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**Items of Importance**

Flu season is here! Medicare patients give many reasons for not getting their flu shot, including—"It causes the flu; I don't need it; it has side effects; it's not effective; I didn't think about it; I don't like needles!" The fact is that out of the average 36,000 people in the U.S. who die each year from influenza and complications of the virus, greater than 90 percent of deaths occur in persons 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk to your Medicare patients about the importance of getting their annual flu shot--and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. Get Your Flu Shot. Remember - Influenza vaccination is a covered Part B benefit. Note that influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of adult immunizations and educational resources, go to CMS's Website:  
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0667.pdf>

**2007 FEE INFORMATION NOW AVAILABLE!**

The 2007 Medicare Physician Fee Schedules are now available on the WPS Medicare Website at: [http://www.wpsmedicare.com/provider/pricing\\_fees.shtml](http://www.wpsmedicare.com/provider/pricing_fees.shtml)

Fee information will not be available on the Participation and Enrollment CD-ROM this year; however; we have provided the schedules in a variety of formats (Excel, Word, and Adobe) in order to meet your needs.

These fees will be valid as of January 1, 2007, and serve as important resources. Please visit the Pricing and Fees Page for more information.

**ALERT: CHANGE IN 2007 FEES AS OF NOVEMBER 27, 2006**

Please be aware that the Centers for Medicare & Medicaid Services (CMS) has issued updated fees for 2007 Medicare Part B services under the Medicare Physician Fee Schedule (MPFS). We updated the 2007 fees on our Website at [http://www.wpsmedicare.com/provider/pricing\\_fees.shtml](http://www.wpsmedicare.com/provider/pricing_fees.shtml) on November 27, 2006.

Fees previously posted on November 13, 2007 were updated to reflect a corrected rounding error. This correction was universally applied. Please update ALL fees in any billing systems that you may use to bill 2007 services. Register for our e-News Listserv at <http://wpsmedicare.com/listserv> and receive immediate notification of important Medicare program changes like these.

**APPLICATION UPDATE TO MEDICARE DEDUCTIBLE,  
COINSURANCE, AND PREMIUM RATES FOR 2007**  
~ CMS MLN Matters ~

MLN Matters Number: MM5345  
Related CR Release Date: October 27, 2006  
Related CR Transmittal #: R41GI

Related Change Request (CR) #: 5345  
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), DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs) including Regional Home Health Intermediaries (RHHIs), and Part A/B MACs for services provided to Medicare beneficiaries.

**Provider Action Needed**

This article is based on Change Request (CR) 5345 which announces the 2007 Medicare rates and instructs your Medicare contractors to make necessary updates to their claims processing systems.

**Background**

There are beneficiary-related costs for using certain services under Parts A and B of Medicare, typically in the form of deductibles, co-payments, and/or premium payments. Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital, for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for **more than 60 days** during a spell of illness, he or she is responsible for **a coinsurance amount equal to one-fourth** of the inpatient hospital deductible **per-day for the 61<sup>st</sup> -90<sup>th</sup> day** spent in the hospital.

An individual has 60 lifetime reserve days (LRDs) of coverage, which they may elect to use after the 90<sup>th</sup> day in a spell of illness. The coinsurance amount for these LRDs is equal to one-half of the inpatient hospital deductible.

For Skilled Nursing Facility (SNF) services furnished during a spell of illness, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21<sup>st</sup> through the 100<sup>th</sup> day.

Most individuals age 65 and older, and many disabled individuals under age 65, are insured for Health Insurance (HI) benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly premium.

Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment occurs more than 12 months after the date a person is initial eligibility to enroll, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Supplementary Medical Insurance (SMI) or Part B, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When SMI enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

**Medicare Part A for 2007**

For Calendar Year (CY) 2007, the following rates are applicable for Medicare Part A Deductible, Coinsurance, and Premium amounts:

Deductible	\$992.00 per benefit period
Coinsurance	\$248.00 a day for days 61-90 in each period
	\$496.00 a day for days 91-150 for each LRD used
	\$124.00 a day in a SNF for days 21-100 in each benefit period
Premium	\$410.00 per month for those who must pay a premium
	\$451.00 per month for those who must pay both a premium and a 10 % increase
	\$226.00 per month for those who have 30-39 quarters of coverage
	\$248.60 per month for those who have 30-39 quarters of coverage and must pay a 10 % increase

**Medicare Part B for 2007**

For CY 2007, the following rates are applicable for Medicare Part B Deductible and Coinsurance :

Deductible	\$131.00 per year
Coinsurance	20 percent

CMS updates the Part B premium each year. These adjustments are made according to formulas set by statute. By law, the monthly Part B premium must be sufficient to cover 25 percent of the program's costs, including the costs of maintaining a reserve against unexpected spending increases. The federal government pays the remaining 75 percent.

Below are the annual Part B premium amounts from Calendar Year (CY) 1996 to 2006. For these years, and years prior to 1996, the Part B premium is a single established rate for all beneficiaries.

Year	Part B Premium	Year	Part B Premium	Year	Part B Premium
1996	\$42.50	2000	\$45.50	2004	\$66.60
1997	\$43.80	2001	\$50.00	2005	\$78.20
1998	\$43.80	2002	\$54.00	<b>2006</b>	<b>\$88.50</b>
1999	\$45.50	2003	\$58.70		

Beginning on January 1, 2007, the Part B premium will be based on the income of the beneficiary. Below are the CY 2007 **Part B premium amounts based on beneficiary income parameters.**

Income Parameters for Determining Part B Premium		
Premium/month	Individual Income	Combined Income (Married)
\$ 93.50	\$ 80,000.00 or less	\$160,000.00 or less
\$105.80	\$ 80,000.01 - \$100,000.00	\$160,000.01 - \$200,000.00
\$124.40	\$100,000.01 - \$150,000.00	\$200,000.01 - \$300,000.00
\$142.90	\$150,000.01 - \$200,000.00	\$300,000.01 - \$400,000.00
\$161.40	\$200,000.01 or more	\$400,000.01 or more

### Implementation

The implementation date for CR5345 is January 2, 2007.

### Additional Information

For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC, intermediary, RHHI, or A/B MAC regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R41GI.pdf> on the CMS Website.

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

## COMPETITIVE ACQUISITION PROGRAM (CAP) FOR PART B DRUG: APPEALS – MMA ~ CMS MLN Matters ~

MLN Matters Number: MM5207

Related CR Release Date: October 13, 2006

Related CR Transmittal #: R1076CP

Related Change Request (CR) #: 5207

Effective Date: July 1, 2006

Implementation Date: November 13, 2006

### Provider Types Affected

Physicians billing Medicare carriers for Part B drugs and biologicals under the Medicare CAP program

### Provider Action Needed

#### **STOP – Impact to You**

This article is based on Change Request (CR) 5207, which instructs local Medicare carriers and the CAP designated carrier how to execute the appeals process within the unique requirements of CAP. Please note that the CAP claims processing arrangement is **not the same** as the standard Part B claims processing routine.

#### **CAUTION – What You Need to Know**

CR5207 provides additional information and instructions for the implementation of the CAP pertaining to the CAP appeals and dispute resolution process. This is not a stand-alone CR. It builds on previously published related CAP CRs which include: CRs 4064, 4306, 4309,

and 4404. The links to those CRs and the related Medicare Learning Network (MLN) articles are provided in the *Additional Information* section below.

**GO – What You Need to Do**

See the *Background* section of this article and the information in CR5207 for further details regarding these special CAP appeals requirements and delivery of dispute resolution services. MLN Matters Number: MM5207 Related Change Request Number: 5207

**Background**

Section 303 (d) of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003, requires the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals (“drugs”) not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians will be given a choice between buying and billing these drugs under the average sales price (ASP) system, or obtaining these drugs from vendors selected in a competitive bidding process. A participating CAP physician will submit a claim for drug administration to the Medicare local carrier. An approved CAP vendor will submit a claim for the drug product to the CAP Medicare designated carrier.

***Appeal Process for CAP Drug Claims I***

As mentioned above, the CAP claims processing arrangement departs from the standard Part B claims processing routine. Specifically, the CAP uses a local carrier’s determination about the physician’s drug administration claim that is associated with a CAP drug’s claim as an indicator of whether a CAP vendor’s matching drug claim should be paid. Therefore, if a local carrier denies the physician’s drug administration claim that is to be matched to a CAP vendor’s drug claim and causes the vendor’s CAP drug claim to deny, the appeals process for the vendor’s drug claim’s denial must begin with the local carrier that denied the claim. In this situation, in order to pursue an appeal of a denied CAP drug claim, the approved CAP vendor becomes a party to the appeal of a denied drug administration claim filed by a participating CAP physician with the local carrier.

If a CAP vendor’s drug claim has been denied because there is no matching participating CAP physician claim on file with the local carrier, the Medicare designated carrier will deny the claim and will suppress appeal rights if there is still no matching drug administration claim after 90 days. The remittance notice will instruct the approved CAP vendor that it may request a reopening. In this case, if the approved CAP vendor accepts the designated Medicare carrier’s offer and requests a reopening, the designated carrier will call the participating CAP physician to encourage the physician to file the drug administration claim. If the participating CAP physician does not file the claim, the designated Medicare carrier will engage in dispute resolution activities which may result in a recommendation to terminate the participating CAP physician’s involvement in CAP.

The Medicare designated carrier will use group code CO for claims that are denied because the participating CAP physician has not filed his/her claim, will return the following messages:

- Medicare Summary Notice (MSN) – 16.34 – “You should not be billed for this service. You do not have to pay this amount.”
- Remark code N211 – “You may not appeal this decision.”

- These messages are provided in addition to MSN message 21.21 and Remittance Advice (RA) reason code 107 for these claim denials. (See CR4064, Business Requirement (BR) 4064.9.2.1, link provided below.)

### **Additional Information**

CR5207 adds sections 100.9-100.94 to Publication 100-04, the Medicare Claims Processing Manual, Chapter 17, “Drugs and Biologicals for CAP.” CR5207 is the official instruction issued to your Medicare carrier regarding changes mentioned in this article. CR 5207 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1076CP.pdf> on the CMS Website.

CR4064, dated December, 9 2005, “Competitive Acquisition Program (CAP) for Part B Drugs” is located at <http://www.cms.hhs.gov/transmittals/downloads/R777CP.pdf> on the CMS Website. The related MLN article, MM4064 “Competitive Acquisition Program (CAP) for Part B Drugs” can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf> on the CMS Website.

CR4306, dated February 6, 2006, “MCS Screen Expansion for the Prescription Order Number for the Competitive Acquisition Program (CAP) for Part B Drugs to be Developed Over the July 2006 and October 2006 Release, With Final Implementation on October 2, 2006” is available at the following link <http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf> on the CMS Website.

CR 4309, dated February 17, 2006, “Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs” can be found at the following link <http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf> on the CMS Website.

The related MLN article, MM4309 “Additional Requirements for the Competitive Acquisition Program (CAP) for Part B Drugs” can be reached at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf> on the CMS Website.

CR4404, dated April 28, 2006 “Competitive Acquisition Program (CAP) for Part B Drugs Physician Election” is located at <http://www.cms.hhs.gov/transmittals/downloads/R932CP.pdf> on the CMS Website.

MM4404, “Competitive Acquisition Program (CAP) for Part B Drugs Physician Election” the related MLN article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4404.pdf> on the CMS Website.

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

## **FIRST COAST SERVICE OPTIONS, INC. BEGINS QIC PART B NORTH OPERATIONS EFFECTIVE NOVEMBER 15, 2006**

As you are aware, a separate contractor called a Qualified Independent Contractor, or "QIC," handles second level appeals, termed "reconsiderations." Beginning November 6, 2006, all redetermination letters, which communicate the results of the first level of appeal, will include instructions on how to request a reconsideration to the new QIC contractor, First Coast Service Options, Inc. (FCSO).

**FCSO will begin processing these reconsiderations on November 15, 2006 for the North jurisdiction, which includes:** Alaska, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, District of Columbia, New York, Pennsylvania, New Jersey, Delaware, Maryland, Ohio, Kentucky, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Missouri, Iowa, Kansas, Nebraska, South Dakota, North Dakota, Wyoming, Montana, Idaho, Washington, Oregon, California, Nevada, Arizona, Utah, Hawaii, Guam, Northern Mariana Islands, and American Samoa. The address to send the QIC reconsiderations to will be:

**First Coast Service Options, Inc.  
QIC Part B North Reconsiderations  
P.O. Box 45208  
Jacksonville, FL 32232-5208**

Any additional documentation, new information or medical evidence that may assist the QIC in reevaluating the claim(s) should be attached to the written reconsideration request. If no additional information is submitted, a decision will be made based on the documentation contained in the AC's redetermination case file.

**NOTE:** To aid in the processing of your request and to avoid significant delays, a copy of the redetermination letter should accompany your reconsideration request.

## **MEDICARE PROVIDER INQUIRY ALERT: HELPING MEDICARE HELP YOU**

The WPS Provider Inquiry toll-free lines are exceptionally busy due to high demand. This situation results in longer wait times. When you call the toll-free lines, you will be informed of the expected wait time. Due to budget constraints, CMS revised the requirement for the "Average Speed of Answer" in the call centers from 60 seconds to 120 seconds for the new fiscal year, which began on October 2, 2006. We wish to assure you that we are monitoring the situation very closely and analyzing ways to optimize all of our available resources to ensure continued provider satisfaction.

We encourage Medicare providers to utilize self-service options for routine questions. Following is a listing of possible options. These options are required for more routine questions, such as eligibility and claim status. If you need to speak with a customer service representative, please be prepared to give your provider number.

## Self Service Options include:

Option	Use:
<b>Interactive Voice Response</b> <b>Toll-free lines:</b> <b>Illinois (877) 908-9499</b> <b>Michigan (877) 567-7201</b> <b>Minnesota (877) 908-8470</b> <b>Wisconsin (877) 567-7176</b>	Hours of operation for all functions <ul style="list-style-type: none"> <li>• Monday-Friday 6 AM to 6 PM CT</li> <li>• Saturday 7 AM to 12 PM CT</li> </ul> Instructions located at: <a href="http://www.wpsmedicare.com/provider/pdfs/ivr.pdf">http://www.wpsmedicare.com/provider/pdfs/ivr.pdf</a> Access information regarding claim status, patient eligibility, deductible, checks, <b>Provider Summary (New)</b> , pricing, phone numbers, addresses, and appeal rights.
<b>CMS Secure Net Access Pilot (CSNAP)</b> Become a registered user at: <a href="https://medicareinfo.com">https://medicareinfo.com</a>  For more information about CSNAP call our toll-free number 877-476-8116, Monday through Friday 8 AM to 4 PM CT.	This is a FREE Internet based self service application which allows providers access to: <ul style="list-style-type: none"> <li>• Claim status Information</li> <li>• Patient Eligibility Information</li> <li>• Deductible Information</li> <li>• Medicare Secondary Payer Information</li> <li>• HMO/MCO Information</li> <li>• Ask your claim specific questions through this secure Internet application.</li> </ul>
<b>WPS Medicare Website at</b> <a href="http://www.wpsmedicare.com">http://www.wpsmedicare.com</a>	<ul style="list-style-type: none"> <li>• Find information on Pricing and Fees</li> <li>• Locate coverage and billing information</li> <li>• Access to the provider newsletter, <i>Communiqué</i></li> <li>• Join one or more of our Listservs and receive quick notification of Medicare changes</li> <li>• Communicate with us through the "Contact Us" page of the Website. Use this for asking general coverage and billing questions.</li> <li>• Access to Provider Education materials that can help answer your billing questions.</li> <li>• Access training and seminar schedules</li> </ul>

**When you must speak with someone please have the following information ready when calling the toll free lines or using the IVR:**

- Your provider number
- The patient's name
- The patient's Medicare number - usually nine numbers followed by a letter
- The patient's birth date in MMDDYY format
- The date of service (DOS) in question in MMDDYY format

Your feedback is important to us. You can also communicate with WPS Medicare by completing the *Contact Us* portion on our Website at:

[http://www.wpsmedicare.com/misc/contact\\_form.html](http://www.wpsmedicare.com/misc/contact_form.html)

## **NPI NOW REQUIRED ON ALL EDI FORMS**

Effective immediately, as a condition of Electronic Data Interchange (EDI) enrollment, your National Provider Identifier (NPI) is required on all EDI documents. This business decision is to both encourage and facilitate implementation of NPI for claims, which goes into effect in less than 200 days.

May 23, 2007 is not when the process starts, but when the process must be completed.

The NPI requires a transition period of no less than 120 days. Providers must begin to test and use their NPIs in electronic health care claims well before the compliance date.

EDI forms that currently require Medicare Part B Provider Numbers, for example, Enrollment Form, Electronic Remittance Advice, Electronic Funds Transfer, and Submitter Profile, will now require the NPI number in order to be processed.

