, the physician performing the re-evaluation should report a subsequent hospital/nursing facility visit (99231-99233, \*99307-99310).



## Local Coverage Determination

**Contractor's Determination Number**  
PSYCH-014

**LCD**  
Psychiatry and Psychology Services

**Article Published Date**  
11/01/2006

**Central Nervous System Assessments/Tests**  
**CPT codes 96101 - 96120**

### **Diagnostic Psychological and Neuropsychological Tests**

Effective with dates of service January 1, 2006, non-physicians practitioners such as nurse practitioners, clinical nurse specialists and physician assistances may bill Medicare diagnostic psychological and neuropsychological tests when they personally perform the services and the services are within the scope of their state license and clinical practice/education.

The range of CPT codes used to report psychological and neuropsychological tests is 96101-96120. CPT codes 96101, 96102, 96103, 96105, 96110, and 96111 are appropriate for use when billing for psychological tests. CPT codes 96116, 96118, 96119 and 96120 are appropriate for use when billing for neuropsychological tests.

The technician and computer CPT codes for psychological and neuropsychological tests include practice expense, malpractice expense, and professional work relative value units.

CPT psychological test code 96101 may not be billed for the same tests or services performed under psychological test codes 96102 or 96103. CPT neuropsychological test code 96118 may not be billed for the same tests or services performed under neuropsychological test codes 96119 or 96120. However, CPT codes 96101 and 96118 can be paid separately on the rare occasion when billed on the same date of service for different and separate tests from 96102, 96103, 96119 and 96120.

In addition, physical therapists (PTs), occupational therapists (OTs) and speech language pathologists (SLPs) are authorized to bill CPT codes 96105, 96110 and 96111 "sometimes therapy" codes. However, when PTs, OTs and SLPs perform these three tests, they must be performed under the general supervision of a physician or a CP.

There is no authorization for payment for diagnostic tests when performed on an "incident to" basis.

**See Local Coverage Determination PSYCH 014 Billing and Coding Guidelines for more information**

Source CR 5204 MBPM 80.2

**LCD Policy Revision****Contractor's Policy Number:**

RAD-034

**LCD Title:**

Computed Coronary Tomography Angiography

**Primary Geographic Jurisdiction**

Wisconsin, Illinois, Michigan, Minnesota

**Effective Date:**

04/15/2006

**CPT/HCPCS Codes**

\*0145T, 0146T, 0147T, \*0148T, \*0149T

Category III CPT Codes for CCT and CCTA are effective as of January 01, 2006. Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided.

These codes replace all CPT codes previously used for these procedures. The use of Category III CPT Codes is mandatory to report coronary CTA.

**\*0145T** Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post process; cardiac structure and morphology

**0146T** Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing; computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium

**0147T** Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing; computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium

**\*0148T** Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), without quantitative evaluation of coronary calcium

**\*0149T** Computed tomography, heart, without contrast material followed by contrast material(s) and further sections, including cardiac gating and 3D image post processing; cardiac structure and morphology and computed tomographic angiography of coronary arteries (including native and anomalous coronary arteries, coronary bypass grafts), with quantitative evaluation of coronary calcium

**Does the CPT 30% Rule Apply**

No

**ICD-9 Codes that Support Medical Necessity***Note: ICD-9 codes must be coded to the highest level of specificity.*

TRUNCATED DIAGNOSIS CODES ARE NOT ACCEPTABLE.

**\*ICD-9 Codes for use with CPT Codes 0146T and 0147T**

413.0	*Angina decubitus
413.1	*Prinzmetal angina
413.9	Other and unspecified angina pectoris
414.8	Other specified forms of chronic ischemic heart disease
425.4	Other primary cardiomyopathies
427.31	Atrial fibrillation
427.32	Atrial flutter
428.0	Congestive heart failure, unspecified
746.85	Congenital anomalies of the heart
747.41	Total anomalous pulmonary venous connection
747.42	Partial anomalous pulmonary venous connection
786.05	Shortness of breath
786.50	Chest pain, unspecified
786.51	Chest pain, precordial pain
786.59	Other chest pain
794.30	Cardiovascular, abnormal function study, unspecified

**\*ICD-9 Codes for use with CPT Codes 0145T, 0148T and 0149T**

425.4	Other primary cardiomyopathies
427.31	Atrial fibrillation
427.32	Atrial flutter
428.0	Congestive heart failure, unspecified
746.85	Congenital anomalies of the heart
747.41	Total anomalous pulmonary venous connection
747.42	Partial anomalous pulmonary venous connection

CPT codes 0145T, 0148T, and 0149T have been added to this policy effective for dates of service 04/15/2006 onward.

**LCD Companion Document Revision****Article Title;**

Billing and Coding Guidelines for RAD-034; Computed Coronary Tomography Angiography

**Effective Date:**

04/15/2006

**Reasons for Denial:**

1. \*0144T, 0150T, and 0151T are at this time deemed to be Experimental and Investigational (I&E) and therefore, not covered by Medicare.

Deleted CPT Codes 0145T, 0148T and 0149T from sentence number one, "Reasons for Denial."

**Electronic Data Interchange (EDI)**

**CHANGE IN BATCH DETAIL CONTROL LISTING EMC PRE-PASS REPORT**

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

As part of the Stage 2 National Provider Identifier (NPI) implementation, slight changes are being made to the Batch Detail Control Listing (a.k.a Prepass Report). The revised report will now include NPI.

H99RAR04	WISCONSIN PHYSICIANS SERVICE				PAGE 1			
PRODUCTION	PROFESSIONAL EMC PROGRAM							
	MEDICARE-B EMC INPUT							
	BATCH DETAIL CONTROL LISTING							
	SUBMITTER ID: 99999	SUBMITTER NAME: BUSINESSXX						
	ADDRESS: STREETXX.							
	CITY: CITYXX							
	STATE/ZIP: STXX ZIPCODEXX							
	PROCESS DATE: 01/20/95							
EMC PROVIDER : [NPI#: 1234567890] PIN#: B00999 BATCH NUMBER : 9999								
PROV	PROV	REFERENCE	REC TYP	DTL IELD IN	FIELD	ERR	MESSAGE	ERROR
NPI#	NUM	NUMBER	NUM	ERROR	CONTENTS	NUM	SEVERITY	
-----								
EMC PROVIDER : [NPI#: 1234567890] PIN B99999 BATCH STATUS : ACCEPTED								
1234567890	B99999	000000099999999	JT9	PAT ADDR2	BLDG 16-G	1346	INVALID CHAR IN ADDRESS2	
INFORMATIONAL								
HIC FOR ABOVE CLAIM IN ERROR: 999999999B ICN: 9995555555555								
999000999000999B	FA0	99	PROC CODE	REF		2068	CHARS 2 - 5 NOT NUMERIC	
INFORMATIONAL								
HIC FOR ABOVE CLAIM IN ERROR: 999999999M ICN: 555777333								
MAXIMUM OF 30 ERRORS REACHED - FURTHER ERRORS NOT DISPLAYED								