Until testing is complete within the Medicare processing systems, Medicare urges providers to continue submitting Medicare claims with both their NPI and their legacy Medicare number.

NPIs will be required on claims sent on or after May 23, 2007. Learn more about NPI and how to apply by visiting <http://www.cms.hhs.gov/NationalProviderStand/> on the CMS Website. For technical questions about the NPI, the application process, and to receive a paper application, call the NPI Enumerator Helpline at (800) 465-3203.

If you have any questions, please contact the EDI Hotline for IL/MI/WI (877) 567-7261  
For Minnesota, please contact (952) 885-2882, (952) 885-2881 or (952) 885-2811

### **REPORTING THE NATIONAL PROVIDER IDENTIFIER (NPI) ON PHYSICIAN CLAIMS FOR CLINICAL DIAGNOSTIC SERVICES PURCHASED OUTSIDE OF THE LOCAL CARRIER'S JURISDICTION ~ CMS MLN Matters ~**

**MLN Matters Number: MM5289**  
**Related CR Release Date: October 27, 2006**  
**Related CR Transmittal #: R243OTN**

**Related Change Request (CR) #: 5289**  
**Effective Date: April 1, 2007**  
**Implementation Date: April 2, 2007**

#### **Provider Types Affected**

Physicians billing Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for diagnostic services purchased outside the local carrier or A/B MAC's jurisdiction.

#### **Background**

This article relates to Change Request (CR) 5289, in which the Centers for Medicare & Medicaid Services (CMS) provides specific instructions for physicians to modify their current reporting guidelines and requires physicians to begin **reporting, as of May 23, 2007, a National Provider Identifier (NPI) on claims for clinical diagnostic services purchased outside of the local carrier's jurisdiction.** Previously CMS instructed physicians to report their provider identification number (PIN) on claims when billing for clinical diagnostic services purchased outside of the local carrier's jurisdiction. (See Change Request 3630,

Transmittal 415, issued on December 23, 2004 at:

<http://www.cms.hhs.gov/Transmittals/downloads/R243OTN.pdf> on the CMS Website).

As of May 23, 2007, physicians must begin using their NPI to bill the local carrier for a clinical diagnostic service purchased outside of the jurisdiction of the local carrier or A/B MAC. As of May 23, 2007, remember the following:

- When reporting the 2400 PS1 segment (Purchased Service Information) of the ANSI X12 837 electronic claim format, version 4010A, the billing physician must report their NPI.
- When submitting paper claims, physicians must report their NPI for both the purchased portion of the test and the portion of the test that they performed.
- Physicians may no longer report a PIN after May 22, 2007.

Prior to May 23, 2007, physicians may report the PIN, the NPI, or both PIN and the NPI.

### **Additional Information**

For complete details, please see the official instruction issued to your Medicare carrier or A/B MAC, regarding this change. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R243OTN.pdf> on the CMS Website.

To learn more about the NPI and how to apply for one, visit <http://www.cms.hhs.gov/NationalProvidentStand/> on the CMS Website.

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

### **Do you have your NPI?**

National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. Every health care provider needs to get an NPI. Learn more about the NPI and how to apply for an NPI by visiting <http://www.cms.hhs.gov/NationalProvidentStand/> on the CMS Website.

### **Do You Have NPI Questions?**

Do you have questions about the National Provider Number (NPI)? The following Websites could have the answer you're looking for:

<http://www.cms.hhs.gov/NationalProvidentStand/>  
[http://www.cms.hhs.gov/NationalProvidentStand/Downloads/NPI\\_Resource\\_Sheet.pdf](http://www.cms.hhs.gov/NationalProvidentStand/Downloads/NPI_Resource_Sheet.pdf)

Please do NOT contact the NPI Enumerator with any questions, unless they are operational concerns (e.g., How do I obtain an NPI? What information do I enter in item 11, etc.). The NPI Enumerator cannot tell providers how many NPIs they should obtain.

**Claim Submission**

**ADDITIONAL REQUIREMENTS NECESSARY TO IMPLEMENT THE  
REVISED HEALTH INSURANCE CLAIM FORM CMS-1500**

~ Revised CMS MLN Matters ~

**MLN Matters Number: MM5060 Revised**  
**Related CR Release Date: September 15, 2006**  
**Related CR Transmittal #: R1058CP**

**Related Change Request (CR) #: 5060**  
**Effective Date: January 1, 2007**  
**Implementation Date: January 2, 2007**

**Note:** Page 3 of this article was revised on October 13, 2006, to reflect that the **appropriate NPI** must be entered in certain fields on Form CMS-1500. Previously, the article incorrectly stated the NPI of the billing provider. All other information remains the same.

**Provider Types Affected**

Physicians and suppliers who bill Medicare carriers including durable medical equipment regional carriers (DMERCs) for their services using the Form CMS-1500.

**Key Points**

- The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the National Provider Identifier (NPI).
- The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.
- During this transition time there will be a dual acceptability period of the current and the revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the **split provider identifier fields**.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.
- There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

<b>January 2, 2007- March 30, 2007</b>	Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version. <b>Note:</b> Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08-05) by January 2, 2007.
<b>April 2, 2007</b>	The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used. <b>Note:</b> All <b>rebilling</b> of claims should use the <b>revised</b> Form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12-90).

**Background**

Form CMS-1500 is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification

Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The CMS-1500 form is being revised to accommodate the reporting of the National Provider Identifier (NPI).

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Thus, small plans may need to receive legacy provider numbers on coordination of benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

In a related Change Request, CR4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report Provider Identification Numbers (PINs) and Unique Physician Identification Numbers (UPINs) as applicable.

There were no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. Change Request 4293 provided guidance for implementing the revised Form CMS-1500 (08-05). This article, based on CR 5060, provides additional Form CMS-1500 (08-05) information for Medicare carriers and DMERCs, related to validation edits and requirements.

### **Billing Guidelines**

- When the NPI number is effective and required (May 23, 2007, although it can be reported starting January 1, 2007), claims will be **rejected** (in most cases with reason code 16 – “claim/service lacks information that is needed for adjudication”) in tandem with the appropriate remark code that specifies the missing information, **if**
- The appropriate NPI is not entered on Form CMS-1500 (08-05) in items:
  - 24J (replacing item 24K, Form CMS-1500 (12-90));
  - 17B (replacing item 17 or 17A, Form CMS-1500 (12-90));
  - 32a (replacing item 32, Form CMS-1500 (12-90)); and
  - 33a (replacing item 33, Form CMS-1500 (12-90)).

### **Additional Information**

When the NPI Number is Effective and Required (May 23, 2007)  
To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.

Legacy identifiers are pre-NPI provider identifiers such as:

- PINs (Provider Identification Numbers)
- UPINs (Unique Physician Identification Numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSCs (National Supplier Clearinghouse numbers) for DMERC claims.

### **Additional NPI-Related Information**

Additional NPI-related information can be found at <http://www.cms.hhs.gov/NationalProvidentStand/> on the CMS Website. The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Website at [http://www.nucc.org/images/stories/PDF/change\\_log.pdf](http://www.nucc.org/images/stories/PDF/change_log.pdf)

MLN Matters article MM4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms," can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf> on the CMS Website.

CR4293, Transmittal Number 899, "Revised Health Insurance Claim Form CMS-1500," provides contractor guidance for implementing the revised Form CMS-1500 (08-05). It can be found at <http://www.cms.hhs.gov/transmittals/downloads/R899CP.pdf> on the CMS Website.

MLN Matters article MM4023, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms," can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf> on the CMS Website.

CR5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1058CP.pdf> on the CMS Website.

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

## **ANNUAL UPDATE OF HCPCS CODES USED FOR HOME HEALTH CONSOLIDATED BILLING ENFORCEMENT ~ CMS MLN Matters ~**

**MLN Matters Number: MM5356**  
**Related CR Release Date: October 27, 2006**  
**Related CR Transmittal #: R1082CP**

**Related Change Request (CR) #: 5356**  
**Effective Date: January 1, 2007**  
**Implementation Date: January 2, 2007**

### **Provider Types Affected**

Physicians, suppliers, and providers who bill Medicare contractors (Fiscal Intermediaries (FIs), Carriers, Durable Medical Equipment Regional Carriers (DMERC), regional home health intermediaries (RHHIs), and DME Medicare Administrative Contractors (DME MACs) and Part A/B Medicare Administrative Contractors (A/B MACs)) for medical supply or therapy services.

### **Provider Action Needed**

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2007. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the *Additional information* section of this article.

### **Background**

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA.) As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes. Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physicians;
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare periodically publishes Routine Update Notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

### **Key Points**

CR5356 provides the annual HH consolidated billing update effective January 1, 2007. The following tables describe the HCPCS codes and the specific changes to each that this notification is implementing on January 2, 2007.

**Table 1: Non Routine Supplies**

<b>Code</b>	<b>Description</b>	<b>Action</b>	<b>Replacement Code or Code being Replaced</b>
A4213	Syringe, Sterile, 20 CC or Greater	Add	
A4215	Needle, Sterile, Any Size, Each	Add	
A4348	Male External Catheter with Integral Collection Compartment, Extended Wear, Each (e.g., 2 per month)	Delete	
A4359	Urinary Suspensory without Leg Bag	Delete	
A4244	Alcohol or Peroxide, per Pint	Add	
A4245	Alcohol Wipes, per Box	Add	
A4246	Betadine or PhisoHex Solution, per Pint	Add	
A4247	Betadine or Iodine Swabs/Wipes, per Box	Add	
A4461	Surgical Dressing Holder, Non-reusable, Each	Add	Replaces code: A4462
A4462	Abdominal Dressing Holder, Each	Delete	Replacement code: A4461 and A4463
A4463	Surgical Dressing Holder, Reusable, Each	Add	Replaces code: A4462
A4932	Rectal Thermometer, Reusable, Any Type, Each	Add	
A6412	Eye Patch, Occlusive, Each	Add	

**Table 2: Therapies**

<b>Code</b>	<b>Description</b>	<b>Action</b>	<b>Replacement Code or Code being Replaced</b>
97020	Application Microwave	Delete	Replacement Code: 97024
97024	Application of a Modality to One or More Areas: Diathermy (e.g., Microwave)	Redefine	Replaces code: 97020
97504	Orthotic(s) Fitting and Training, Upper Extremity(ies), Lower Extremity(ies), and/or Trunk, Each 15 Minutes	Delete	Replacement code: 97760
97520	Prosthetic Training, Upper and/or Lower Extremity(ies), Each 15 Minutes	Delete	Replacement code: 97761
97703	Checkout for Orthotic/Prosthetic Use, Established Patient, Each 15 Minutes	Delete	Replacement code: 97762
97760	Orthotic(s) Management and Training (Including Assessment and Fitting when not Otherwise Reported), Upper Extremity(s), Lower Extremity(s) and/or Trunk, Each 15 Minutes	Add	Replaces code: 97504
97761	Prosthetic Training, Upper and/or Lower Extremity(s), Each 15 Minutes	Add	Replaces code: 97520
97762	Checkout for Orthotic/Prosthetic Use, Established Patient, Each 15 Minutes	Add	Replaces code: 97703

**Additional Information**

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

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

For complete details regarding this CR please see the official instruction issued to your Medicare FI, carrier, A/B MAC, DMERC, RHHI, or DME MAC. That instruction may be viewed by going to **<http://www.cms.hhs.gov/Transmittals/downloads/R1082CP.pdf>** on the CMS Website.

A complete historical listing of codes subject to HH consolidated billing can be found at **[http://www.cms.hhs.gov/HomeHealthPPS/03\\_coding&billing.asp](http://www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp)** on the CMS Website.

To review the Medicare regulations discussed in this article see the Medicare Claims Processing Manual Chapter 10, Section 10.1.25 at **<http://www.cms.hhs.gov/manuals/downloads/clm104c10.pdf>** on the CMS Website.

## CARRIER JURISDICTION FOR AMBULANCE SUPPLIER CLAIMS ~ CMS MLN Matters ~

MLN Matters Number: MM5203  
Related CR Release Date: November 3, 2006  
Related CR Transmittal #: R1100CP

Related Change Request (CR) #: 5203  
Effective Date: January 1, 2008  
Implementation Date: January 1, 2008

### Provider Types Affected

Ambulance suppliers who submit claims to Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for ambulance services furnished to Medicare beneficiaries

### Provider Action Needed

#### **STOP – Impact to You**

Effective for claims processed January 1, 2008 and later, a claim for an ambulance service furnished by a supplier must be filed with the carrier or A/B MAC having jurisdiction for the “point of pickup” (POP).

#### **CAUTION – What You Need to Know**

Effective April 1, 2007, each carrier will begin processing applications from ambulance suppliers that are rendering services in their jurisdiction. For claims with dates of service January 1, 2008 and later, carriers will return claims as unprocessable any claim for a ground or air ambulance service where the POP is not within its jurisdiction.

#### **GO – What You Need to Do**

Be sure your staff knows to file Medicare claims with the carrier or A/B MAC having jurisdiction for the POP to assure prompt and accurate payment.

### Background

The Medicare claims filing jurisdiction rule for ambulance services has been that an ambulance must file the claim with the carrier or A/B MAC having jurisdiction for where the service was furnished. When the ambulance fee schedule policies and systems changes were being developed, most carriers interpreted this rule to mean that a claim for an ambulance service must be filed with the carrier or A/B MAC having jurisdiction for the area where the vehicle is garaged or hangered. When the ambulance fee schedule was implemented beginning January 1, 2000, CMS determined that this de facto interpretation of the claims filing jurisdiction rule would not be changed during the fee schedule transition period which was completed on January 1, 2006. (See Program Memorandum (PM) AB-00-88, Change Request (CR) 1281, dated September 18, 2000 which was re-issued as PM AB-01-185 dated December 14, 2001. CR1281 can be found at the following link <http://www.cms.hhs.gov/Transmittals/Downloads/AB01185.pdf> on the CMS Website.)

Currently all ambulance services are paid under the fee schedule which is based on the location from which the beneficiary is transported, i.e., the “point of pickup” (POP). Because the basis for payment under the fee schedule is based on the POP, it is reasonable for the claims filing jurisdiction rule to also be based on the POP.

Changing the claims filing jurisdiction to the POP will ensure jurisdictional congruence between the policies for payment and claims filing. It will additionally ensure that the

ambulance supplier meets the State and local requirements where the service was furnished, which was the original intent of the claim filing jurisdiction rule. This change will:

- Bring administrative practice into congruence with the longstanding regulatory standards at 42 C.F.R. § 410.41;
- Avoid having Federal administrative practice undercut appropriate State and local regulatory standards; and
- Promote an appropriate level of service for all Medicare beneficiaries.

For dates of service of January 1, 2008, or later, ground and air ambulance supplier claims for a point of pick-up not rendered in the carrier's (or A/B MAC's) jurisdiction will be returned to the supplier as "unprocessable", accompanied by the following remittance advice message:

- "N104 This claim/service is not payable under our claims jurisdiction area. You can identify the Medicare contractor to process this claim/service through the CMS Website at <http://www.cms.hhs.gov>."

Carriers and A/B MACs will not apply this rule to:

- Ambulance claims submitted to the carrier that processes Indian Health Service ambulance claims, or
- Any future ambulance demonstration claims unless CMS so directs that this policy applies.

As a consequence of changing the claims filing rule to the POP, ambulance suppliers (including those who operate in multiple States) must be enrolled with the carrier in each jurisdiction where they furnish services to Medicare beneficiaries. This is the case even if that supplier does not garage or hanger its vehicles in each State in which the supplier operates (Required by 42 C.F.R. § 410.41 located at [http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410\\_41.pdf](http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410_41.pdf) on the Centers for Medicare & Medicaid (CMS) Website).

Note: As early as April 1, 2007, each carrier or A/B will begin processing applications from ambulance suppliers that are rendering services in their jurisdiction.

Exception: Where the POP is outside the United States, the claim for an ambulance service furnished by a supplier must be filed in accordance with the instructions in Publication 100-4, The Medicare Claims Processing Manual, Chapter 1 § 10.1.4.1. Carrier jurisdiction is defined in Publication 100-04, Chapter 1 § 10.1.4.2. These instructions can be found at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> on the CMS Website.

### **Additional Information**

CR5203 is the official instruction issued to your Medicare carrier or A/B MAC regarding changes mentioned in this article. CR 5203 may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1100CP.pdf> on the CMS Website.

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

## COMMON WORKING FILE (CWF) DUPLICATE CLAIM EDIT FOR THE TECHNICAL COMPONENT (TC) OF RADIOLOGY AND PATHOLOGY LABORATORY SERVICES PROVIDED TO HOSPITAL PATIENTS

~ CMS MLN Matters ~

MLN Matters Number: MM5347  
Related CR Release Date: November 2, 2006  
Related CR Transmittal #: R1098CP

Related Change Request (CR) #: 5347  
Effective Date: April 1, 2007  
Implementation Date: April 2, 2007

### Provider Types Affected

Radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the TC of **radiology** laboratory services provided to Medicare fee-for-service hospital inpatients. Also affected are independent laboratories billing Medicare carriers for the TC of **pathology** laboratory services provided to Medicare fee-for-service hospital patients.

### Provider Action Needed

Effective April 1, 2007, CMS will install systems edits to prevent improper payments to radiology suppliers, physicians and non-physician practitioners for the TC of radiology laboratory services during an inpatient stay. The system edits will also apply to independent laboratories for the TC of pathology laboratory services provided to beneficiaries during a covered inpatient hospital stay or provided on the same date of service as an outpatient service. This change applies to claims with dates of service on or after January 1, 2007, where the claim is received on or after April 1, 2007. Please be sure billing staff are aware of these changes.

### Background

Current Medicare billing practices allow either the hospital or the supplier performing the technical component (TC) of physician pathology laboratory services to bill the carrier for these services. This policy has contributed to the MLN Matters Number: MM5347 Related Change Request Number: 5347

Medicare program paying twice for the TC service, first through the Prospective Payment System (PPS) to the hospital and again to the supplier that bills the carrier, instead of the hospital, for the TC service.

Effective for claims received on or after April 1, 2007 for services on or after January 1, 2007, CMS will install systems edits to prevent additional improper payments to radiology suppliers, physicians and non-physician practitioners billing Medicare carriers for the TC of radiology laboratory services during an inpatient stay. The edits will also apply to independent laboratories for the TC of pathology services provided to beneficiaries during an inpatient stay or for the same date of service as an outpatient service.

### Key Points

- Effective for claims received on or after April 1, 2007, Medicare will reject/deny a Part B TC or globally billed radiology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay. Such services will also be rejected/denied when they match with a date of service of a hospital inpatient previously processed by Medicare.

- Effective for claims received on or after April 1, 2007, Medicare will reject/deny reject a Part B TC or globally billed pathology service with a service date on or after January 1, 2007, that falls within the admission and discharge dates of a covered hospital inpatient stay when billed by a physician/supplier. Such services will also be rejected/denied when they match with a date of service of a hospital outpatient bill (bill types 13X and 85X0 previously processed by Medicare.
- If providers submit a TC of a radiology or pathology service with a service date that falls within the admission and discharge dates of a covered hospital inpatient stay the carrier will use Remittance Advice Reason Code 109 "Claim not covered by this payer/contractor." when denying a service line item.
- Where Medicare systems detect that a Part B TC or globally billed radiology or physician pathology service has been paid and Medicare subsequently receives a hospital inpatient bill for the same date of service, the Medicare carrier will adjust a TC of a radiology or physician pathology service line item and recoup the payment made for that service from the physician/supplier. The Medicare carrier will also adjust a TC of a pathology service for an outpatient claim. The same Remittance Advice Reason Code of 109 will be used in such cases.
- Effective for claims received on or after April 1, 2007, the carrier will deny an incoming Part B TC or globally billed radiology or physician pathology service line item with a service date that falls outside the occurrence span code 74 (non-covered level of care) from and through dates plus one day on a posted hospital inpatient bill. Again, the carrier will use Remittance Advice Reason Code 109. In addition, the Medicare carrier will recoup payment made to the physician/supplier if a subsequent hospital inpatient bill is received for those same services.
- Carriers will not search their files to either retract payment or retroactively pay claims prior to the implementation of CR5347. However, they will adjust claims if they are brought to their attention.

**Implementation**

This change will be implemented on April 2, 2007.

**Additional Information**

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

For complete details regarding this CR, please see the official instruction issued to your Medicare FI, Carrier, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1098CP.pdf> on the CMS Website.

## OUTPATIENT THERAPY CAP EXCEPTIONS CLARIFICATIONS ~ CMS MLN Matters ~

MLN Matters Number: MM5271 Revised  
Related CR Release Date: November 9, 2006  
Related CR Transmittal #: R60BP, R171PI, R1106CP

Related Change Request (CR) #: 5271  
Effective Date: January 1, 2007  
Implementation Date: January 2, 2007

**Note:** This article was revised on November 20, 2006, to reflect the correct effective and implementation dates of January 1, 2007, and January 2, 2007, respectively. All other information remains the same.

### Provider Types Affected

Providers, physicians, and non-physician practitioners (NPPs) who bill Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and carriers) under the Part B benefit for therapy services.

### Provider Action Needed

CR 4364, released February 15, 2006, described the exception process to the caps set on outpatient therapy services (physical therapy and occupational therapy). CR 5271, upon which this article is based, clarifies questions (below) that have arisen about this exception process. Thus, the article is meant primarily for informational purposes.

### Background

A brief history may be beneficial at this point. The Balanced Budget Act of 1997 placed Financial limitations on Medicare covered therapy services (therapy caps), that were implemented in 1999 and again for a short time in 2003. Congress placed moratoria on these caps for 2004 and 2005, but the moratoria are no longer in place, and the caps were re-implemented on January 1, 2006. However, Congress, through the Deficit Reduction Act has provided that (only for calendar year 2006) exceptions to caps may be made when provision of additional therapy services is determined to be medically necessary.

### Review of this exception process

Section 1833(g)(5) of the Social Security Act provides that, for services provided during calendar year 2006, FIs, RHHIs, and carriers can, in certain circumstances, grant an exception to the therapy cap when requested by the individual enrolled under the Part B benefit (or by a person acting on behalf of that individual).

Exception Processes fall into two categories: 1) Automatic Process Exceptions, or 2) Manual Process Exceptions. Medicare beneficiaries will be automatically excepted from the therapy cap and will not be required to submit requests for exception or supporting documentation if:

- They meet specific conditions and complexities listed in the Medicare Claims Processing Manual, Publication 100-04, Chapter 5, (as revised by CR4364) for exception from the therapy cap for 2006; or,
- Meet specific criteria for exception, in addition to those listed in the above referenced Manual, when the Medicare contractor believes (based on the strongest evidence available) that the beneficiary will require additional therapy visits beyond those payable under the therapy cap.

Medicare beneficiaries may be manually excepted from the therapy cap if their providers believe that the beneficiaries will require more therapy visits than those payable under the therapy cap, but the patients do not meet at least one of the above bulleted criteria for automatic exceptions.

### **The clarifications to questions generated from CR 4364**

Your FI, RHHI, or carrier:

1. Will grant exceptions for any number of medically necessary services for 2006 that meet the automatic process exception criteria, if the beneficiary meets the conditions described in Medicare Claims Processing Manual, Pub. 100-04, Chapter 5, (as revised by CR4364)
2. Will grant an exception to the therapy cap, by approving any number of additional therapy treatment days, when these additional treatment days are deemed medically necessary based on documentation that you have submitted in 2006.
3. Will utilize clinical judgment in approving or disapproving requests for additional treatment days in the exceptional circumstance in which you do not submit all required documentation with the exception request in 2006.
4. Must reply as soon as practicable to a request for exception. They will grant an exception to the therapy cap, approving the number of treatment days that you or the beneficiary request (not to exceed 15 future treatment days), if they do not make a decision within 10 business days of receipt of any request and appropriate documentation in 2006.
5. Will allow automatic process exceptions when medically necessary services are provided for two or more separate, billable, conditions in the same calendar year in 2006.
6. Will follow the manual description for allowing exceptions when the same patient has two conditions or complexities in the same year, one of which qualifies the beneficiary for use of the automatic exception process in 2006.
7. Will allow automatic process exceptions when complexities occur in combination with other conditions that may or may not be on the list in the Medicare Claims Processing Manual in 2006.
8. Will, when a patient is being treated under the care of two physicians for separate conditions, accept as appropriate documentation either 1) A combined plan of care certified by one of the physicians/NPPs, or 2) Two separate plans of care certified by separate physicians/NPPs
9. Will update the list of exceptions in 2006 according to the changes provided in this transmittal. You should be aware that they may expand (but not contract) this list if their manual process exception decisions lead them to believe further exceptions should be allowed.
10. Will not require the additional documentation that is encouraged but not required in the manuals
11. Will interpret a referral or an order or a plan of care dated after an evaluation, as certification of the plan to evaluate the patient when only an evaluation was performed. It is not required that a plan, order or referral be written prior to evaluation.
12. Will not deny payment for re-evaluation only because an evaluation or re-evaluation was recently done, as long as documentation supports the need for re-evaluation. A re-evaluation may be appropriate prior to planned discharge for the purposes of determining whether goals have been met, or to provide further information, beyond that required to be included in the discharge summary, for the use of the physician or the treatment site at which treatment will be continued.

13. Will, on pre or postpay medical review, require clinicians to write Progress Reports at least during each Progress Report Period. Note that required elements of the Progress Report that are written into the Treatment Notes or in a Plan of Care, acceptably fulfill the requirement for a Progress Report. In these instances, a separate Progress Report is not required.
14. Will require, on pre or postpay medical review of documentation, that when the services incident to a physician are provided by qualified personnel who are not therapists, the ordering or supervising physician/NPP must personally provide at least one treatment session during each Progress Report Period and sign the Progress Report.
15. Will continue to use Medicare Summary Notice (MSN) message 38.18 on all Medicare MSN forms, both in English and in Spanish. This message reads: "ALERT: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2006 through December 31, 2006. The limits are \$1,740 for PT and SLP combined and \$1,740 for OT. Medicare pays up to 80 percent of the limits after the deductible has been met. These limits don't apply to certain therapy approved by Medicare or to therapy you get at hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have questions, please call 1-800-MEDICARE."
16. Will continue to enforce Local Coverage Determinations (LCDs).

Final Note: You should keep in mind that claims for services above the cap for which an exception is not granted will be denied as a benefit category denial, and the beneficiary will be liable.

### **Additional Information**

You can find more information about outpatient therapy cap exceptions by going to CR5271, issued in 3 transmittals. As attachments to those transmittals, you will find updated manual sections for:

- The Medicare Claims Processing Manual, Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), section 10.2 (The Financial Limitation); (This will be at <http://www.cms.hhs.gov/Transmittals/downloads/R1106Cp.pdf>)
- The Medicare Program Integrity Manual, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.1.1 (Exception from the Uniform Dollar Limitation ("Therapy Cap")). (This will be at <http://www.cms.hhs.gov/Transmittals/downloads/R171PI.pdf>); and,
- The Medicare Benefit Policy Manual, Chapter 15, Section 220.3 (Documentation Requirements for Therapy Services.) This is available at <http://www.cms.hhs.gov/Transmittals/downloads/R60BP.pdf> on the CMS site.

These manual revisions include numerous additional changes clarifications.

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

## **PROCESSING ALL DIAGNOSIS CODES REPORTED ON CLAIMS SUBMITTED TO CARRIERS**

~ CMS MLN Matters ~

MLN Matters Number: MM4276  
Related CR Release Date: October 27, 2006  
Related CR Transmittal #: R1095CP

Related Change Request (CR) #: 4276  
Effective Date: April 1, 2007  
Implementation Date: April 2, 2007

### **Provider Types Affected**

All physicians and providers submitting claims to carriers

### **Provider Action Needed**

#### **STOP – Impact to You**

Effective, at the earliest, July 1, 2007, the carrier standard system for Medicare will automatically process all diagnosis codes that you submit on your claims.

#### **CAUTION – What You Need to Know**

CR4276, the second phase in the implementation of the Negotiated Rulemaking agreement to automatically consider all diagnosis codes reported on claims, includes finalization of the requirements and coding development for the standard system used by Medicare carriers.

#### **GO – What You Need to Do**

Make sure that your billing staffs are aware of these changes that allow eight diagnosis codes on Medicare claims effective, at the earliest, July 1, 2007.

### **Background**

While the American National Standards Institute (ANSI) 837P 4010A allows the reporting of up to eight diagnosis codes in the 2300 loop, the Medicare carrier standard system uses only the first four diagnosis codes when processing HIPAA format claims. Carriers have used a manual process to consider the remaining diagnosis codes in the Medicare payment determination.

In CR4276, from which this article is taken, CMS is requiring that (effective no earlier than July 1, 2007) the Medicare carrier standard system capture and process all diagnosis codes that are reported, up to the maximum of eight, on any claim (both electronic and paper) processed.

### **Additional Information**

You can find more information about the application of all diagnosis codes reported in processing carrier claims by viewing CR4276 at <http://www.cms.hhs.gov/Transmittals/downloads/R1095CP.pdf> on the CMS Website.

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

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

## UNPROCESSABLE CLAIM GUIDELINES

Since 1996, to help prevent the inappropriate use of the appeals system, the Centers for Medicare & Medicaid Services (CMS) has followed an editing process for assigned claims that lack certain information. When a Medicare paper or electronic claim contains incomplete or invalid information, it may be returned to a provider as *unprocessable*. Because no "initial determination" was made on a claim returned as unprocessable, the submitter may not ask for a review or appeal.

Unprocessable claims may be corrected and resubmitted to Medicare. Providers may resubmit the claim with the needed information as a "new claim," as this will minimize delays in payment or proper denial.

Providers should promptly correct returned claims using the Medicare editing system to meet their legal obligation for submitting a Medicare claim. Non-participating providers who currently bill beneficiaries prior to submitting a claim may continue to bill them.

In an ongoing effort to reduce cost and administrative waste, we ask that providers resolve incorrect claim submission resulting in unprocessable denials. Unprocessable denials result in delays in payment of Medicare benefits.

### **What does "Unprocessable" mean?**

When a Medicare claim cannot be processed because the information is missing or incorrect, it is called an unprocessable claim. It cannot be processed as submitted and must be corrected before an initial claim determination can be made. **Claims denied as unprocessable have no appeal rights. The claim must be corrected and resubmitted to our office.** Please ensure that you are submitting all REQUIRED information. Share this information with your electronic claim vendor.

### **What Does "Return as Unprocessable" Mean?**

When a Medicare claim cannot be processed because information is missing or incorrect, it is called a "return as unprocessable" claim. It cannot be processed as submitted and must be corrected before an initial claim determination can be made. **Claims denied as unprocessable have no appeal rights. The claim must be corrected and resubmitted to our office.** Please ensure that you are submitting all REQUIRED information. Share this information with your electronic claim vendor. The Internet-Only Manual (IOM) gives carriers three options for returning claims as unprocessable.

- **Option 1** *Incomplete or invalid information is discovered before the claim is entered into the Medicare carrier's claim processing system.* The carrier may return any claims with incomplete or missing information before they are assigned a control number and/or entered into the claims system. Claims are returned to providers in hardcopy form or electronically with an explanation of any errors in the form of a description or code. Providers may correct and return the claim.
- **Option 2** *Incomplete or invalid information is detected at the front-end of the process, the claim is assigned a control number and entered into the claims processing system.* Claims with incomplete or invalid information are suspended and a development letter is generated and sent to the provider. If the provider submits corrections within a 45-day period, the claim is processed. If corrections are not made, the suspended claim is "returned as unprocessable" and the provider is notified with a remittance notice.

- **Option 3** *Incomplete or invalid information is detected within the claims processing system.* Claims with incomplete or invalid information are rejected through the remittance process along with an explanation of errors and possible corrections. The explanation will either be in the form of a description or a code. This is the option that WPS employs.

### **What Does "Incomplete" or "Invalid" Mean?**

A Medicare claim that is missing certain **required** information is returned as unprocessable because the claim cannot be processed with *incomplete information*. A *required data element* is one that is needed to process a claim (e.g., a provider number or date of service).

A *conditional data element* is one that must be completed if other conditions exist (e.g., if the patient is not the insured under the policy, both the patient's and the insured's name must be entered on the claim.) If a Medicare claim contains complete and required information but the information is **illogical or incorrect** (such as the wrong provider number), the claim is returned as unprocessable because it has *invalid information*.

**Special Note:** If information is missing from required or conditional field(s) but the Medicare carrier keeps the information on file and can supply it, the claim will not be returned as unprocessable.

### **What Information Will Be Provided to Assist You in Correcting a Claim?**

To assist you in making the appropriate corrections, the carrier supplies the following information (as long as it is on the received claim):

- Beneficiary's name;
- HIC number;
- Dates of service; and
- Patient account or control number.

An explanation of the errors in the form of a description or code is also provided.

### **When Will a Claim be Returned as Unprocessable?**

To assist providers in completing paper claims, refer to the CMS-1500 instructions on the CMS Website at <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>. Electronic submitters should refer to the specifications for the ANSI X12 837. Printing specifications must be correct on the claim.

In general, your claim will be returned or rejected as unprocessable:

1. If a service was ordered or referred by a physician (other than those services specified below) and the physician's name and/or UPIN (or surrogate) is not present in items 17 or 17A.
2. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or UPIN of the supervising physician is not entered in items 17 or 17A.
3. For diagnostic tests subject to purchase price limitations: (a) if a "YES" or "NO" is not indicated in item 20; (b) if "YES" is indicated in item 20 and the purchase price is not entered under the word "\$CHARGES:" or (c) if "YES" is indicated and the purchase price is entered under \$CHARGES, but item 32 is blank (no name or PIN number is provided).