A complete list of current 4010A1 pre-pass edits, as well as a detailed description, is available in the WPS Bulletin Board in the EDI file library in the HIPAA directory (file name: 4010\_401.doc) or on the WPS web site: [http://www.wpsic.com/edi/pdf/hipaa\\_mcs837.pdf](http://www.wpsic.com/edi/pdf/hipaa_mcs837.pdf)

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

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 1081</b>	<b>Date: OCTOBER 20, 2006</b>
	<b>Change Request 5225</b>

**NOTE: Transmittal 1077, dated October 13, 2006 is rescinded and replaced by Transmittal 1081, dated October 20, 2006, to correct the implementation date from January 16, 2007 to April 2, 2007. The implementation date has been revised. All other information remains the same.**

**Subject: Electronic Data Interchange (EDI) Media Changes**

**I. SUMMARY OF CHANGES:** Some contractors permitted providers to submit EDI claims via fax-imaging, diskette, tape, or similar storage media. The CMS has determined that use of such media is not cost effective and must be terminated.

**New / Revised Material**

**Effective Date: April 1, 2007**

**Implementation Date: April 2, 2007**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

**R/N/D Chapter / Section / Subsection / Title**

R 24/30/30.2/Media

**III. FUNDING:**

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

*\*Unless otherwise specified, the effective date is the date of service.*

**Attachment - Business Requirements**

Pub. 100-04	Transmittal: 1081	Date: October 20, 2006	Change Request 5225
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**NOTE:** *Transmittal 1077, dated October 13, 2006 is rescinded and replaced by Transmittal 1081, dated October 20, 2006, to correct the implementation date from January 16, 2007 to April 2, 2007. The implementation date has been revised. All other information remains the same.*

**SUBJECT:** Electronic Data Interchange (EDI) Media Changes

**I. GENERAL INFORMATION**

**A. Background:**

Some contractors allowed providers to submit EDI claims via fax-imaging, diskette, tape, or other similar storage media.

**B. Policy:**

It is no longer cost effective for the Medicare program to accept claims submitted in this manner.

**II. BUSINESS REQUIREMENTS**

*"Shall" denotes a mandatory requirement*

*"Should" denotes an optional requirement*

Requirement Number	Requirements	Responsibility("X" indicates the columns that apply)								
		F I	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5225.1	Contractors shall reject EDI claims received via fax-imaging, diskette, tape, or other similar storage media after March 31, 2007.	X	X	X	X					DME MACs A/B MACs

**III. PROVIDER EDUCATION**

Requirement Number	Requirements	Responsibility("X" indicates the columns that apply)								
		F I S S	R H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
5225.2	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic.	X	X	X	X					DME MACs A/B MACs

**IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS**

**A. Other Instructions: N/A**

X-Ref Requirement #	Instructions

**B. Design Considerations: N/A**

X-Ref Requirement #	Recommendation for Medicare System Requirements

**C. Interfaces: N/A**

**D. Contractor Financial Reporting /Workload Impact: N/A**

**E. Dependencies: N/A**

**F. Testing Considerations: N/A**

**V. SCHEDULE, CONTACTS, AND FUNDING**

<p><b>Effective Date*:</b> April 1, 2007  <b>Implementation Date:</b> April 2, 2007  <b>Pre-Implementation Contact(s):</b> Matt Klischer          (matthew.klischer@cms.hhs.gov)  <b>Post-Implementation Contact(s):</b> Matt Klischer          (matthew.klischer@cms.hhs.gov)</p>	<p><b>Medicare contractors shall implement these instructions within their current FY 2007 operating budget.</b></p>
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\*Unless otherwise specified, the effective date is the date of service.

**30.2 – Media**

*(Rev. 1081, Issued: 10-20-06; Effective: 04-01-07, Implementation: 04-02-07)*

An EDI transaction is defined by its initial manner of receipt. Depending upon the capability of a carrier, DMERC, or FI and the details as negotiated between carrier/DMERC/FI and electronic claim submitters, an electronic claim could be submitted via central processing unit (CPU) to CPU transmission, dial up frame relay, direct wire (T-1 line or similar), or personal computer modem upload or download (also see §30.3).

When counting electronic claims for workload reporting, the contractor includes data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through another FI, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. See § 90 of this chapter for information about application of the claims payment floor when a claim is submitted electronically in a non-HIPAA compliant format.

Carriers, DMERCs, and FIs are not permitted to classify the following as electronic claims for CROWD reporting, for payment floor or Administrative Simplification Compliance Act (ASCA, see section 90) mandatory electronic claim submission purposes:

- Bills received from providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for these bills;
- Adjustment bills (FIs only);
- Misdirected bills transferred to another carrier, DMERC, or FI;
- HHA bills where no utilization is chargeable and no payment has been made, but which have been requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.);
- Bills paid by an HMO and processed by the contractor; and
- Transactions submitted on diskettes, CDs, DVDs or similar storage media that should only be accepted as part of a disaster recovery process.

Carriers, DMERCs, *DME MACs*, *A/B MACs*, and FIs are *no longer* permitted to accept claims via fax-imaging, tape/diskette/similar storage media. Carriers, DMERCs, *DME MACs*, *A/B MACs*, and FIs are to assist billers using such media to transition to more efficient electronic media, such as the free Medicare claim submission or commercially available software that are considered to be more cost effective.

## NEW MEDICARE EDIT M387

Before an electronic claim is accepted for processing, it is edited to ensure that information in the electronic segment and element is logical and validly formatted. The MCS processing system subjects every input record to a number of prepass edits. These edits determine whether a file, claim, or batch will be accepted into the claim processing system.

Effective 10-2-2006 Medicare will have a new prepass edit number M387. This edit will set if the 2010AA and the 2010AB do not contain a REF01 of 1C. The contractor number found in the 1000B NM109 is not found on the PIN/NPI Crosswalk file for the NPI in the 2010AA NM109 or the 2010AB NM109 when the NM108 is XX.

This edit will be turned on 10-2-2006. This edit will become a batch delete.

If you have any questions please contact the EDI Hotline at 877-567-7261 for IL, MI and WI, or 952-885-2811, or 952-885-2881, or 952-885-2882 for MN.

## PC-ACE PRO32 BILLING SOFTWARE FOR VACCINATION BILLING

WPS-Medicare has a HIPAA-compliant software product available for vaccination billing PC-ACE Pro32. This software has the ability to do roster billing. This software 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 Windows 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 web site.

If you are interested in using PC Ace Pro32, download the PC-Ace request form from:

<http://www.wpsic.com/edi/pdf/medbpcace.pdf> or call the EDI Hotline at the numbers below.