4. If a provider of service or supplier is required to submit a diagnosis in item 21, a ICD-9-CM code is either missing, incorrect or truncated, or a narrative diagnosis was not provided on an attachment.
5. If modifier "AQ" is entered in item 24D to refer to a Health Professional Shortage Area, but item 32 is left blank, or contains no facility/laboratory name, address, or carrier assigned PIN. Also, if the AR modifier is billed for the Physician Scarcity Area incentive, and item 32 is left blank, or does not contain the facility information.
6. If a performing physician/supplier/or other practitioner is a member of a group practice and does not enter his or her carrier assigned Provider Identification Number (PIN) in item 24K and the group practice's number in item 33.
7. If a primary insurer to Medicare is indicated in item 11, but fields 4, 6, and 7 are incomplete.
8. If there is insurance primary to Medicare that is indicated in item 11 by either an insured/group policy number or the Federal Employee Compensation Act (FECA) number, but the primary payer's program or plan name in item 11C is incomplete.
9. If a HCPCS modifier must be associated with a HCPCS procedure code or if the HCPCS modifier is invalid or obsolete.
10. If a date of service extends more than one day and a valid "to" date (MMDDCCYY) is not present in item 24A.
11. If the statement "Attending physician, not hospice employee" is not entered in item 19 for physicians rendering services to a patient in a hospice but the hospice the patient resides in does not employ the physician.
12. If an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment.
13. If the name, address or PIN of the facility where services were furnished in a hospital, clinic, laboratory, or facility other than a patient's home or physician's office is not entered in item 32.

### **List of Requirements for Specific Claim Types**

*[Editor's note: The following instruction describes some "conditional" requirements that are claim specific and necessary for processing a Part B claim submitted on the CMS-1500 or the electronic equivalent. A "conditional data element" is one that must be completed if other conditions exist (e.g., if the insured is different from the patient, then the insured's name must be entered on a claim). A data element is considered not required if it is optional or is not needed in order to process a claim (e.g., patient status).*

*This instruction is minimal and does not include all conditional data element requirements that are claim specific. Some claim types covered by Part B are not included in these instructions. Effective October 1, 2002, providers must enter the name, address, and zip code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. **You may no longer enter the word "same" in item 32 if the address is identical to the address entered in item 33.** ]*

Your claim will be returned or rejected as unprocessable:

<b>CMS-1500 Item</b>	<b>Field Requirement</b>	<b>Unprocessable Situation</b>
1a	Insured's Medicare Health Insurance Claim Number (HICN)	Field is blank or contains an invalid HICN
2 and 3	Patient's Name	Field is blank or contains an invalid patient's first and last name

<b>CMS-1500 Item</b>	<b>Field Requirement</b>	<b>Unprocessable Situation</b>
11	Group Number (or the word "NONE" if Medicare is primary)	Field is blank or contains something other than the Group Number or the word "NONE"
12	Patient's or authorized person's signature ( <i>with some exceptions</i> )	Field is blank or contains invalid information
14	Date of Initial Treatment	For chiropractic services, the initial treatment date is not indicated.
17	Referring/Ordering physician name (if service was referred or ordered)	-Field is blank or does not contain the Referring / Ordering physician's name -For parenteral and enteral nutrition claims: if the services of an ordering/referring physician(s) are used and their name and/or UPIN is not present in item 17 or 17A.
17a	Referring/Ordering physician UPIN (if service was referred or ordered)	Field is blank or does not contain the Referring/ Ordering physician's UPIN
19	Miscellaneous Requirements	-A drug "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24d but an accompanying narrative is not present in item 19. -For other NOCs, the accompanying narrative is not present in item 19 or on an attachment. -For independent laboratory claims, the claim does not contain validation from the prescribing physician that laboratory services were conducted at home or in an institution. -For outpatient services provided by a qualified, independent physical or occupational therapist, the UPIN of the attending physician is not present or the date the patient was last seen by the attending physician is not present. -For routine foot care claims, the date the patient was last seen and the attending physician's PIN are not indicated.
20	Purchased Service	A "Yes" or "No" is not indicated or a "Yes" is indicated but the purchase price and item 32 are blank or incomplete.
21	Diagnosis Code	An ICD-9-CM code is missing, invalid or truncated.

CMS-1500 Item	Field Requirement	Unprocessable Situation
23	Prior Authorization Number/CLIA Number	-For all physician office laboratory claims, a 10-digit CLIA certification number is not present -For investigational devices billed in an FDA-approved clinical trial, an investigational device exemption (IDE) number is not present -For physicians performing care plan oversight services, if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present
24a	Date of Service	Field is blank or contains an invalid date of service
24b	Place of Service	Field is blank or contains an invalid place of service
24d	CPT or HCPCS Modifier	Field is blank or contains an invalid or obsolete CPT or HCPCS code or a modifier is added that is invalid or obsolete
24k	Performing provider (if a member of a group practice)	Field is blank or contains an invalid PIN
31	Provider Signature ( <i>with some exceptions</i> )	-Field is blank or contains invalid information -Effective October 1, 2002, providers and suppliers must complete this item and include the signature of the provider of service or supplier or his/her representative, and the date the form was signed. For electronic claims, it is necessary to enter a "Y" in the provider signature field (NSF: EAO.37 position 200) (ANSI: yes/no condition response - 2300 Loop, Element CLM 06) to indicate the providers signature was obtained. You may also enter an "N" in this field if no signature was obtained; however, the claim will be denied.

CMS-1500 Item	Field Requirement	Unprocessable Situation
32	Name and address (including ZIP code) of facility where services were performed	<p>-Field does not contain the complete information required. (Effective October 1, 2002, providers must enter the name, address, and zip code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. You may no longer enter the word "same" in item 32 if the address is identical to the address entered in item 33.)</p> <p>-For certified registered nurse anesthetists (CRNAs) and anesthesia assistant (AAs) employed by a group (such as a hospital, physician, or ASC), item 32 does not contain their personal PIN number and they do not enter the group's name, address, or billing number in item 24K.</p> <p>-For durable medical, orthotic and prosthetic claims: if the name, address, or PIN of the location where the order was accepted is not entered</p> <p>-For laboratory services performed by participating hospital-leased laboratory or an independent laboratory (including services to a patient at home or in an institution), name, address or PIN of the laboratory where services were performed is not included.</p> <p>-For all laboratory work performed outside a physician's office, the claim does not contain a name, address or PIN where the laboratory services were performed</p> <p>-For mammography "screening" and "diagnostic" claims, a qualified screening center does not accurately enter their six-digit, FDA-approved facility identification number when billing the technical or global component.</p>
33	Billing provider name, address, and Provider Number (PIN)	Field is blank or does not contain the required information

The following are the top five unprocessable denials for our 4-state jurisdiction. These unprocessable situations resulted in almost 250,000 denials in one month. This type of denial can be avoided by following correct claim submission instructions.

1. **Rendering Physician Invalid** - Loop 2310B/2420A, REF02 (1C) for electronic submitters; Item 24K for CMS-1500 form. Enter the carrier assigned Provider Identification Number (PIN) when the performing provider/supplier is a member of a group practice. If you have received denials for invalid rendering physician number, please call the appropriate phone number listed below to verify the correct number.

Wisconsin, Illinois, and Michigan: 877-908-8476

Minnesota: 877-564-0315

2. **Missing or Invalid Modifier** - Loop 2400, SV101-3 through SV101-6 for electronic submitters; Item 24D for CMS-1500 form. Modifiers are required when they clarify/improve the reporting accuracy of the associated procedure codes. Please verify correct modifiers either by HCPCS Coding Guide or CPT 2005.
3. **Facility Name or PIN Missing** - Facility Name: Loop 2310D/2420C NM103 (FA), entire segment needed for electronic submitters; Item 32 for CMS-1500 form. Providers must enter the name of the facility where the service was performed unless it is Place of Service (POS) 11 (office) or 12 (home).

Item 32 for CMS-1500 Paper form: Providers must enter the address where the service was performed unless the POS is 12 (home). Please remember, effective for claims received on or after April 1, 2004, for POS 'home,' the Medicare carriers will use the beneficiary address on file to determine geographical payment.

Facility PIN: Loop 2310D/2420C, REF02 (1C), entire segment needed for electronic submitters; Item 32 for CMS-1500 form. If an independent laboratory is billing, enter the place where the test was performed and the carrier assigned PIN. The reference lab identification number should also be reported here. Only bill one unique facility number per claim.

4. **Referring Physician Name and PIN** - Referring Name - 2310A Loop NM1 and REF segments for electronic submitters; Item 17 for CMS-1500 form. Required if the claim involves a referral. Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.
5. **ID Number of Referring Physician** - 2310A Loop NM1 and REF segments for electronic submitters; Item 17A for CMS-1500 form. Enter the CMS assigned UPIN of the referring physician listed in Item 17.

The MA130 code indicating that the claim was unprocessable will appear on the Remittance Advice for any claim returned for incomplete or invalid information. There are no appeal rights on rejected claims.

Additional information about unprocessable claims is available in the CMS Internet-Only Claims Processing Manual, Publication 100-4, Chapter 1, Section 80.3.1, available at: <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>

**Comprehensive Error Rate Testing (CERT)**

**CERT ERROR FOCUS – PROVIDER REPORTED BILLING ERRORS**

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 and provider specialties that contribute to our CERT error rate. In this issue, our focus is on errors related to provider-reported billing errors, and their affect on our CERT error rate.

Analysis of our current CERT error findings (claims submitted 04/01/05-03/31/06) reveals that services reported as billing errors by providers had a greater impact on our error rate than in previous review periods. This was due in part to the relatively high dollar amount of a small number of the claims in this error category. The types of issues involved in these cases were reported as follows:

- The service was performed by another physician
- A clerical error occurred and the service was billed under the wrong patient
- Review of the file shows that the evaluation and management service was billed in error
- The abdominal ultrasound was provided on a different date of service than billed
- Nursing home service was provided on a different date of service than billed
- The patient did not have an EKG on that day
- This service was not performed on the date by this provider
- Secondary [surgery] was not performed. This was billed in error.

It is important that providers use caution when billing services to Medicare Part B. Prior to claims submittal, please ensure the accuracy of the beneficiary and date of service, the performing physician, and the HCPCS code(s). If your office discovers a billing error after a claim has been submitted, please contact WPS Medicare Part B immediately. Minor errors or omissions in filing claims can be corrected by requesting a claim reopening via the appropriate telephone line as indicated below.

<b>Reopenings</b>		
<b>All Hours are Local Time</b>		
<b>WI</b>	8:00 - 4:00	(877) 674-5354
<b>IL</b>	8:00 - 4:00	(877) 867-3418
<b>MI</b>	8:00 - 4:00 ET	(877) 674-5416
<b>MN</b>	8:00 - 4:00	(866) 380-4744

If the claim has processed and it is found that the services billed were not rendered, please submit a refund of the Medicare Part B payment as soon as possible. The check should be made out to “Medicare” and sent to the appropriate address for your state. For more information regarding this process and to obtain a refund form, please visit our Website at [http://www.wpsmedicare.com/provider/vol\\_refund\\_prov\\_supp.shtml](http://www.wpsmedicare.com/provider/vol_refund_prov_supp.shtml).

Correcting these billing errors in a timely manner can have a positive impact on the CERT error rate. In cases where a claim is corrected or a refund is received prior to inclusion in the CERT

transaction file, the CERT contractor will review the latest action on the claim and a CERT error may be avoided.

Proper documentation and accurate billing of services to Medicare Part B is crucial in order to meet CMS' CERT error rate reduction expectations, and WPS continues to identify problem areas contributing most significantly to our jurisdiction's error rate. Continued cooperation from providers 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 email 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, not your patient's Medicare Health Insurance Claim Number.

## Coverage – General

### CHANGES TO THE LABORATORY NATIONAL COVERAGE DETERMINATION (NCD) EDIT SOFTWARE FOR JANUARY 2007 ~ CMS MLN Matters ~

MLN Matters Number: MM5384  
Related CR Release Date: October 27, 2006  
Related CR Transmittal #: R1093CP

Related Change Request (CR) #: 5384  
Effective Date: January 1, 2007  
Implementation Date: January 2, 2007

#### Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

#### Provider Action Needed

This article is based on Change Request (CR) 5384, which announces the changes that will be included in the January, 2007 release of the edit module for clinical diagnostic laboratory NCDs.

#### Background

The National Coverage Determinations (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published as a final rule on November 23, 2001. Subsequently, the Centers for Medicare & Medicaid Services (CMS) contracted for nationally uniform software to be developed and incorporated into its shared systems so that laboratory claims subject to one of the 23 NCDs can be processed uniformly throughout the nation effective January 1, 2003.

The laboratory edit module for the NCDs is updated quarterly (as necessary) to reflect coding updates and substantive changes to the NCDs developed through the NCD process. (See the Medicare Claims Processing Manual (Pub. 100-04), Chapter 16, Section 120.2., available at <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf> on the CMS Website.)

These updating changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs, and biannual updates of the ICD-9-CM codes. In addition, many of the listed changes may correct Current Procedural Terminology (CPT) codes to reflect the current CPT update.

CR5384 informs your Medicare carrier, FI, or A/B MAC about changes to the laboratory edit module and changes in laboratory NCD code lists effective for services furnished on or after January 1, 2007.

CR5384 specifically announces the addition of the following ICD-9-CM code(s):

- V58.83 (Encounter for therapeutic drug monitoring) to the list of 1) ICD-9-CM codes covered by Medicare for the Prothrombin Time (190.17) NCD and 2) ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (190.16) NCD;
- 783.0 (Anorexia) and 793.99 (Other nonspecific abnormal findings on radiological and other examinations of body structure) to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD; and
- 995.20 (Unspecified adverse effect of unspecified drug, medicinal and biological substance) to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.

CR5384 also modifies the descriptor for CPT code 87088 in Urine Culture, Bacterial NCD (190.12) to read "Culture, bacterial; with isolation and presumptive identification of each isolates, urine."

### **Additional Information**

For complete details, please see the official instruction issued to your carrier, FI, or A/B MAC regarding this change. That instruction may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1093CP.pdf> on the CMS Website.

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

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

## **CODING FOR STRIPPING KERATOPLASTY PROCEDURES**

Keratoplasty is the general term for several variants of corneal transplant. Current Procedural Terminology (CPT) code 65710 covers lamellar keratoplasty, in which only the outermost layers of cornea are transplanted. CPT codes 65730, 65750, and 65755 refer respectively to full-thickness (penetrating) corneal transplant in a phakic patient, an aphakic patient (with no native lens), and a pseudophakic patient (with an artificial lens). The physician work allowance (Relative Value Unit (RVU)) for each of the three penetrating keratoplasty codes is similar.

A newer procedure is termed "Descemet's stripping endothelial keratoplasty" or "deep lamellar

endothelial keratoplasty" (also known as DSAEK). This procedure involves a small incision to allow intraocular placement of endothelium harvested from a donor cornea after the stripping off of diseased corneal endothelium. Microkeratome-based (automated) preparation of the donor endothelium may be used. This technique offers certain clinical advantages while achieving the goal of penetrating keratoplasty in patients with disease largely related to endothelial dysfunction.

For Medicare Part B, the new Descemet's stripping procedure may be adequately coded as 65730, 65750, or 65755 (based on the patient's lens status), until such time as a more specific code is released. Coding with an unlisted procedure code such as 66999 is not incorrect, but will trigger delays for additional documentation requests, processing, review, and cross-walking of reimbursement.

Note that keratoplasty procedures primarily for refractive correction and radial keratotomy are NOT covered by Medicare. (CMS Manual System, Pub. 100-03, Medicare National Coverage Determinations Manual, Section 80.7, Refractive Keratoplasty.) The CPT manual (at 65710) gives an instruction to use other codes for refractive keratoplasty such as CPT codes 65760, 65765, and 65767.

References:

- Van Rij G, Bartels M. (2006) Descemet's stripping with endothelial keratoplasty in 50 eyes: a refractive neutral corneal transplant. J Refract Surg. 22:529-30
- Price FW Jr, Price MO (2006) Descemet's stripping with endothelial keratoplasty in 200 eyes. J Cataract Refract Surg. 2006 32:411-8. By the same authors: Descemet's Stripping with Endothelial Keratoplasty :Comparative Outcomes, in Ophthalmology, August 2006.
- Terry MA, Ousley PJ (2005) Deep Lamellar Endothelial Keratoplasty: Visual Acuity, Astigmatism, and Endothelial Survival in a Large Prospective Series. Ophthalmology 112:1541-8
- CMS Manual System, Pub. 100-03, Medicare National Coverage Determinations Manual, Section 80.7, Refractive Keratoplasty

## **IMPLEMENTATION OF AN ULTRASOUND SCREENING FOR ABDOMINAL AORTIC ANEURYSMS (AAA)**

~ CMS MLN Matters ~

**MLN Matters Number:** MM5235

**Related CR Release Date:** November 17, 2006

**Related CR Transmittal #:** R1113CP

**Related Change Request (CR) #:**5235

**Effective Date:** January 2, 2007

**Implementation Date:** January 1, 2007

### **Provider Types Affected**

All physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), and Medicare Administrative Contractors (MACs) for subject services

### **Background**

This article and related CR5235 highlight the fact that section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysms (AAA) under Medicare Part B, effective for services furnished on or after January 1, 2007,

subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test.