Illinois, Michigan, Wisconsin	877-567-7261
Minnesota	952-885-2811
	952-885-2881
	952-885-2882

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\\_p.shtml](http://www.wpsic.com/edi/pcacepro32_p.shtml)

**General Information**
**CLAIMS INVOLVING BENEFICIARIES WHO HAVE ELECTED  
HOSPICE COVERAGE**

*This article was originally included within the October 2006 Communiqué with an incorrect URL. We apologize for any inconvenience, the correct URL is now included.*

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 whom:

- 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.
- Nurse Practitioners (For further explanation, see CMS Medlearn 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 **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.

**COMMUNICATIONS INFRASTRUCTURE TESTING**

~CMS Manual System~

**SUMMARY OF CHANGES:**

CMS is working to ensure that its communications infrastructure can reach providers in the event of a regional or national disaster. This CR will provide instructions to Medicare contractors to suggest to providers/suppliers to subscribe to their listserv to receive important messages.

**Background:**

CMS is working to ensure that its communications infrastructure can reach providers in the event of a regional or national disaster. It is important that at such times we can reach providers with critical information in a timely fashion. The contractors' relationship with the Medicare providers is a key component of the infrastructure. In order to strengthen our level of emergency preparedness, CMS will be providing ways to test your communications infrastructure in the near future and instructions will be forthcoming.

Please read this entire instruction on the CMS Website at:

<http://www.cms.hhs.gov/transmittals/downloads/R2390TN.pdf>

**COMPETITIVE ACQUISITION PROGRAM (CAP) - CREATION OF  
AUTOMATED TABLES FOR PROVIDER INFORMATION, EXPANSION  
OF CAP FEE SCHEDULE FILE LAYOUT, AND ADDITIONAL  
INSTRUCTIONS FOR CLAIMS RECEIVED FROM RAILROAD  
RETIREMENT BOARD BENEFICIARIES**

~CMS MLN Matters~

**MLN Matters Number:** MM5079 Revised  
**Related CR Release Date:** September 11, 2006  
**Related CR Transmittal #:** R1055CP

**Related Change Request (CR) #:** 5079  
**Effective Date:** October 1, 2006  
**Implementation Date:** October 2, 2006

**Note:** This article was revised on September 12, 2006, to reflect changes made to CR5079. The CR release date, transmittal number (see above), and the Web address for accessing CR5079 were changed. All other information remains the same.

**Provider Types Affected**

Physicians submitting claims to carriers for services to Medicare beneficiaries under the CAP

**Impact on Providers**

This article is based on Change Request (CR) 5079, which provides additional information and instructions for the implementation of the CAP pertaining to CAP drug categories and fee schedule as outlined in CR4064 (Transmittal 777, dated December 9, 2006).

**Background**

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 303 (d); <http://www.cms.hhs.gov/MMAUpdate/>) requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. The Social Security Act (Section 1847B(a)(1)(B); [http://www.ssa.gov/OP\\_Home/ssact/title18/1847B.htm](http://www.ssa.gov/OP_Home/ssact/title18/1847B.htm)) states that for purposes of implementing the CAP:

“The Secretary (of the Department of Health and Human Services) shall establish categories of competitively biddable drugs and biologicals. The Secretary shall phase in the program with respect to those categories beginning in 2006 in such manner as the Secretary determines to be appropriate.”

In addition, the Social Security Act also permits the creation of appropriate geographic regions established by the secretary for contract award purposes.

The Centers for Medicare & Medicaid Services (CMS) will implement the CAP with one category of drugs and one geographic area. However, as the program evolves, additional geographic areas and additional drug categories may be created. Also, approved CAP vendors will be able to request approval for changes to the lists of drugs that they supply under the CAP.

CR4064 (Transmittal 777, dated December 9, 2006) described requirements for carriers to develop provider files that list physicians who have enrolled with an approved CAP vendor and the category (or categories) of drugs that the CAP vendor will furnish under the CAP.

CMS is issuing CR5079 to automate the process of updating the list of drugs paid under the CAP. CR5079 provides additional information and instructions for the implementation of the CAP pertaining to the CAP drug categories and fee schedule as outlined in:

- CR4064 (Transmittal 777, dated December 9, 2006 at <http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf>); MLN Article MM4064 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf>; and
- CR4309 (Transmittal 866, dated February 6, 2006 (rescinded and replaced with transmittal 866 dated February 17, 2006 at <http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf>); MLN article MM4309 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf>

For the table defined in CR4064.1.1.2.1, when Medicare carriers receive election forms from providers, the carriers will indicate for each provider:

- Which categories of drugs the provider has chosen to receive; and
- From which approved CAP vendor the provider will receive CAP drugs

### ***CAP Drugs and Drug Categories***

Approved CAP vendors will be permitted to request certain changes to the list of drugs that they supply under the CAP. Beginning in July 2006 with changes to be effective October 1, 2006, approved CAP vendors may request that CMS (or its designee) approve the following types of changes:

- **NDC Substitution(s):** Approved CAP vendor may request approval to replace one or more National Drug Codes (NDCs) in a Healthcare Common Procedure Coding System (HCPCS) code supplied by the approved CAP vendor with one or more other NDCs.
- **NDC Addition(s):** Approved CAP vendor may request that CMS allow it to supply additional NDCs under a HCPCS code that the approved CAP vendor already supplies under the CAP.
- **HCPCS Addition(s):** Approved CAP vendor may request that CMS allow it to supply newly issued HCPCS codes under the CAP.
- **Orphan Drugs:** Approved CAP vendor may request that CMS allow it to supply single indication orphan drugs under the CAP.

As CMS continues to develop the CAP, additional geographical areas and additional drug categories may be created. If additional drug categories are created, certain drugs may appear in more than one drug category.

**Changes to the Drug List**

Written requests for changes to the approved CAP vendor's drug list must be submitted to CMS and the CAP designated carrier. The requests must include a rationale for the proposed change, and a discussion of the impact on the CAP, including safety, waste, and potential for cost savings. If approved, changes will become effective at the beginning of the following quarter. CMS will post the changes on the CMS web site (<http://www.cms.hhs.gov/competitiveacquisforbios/>) and notify the carriers and participating CAP physicians of any changes on a quarterly basis.

Participating CAP physicians will be notified of changes to their approved CAP vendor's CAP drug list on a quarterly basis and at least 30 days before the approved changes are due to take effect. Physicians who participate in the CAP are required to obtain all CAP drugs, including those that have been added or otherwise updated, from the approved CAP vendor unless medical necessity requires the use of a formulation not supplied by the vendor. Please note that approved changes will apply only to the list of drugs supplied by the approved CAP vendor who submitted the request; therefore, each vendor's drug list may contain different drugs after changes to the initial drug list are approved.

**Payment Amount**

The payment amount for new HCPCS codes added to an approved CAP drug vendor's drug list will be Average Sales Price (ASP) plus six percent (ASP+ 6%).

Addition or substitution of NDC numbers under an existing HCPCS code supplied by an approved CAP vendor will not change the CAP single payment amount for that HCPCS code.

CMS will update the single payment amount based on the approved CAP vendor's reported net acquisition costs for the category of drugs on an annual basis.

**Disaster Contingency**

Business requirements intended to cover situations where an approved CAP vendor is not able to fill CAP orders or is no longer able to supply drugs under the CAP have also been added. Physicians will be able to revert to the ASP (buy and bill) payment methodology.

**Claims for Railroad Retirement Board (RRB) Beneficiaries**

As claims for RRB beneficiaries can not be paid under the CAP, physicians should not order drugs for RRB beneficiaries under the program. However, should this occur, and the claim is sent to the carrier that processes claims for RRB beneficiaries, that carrier will treat the claim as unprocessable. The physician will have to resubmit the claim as a non-CAP claim with the drugs billed as ASP. The vendor will then have to look to the physician for reimbursement of the drugs that were mistakenly ordered under CAP.

**Implementation**

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

**Additional Information**

For complete details, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1055CP.pdf> on the CMS web site.

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

## DUAL USE STRATEGY FOR THE 837 PROFESSIONAL TRANSACTION

### What is the purpose of Dual Use Strategy?

Dual Use Strategy is the voluntary transitional use of both National Provider Identifier (NPI) and legacy identifiers in HIPAA X12 837 Professional transaction. The goal of Dual Use Strategy is to make the NPI transition easier within the health care industry. Dual Use Strategy will ease implementation without phase delays and extended bilateral testing and conversion.

### Legacy Identifier

Any identifier payers previously used to identify a provider as a health care provider prior to NPI (e.g. Medicare provider identification number, TRICARE provider identification number, private health care insurance provider identification number) is referred to as a "Legacy Identifier." After the compliance date, NPI must be used to identify a provider in health care standard transactions.

When used to identify the provider as a health care provider on standard transactions, Federal Tax ID is considered a legacy identifier. It is not, however, considered a legacy identifier when used to identify the provider as a taxpayer for IRS reporting.

This document provides information on use of legacy identifiers with NPI during the dual use period.

The Dual Use Strategy is transitional. Use the strategy between now and the NPI compliance date of May 23, 2007 (2008 for small health plans). Do not use the Dual Use Strategy after the compliance date. After the compliance date, HIPAA laws mandate the use of NPI to identify a provider, and the use of legacy identifiers is not permissible. Continued use of Tax IDs is acceptable where required for reporting to the IRS.

### 837 Professional Health Care Claim

The following table specifies the use of NPI and Legacy identifiers on a standard 837 Professional Health Care Claim during the transition. The table only lists provider entries that will employ the NPI. All the additional or secondary identifier entries are within a repeated loop. The legacy identifier may be any iteration in the loop.

#### **837 Professional Health Care Claim, 4010A1 Implementation Guide**

<b>Loop</b>	<b>Data Element</b>	<b>Industry Name</b>	<b>Content</b>
<b>2010AA</b>		<b>BILLING PROVIDER NAME</b>	
	NM109	Billing Provider Identifier	NPI
	REF02	Billing Provider Additional Identifier	Tax ID
	REF02	Billing Provider Additional Identifier	Legacy
<b>2010AB</b>		<b>PAY-TO PROVIDER NAME</b>	
	NM109	Pay-To Provider Identifier	NPI
	REF02	Pay-To Provider Additional Identifier	Tax ID
	REF02	Pay-To Provider Additional Identifier	Legacy

Loop	Data Element	Industry Name	Content
2310A	NM109	<b>REFERRING PROVIDER NAME</b>	NPI
	REF02	Referring provider Primary Identifier Referring provider Secondary Identifier	Legacy
2310B	NM109	<b>RENDERING PROVIDER NAME</b>	NPI
	REF02	Rendering provider Primary Identifier Rendering provider Secondary Identifier	Legacy
2310C	NM109	<b>PURCHASED SERVICE PROVIDER NAME</b>	NPI
	REF02	Purchased service Provider Primary Identifier Purchased service Provider Secondary Identifier	Legacy
2310D	NM109	<b>SERVICE FACILITY LOCATION</b>	NPI
	REF02	Laboratory or Facility Primary Identifier Laboratory or Facility Secondary Identifier	Legacy
2310E	NM109	<b>SUPERVISING PROVIDER NAME</b>	NPI
	REF02	Supervising Provider Primary Identifier Supervising Provider Secondary Identifier	Legacy
2420A	NM109	<b>RENDERING PROVIDER NAME</b>	NPI
	REF02	Rendering provider Primary Identifier Rendering provider Secondary Identifier	Legacy
2420B	NM109	<b>PURCHASED SERVICE PROVIDER NAME</b>	NPI
	REF02	Purchased service provider Primary Identifier Purchased service provider Secondary Identifier	Legacy
2420C	NM109	<b>SERVICE FACILITY LOCATION</b>	NPI
	REF02	Laboratory or Facility Primary Identifier Laboratory or Facility Secondary Identifier	Legacy
2420D	NM109	<b>SUPERVISING PROVIDER NAME</b>	NP
	REF02	Supervising Provider Identifier Supervising Provider Secondary Identifier	Legacy

**PANCREAS TRANSPLANTS ALONE (PA)**  
~CMS MLN Matters~

**MLN Matters Number:** MM5093 **REVISED**  
**Related CR Release Date:** May 19, 2006  
**Related CR Transmittal #:** R56 NCD and R957CP

**Related Change Request (CR) #:** 5093  
**Effective Date:** April 26, 2006  
**Implementation Date:** July 3, 2006 for carriers, October 2, 2006 for FIs

**Note:** This article was revised on October 5, 2006, to include this statement alerting affected providers to review MLN Matters article SE0674 for important information regarding the continued hold of affected claims. This article is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0674.pdf> on the CMS site.

**Provider Types Affected**

Physicians and providers billing Medicare fiscal intermediaries (FIs) and carriers for PA

**Background**

Medicare covers whole organ pancreas transplantation when it is performed in conjunction with or after kidney transplantation (*National Coverage Determination (NCD) Manual, Section 260.3*). However, Medicare does not cover PA in diabetes patients without end-stage renal failure because of a lack of sufficient evidence, based in large part on a 1994 Office of Health Technology Assessment report.