**Key Points**

This article and CR 5235 define the parameters for AAA to Medicare beneficiaries as follows:

- The term “ultrasound screening for abdominal aortic aneurysm” means:
  - A procedure using sound waves (or such other procedures using alternative technologies, of commensurate accuracy and cost, as specified by the Secretary of Health and Human Services through the national coverage determination process) provided for the early detection of abdominal aortic aneurysms; and
  - Includes a physician's interpretation of the results of the procedure.
- Effective for dates of service on and after January 1, 2007 Medicare will pay for a one-time ultrasound screening for AAA, for beneficiaries who meet the following criteria:
  - Receives a referral for such an ultrasound screening as a result of an initial preventive physical examination (IPPE) (See MLN Matters article MM3638 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3638.pdf> for more details on the IPPE.)
  - Receives such ultrasound screening from a provider or supplier who is authorized to provide covered diagnostic services.
  - Has not been previously furnished such an ultrasound screening under the Medicare Program
  - Is included in at least one of the following risk categories:
    1. Has a family history of abdominal aortic aneurysm;
    2. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime;
    3. Is a beneficiary, who manifests other risk factors in a beneficiary category recommended for screening by the United States Preventive Services Task Force regarding AAA, as specified by the Secretary of Health and Human Services, through the national coverage determinations process.

***Payment***

- The Part B deductible for screening AAA is waived effective January 1, 2007, but coinsurance is applicable.
- If the screening is provided in a physician office, the service is billed to the carrier using the HCPCS code G0389: Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening.
  - Short Descriptor: Ultrasound exam AAA screen
  - Modifiers: TC, 26 (modifiers are optional)
  - Payment is under the Medicare Physician Fee Schedule (MPFS).

**Fls will pay for the AAA screening only** when the services are performed in a hospital, including a **CAH, IHS facility, an SNF, RHC, or FQHC** and submitted on one of the following types of bills (TOBs): **12X, 13X, 22X, 23X, 71X, 73X, 85X.**

- The following table describes the payment methodology Medicare will use for AAA Screening:

<b>Facility</b>	<b>Type of Bill</b>	<b>Payment</b>
Hospitals subject to OPPS	12X, 13X	OPPS
Method I and Method II Critical Access Hospitals (CAHs)	12X and 85X	101% of reasonable cost

Facility	Type of Bill	Payment
IHS providers	13X, revenue code 051X	OMB-approved outpatient per visit all inclusive rate (AIR)
IHS providers	12X, revenue code 024X	All-inclusive inpatient ancillary per diem rate
IHS CAHs	85X, revenue code 051X	101% of the all-inclusive facility specific per visit rate
IHS CAHs	12X, revenue code 024X	101% of the all-inclusive facility specific per diem rate
SNFs **	22X, 23X	Non-facility rate on the MPFS
RHCs*	71X, revenue code 052X	All-inclusive encounter rate
FQHCs*	73X, revenue code 052X	All-inclusive encounter rate
Maryland Hospitals under jurisdiction of the Health Services Cost Review Commission (HSCRC)	12X, 13X	94% of provider submitted charges or according to the terms of the Maryland Waiver

\*If the screening is provided in an RHC or FQHC, the professional portion of the service is billed to the FI using TOBs 71x and 73x, respectively, and the appropriate site of service revenue code in the 052x revenue code series. If the screening is provided in an independent RHC or freestanding FQHC, the technical component of the service can be billed by the practitioner to the carrier under the practitioner's ID following instructions for submitting practitioner claims to the Medicare carrier. If the screening is provided in a provider-based RHC/FQHC, the technical component of the service can be billed by the base provider to the FI under the base provider's ID, following instructions for submitting claims to the FI from the base provider.

\*\* The SNF consolidated billing provision allows separate part B payment for screening services for beneficiaries that are in skilled Part A SNF stays, however, the SNF must submit these services on a 22x bill type. Screening services provided by other provider types must be reimbursed by the SNF.

### **Implementation**

The implementation date for this instruction is January 2, 2007.

**Information Regarding Advanced Beneficiary Notices:** Medicare contractors will deny an AAA screening service billed more than one in a beneficiary's lifetime.

If a second G0389 is billed for AAA for the same beneficiary or if any of the other statutory criteria for coverage listed in Section 1861(s)(2)(AA) of the Social Security Act are not met, the service would be denied as a statutory (technical) denial under Section 1861(s)(2)(AA), not a medical necessity denial.

If a provider cannot determine whether or not the beneficiary has previously had an AAA screening, but all of the other statutory requirements for coverage have been met, the provider should issue the ABN-G. Likewise, if all of the statutory requirements for coverage

have been met, but a question of medical necessity still exists, the provider should issue the ABN-G.

### **Additional Information**

The official instructions for CR 5235, issued to your Medicare carrier, FI, MAC, FQHC, RHC, SNF, or CAH regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1113CP.pdf> on the CMS Website. The Medicare Claims Processing Manual, Publication 100-04, Chapter 18, has been updated to include the requirements to implement section 5112 of the DRA of 2005. The new sections of this chapter address the payment and allowable settings for AAA and the sections are attached to CR5235.

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

## **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, Wisconsin Physicians Service (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 is Wednesday, December 13, 2006 at 1:00 p.m. CST, 2:00 p.m. EST. Copies of the LCD's that will be discussed, location details, and other meeting information is on the WPS Website at:

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

Interested parties, who wish to make presentations of scientific evidence and other information related to draft local coverage decisions, must submit a written request to Stephen Boren, MD at [Stephen.Boren@wpsic.com](mailto:Stephen.Boren@wpsic.com)

## **Coverage – Policies**

### **INFORMATION ON WEBSITE**

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

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

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

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



### Revised Policies for December 2006

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
CV-006	<i>Cardiac Catheterization and Coronary Angiography (CV-006) Billing and Coding Guidelines</i>	LCD Billing and Coding Guidelines	Click here to view	Page 40
CV-016	<i>Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring)</i>	LCD	Click here to view	Page 41
HONC-010	<i>Antineoplastics and their Adjuncts</i>	LCD	Click here to view	Page 41
INJ-019	<i>Human Granulocyte/Macrophage Colony Stimulating Factors</i>	LCD	Click here to view	Page 42
INJ-023	<i>Erythropoiesis Stimulating Proteins Epoetin alfa (EPO), Darbepoetin alfa (DPA) Billing and Coding Guidelines</i>	LCD Billing and Coding Guidelines	Click here to view	Page 42
PHYS-073 – <b>RETIRED</b>	<i>Diabetic Peripheral Neuropathy with Loss of Protective Sensation (LOPS)</i>	NCD	Click here to view	Page 43
PHYSMED-001	<i>Outpatient Physical Therapy, Occupational Therapy and Speech-Language Pathology</i>	NCP	Click here to view	Page 44
PHYSMED-009	<i>Physical Medicine Rehabilitation Procedures and Modalities</i>	LCD	Click here to view	Page 44

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
PULM-003	<i>Sleep-Disorder Clinics and Diagnostic Tests</i>	NCP	Click here to view	Page 45
RAD-014	<i>Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT)</i>	LCD	Click here to view	Page 45

**Coverage – Revised Policies**

**Cardiac Catheterization and Coronary Angiography (CV-006) Billing and Coding Guidelines**

**\*Revision Effective Date**

\*01/16/2007

Cardiac catheterizations are not allowed in Independent Diagnostic Testing Facilities (IDTF). The term "Independent Diagnostic Testing Facilities" has been replaced with free standing facility in the following paragraph:

- \*11. The global (technical [TC] and professional [26] components) procedures are covered under Part B in the following circumstances:
  - \*a. The procedure is performed in a \*free-standing facility. Cardiac catheterization may be covered in a free-standing facility when the catheterization is performed under personal physician supervision. Personal physician supervision means the physician would have to be present in the room while the cardiac catheterization is being performed.
  - b. The cardiac catheterization is performed in an entity set up as a physician specialty group or physician directed clinic.

- \*12. Cardiac catheterizations under Part B can be performed in the following place of service (POS):

**Professional and /or technical services are payable in an:**

- 11-office,
- 81-independent lab

**Professional service is payable by Part B in:**

- 21 inpatient,
- 22 outpatient

- \*13 Cardiac catheterizations will be payable when performed by the following specialties:
  - 06 Cardiology,
  - 78 Cardiac Surgery



### Local Coverage Determination (LCD)

#### LCD Title

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

#### Contractor's Determination Number

CV-016

LCD CV-016, Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring), is revised. Please see the entire LCD on our Website.



### Local Coverage Determination (LCD)

#### LCD Title

Antineoplastics and their Adjuncts

#### Contractor's Determination Number

HONC-010

#### Revision Effective Date:

09/29/2006 - FDA approval date

#### Indications and Limitations:

The recent FDA approved indications for Rituximab (Rituxan) have been added to the LCD.

#### Rituximab (Rituxan) 100 mg, (J9310)

Rituxan is indicated for the treatment of patients with CD20 positive, B-cell non-Hodgkin's lymphoma:

- Relapsed or refractory low-grade or follicular,
- First-line treatment of follicular in combination with cyclophosphamide, vincristine and prednisone (CVP),
- Low grade in patients with stable disease or who receive a partial or complete response following first line treatment with CVP,
- Diffuse large cell in combination with cyclophosphamide, doxorubicin, vincristine, and prednisone (CHOP) or other anthracycline based chemotherapy.

Non-Hodgkin's Lymphoma

200.00-200.88, 202.00-202.98



**Local Coverage Determination (LCD)**

**LCD Title**

Human Granulocyte/Macrophage Colony Stimulating Factors

**Contractor's Determination Number**

INJ-019

**\*Revision Effective Date**

\*01/16/2007

**Indications**

ICD-9 code 288.04 has been changed to 288.03 in the following indication to be consistent with the other indications listed. 288.04 is being removed from this LCD.

**\*C. Indications for Filgrastim (Neupogen™) \*(J1440, J1441):**

- \*1. To decrease the incidence of infection as manifested by febrile neutropenia, for patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever (\*288.03)



**INJ-023 Billing and Coding Guidelines**

**LCD Title**

Erythropoiesis Stimulating Proteins  
Epoetin alfa (EPO), Darbepoetin alfa (DPA)

**Contractor's Determination Number**

INJ-023

**EPO/DPA Worksheet**

ICD-9 HCPCS	HCPCS	OR
<b>285.21- anemia in end-stage renal disease [The patient is on dialysis] ONLY CODE NEEDED</b>	<b>J0886</b> EPO, per 1000 units	<b>J0882</b> DPA, per 1mcg
<b>585.1 – 585.9 Chronic renal disease The patient is not on dialysis Requires either 285.8 or 285.9 to indicate the anemia.</b>	<b>J0885</b> EPO, per 1000 units	<b>J0881</b> DPA, per 1 mcg
<b>042, 079.53 AZT treatment with AIDS Requires either 285.8 or 285.9 to indicate the anemia.</b>	<b>J0885</b> EPO, per 1000 units	<b>J0881</b> DPA, per 1 mcg

995.20 Adverse effect of drug properly administered. Use this to indicate that the chemotherapy induced the anemia Requires 285.8 or 285.9 to indicate the anemia.	J0885 EPO, per 1000 units	J0881 DPA, per 1 mcg
238.72, *238.73, *238.74, 284.9, 285.0 Myelodysplastic syndrome Requires either 285.8 or 285.9 to indicate the anemia.	J0885 EPO, per 1000 units	J0881 DPA, per 1 mcg
Chronic myelomonocytic leukemia (CMML) This is a relative of MDS and is not a leukemia as such. It is very rare. Use the myelodysplastic codes to bill for this. 238.72, *238.73, *238.74, 284.9, 285.0 Requires either 285.8 or 285.9 to indicate the anemia	J0885 EPO, per 1000 units	J0881 DPA, per 1 mcg
V07.8 Prophylactic pre-operative use prior to elective hip and knee replacement surgery. Requires either 285.8 or 285.9 to indicate the anemia	J0885 EPO, per 1000 units	J0881 DPA, per 1 mcg
140.0-204.91, 230.0-238.6, 238.8-239.9, 273.3. non-myeloid malignancies or multiple myeloma Requires code 285.22 - anemia in neoplastic disease	J0885 EPO, per 1000 units	J0881 DPA, per 1 mcg
285.29 Anemia of Chronic disease Requires documentation. Documentation will be requested by the carrier for the initial claim	J0885 EPO, per 1000 units	J0881 DPA, per 1 mcg



### National Coverage Determination (NCD) - Retired

**Subject:**

Diabetic Peripheral Neuropathy with Loss of Protective Sensation (LOPS)

**Policy Number:**

PHYS-073

**Effective Date:**

12/31/2006

This WPS policy is being retired effective 12/31/2006.

The Medicare coverage criteria and billing/coding requirements may be found on the CMS Regulations & Guidelines Website at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> in the Medicare National Coverage Determination Manual (Pub.100-03 §70.2.1) and the Medicare Claims Processing Manual (Pub.100-04 Ch.32 §§80-80.8).



### **National Coverage Provision (NCP)**

#### **Subject**

*Outpatient Physical Therapy, Occupational Therapy and Speech-Language Pathology*

#### **NCP Number**

PHYSMED-001

#### **Effective Date**

01/01/2007

Revisions to the **Indications and Limitations of Coverage** and **Documentation Requirements** sections of this NCP are included, based on revisions made to the CMS Manual related to this subject. Please read this NCP in its entirety on our Website.



### **Local Coverage Determination (LCD)**

#### **LCD Title**

Physical Medicine Rehabilitation Procedures and Modalities

#### **Contractor's Determination Number**

PHYSMED-009

#### **Effective Date**

01/01/2007

Revisions to the **Indications and Limitations of Coverage** and **Companion Article** have been added to this LCD. Please read this LCD in its entirety on our Website.



## National Coverage Provision (NCP)

### Subject

*Sleep-Disorder Clinics and Diagnostic Tests*

### NCP Number

PULM-003

### Effective Date

\*12/01/2006

Revisions to the Indications and Limitation of Coverage and additional Coding Guidelines have been included in this NCP. Please read this NCP in its entirety on our Website.



## Local Coverage Determination (LCD)

### LCD Title

Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT)

### Contractor's Determination Number

RAD-014

### ICD-9 Codes that Support Medical Necessity

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

77301,77418, 0073T (IMRT)

140.0-208.91	Malignant neoplasms
212.6	Benign neoplasm of respiratory and intrathoracic organs; thymus
213.0-213.9	Benign neoplasm of bone and articular cartilage
225.0-225.9	Benign neoplasm of brain and other parts of nervous system
*227.3	Benign neoplasm, pituitary gland and craniopharyngeal duct (pouch)
228.00-228.09	Hemangioma, any site
*237.0	Neoplasm of uncertain behavior, pituitary gland and craniopharyngeal duct
446.4	Wegener's granulomatosis

**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. The information regarding the pre-pass edit is communicated in the Batch Detail Control Listing (a.k.a Prepass Report).

In October 2006, as part of the Stage 2 National Provider Identifier (NPI) implementation, slight changes were made to the Prepass Report in order to accommodate the addition of NPI. Those changes temporarily decreased the size of the Reference Number. The Reference Number field carries information on the encountered error which could be the patient account number, file, group or set control number or the submitted HIC number (in the case of a beneficiary error). The size of the Reference Number field will be restored and the field contents size decreased. The change will be made in late January 2007.