**Key Points**

This article is based on information contained in Change Request (CR) 5093, which informs physicians and providers that, effective for services performed on or after April 26, 2006, Medicare will cover PA for beneficiaries in the following limited circumstances:

- Facilities must be Medicare-approved for kidney transplantation (Approved centers are found at [http://www.cms.hhs.gov/ESRDGeneralInformation/02\\_Data.asp#TopOfPage](http://www.cms.hhs.gov/ESRDGeneralInformation/02_Data.asp#TopOfPage) on the CMS web site).
- Patients must have a diagnosis of Type I diabetes:
  - The patient with diabetes must be beta cell autoantibody positive; or
  - The patient must demonstrate insulinopenia, defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. Fasting C-peptide levels will be considered valid only with a concurrently obtained fasting glucose  $\leq 225$  mg/dL.
- Patients must have a history of medically-uncontrollable labile (brittle) insulin-dependent diabetes mellitus with documented recurrent, severe, acutely life-threatening metabolic complications that require hospitalization.
- These complications include frequent hypoglycemia unawareness or recurring severe ketoacidosis, or recurring severe hypoglycemic attacks.
- Patients must have been optimally and intensively managed by an endocrinologist for at least 12 months with the most medically recognized advanced insulin formulations and delivery systems.
- Patients must have the emotional and mental capacity to understand the significant risks associated with surgery and to effectively manage the lifelong need for immunosuppression.
- Patients must otherwise be suitable candidates for transplantation.

**Billing and Claims Processing**

- The following ICD-9 CM codes will be recognized by FIs and carriers for pancreas transplantation alone for beneficiaries with type I diabetes when billed with HCPCS 48554:
- 25001, 25003, 25011, 25013, 25021, 25023, 25031, 25033, 25041, 25043, 25051, 25053, 25061, 25063, 25071, 25073, 25081, 25083, 25091, and 25093.
- Carriers and FIs who receive claims for PA services that were performed in an unapproved facility should use the following messages upon the reject or denial:
  - Medicare Summary Notice MSN Message - MSN code 16.2 (This service cannot be paid when provided in this location/facility)
  - Remittance Advice Message - Claim Adjustment Reason Code 58 (Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service)
- Carriers and FIs who receive claims for PA services that are not billed using the covered diagnosis/procedure codes listed above should use the following messages upon the reject or denial:
  - Medicare Summary Notice MSN Message - MSN code 15.4 (The information provided does not support the need for this service or item)
  - Remittance Advice Message – Claim Adjustment Reason Code 50 (These are non-covered services because this is not deemed a 'medical necessity' by the payer)
- Modification of the current coverage policy on pancreas transplants can be found in Publication 100-03, Section 260.3 and claims processing information is located in Publication 100-04, Chapter 3, Section 90.5.1. The location of this information is listed in the Additional Information section of this article.

**Note:** Carriers and FIs will hold any PA claims with dates of service on or after April 26, 2006, until the claims can be processed in their systems. For FIs this date is October 2, 2006, and for carriers the date is July 3, 2006.

**Implementation**

The implementation date for this instruction is no later than:

- July 3, 2006, for carriers; and
- October 2, 2006, for FIs.

**Additional Information**

The official instructions issued to your Medicare FI or carrier regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R56NCD.pdf> for the NCD manual revision and <http://www.cms.hhs.gov/Transmittals/downloads/R957CP.pdf> for changes to the Medicare Claims Processing Manual.

If you have questions, please contact your Medicare FI or carrier at their toll-free number, which may be found at

<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf> on the CMS web site.

**RECENT UPDATES**

The Medical Review (MR) department recently conducted a review and updated several articles as a result. Please visit our Website to view the following updated articles.

<b>Article</b>	<b>Location</b>
NOC Billing	<a href="http://www.wpsmedicare.com/provider/noc_billing.shtml">http://www.wpsmedicare.com/provider/noc_billing.shtml</a>
Evaluation & Management Documentation	<a href="http://www.wpsmedicare.com/provider/eval_manage.shtml">http://www.wpsmedicare.com/provider/eval_manage.shtml</a>
Submission of Medical Records to Program Safeguard Contractor for CERT	<a href="http://www.wpsmedicare.com/provider/advance_med.shtml">http://www.wpsmedicare.com/provider/advance_med.shtml</a>
Documentation of Medical Decision Making for Evaluation and Management Services	<a href="http://www.wpsmedicare.com/provider/em_documentation.shtml">http://www.wpsmedicare.com/provider/em_documentation.shtml</a>
“Carve Out” Preventative Services	<a href="http://www.wpsmedicare.com/provider/carveout_services.shtml">http://www.wpsmedicare.com/provider/carveout_services.shtml</a>
Clarification of Carve-Outs for Preventative Services	<a href="http://www.wpsmedicare.com/provider/carve_outs.shtml">http://www.wpsmedicare.com/provider/carve_outs.shtml</a>
Is Your Office Submitting Accurate Claims Information for Chiropractic Services?	<a href="http://www.wpsmedicare.com/provider/accurate_chiro.shtml">http://www.wpsmedicare.com/provider/accurate_chiro.shtml</a>
Don't Let Your Sleep Studies Keep You Up at Night	<a href="http://www.wpsmedicare.com/provider/sleep_study.shtml">http://www.wpsmedicare.com/provider/sleep_study.shtml</a>
Nail Debridement	<a href="http://www.wpsmedicare.com/provider/nail_debridement.shtml">http://www.wpsmedicare.com/provider/nail_debridement.shtml</a>

## 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.

Wisconsin Physicians Service (WPS) will not issue payments for services performed, ordered, or referred by these providers after the indicated dates. All providers are excluded as of September 20, 2006, 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	Name/Specialty/Address/Date of Birth
Shelia Swan Officer/Execut/Board PO Box 5000, #16413-424 Pekin, IL 61555 05/15/1965	Michelle Lynn Torgerson Nurse/Nurses Aide PO Box 5000, #12207-041 Pekin, IL 61555 11/14/1971
Gabriel C. Taganyi, M.D. General Practice Physician PO Box 10, #20689-424 Lisbon, OH 44432 05/03/1955	

**Illinois Reinstated Providers**

Name/Specialty/Date of Birth /Effective Date
Choi Syn Handley, R.N. AKA: Choi Banks Reed, R.N. 626 Cross Creek Drive. St. Louis, MO 63141 03/15/1968 <b>REINSTATED: 08/16/2006</b>

Name/Specialty/Date of Birth /Effective Date
Robert Scott Leiser, M.D. General Practice Physician 3098 Greenlake Dr. Decatur, IL 62521 11/24/1956 <b>REINSTATED: 08/16/2006</b>

**Michigan Sanctioned Providers**

Name/Specialty/Address/Date of Birth
Robert Marrion Beavo Nurse/Nurses Aide 263 Sparks Drive Battle Creek, MI 49017 07/28/1946
Dewundara Patabendi Dayananda, M.D. Internist 334 Sycamore Court Bloomfield Hills, MI 48302 03/04/1948
Subadra Patabandige Deandra, M.D. Family Practice Physician 334 Sycamore Court Bloomfield Hills, MI 48302 02/15/1954
Imex Medical Equipment & Supplies DME/General 15600 W. 10 Mile Rd, Unit 14 Southfield, MI 48075 N/A

Name/Specialty/Address/Date of Birth
Irakly M. Shanidze Owner/Operator 15463 Windmille Pointe Grosse Pointe Park, MI 48230 10/18/1968
Mervyn W. Smith, M.D. General Practice Physician 49 S. Bridgestone Court, NE Grand Rapids, MI 49546 04/25/1949
Christopher P. Stychno, D.C. Chiropractor 186 Oak Hill Ave., NE Warren, OH 44483 06/28/1967 <b>EXCLUDED: 08/01/2006</b>

### Michigan Reinstated Providers

Name/Specialty/Date of Birth /Effective Date
<p>Leon Everet Butler, M.D. Internist 6904 Timbersprings Circle Louisville, KY 40241 12/15/1949 <b>REINSTATED: 08/21/2006</b></p>
<p>Robert Raymond Daiber, M.D. Surgeon 3240 Goddard Rd. Toledo, OH 43606 01/19/1963 <b>REINSTATED: 08/21/2006</b></p>
<p>Dan Robert Ketchum, R.Ph. Registered Pharmacist 11628 Brookland Drive Allendale, MI 49401 07/07/1979 <b>REINSTATED: 09/21/2006</b></p>

Name/Specialty/Date of Birth /Effective Date
<p>Debra A. McLaughlin Nurse/Nurses Aide 1730 N. Broadway Hastings, MI 49058 10/23/1955 <b>REINSTATED: 08/11/2006</b></p>
<p>Dennis G. Rennhack, Ph. Pharmacist 1560 S. Bonny Bruce Dr. Stevensville, MI 49127 10/26/1955 <b>REINSTATED: 08/11/2006</b></p>
<p>Aletha Boyce Terrell Officer/Execut/Board 29980 Rock Creek Dr. Southfield, MI 48076 03/21/1960 <b>REINSTATED: 08/16/2006</b></p>

### Minnesota Sanctioned Providers

Name/Specialty/Address/Date of Birth
<p>Barbara J. Benjamin Home Health Employee 7715 Tanglewood Court Edina, MN 55439 05/10/1953</p>
<p>Brian Robert Denny Sales/ Market/Retail 16615 Interlachen Minneapolis, MN 55044 07/03/1963 <b>EXCLUDED: 04/12/2005</b></p>
<p>Andrew Weah Massey Nurse/Nurses Aide 7508 120<sup>th</sup> Avenue North Champlin, MN 55316 12/12/1981</p>

Name/Specialty/Address/Date of Birth
<p>Michele Lyn Parsons Nurse/Nurses Aide 6407 376<sup>th</sup> Street North Branch, MN 55056 11/11/1981</p>
<p>Vernon Wesley Strauch Owner/Operator #18207-047 FMC Rochester Rochester, MN 55903 03/29/1924 <b>EXCLUDED: 02/08/2006</b></p>

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

Craig Carlson  
Psychologist  
5501 Pillsbury Ave., S.  
Minneapolis, MN 55419  
02/19/1959  
**REINSTATED: 08/16/2006**

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

Richard K. Anglemyer  
Nurse/Nurses Aide  
1004 Pinos Street  
Rhineland, WI 54501  
05/12/1946

Vicki Sue Debolt, D.O.  
Doctor of Osteopath  
PO Box 2774  
Roswell, NM 88202  
06/08/1966

Marilyn Ruth Eggebraaten  
Nurse/Nurses Aide  
106 Church Ave., PO Box 24  
Casco, WI 54205  
08/24/1947

**Name/Specialty/Address/Date of Birth**

Thelma Jean Olson  
Nurse/Nurses Aide  
1745 S. Locust St.  
Green Bay, WI 54304  
11/29/1960

Sheila A. Thelen  
Private Cit/Entity  
417 N. Rusk Ave.  
Viroqua, WI 54663  
11/12/1954

## Provider Education

### PROVIDER EDUCATION SCHEDULE

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

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

#### National Provider Identifier: Electronic File Interchange (EFI) Question and Answer Teleconference

Date/Time	Course Number	Handouts
11/14/06 10:00 - 11:30 am CT	TNPI3	Not Yet Available

Do you have questions on the National Provider Identifier (NPI) Electronic File Interchange (EFI) process? Would you like to know more? Take the National Provider Identifier: Electronic File Interchange Computer-Based Training (CBT), located at: <http://www.wpsmedicare.com/provider/tutorials.shtml>

The CBT, available on the WPS Medicare Website today (October 9, 2006), covers:

- NPI Facts
- NPI EFI: What is it?
- NPI EFI: What are the benefits?
- NPI EFI: What is the process?
- NPI Enumerator information

If you have questions on the information in the CBT, attend the second in a series of question and answer teleconference on November 14, 2006.

This teleconference is designed as a question and answer period about the National Provider Identifier: Electronic File Interchange CBT and the National Provider Identifier: General Information CBT. WPS Medicare will hold a teleconference at 10:00 a.m. CT (11:00 a.m. ET) and will last for approximately one and a half hours.

**CMS Chiropractic Demonstration Education Project**

<b>Date/Time</b>	<b>Course Number</b>	<b>Address</b>	<b>Handouts</b>
11/30/06 9:00 am - 12:00 pm CT	ICH9	Hickory Grove Banquet & Conference Center Comfort Inn & Suites 1133 N. 7th Street Hwy 251 & Route 38 Rochelle, IL 61068	Not Yet Available

At this half-day session, WPS will assist Chiropractors and their staff with the most current information regarding Medicare billing as it relates to the Chiropractic Demonstration Project claim filing. In addition, this session will provide up-to-date information on the expansion of coverage for Chiropractic services in selected areas. If you provide Chiropractic services in any of the following 26 counties in **Illinois** and currently are or plan on participating in the Chiropractic demonstration project, this seminar will provide you with the most up-to-date information on this project.

Boone	Henry	Lee	Stark
Bureau	JoDaviess	Marshall	Stephenson
Carroll	Kane	McHenry	Whiteside
Cook	Kankakee	Mercer	Will
DeKalb	Kendall	Ogle	Winnebago
DuPage	Lake	Putnam	
Grundy	LaSalle	Rock Island	

Scott County, Iowa is also included in this Chiropractic demonstration.

Specific topics for review of coverage provisions and billing requirements include:

Modifiers: AT, GP, 25, 59, KX	Services provided "Incident to"
Modifier positions	New vs. established patients
Medical Necessity	Requirements for separate claims
E/M services and documentation	Demo 45 documentation requirements
Diagnostic services	Electronic claims filing instructions
Therapy services	Project participation
Referrals by chiropractors	Effectiveness measures
Non-covered services	Provider Education resources
(Modifier GY)	Medicare Part D Prescription Drug Benefit

Please note: You will only be able to participate in the demonstration if you provide services in the counties listed above.