- Reference Number field will be increased from 11 to 20
- Field Contents field will be decreased from 22 to 13 characters.

```

1 H99RAR04 WISCONSIN PHYSICIANS SERVICE - STATE PAGE 1
PRODUCTION PROFESSIONAL EMC PROGRAM
MEDICARE-B EMC INPUT
BATCH DETAIL CONTROL LISTING
SUBMITTER ID: 99999 SUBMITTER NAME: BUSINESSXXX
ADDRESS: STREET XX
CITY: CITYXXX
STATE/ZIP: ST ZIP CODE
PROCESS DATE: 11/08/2006
-----
PROV PROV REFERENCE REC TYPE DTL FIELD IN FIELD ERR MESSAGE ERROR
NPI# PIN# NUMBER NUM ERROR CONTENTS NUM SEVERITY
-----
0 619507114 ISA IC CTRL HDR 619507114 M151 AT LEAST ONE VALID CLAIM INFORMATIONAL
0 EMC PROVIDER : NPI: 1234567890 PIN: DJL10 BATCH NUMBER : 1
PROV PROV REFERENCE REC TYPE DTL FIELD IN FIELD ERR MESSAGE ERROR
NPI# PIN# NUMBER NUM ERROR CONTENTS NUM SEVERITY
-----
0 2654755547 DJL10 1 2000A HL B/PY-TO PRV 000000000 M152 AT LEAST ONE VALID CLAIM INFORMATIONAL
0 EMC PROVIDER : NPI: 1234567890 PIN: DJL10 BATCH STATUS : DELETED ENTIRE BATCH MUST BE RESUBMITTED
XXXXXXXXXXXXXXXX TCN 19.4.1-XXXXXXXXXXXX 2400 LX 02 ASN NO XXXXXXXXXXXXXXXX 1089 MUST BE +1 BY +1 NOT SKI CLAIM DELETED
XXXXXXXXXXXXXXXX TCN 19.4.1-XXXXXXXXXXXX 2400 LX 03 ASN NO XXXXXXXXXXXXXXXX 1089 MUST BE +1 BY +1 NOT SKI CLAIM DELETED
XXXXXXXXXXXXXXXX TCN 19.4.1-XXXXXXXXXXXX 2400 LX 04 ASN NO XXXXXXXXXXXXXXXX 1089 MUST BE +1 BY +1 NOT SKI CLAIM DELETED
0 HIC FOR ABOVE CLAIM IN ERROR: 999999999A TCN: 00000000000000
- TOTAL CLAIMS RECEIVED : 1
TOTAL CLAIMS ACCEPTED : 0
TOTAL CLAIMS DELETED : 1
TOTAL CLAIMS WITH ERRORS : 1
TOTAL CHARGES ACCEPTED : $ 0.00

```

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 Website: [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.

## **NEW MEDICARE EDIT M387 – CLARIFICATION**

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 Multi-Carrier System (MCS) 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.

As of October 2, 2006, Medicare has a new prepass edit number M387. This edit sets if the 2010AA and the 2010AB do not contain a REF01 of 1C and 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.

Until testing of the new software that uses the National Provider Identifier (NPI) in the Medicare system is complete, providers are urged to bill claims using the provider's legacy number and the provider's NPI. Claims received with only the NPI during the testing process may be paid, however 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, and then the provider will need to resubmit the claim with the appropriate legacy number.

## **NEW WEB-BASED TRAINING COURSE FOR INSTITUTIONAL PROVIDERS**

Understanding the Remittance Advice for Institutional Providers Web-based training (WBT) course is now available through the Medicare Learning Network. This WBT course is designed to provide institutional providers and their billing staff with general remittance advice (RA) information. This course provides instructions to help institutional providers interpret the RA received from Medicare and reconcile it against submitted claims. Course participants will receive guidance on how to read Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices (SPRs), as well as information regarding balancing an RA. The course also provides an overview of software that Medicare provides free to providers for viewing ERAs. The course takes approximately 90 minutes to complete and participants may receive .2 CEUs for successful completion. To register to take this WBT course participants can go to the Medicare Learning Network's Product Ordering Page located at [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5) and click on the course title.

## **PC-ACE PRO32 SOFTWARE FOR SPECIALTY BILLING**

WPS Medicare has a Health Insurance Portability and Accountability Act (HIPAA)-compliant software product available for all types of Medicare billing called PC-ACE Pro32. This software can not only be used for regular office visit billing but can also be used for specialty billing such as ambulance, Medicare Secondary Payer (MSP), chiropractic, podiatry, physical therapy, purchased services, and roster.

This software will allow you to submit your Medicare claims electronically. The newest version of PC Ace Pro32 also allows for your new NPI number.

**Software Cost**

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

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

PC-ACE Pro32 software can now be downloaded from our Website. If you are interested in using PC Ace Pro32, download the PC-Ace Pro32 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, or 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)**.

**PC-ACE PRO32 VERSION 1.80 WILL SOON BE AVAILABLE**

If you are currently using the PC-ACE Pro32 billing software, you will soon be able to download the latest upgrade online. Currently, upgrade version 1.74 is available at:

**[http://www.wpsic.com/edi/pcacepro32\\_p.shtml](http://www.wpsic.com/edi/pcacepro32_p.shtml)**

When upgrade version 1.80 is made available, you can go to the above Website to download. The PC-ACE Pro32 version 1.80 upgrade features updates of procedure codes, taxonomy codes, Claim Adjustment Reason Codes, Remittance Remark Codes and ICD-9 codes. It also modified an existing edit for Care Plan Oversight (CPO) claims to no longer require the HHA or Hospice provider number per CR 4374.

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

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

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

**RETURNING PAPER CLAIMS RECEIVED FROM CLEARINGHOUSES**

~ CMS MLN Matters ~

**MLN Matters Number: MM5341**

**Related CR Release Date: November 3, 2006**

**Related CR Transmittal #: R247OTN**

**Related Change Request (CR) #: 5341**

**Effective Date: January 1, 2007**

**Implementation Date: January 2, 2007**

**Provider Types Affected**

All Medicare providers who submit paper claims to clearinghouses for filing with Medicare

**Provider Impact**

If a clearinghouse submits claims for you on paper (rather than electronically) your payments may be affected. The Administrative Simplification Compliance Act (ASCA) requires that claims a clearinghouse submits to Medicare on your behalf must be submitted

electronically. When your carrier or fiscal intermediary (FI) identifies that a clearinghouse has submitted a claim for you on paper, they will return the claim unprocessed to the clearinghouse.

### **Background**

Section 3 of the Administrative Simplification Compliance Act (ASCA), PL 107-105; the implementing regulation at 42 CFR 424; and the **Medicare Claims Processing Manual** Chapter 24, Section 90-90.6 and its exhibits all require (except in limited situations) that you submit claims to Medicare electronically. And, while ASCA regulations do allow you (as a provider) to submit some, or all, claims on paper in very specific and limited instances; HIPAA covered entities (other than providers) are not eligible for an exemption from these electronic Medicare claim submission requirements.

CR 5341, from which this article is taken, addresses claims that your clearinghouse submits to Medicare on your behalf. To be specific, if you contract with a clearinghouse to send claims to Medicare for you, they are required to submit these claims electronically.

But this being said, there is evidence that some clearinghouses are routinely submitting paper claims without the providers' knowledge. You should be aware that your carriers and FIs, having identified that a provider's clearinghouse has submitted your claims in paper form, will return them back to the clearinghouse without action.

### **Additional Information**

The official instruction (CR5341) issued to your Medicare contractor (carriers, durable medical equipment regional carrier (DMERC), DME Medicare Administrative Contractor (DME MAC), fiscal intermediary (FI), or Part A/B Medicare Administrative Contractor (A/B MAC)) regarding paper claims that they receive from clearinghouses is located at <http://www.cms.hhs.gov/Transmittals/downloads/R247OTN.pdf> on the CMS Website.

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

## **General Information**

### **GUIDELINES FOR TEACHING PHYSICIANS, INTERNS AND RESIDENTS FACT SHEET NOW AVAILABLE FOR ORDER**

The updated Guidelines for Teaching Physicians, Interns, and Residents Fact Sheet is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit <http://www.cms.hhs.gov/mlngeninfo>, scroll down to "Related Links Inside CMS," and select "MLN Product Ordering Page."

## **LABORATORY COMPETITIVE BIDDING DEMONSTRATION ~ CMS MLN Matters ~**

**MLN Matters Number: MM5359**  
**Related CR Release Date: November 1, 2006**  
**Related CR Transmittal #: R50DEMO**

**Related Change Request (CR) #: 5359**  
**Effective Date: April 1, 2007**  
**Implementation Date: April 2, 2007**

**Note:** This article was previously published as MM5205, based on CR5205, which discussed the initial phase of implementing this demonstration.

### **Provider Types Affected**

Physicians and all providers who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites

### **Background**

Section 302(b) of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to conduct a demonstration project on the application of competitive acquisition for payment of most clinical laboratory services that would otherwise be payable under the Medicare Part B fee schedule.

Under this statute, pap smears and colorectal cancer screening tests are excluded from this demonstration. Requirements under the Clinical Laboratory Improvement Amendments (CLIA), as mandated in section 353 of the Public Health Service Act, are applicable.

The payment basis determined for each CBA will be substituted for payment under the existing clinical laboratory fee schedule. Multiple winners are expected in each CBA.

### **Key Points**

This article and Change Request (CR) 5359 provides instructions for the implementation of a laboratory competitive bidding demonstration. The requirements specified in this article and CR5359 are in preparation for the implementation of the demonstration in the first CBA on April 1, 2007.

- The project will cover demonstration tests for all Medicare Part B beneficiaries who live in the demonstration sites, as determined by the zip code of the beneficiary's residence.
- Hospital inpatient testing is covered by Medicare Part A and is therefore exempt from the demonstration.
- Physician office laboratory (POL) testing and hospital outpatient testing are not included in the demonstration, except where the physician office or hospital laboratory functions as an independent laboratory performing testing for a beneficiary who is not a patient of the physician or hospital outpatient department.
- CMS will continue to pay POL patient and hospital outpatient laboratory services in accordance with the existing clinical laboratory fee schedule.

### **Required Bidders**

Laboratory firms with \$100,000 or more in annual Medicare Part B (fee-for-service) payments as of calendar year (CY) 2005 for "demonstration tests" provided to beneficiaries

residing in the CBAs (regardless of where the laboratory firm is located) will be required to bid in the demonstration.

These laboratory firms will be referred to as “required bidders.”

### **Passive Laboratories**

Small laboratories or laboratory firms with less than \$100,000 in annual Medicare Part B (fee-for-service) payments for demonstration tests provided to beneficiaries residing in the CBAs will not be required to bid in the demonstration. These laboratories are considered “passive” laboratories.” Passive laboratories will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBA.

During the demonstration period, CMS will monitor the volume of services performed by passive laboratories to ensure that their annual payments under Medicare Part B for demonstration tests provided to beneficiaries residing in the demonstration sites do not exceed the annual ceiling of \$100,000.

Passive laboratory firms exceeding the annual ceiling of \$100,000 will be:

- Terminated from the demonstration project; and
- Will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.
- **Laboratories or laboratory firms providing clinical laboratory services exclusively to beneficiaries with end stage renal disease (ESRD) residing in the CBA will not be required to bid in the demonstration. These laboratories are considered “passive-ESRD” laboratories.** Passive-ESRD laboratories will be paid the laboratory competitive bidding demonstration fee schedule for Part B demonstration tests provided to ESRD beneficiaries residing in the CBA. During the demonstration period (April 1, 2007 through March 31, 2010, inclusive), passive-ESRD laboratories that expand their business to provide clinical laboratory services to non-ESRD beneficiaries residing in the CBA will be terminated from the competitive bidding demonstration.

### **Winners**

Both required and non-required bidders that bid and win will be paid the laboratory competitive bidding demonstration fee schedule for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located). These laboratories will be labeled “winners.”

### **Non-Winners**

Both required and non-required bidders that bid and do not win will not be paid anything by Medicare (neither under the Part B clinical laboratory fee schedule nor under the competitively bid price) for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration. These laboratories will be labeled “non-winners.”

Similarly, required bidders that do not bid will not be paid anything by Medicare for demonstration tests provided to beneficiaries residing in the CBAs (regardless of where the laboratory firm is located) for the duration of the demonstration.

Non-winner laboratories that furnish a demonstration test to a Medicare beneficiary residing in the CBA during the demonstration have no appeal rights when Medicare payment for the test is denied. Moreover, non-winner laboratories may not charge the beneficiary for Part B laboratory services.

***Demonstration-Covered Laboratory Tests***

Only the laboratory that performs the test may bill for the service and only winning or passive laboratories are eligible to receive the laboratory competitive bidding demonstration fee schedule payment for services covered under the demonstration.

Although non-winner laboratories may not bill either Medicare or the beneficiary for any demonstration-covered services, such laboratories may refer such services to a winner laboratory or a passive laboratory.

For all other tests (i.e., those not covered under the demonstration or for tests for beneficiaries not residing in the service area), all laboratories will be paid according to the clinical laboratory fee schedule and in accordance with Medicare payment policies.

***Demonstration Sites***

There are two demonstration sites and each site runs for three years with a staggered start of one year. The demonstration uses Metropolitan Statistical Areas (MSAs) to define the CBAs.

The residence status of beneficiaries will be determined by information in the Medicare system as of the date the claim is processed. The residence of the beneficiary receiving services must be in the same CBA as determined by review of a beneficiary's zip code of residence.

CMS will provide the contractors with a list of zip codes included in each MSA, which will be used to determine whether a beneficiary's residence is included in one of the CBAs.

The demonstration will set (competitively bid) fees in the demonstration areas for all tests paid under the Medicare Part B clinical laboratory fee schedule, with the exception of pap smears, colorectal cancer screening tests, and new tests added to the Medicare Part B clinical laboratory fee schedule during the course of the demonstration. Demonstration fees will be set for each service payable under the demonstration in each of the CBAs.

Only CLIA-certified laboratories will be allowed to participate in the demonstration.

***Implementation***

CR5359 is being implemented in multiple phases. The requirements specified in this instruction are for the implementation of the demonstration in the first CBA (CBA1).

During the first quarter of 2007, CMS will provide Medicare carriers, FIs, and A/B MACs with a national zip code pricing file identifying the zip codes included in the first CBA. Also, in that same timeframe, CMS will provide to the carriers, FIs, and A/B MACs a list of the laboratories eligible to participate in the first CBA demonstration ("winners" and passive laboratories) and a list of those laboratories not selected to participate in CBA1.

For covered demonstration laboratory services in CBA1 with dates of service between April 1, 2007, and March 31, 2010, Medicare will pay the laboratory competitive bidding demonstration fee schedule amounts for laboratory services on that schedule. For services not on the demonstration schedule, Medicare will pay based on the clinical laboratory fee schedule.

Claims submitted by non-winner laboratories for dates of service of April 1, 2007, through March 31, 2010, for Medicare beneficiaries in CBA1 will be denied using:

- Reason code 96 (non-covered charges);
- Remark code M114 (*This service was processed in accordance with rules and guidelines under the Medicare Clinical Laboratory Services Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may contact your local contractor.*); and
- Remark code N83 (No appeal rights. Administrative decision based on the provisions of a demonstration project.).

Using these same reason and remark codes, Medicare will reject any laboratory claims with a date of service between April 1, 2007, and March 31, 2010 with a modifier of "90" submitted by laboratories for demonstration-covered services provided to beneficiaries residing in the CBA, regardless of the referring laboratory's participation status.

Medicare will pay claims during the demonstration period submitted by non-demonstration laboratories for beneficiaries residing in the CBA who receive services outside of those areas (e.g., "snow birds") according to the laboratory competitive bidding demonstration.

Non-winning laboratories should know that Advance Beneficiary Notices (ABNs) and Notices of Beneficiary Exclusion from Medicare Benefits (NEMBs) are not to be used to transfer liability to beneficiaries when services under the demonstration are obtained at non-winner laboratories.

Line items for demonstration services and for non-demonstration services may be submitted on the same claim.

A subsequent CR will be issued with requirements to implement the demonstration in the second CBA (CBA2).

Medicare contractors will be prepared to begin processing claims under the laboratory competitive bidding demonstration in the first CBA on April 1, 2007. The tentative start date for the demonstration in the second CBA is April 1, 2008.

Remember that required and non-required bidders that bid and lose will be paid nothing under the Part B clinical laboratory fee schedule and will have no appeal rights for demonstration tests provided to beneficiaries residing in the CBAs, regardless of the location of the laboratory itself.

### **Implementation**

The implementation date for this instruction is April 2, 2007.

**Additional Information**

The official instructions issued to your Medicare carrier, FI, or A/B MAC regarding this change can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R50DEMO.pdf> on the CMS Website.

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

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

**MEDICARE BENEFICIARIES IN STATE OR LOCAL CUSTODY**

Effective April 1, 2003, Medicare denies claims for beneficiaries who are in the custody of a State or local government under the authority of a penal statute at the time the provider rendered the service. Using Social Security records showing health insurance claim (HIC) numbers and incarceration dates, Medicare identifies and rejects these claims.

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for directly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b), respectively.

Regulations at 42 CFR 411.4(b) state that "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

**Exclusion from Coverage**

Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute, unless it is determined that the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way, and with the same vigor, as it pursues other debts. CMS presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody.

**Claims Processing Procedures**

Providers and suppliers rendering services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of the **QJ modifier** *Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b)*. This modifier indicates the state or local government agency requesting the healthcare items or services provided to the patient has notified the provider that the prisoner or patient is

responsible to repay the cost of Medical services. Furthermore, the agency will pursue the collection of debts for furnishing such items and services with the same vigor and in the same manner as any other debt.