## Registration Information

Registration for **ALL IN-PERSON SEMINARS** begins 30 minutes before the **ACTUAL** start time.

Full day courses run from 9:00 a.m. to 3:00 p.m.; lunch is on your own. Times may vary for teleconferences and half-day courses (see schedule above for exact times). Handouts for the teleconferences will be available on the Internet two weeks prior to the teleconference date. If you will not be able to download handouts from the Internet, please inform us at the time you register. Please note course availability may vary from state to state. All courses are free of charge. Additional courses will be scheduled at a later time. Watch for future postings to the WPS Website.

### Registration Steps\*

1. Review the following schedule
2. Select a course near you
3. Register online at [http://www.wpsmedicare.com/provider/proved\\_seminar.shtml](http://www.wpsmedicare.com/provider/proved_seminar.shtml)
  - a. Click on the appropriate course number.
  - b. Fill out the form accordingly.
  - c. You will receive a message back from our Website stating we have received your request. This is **NOT** a confirmation of your registration. You will however receive a confirmation via telephone or email.
  - d. PLEASE NOTE: When a confirmation email for this seminar is sent from WPS it will come from a mailbox named **Medsemin**.

\*If you experience technical difficulty registering online, or unable to use online registration, please contact us at 618-998-5240.

If you have registered for a course and received a confirmation number but are unable to attend, please contact us at 618-998-5240 as soon as possible so we may accommodate others.

## QUARTERLY COMMUNIQUÉ SUBSCRIPTION

WPS will again be offering quarterly *Communiqué* subscriptions in hardcopy format for Fiscal Year 2007 (which runs from October 2006 through September 2007). Since October 2002, WPS has maintained the comprehensive, monthly *Communiqué* on our Website only, while offering the quarterly *Communiqué* both on our Web site and in hardcopy format via subscription. In 40 pages, the quarterly edition of the *Communiqué* provides brief summaries of key information from the quarter, with Web address information for full text on the WPS Medicare Website. The cost for the subscription to the Fiscal Year 2007 hardcopy quarterly *Communiqué* is \$30.00.

If you are interested in a subscription, please complete and return the following order form along with your check to WPS Medicare.

The 2007 Fiscal Year hardcopy *Communiqué* subscription will run from October 2006 through September 2007. With this subscription, you will receive four quarterly *Communiqué* editions. A copy of the first edition, (Fall 2006,) will be mailed to you in late December 2006, and will include summary information from the October, November, and December 2006 monthly *Communiqués*. The second edition (Winter 2007) will be mailed in late March 2007, and will include summary information from the January, February, and March 2007 monthly *Communiqués*. The third edition (Spring 2007) will be mailed in late June 2007, and will include summary information from the April, May, and June 2007 *Communiqué* issues. The fourth and final edition (Summer 2007) will be mailed to you in late September 2007, and will include summary information from the July, August, and September 2007 *Communiqué* issues.

If you have any questions, please contact us directly at 618-998-5240.

**PLEASE NOTE:** This subscription does not provide copies of the monthly *Communiqué*. You can, however, download both the monthly and Quarterly *Communiqués* from our Website at: [http://www.wpsmedicare.com/provider/pub\\_home.shtml](http://www.wpsmedicare.com/provider/pub_home.shtml)

Name: \_\_\_\_\_

Address: \_\_\_\_\_ PO Box/Suite: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Attn: \_\_\_\_\_

QTY	PRICE	ITEM
	\$30.00	2007 Fiscal Year Quarterly <i>Communiqué</i> Subscription
You will receive 4 Quarterly issues, as detailed below:		
Fall 2006	Summary of October, November, and December 2006 monthly <i>Communiqués</i> (First edition, mailed late Dec. 2006)	
Winter 2007	Summary of January, February, and March 2007 monthly <i>Communiqués</i> (Second edition, mailed late March 2007)	
Spring 2007	Summary of April, May, and June 2007 monthly <i>Communiqués</i> (Third edition, mailed late June 2007)	
Summer 2007	Summary of July, August, and September 2007 monthly <i>Communiqués</i> (Final edition, mailed late September 2007)	

Orders must be pre-paid and check made payable to **WPS Medicare**.

Send check or money order to:  
 WPS Medicare  
 Provider Outreach  
 PO Box 999  
 Marion, IL 62959

## SKILLED NURSING FACILITY CONSOLIDATED BILLING WEB-BASED TRAINING COURSE IS NOW AVAILABLE

The Skilled Nursing Facility Consolidated Billing Web-Based Training Course is now available on the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN). The course provides general information about Skilled Nursing Facilities (SNF), SNF Consolidated Billing, and "under arrangement" agreements between SNFs and other providers or suppliers. To access the course, visit [http://www.cms.hhs.gov/mlngeninfo/01\\_overview.asp](http://www.cms.hhs.gov/mlngeninfo/01_overview.asp), scroll down to "Related Links Inside CMS," and select "Web-Based Training Modules."

The Skilled Nursing Facility Prospective Payment System Fact Sheet, which is the first in an upcoming series of payment fact sheets, is now available in downloadable format on the CMS MLN. To access the fact sheet, visit <http://www.cms.hhs.gov/MLNProducts/downloads/snfprospaymtfctsht.pdf> 453KB. The fact sheet will be available for ordering through the MLN in approximately six weeks.

### Reimbursement

## OCTOBER 2006 QUARTERLY AVERAGE SALES PRICE (ASP) MEDICARE PART B DRUG PRICING FILE, EFFECTIVE OCTOBER 1, 2006, AND REVISIONS TO APRIL 2006 AND JULY 2006 QUARTERLY ASP MEDICARE PART B DRUG PRICING FILES ~CMS MLN Matters~

**MLN Matters Number:** MM5270  
**Related CR Release Date:** September 22, 2006  
**Related CR Transmittal #:** R1066CP

**Related Change Request (CR) #:** 5270  
**Effective Date:** October 1, 2006  
**Implementation Date:** October 2, 2006

**Note:** This article was revised on September 25, 2006, to reflect changes to CR5270, which CMS re-issued on September 22, 2006. The article was revised, as was CR5270, to remove references to the revised January 2006 file. The CR transmittal number, release date, and Web address for accessing CR5270 were also changed. All other information remains the same.

### Provider Types Affected

All Medicare providers who bill Medicare for Part B drugs

### Provider Action Needed

#### STOP – Impact to You

Change Request (CR) 5270, upon which this article is based, provides notice of the updated payment allowance limits effective October 1, 2006, and revisions to the April 2006 and July 2006 quarterly drug pricing files.

### CAUTION – What You Need to Know

Be aware that certain Medicare Part B drug payment limits have been revised and that CMS updates the payment allowance on a quarterly basis. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to this document.

**GO – What You Need to Do**

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

**Background**

CR5270, upon which this article is based, provides the quarterly average sales price (ASP) Medicare Part B drug pricing file update for October 1, 2006, and also provides revisions to the April 2006 and July 2006 quarterly files.

Section 303(c) of the Medicare Modernization Act of 2003 (MMA) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis; and mandated that since January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis be paid based on the average sales price (ASP) methodology.

In the same way in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities; specified, covered outpatient drugs; and drugs and biologicals with pass-through status under the OPPTS will be paid according to this ASP methodology, which is based on quarterly data submitted to CMS by manufacturers.

Note that MMA also requires CMS to update the payment allowance limits quarterly, which CR5270 does.

Beginning January 1, 2005, Part B drugs that are not paid on a cost or prospective payment basis) have been paid based on **106%** of the average sales price (ASP). Additionally, Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPTS, will be paid based on **106%** of the ASP.

There are exceptions to this general rule as summarized below.

**1. Blood and Blood Products**

Blood and blood products furnished in the hospital outpatient department are paid under the outpatient prospective payment system (OPPS) at the amount specified for the APC to which the product is assigned. Conversely, for blood and blood products, not paid on a prospective payment basis (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner used to determine them on October 1, 2003.

The payment allowance limits for blood and blood products are 95% of the Average Wholesale Price (AWP) as reflected in the published compendia. These payment allowance limits will be updated on a quarterly basis, along with the others.

**2. Infusion Drugs**

The payment allowance limits for infusion drugs, furnished through a covered Item of durable medical equipment, on or after January 1, 2005, will continue to be 95% of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. The payment allowance limits were not updated in 2006.

The payment allowance limits for infusion drugs (unless compounded), furnished through a covered item of durable medical equipment, that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95% of the first published AWP.

### **3. Influenza, Pneumococcal and Hepatitis B vaccines**

The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95% of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. In this latter instance, the vaccine is paid at reasonable cost.

### **4. Drugs not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File**

The payment allowance limits for drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration) are based on the published wholesale acquisition cost (WAC) or invoice pricing.

In determining the payment limit based on WAC, Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries, including regional home health intermediaries (RHHIs)) follow the methodology in the Medicare Claims Processing Manual specified for calculating the AWP, but substitute WAC for AWP. (See Publication 100-04, Chapter 17, Drugs and Biologicals at <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf> on the CMS web site.)

The payment limit is 100% of the lesser of the lowest brand or median generic WAC. And note that for 2006, when the blood clotting factor is not included on the ASP file, the blood clotting furnishing factor of \$0.146 per I.U. is added to the blood clotting factor payment amount.

Your Medicare contractor may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting contractor or will post them in an MS Excel file on the CMS web site. If the payment limit is available from CMS, contractors will substitute the CMS-provided payment limits for pricing based on WAC or invoice pricing.

### **1. New Drugs**

The payment allowance limits for new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106% of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005. As mentioned above, for 2006, the blood clotting furnishing factor of \$0.146 per I.U. is added to the payment amount for a new blood clotting factor when a new blood clotting factor is not included on the ASP file.

**2. Radiopharmaceuticals**

The payment allowance limits for radiopharmaceuticals are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio. And your carrier/FI will determine payment limits for radiopharmaceuticals not furnished in the hospital outpatient department based on the methodology in place as of November 2003.

**3. Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir**

CR 5270 clarifies that payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology, as described above. Your carrier or FI will develop the pricing for compounded drugs.

Physicians (or a practitioner described in Section 1842(b)(18)(C)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for them to perform the service. Your carrier/FI must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for: 1) The professional service of filling or refilling the implantable pump or reservoir; and 2) For drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if: 1) The medication administered is accepted as a safe and effective treatment of the patient's illness or injury; 2) There is a medical reason that the medication cannot be taken orally; and 3) The nurse's skills are needed to infuse the medication safely and effectively.

**Here are some important things you should remember.**

- The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.
- Pricing for compounded drugs is performed by your carrier/FI.
- The presence or absence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.
- The October 2006 and revised April 2006 and July 2006 ASP drug pricing files for Medicare Part B drugs will be available via the CMS Data Center (CDC) for your carriers/FIs to download on or after September 19, 2006.
- You can also view the October 2006 and revised April 2006, and July 2006 ASP NOC drug pricing files for Medicare Part B drugs (on or after September 22, 2006) at [http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02\\_aspfiles.asp#TopOfPage](http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#TopOfPage) on the CMS web site.

**Note that:**

- The revised April 2006 payment allowance limits apply to dates of service April 1, 2006 through June 30, 2006;
- The revised July 2006 payment allowance limits apply to dates of service July 1, 2006 through September 30, 2006; and
- The October 2006 payment allowance limits apply to dates of service October 1, 2006 through December 31, 2006.

### Additional Information

You can find the official instructions issued to your carrier/FI/RHHI/DMERC regarding this change by going to CR5270, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1066CP.pdf> on the CMS web site. If you have any questions, please contact your carrier at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS web site.

## OCTOBER UPDATE TO THE 2006 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) DATABASE ~CMS MLN Matters~

**MLN Matters Number:** MM5272

**Related CR Release Date:** September 1, 2006

**Related CR Transmittal #:** R1047CP

**Related Change Request (CR) #:** 5272

**Effective Date:** January 1, 2006

**Implementation Date:** October 2, 2006

### Provider Types Affected

Physicians and other providers who bill Medicare for professional services paid under the MPFS.

### What you need to know

CR5272, from which this article was taken, amends the payment files (based upon the November 21, 2005 Medicare Physician Fee Schedule Final Rule) that were previously issued to your carriers.

### 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. Carriers, in accordance with the *Medicare Claims Processing Manual* (Publication 100-4), Chapter 23, Section 30.1, give providers 30 days notice before implementing the revised payment amounts, which (unless otherwise stated in the CR5272) will be retroactive to January 1, 2006.

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 CR5272 are as follows:

CPT/HCPCS	Action
15000	Assistant at Surgery Indicator = 0
15001	Assistant at Surgery Indicator = 0
47145	Global Period = XXX Preoperative Time = 0.00 Intraoperative Time = 0.00 Postoperative Time = 0.00
52402	Endoscopic Base Code = 52000
G0289	Multiple Surgery Indicator = 0

In addition, some Type of Service (TOS) Codes have been adjusted, effective for services on or after July 1, 2006. Specifically, carriers will apply TOS 4 to the Category III codes of 0159T, 0159T-TC, and 0159T-26 and they will apply TOS 6 to the Category III codes of 0160T and 0161T.

**Additional Information**

You can find the official instruction about the October update to the 2006 Medicare Physician Fee Schedule Database by going to CR 5272, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1047CP.pdf> on the CMS web site.

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

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