Carriers must deny claims identified by the Common Working File (CWF) as non-covered under 42 CFR 411.4(a) and 411.4(b) using Reason Code 96 *Non-covered charges*. The following Remark Code will also be used:

Remark Code	Message
N103	<i>Social Security records indicate that this beneficiary was in the custody of a state or local government when the service was rendered. Medicare does not cover items and services furnished to beneficiaries while they are in state or local government custody under a penal authority, unless under state or local law, the beneficiary is personally liable for the cost of his or her health care while in such custody and the State or local government pursues such debt in the same way and with the same vigor as any other debt.</i>

### Appeals

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) The conditions of 42 CFR 411.4(b) were met, or (2) The beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

## PROVIDERS HELP YOURSELVES AND HELP OTHERS

### Helping Yourself

A Medicare Beneficiary can choose to receive their Medicare benefits through the **fee-for-service** delivery system or through a **managed care plan**.

Please ask to see the beneficiary's Medicare and Prescription Drug Card on a yearly basis. This allows you to determine whether the patient has made any changes. We encourage you to discuss with your patient their enrollment status in Original Medicare or a Medicare Advantage Plan. You need to discuss the patient's possible enrollment in a Medicare Part D Drug Plan and the plan name. This allows both you and the patient to determine whether the drug plan will reimburse for any drug therapy you prescribe.

### Fee for Service System (Original Medicare)

This is the traditional Medicare plan. The beneficiary can use the services of any hospital, health care provider, or facility certified by Medicare. They can also choose any physician enrolled in the Medicare program. Medicare pays a share of the expenses and the beneficiary is responsible for certain deductibles, co-insurance payments and any non-covered charges. Patients enrolled in Original Medicare will have the traditional red, white, and blue Medicare Card.

### Managed Care Plans

Managed Care Plans are also known as prepaid or coordinated care plans, Medicare Advantage Plans or just HMOs. The patient may pay a premium in addition to the Medicare Part B premium. Each plan has its own network of hospital, skilled nursing facilities, doctors, pharmacies, and other health care professionals. The plan will reimburse for services provided

within the plan. The patient may be responsible for services if they go outside the plan. Patients enrolled in a Medicare Advantage Plan will have a card from that plan.

You can find a listing of the Managed Care Plans in your area by logging onto <http://www.medicare.gov/mphcompare/home.asp>

To help you care for your patients and easily obtain information about Part D formularies and whether a plan covers a specific drug, Epocrates, Inc. has provided Part D formulary information through their free Epocrates Rx® software that is available through their Web-based system or hand-held PDA system. You can access this on-line at the following Website: <http://www.epocrates.com>

CMS has also created a Web-based formulary finder:

<http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp>

The CMS Formulary Finder provides a list of all Part D plans in a given state and links directly to a plan's home page for a complete formulary. It also provides general information about a plan's drug utilization and appeals process.

### **Helping Others**

When you request services for your patient from other providers, please share the billing information with the performing provider. This is especially true if the practitioner will not see the patient (i.e., lab services that you have drawn in the office). When you send the patient with your order for the radiology, laboratory service, please include the billing information. Providers performing these services have difficulty in getting the correct information to submit their claims.

## **REOPENINGS AND REVISIONS OF CLAIM DETERMINATIONS AND DECISIONS – MMA**

~ CMS MLN Matters ~

### **Provider Types Affected**

Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs) and carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs) for payment.

### **Provider Action Needed**

#### **STOP – Impact to You**

This article, based on Change Request (CR) 4147, notifies you about changes to the *Medicare Claims Processing Manual*, which ensure that claims with **clerical errors (which include minor errors and omissions)** should be processed as “reopenings” and not as “appeals.”

#### **CAUTION – What You Need to Know**

All reopenings are conducted at the discretion of your Medicare contractor and are therefore not appealable. Your Part A Medicare contractor may continue to handle some errors through the claim adjustment process. The Centers for Medicare & Medicaid Services (CMS) has added “Missing data items, such as provider number or missing date of service” to the definition of clerical errors. Note that clerical errors are limited to errors in form and

content, and that omissions do not include failure to bill for certain items or services. Please note that third party payor errors DO NOT constitute clerical errors.

### **GO – What You Need to Do**

Please refer to the Additional Information section of this article and to the information in the manual attachment to CR4147 (Pub. 100-04, The Medicare Claims Processing Manual, Chapter 34, Section 10) for detailed and updated information regarding reopenings. Please note also that this information replaces what was previously found in Chapter 29, Section 90 of The Medicare Claims Processing Manual.

### **Background**

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 937 of MMA requires the establishment of a process for the correction of minor errors and omissions that do not necessitate the use of the formal appeals process.

### **Additional Information**

“A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record.” (Pub. 100-04, The Medicare Claims Processing Manual, Chapter 34, Section 10) If your reopening request is denied, you may not appeal the contractor’s refusal to reopen but you can appeal the original claim denial as long as the timeframe to request an appeal has not expired. Requesting a reopening does not toll the timeframe to request an appeal. If a reopening results in a revised determination, new appeal rights will be afforded on that revised determination. Not all reopenings result in a revised determination. Some important points to note about reopenings as a result of these changes are as follows:

- Medicare contractors will not use reopenings as an appeal when a formal appeal is not available.
- Medicare contractors may conduct a reopening to revise an initial determination or redetermination. Medicare Secondary Payer (MSP) beneficiary or provider/supplier recovery claims are not reopening actions except where the recovery claim is a MSP provider/supplier recovery claim. All other MSP beneficiary or provider /supplier recovery claims are initial determinations.
- If a claim is suspended for medical review, a request for additional documentation (ADR) may be required to make a determination. If no response is received within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on lack of documentation. In such cases, if appealed with the requested documentation, the Medicare contractor will perform a reopening instead of an appeal. The reopenings will be performed by the medical review department.
- For Part A Medicare, there are a limited number of clerical errors that can be corrected through the reopening process. Many FIs are handling the correction of errors through the submission of an adjustment or corrected claim. FIs who are handling errors through adjustments will continue to do so.
- Medicare contractors will accept reopening requests only if they are made in writing or over the telephone. Please note that the telephone reopenings process is not required for fiscal intermediaries.

- Medicare contractors will ask the providers or suppliers to fax in the proof to support changes and error correction, when necessary.
- In cases where the issue is: (1) too complex to be handled over the phone or (2) there is a need for additional medical documents, the Medicare contractor will inform the party that their request cannot be processed over the phone. In such instances, the contractor will advise the requestor to file their request in writing.
- Medicare contractors will require the following three items from the caller, prior to conducting a telephone reopening: (1) provider/physician/supplier name & ID # or NSC #; (2) Beneficiary last name & first initial; and (3) Medicare HICN. NOTE: Items must match exactly.

CR4147 is the official instruction issued to your FI/RHHI, carrier, DMERC, or DME MAC regarding changes mentioned in this article. CR 4147 may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1069CP.pdf> on the CMS Website

For additional information relating to the Medicare appeals process, you may wish to refer to Chapter 29 of the Medicare Claims Processing Manual, which is available at: <http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf>

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

## **REOPENINGS AND REVISIONS OF CLAIM DETERMINATIONS AND DECISIONS – CHANGES TO THE APPEAL PROCESS EFFECTIVE NOVEMBER 29, 2006**

**~WPS SUPPLEMENTARY ARTICLE TO CMS MLN MATTERS ARTICLE~**

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 937 of MMA requires the establishment of a process for the correction of minor errors and omissions that do not necessitate the use of the formal appeals process.

CR 4147 documents changes to the general appeals process for the correction of minor errors and omissions that do not necessitate the use of the formal appeals process.

### **Important Changes to the Appeals Process:**

#### ***Redeterminations***

For claim determination dated January 1, 2006 and after, redetermination requests must be in writing and must be submitted within 120 days following the initial determination.

#### ***Reopenings***

Providers may call the Carrier to request a claim reopening due to provider minor errors, clerical errors, and omissions.

- All reopenings are conducted at the discretion of the Medicare contractor, and the decision not to perform a reopening is not appealable. The initial claim determination can be appealed as long as the timeframe to request an appeal has not expired.
- If a reopening results in a revised determination, new appeal rights will be afforded on that revised determination
- The Centers for Medicare & Medicaid Services (CMS) has added “Missing data items, such as provider number or missing date of service” to the definition of clerical errors. Note that clerical errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services. Please note that third party payor errors DO NOT constitute clerical errors
- Medicare contractors will not use reopenings as an appeal when a formal appeal is not available.
- Medicare contractors may conduct a reopening to revise an initial determination or redetermination. Medicare Secondary Payer (MSP) beneficiary or provider/supplier recovery claims are not reopening actions except where the recovery claim is a MSP provider/supplier recovery claim. All other MSP beneficiary or provider/supplier claims are initial determinations.
- If a claim is suspended for medical review, a request for additional documentation (ADR) may be required to make a determination. If no response is received within the specified timeframes, the medical review departments will likely deny the service as not reasonable and necessary based on a lack of documentation. In such cases, if appealed with the requested documentation, the Medicare contractor will perform a reopening instead of an appeal.
- Medicare contractors will accept reopening requests only if they are made in writing or over the telephone.
- Medicare contractors will ask the providers or suppliers to fax in the proof to support changes and error correction, when necessary.
- In cases where the issue is (1) too complex to be handled over the phone or (2) there is a need for additional medical documents, the Medicare contractor will inform the party that their request cannot be processed over the phone. In such instances, the contractor will advise the requestor to file their request in writing.
- Medicare contractors will require the following three items from the caller, prior to conducting a telephone reopening: (1) provider/physician/supplier name and ID number; (2) beneficiary last name and first initial; and (3) Medicare HICN.

**NOTE: Items must match exactly.**

### **Additional Information**

A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination was correct based on the evidence of record. Not all reopenings result in a revised determination.

**Requesting a reopening does not extend the timeframe to request an appeal of the initial determination.** However, if the reopening results in a revised determination, new appeal rights apply to the revised determination.

If your claim qualifies for a reopening (due to clerical or minor error or omission) contact the appropriate staff as follows:

Wisconsin 1-877-674-5354	Illinois 1-877-867-3418
Minnesota 1-866-380-4744	Michigan 1-877-674-5416

**Program Safeguards**

**SANCTIONED AND REINSTATED PROVIDERS**

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

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

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

WPS will not issue payments for services performed, ordered, or referred by these providers after the indicated dates. All providers are excluded as of October 19, 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**

<b>Name/Specialty/Address/Date of Birth</b>
Darwin Kevin Hanna Pharmacy Technician P O Box 1101 Bolingbrook, IL 60440 08/25/1964

**Illinois Reinstated Providers**

<b>Name/Specialty/Address/Date of Birth</b>
Ramesh Babu Vemuri, M.D. Medical Physician 7606 Crystal Springs Street Crystal Lake, IL 60012 03/24/1948 <b>REINSTATED: 10/05/2006</b>

**Michigan Sanctioned Providers**

<b>Name/Specialty/Address/Date of Birth</b>	<b>Name/Specialty/Address/Date of Birth</b>
Michael Brazil, D.O. Doctor of Osteopath 1401 S. Joyce St., Apt. 612 Arlington, VA 22202 07/22/1967	David Erland Lapointe Nurse/Nurses Aide 423 Harris St. Boyne City, MI 49712 12/28/1956
William Arthur Greenberg, O.D. Optometrist 4876 Bantry Dr. West Bloomfield, MI 48322 12/08/1943	Herman Rummelt, Jr., C.P. Clinical Psychologist P O Box 1000, #12509-040 Duluth, MN 55814 11/10/1942
Margaret Anne Haeck Nurse/Nurses Aide 7815 W. St. Joseph Hwy. Lansing, MI 48917 10/26/1937	Robert Martin Stang, D.O. Doctor of Osteopath 7401 E. Walton Rd., Num 514082 Kingsley, MI 49649 07/22/1966
David Wright Halsted, C.P. Clinical Psychologist 2300 Montmorency Lane Traverse City, MI 49686 10/07/1939	

**Michigan Reinstated Providers**

<b>Name/Specialty/Address/Date of Birth</b>	<b>Name/Specialty/Address/Date of Birth</b>
Dan Robert Ketchum, R.Ph. Pharmacist 11628 Brookland Dr. Allendale, MI 49401 07/07/1979 <b>REINSTATED: 09/21/2006</b>	Mervyn W. Smith, M.D. General Practice Physician 669 Stocking NW Grand Rapids, MI 49504 04/25/1949 <b>REINSTATED: 09/20/2006</b>

**Wisconsin Sanctioned Providers**

<b>Name/Specialty/Address/Date of Birth</b>
Pamela Mildred Hartkopf Nurse/Nurses Aide 30 Brown Boulevard, Apt. 5 Rothschild, WI 54474 11/21/1958

**Wisconsin Reinstated Providers**

<b>Name/Specialty/Address/Date of Birth</b>
Ramesh Babu Vemuri, M.D. Medical Physician 7606 Crystal Springs Street Crystal Lake, IL 60012 03/24/1948 <b>REINSTATED: 10/05/2006</b>

**Provider Education****A REMINDER ABOUT MEDICARE PREVENTIVE SERVICES  
PROVIDER EDUCATION PRODUCTS****~ An Overview of Medicare Preventive Services Video ~**

The Medicare Learning Network is pleased to announce the availability of the latest provider education resource on Medicare's coverage of preventive benefits, An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals video program. This educational video program provides an overview of preventive services covered by Medicare including the newest preventive services that became effective January 2005 as a result of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This program provides information on risk factors associated with various preventable diseases and highlights the importance of prevention, detection, and early treatment of disease. The information presented in this program is useful for physicians, providers, suppliers, and other health care professionals involved in providing preventive services to Medicare beneficiaries. The program runs approximately 75 minutes in length.

(CMS has approved this educational video program for .1 International Association for Continuing Education and Training (IACET) CEU for successful completion. This program is appropriate for use by a single individual or may be shown to a large group. To order your DVD or VHS copy of the video program, go to

[http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5)

**~ Preventive Services Web-Based Training Course ~**

The updated Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based training course is now available on the Medicare Learning Network (MLN) Product Ordering Page located at

[http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=5](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5)

The course provides information about Medicare coverage for the following adult immunizations:

- Influenza;
- Pneumococcal; and
- Hepatitis B.

(CMS has approved this Web-based training course for .1 IACET CEU for successful completion. The Centers for Medicare & Medicaid Services (CMS) has been reviewed and approved as an Authorized Provider by the International Association for Continuing Education and Training (IACET), 1620 I Street, NW, Suite 615, Washington, DC 20006. The authors of these programs have no conflicts of interest to disclose. These courses were developed without the use of any commercial support.)

**~ Flu Season Resources for Health Care Professionals ~**

The Medicare Learning Network has developed the 2006 - 2007 Influenza (Flu) Season Educational Products and Resources online PDF document. This online document includes links to flu-related educational products developed by CMS for provider use and links to other resources where clinicians may find useful information and tools for the 2006 - 2007 flu season. The resource document will be updated as new flu information becomes available. The 2006 - 2007 Influenza (Flu) Season Educational Products and Resources online document can be

accessed by going to the Downloads section of the MLN Preventive Services Educational Products Web page, located at  
[http://www.cms.hhs.gov/MLNProducts/35\\_PreventiveServices.asp#TopOfPage](http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage)

## **NOVICE KNOW-HOW – SELF-SERVICE TECHNOLOGY**

Self-service technology is an approach to customer service where a version of electronic support allows customers 24 hour-day access information over the Internet. The applications available assist providers in a variety of ways. The following is a list of offerings that are beneficial to novice Medicare providers and billers.

### **CMS Secure Net Access Pilot (C-SNAP)**

Providers who have had claims processed by WPS Medicare, and who register to receive secured access to the C-SNAP site, can check online for the status of their claims. Users have access to national eligibility information. Patient eligibility data is in real-time and includes information on Medicare Part A and Part B Deductible, Medicare Secondary Payer (MSP), Health Maintenance Organization (HMO), End Stage Renal Disease, Hospice, and Home Health. Users can also communicate with our Customer Service staff within a secure environment using Secure Messaging.

Register today at <http://www.medicareinfo.com>

If you have questions with registration, need technical support, or have questions with the information C-SNAP is providing, contact us at 1-877-476-8116.

### **Computer-Based Training (CBT)**

WPS Medicare has created Computer Based Trainings (CBT) for providers to train at their own rate and time. A CBT is an interactive computer-training course. The CBT allows the person taking the training to read and turn pages at one's own pace. The user can also repeat information as necessary. Designed to present all information necessary without the assistance of another person, a CBT always has a method for the user to ask question after completion.

To view the CBTs available, go to the following Website:  
<http://www.wpsmedicare.com/provider/tutorials.shtml>

### **WPS Medicare e-News Listserv**

Are you often getting important Medicare information long after the fact? Instead of being the last to know, be the first to know by joining the WPS Medicare e-News Listserv! By joining, you can enjoy a free, easy, and secure way to stay up-to-date on the latest Medicare information, with the option to unsubscribe at any time.

Join today by going to <http://www.wpsmedicare.com/listserv>  
Follow the site's instructions for signing up and simply check your e-mail regularly to receive the latest Medicare Part B information!

### **WPS Medicare Website**

You may reach the site at <http://www.wpsmedicare.com>

Tabs on our site's banner take you quickly to separate sections for Beneficiaries, Providers, Electronic Data Interchange (EDI) Partners, and Crossover/Medigap Companies. From the Provider Home page, you can access News & Alerts, Fees, Policies & Coverage, our *Communiqué*, Provider Education, Education Schedule, Provider Enrollment, and much, much more!

Our Website contains a "Contact Us" form for sending an e-mail to WPS Medicare. To ask a question or give feedback, we strongly encourage you to visit this page at <https://corp-ws.wpsic.com/apps/commercial/unauth/DisBeneMedContactAction.do>

### **Interactive Voice Response (IVR)**

WPS Medicare now has an Interactive Voice Response (IVR) system that works on voice commands. Using the voice activated system, providers can obtain a vast amount of information without the need to speak to a Customer Service Representative (CSR). Most information obtainable from the IVR is available 24 hours a day, 7 days a week.

Some of the information you can obtain from the IVR includes, eligibility, claims status, provider summary information (number of pending claims and dollar amount and more), check information, deductible and more.

For more information on the IVR, including instructions, please visit our Website at: [http://www.wpsmedicare.com/provider/pdfs/ivr\\_brochure.pdf](http://www.wpsmedicare.com/provider/pdfs/ivr_brochure.pdf)

## **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.

### **Seminars**

#### **CMS Chiropractic Demonstration Education Project**

<b>Date/Time</b>	<b>Course Number</b>	<b>Address</b>
01/25/07 9:00 am - 12:00 pm CT	ICH10	Hickory Grove Banquet & Conference Center Comfort Inn & Suites 1133 N. 7th Street Hwy 251 & Route 38 Rochelle, IL 61068

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 (Modifier GY)	Provider Education resources
	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.

**Teleconferences**

**Chiropractic Care Demonstration Project Teleconference**

Date/Time	Course Number
12/21/06, 9:00 - 10:30 am CT	TCHD6

Please join WPS Medicare on **December 21, 2006**, for the sixth in our ongoing series of teleconferences to address the **Chiropractic Care Demonstration Project**. This call will begin at **9:00 am** central time, and will last approximately one and one half hours. There will be a brief review of the legislative background and designated sites for this project, **which is restricted to 26 counties in northern Illinois**. We will share some important information about the project data and statistics, and discuss best practices regarding billing. We are also interested in hearing any issues **you** are experiencing regarding this demonstration project, and we will allow plenty of time for questions.

There will be a special segment of the teleconference to present information pertinent to **Modifier 25**. Recent reports show instances of billing issues with this modifier, such as routine reporting by some offices, and we wish to provide clarification for its usage. It is important for us to discuss this with the provider community so as to avoid costly reimbursement for claims paid incorrectly. Education specialists assigned to work with the chiropractic community eligible to participate in this project will facilitate. Clinical staff from our Medical Review area will also be on the call to answer technical questions.

WPS designed this teleconference to proactively educate the provider community on all aspects of the Chiropractic Demonstration Project. As with previous calls in this special series, we will address coverage provisions, demonstration requirements and billing.

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

Procedures 98940-98942	Services provided "Incident to"
Modifier positions	New vs. established patients
Modifiers: <b>AT, 25, 59, KX</b>	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	Non-covered services (Modifier <b>GY</b> )

**Mental Health Teleconference**

*Encore Presentation*

<b>Date/Time</b>	<b>Course Number</b>
12/06/06, 10:00 - 11:30 am CT	TMH3

WPS Medicare is pleased to offer an encore teleconference in response to the demand for this popular topic. This program is a repeat presentation of our May and August 2006, Mental Health Teleconferences.

Medicare Part B helps pay for outpatient mental health services, such as services that are usually given outside a hospital and those that are given in the hospital's outpatient department and do not require an overnight stay. Join us for this teleconference and expand your Medicare Mental Health knowledge. Billers, coders, and people who perform mental health services for their Medicare patients will benefit from this session.

Participation in this educational program affords you an opportunity to learn about Medicare's Mental Health Provider qualifications, the types of treatment considered for Medicare payment, and the specific criteria, which determines whether Medicare does or does not cover a mental health service and under what circumstances. We will include a review of information available in Medicare's Psychiatry and Psychology Services policy.

This session will focus on the basics necessary to understand and properly bill for Medicare Part B Mental Health benefits. Join us – our on-line registration process is easy!

**National Provider Identifier: Medicare Implementation Question and Answer  
Teleconference**

<b>Date/Time</b>	<b>Course Number</b>
01/09/07, 10:00 - 11:30 am CT	TNPI5

Do you have questions on the National Provider Identifier (NPI) Medicare Implementation? Would you like to know more?

Take the National Provider Identifier: Medicare Implementation Computer-Based Training (CBT). If you have questions on the information in the CBT, attend the forth in a series of Question and Answer Teleconference on January 9, 2007, at 10 A.M. CT (11 A.M. ET). This teleconference will last for approximately one and a half hours and does not contain a

presentation; it is a question and answer period only.

The CBT is available on the WPS Medicare Website and covers the following:

- NPI Facts
- NPI Medicare Implementation: CMS' Roles
- NPI Medicare Implementation: Compliance Dates
- NPI Medicare Implementation: Provider Enrollment updates
- NPI Medicare Implementation: Claims Submission
- NPI Medicare Implementation: Claims Processing
- NPI Medicare Implementation: Remittance Advice and Payments
- NPI Enumerator information

The design of the teleconference is a question and answer period about the National Provider Identifier: Medicare Implementation CBT, National Provider Identifier: Subparts CBT, National Provider Identifier: Electronic File Interchange CBT and the National Provider Identifier: General Information CBT.

The CBT is located at <http://www.wpsmedicare.com/provider/tutorials.shtml>

#### National Provider Identifier: Subparts Question and Answer Teleconference

Date/Time	Course Number
12/05/06, 10:00 - 11:30 am CT	TNPI4

Do you have questions on the National Provider Identifier (NPI) Subparts? Would you like to know more?

Take the National Provider Identifier: Subparts Computer-Based Training (CBT). If you have questions on the information in the CBT, attend the third in a series of **Question and Answer Teleconference** on December 5, 2006.

The CBT is available on the WPS Medicare Website and covers the following:

- NPI Facts
- NPI Subparts: What are they
- NPI Subparts: How does a provider determine if they need an NPI
- NPI Subparts: Examples
- NPI Subparts: Medicare rules
- NPI Subparts: Resources for guidance
- NPI Enumerator information

The design of the teleconference is a **question and answer** period about the National Provider Identifier: Subparts CBT, National Provider Identifier: Electronic File Interchange CBT and the National Provider Identifier: General Information CBT. WPS Medicare will hold a teleconference at 10 A.M. CT (11 A.M. ET) and will last for approximately one and a half hours. **This teleconference does not contain a presentation; it is a question and answer period only.**

The CBT is located at <http://www.wpsmedicare.com/provider/tutorials.shtml>

**Webinars**
**Preventive Services for Medicare Part B Providers**

<b>Date/Time</b>	<b>Course Number</b>
12/19/06, 9:00 am - 10:30 am CT	iPRV1 <b>FULL</b>
12/19/06, 2:00 pm - 3:30 pm CT	iPRV2 <b>FULL</b>
01/11/07, 9:00 am - 10:30 am CT	iPRV3
01/11/07, 2:00 pm - 3:30 pm CT	iPRV4
02/01/07, 9:00 am - 10:30 am CT	iPRV5
02/01/07, 2:00 pm - 3:30 pm CT	iPRV6
02/22/07, 9:00 am - 10:30 am CT	iPRV7
02/22/07, 2:00 pm - 3:30 pm CT	iPRV8
03/15/07, 9:00 am - 10:30 am CT	iPRV9
03/15/07, 2:00 pm - 3:30 pm CT	iPRV10

The Centers for Medicare & Medicaid Services (CMS) recognizes the crucial role that health care professionals play in promoting, providing, and educating Medicare patients about potentially life saving preventive services and screenings. Wisconsin Physicians Service (WPS) Medicare is taking significant steps to reach out and educate the provider community about the array of preventive services and screenings covered by Medicare.

Participation in this Webinar program will give Medicare fee-for-service health care professionals a better understanding of these topics:

- Adult Immunizations
- Bone Mass Measurements
- Cancer Screenings
- Cardiovascular Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Medical Nutrition Therapy
- Glaucoma Screening
- Initial Preventive Physical Examination (IPPE)
- Smoking and Tobacco Cessation Counseling

We will also provide information about helpful preventive services educational resources on the WPS Medicare and CMS Websites.

WPS Medicare is offering this educational opportunity at 9:00 a.m. CST and at 2:00 p.m. CST on each of the dates listed above. Please choose to attend a morning or afternoon session on any date that is convenient for you. The program will last 1.5 hours, which will include a question and answer period.

You can enroll today. Registrants will receive an e-mail to confirm their registration. An additional e-mail will follow shortly before the session with instructions on how to attend the Webinar.

### Billing Medicare Part B for EPO

Date/Time	Course Number
12/12/06, 10:00 am - 11:30 am CT	iEP01
12/12/06, 1:00 pm - 2:30 pm CT	iEP02
12/13/06, 10:00 am - 11:30 am CT	iEP03
12/13/06, 1:00 pm - 2:30 pm CT	iEP04
12/14/06, 10:00 am - 11:30 am CT	iEP05
12/14/06, 1:00 pm - 2:30 pm CT	iEP06

Designed for coders, physicians, and medical office staff, this iLinc/Webinar focuses on understanding Medicare's coverage of Erythropoietin (EPO, Epoetin Alfa) outlined by Wisconsin Physicians Service (WPS) Medicare's Local Coverage Determination (LCD) INJ-023. This iLinc session includes a step-by-step review of the EPO policy, including the ICD-9 codes that support medical necessity and coding and billing guidelines for INJ-023.

Each session listed above will contain the same material and presentation. The program will last 1.5 hours, including a question and answer period. You can enroll today. You will receive an e-mail confirming receipt of your registration request. You will then receive an e-mail confirming your registration for the specific session.

Shortly before the session, you will receive an additional e-mail from the iLinc coordinator with instructions on how to attend the iLinc/Webinar.

### 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 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. PLEASE NOTE: When a confirmation e-mail 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.

**Reimbursement**

**AMBULANCE INFLATION FACTOR FOR CY 2007**

~ CMS MLN Matters ~

MLN Matters Number: MM5358  
 Related CR Release Date: November 3, 2006  
 Related CR Transmittal #: R1102CP

Related Change Request (CR) #:5358  
 Effective Date: January 1, 2007  
 Implementation Date: January 2, 2007

**Provider Types Affected**

Providers and suppliers of ambulance services billing Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for those services.

**Provider Action Needed**

This article is for your information only. It provides the Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2007. The AIF for CY 2007 is 4.3%.

**Background**

Section 1834(l)(3)(B) of the Social Security Act (SSA) provides the basis for updating the payment limits that carriers, FIs, and A/B MACs use to determine how much to pay you for the claims that you submit for ambulance services. The national fee schedule for ambulance services has been phased in over a five-year transition period beginning April 1, 2002. The Ambulance Inflation Factor (AIF) updates payments annually and is equal to the percentage increase in the consumer price index for all urban consumers (CPI-U) for the 12-month period ending with June of the previous year.

The AIF for calendar year (CY) 2007 will be 4.3%. The following table displays the AIF for CY 2007 and for the previous 4 years.

<b>Ambulance Inflation Factor by CY</b>	
2007	4.3%
2006	2.5%
2005	3.3%
2004	2.1%
2003	1.1%

Additionally, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established that the ground ambulance base rate (for services furnished during the period July 1, 2004 through December 31, 2009) will have a baseline “floor” amount.

Payment will not be less than this “floor,” which is determined by establishing nine fee schedules (one for each of the nine census divisions) and then using the same methodology that was used to establish the national fee schedule to calculate a regional conversion factor and a regional mileage payment.

Some key issues related to the AIF include:

***National or Regional Fee Schedules***

Either the national fee schedule or regional fee schedule applies for all providers and suppliers in the census division, depending on the payment amount that the regional methodology yields. The national fee schedule amount applies when the regional fee

schedule methodology results in an amount (for a given census division) that is lower than the national ground base rate. Conversely, the regional fee schedule applies when its methodology results in an amount (for the census division) that is greater than the national ground base rate. When the regional fee schedule is used, that census division's fee schedule portion of the base rate is equal to a blend of the national rate and the regional rate.

#### ***Payments Based on Blended Methodology***

During the five-year transition period, your payments are based on a blended methodology. For CY 2007, this blend will be 20% regional ground base rate and 80% national ground base rate. Before January 1, 2007, for each ambulance provider or supplier, the AIF was applied to both the fee schedule portion of the blended payment amount (both national and regional) and to the reasonable cost/charge portion. Then, these two amounts were added together to determine each provider or supplier's total payment amount. As of January 1, 2007, the total payment amount for air ambulance providers and suppliers continues to be based on 100% of the national ambulance fee schedule, while the total payment amount for ground ambulance providers and suppliers will be based on either 100% of the national ambulance fee schedule or 80% of the national ambulance fee schedule and 20% of the regional ambulance fee schedule.

#### ***Part B Coinsurance and Deductible Requirements***

Part B coinsurance and deductible requirements apply.

#### **Additional Information**

You can find more information about the ambulance inflation factor by going to CR 5358, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1102CP.pdf> on the CMS Website. There you will find updated Medicare Claims Processing Manual (100-04), Chapter 15 (Ambulance), Section 20.6.1 (Ambulance Inflation Factor (AIF)) 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>

## **HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) DESIGNATION CHANGES**

In accordance with Section 1833(m) of the Social Security Act, physicians who provide covered professional services in a geographic HPSA are entitled to a 10-percent incentive payment. The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating Health Professional Shortage Areas.

The address where the service is rendered, not the location of the physician's office or the patient's address, is the determining factor in HPSA incentives.

Only physicians furnishing services in a geographic, primary care HPSA are eligible to receive bonus payments. Eligible providers include medical doctors, including psychiatrists, doctors of osteopathy, dentists, doctors of podiatric medicine, licensed chiropractors, and optometrists. In addition, psychiatrists furnishing services in a geographic, mental health HPSA are also eligible

to receive a bonus payment. Non-physician practitioners, such as physician assistants and nurse practitioners, are not eligible for the bonus payment.

The incentive payment is issued quarterly. It is 10 percent of the amount actually paid by Medicare, not the approved amount, for services performed in a geographic HPSA. It is not necessary for the physician to be a participating provider, or for the claim to have been assigned.

For more information about the HPSA incentive, visit our Website at:  
**<http://www.wpsmedicare.com/provider/hpsa.shtml>**

The following are HPSA changes for the WPS Medicare jurisdiction.

### **Illinois**

#### Mental Health HPSA

No changes to the Mental Health HPSA for Illinois

#### Primary Care HPSA

New eligibility for dates of service on or after September 20, 2006:  
Marshall County (Entire County)

### **Michigan**

#### Mental Health HPSA

No changes to Mental Health HPSA for Michigan.

#### Primary Care HPSA

No longer eligible for dates of services December 1, 2006, and after:  
Missaukee County (entire county)

New eligibility for dates of service on or after July 5, 2006:  
Wayne County

Eastside Detroit Service Area – Census Tracts:

5031-5032	5132-5136
5051	5139-5141
5121-5124	5143
5126	5145-5157
5129	

### **Minnesota**

#### Mental Health HPSA

No changes to the Mental Health HPSA for Minnesota

#### Primary Care HPSA

No changes to the Primary Care HPSA for Minnesota

**Wisconsin**

## Mental Health HPSA

New eligibility for dates of service on or after September 14, 2006:  
Fond du Lac County – entire county

## Primary Care HPSA

New eligibility for dates of service on or after August 1, 2006:  
Door County  
Sturgeon Bay Service Area

Brussels Town	Jacksonport Town
Clay Banks Town	Nasewaupee Town
Egg Harbor Town	Sevastopol Town
Egg Harbor Village	Sturgeon Bay City
Forestville Town	Sturgeon Bay Town
Forestville Village	Union Town
Gardner Town	

New eligibility for dates of service on or after September 11, 2006:  
Milwaukee County

## North Milwaukee Service Area – Census Tracts

66 - 72	139 - 141
78 - 86	145 - 147
101 - 107	150 - 151
114 - 118	

## THE HOSPICE PAYMENT SYSTEM FACT SHEET NOW AVAILABLE

The *Hospice Payment System Fact Sheet* is now available in downloadable format on the Centers for Medicare & Medicaid Services **Medicare Learning Network (MLN)**. To access the fact sheet, visit

<http://www.cms.hhs.gov/MLNProducts/downloads/HospicePaymtSysfctshet.pdf>

Print versions of the fact sheet will be available from the **MLN** in approximately six weeks.

## IMPLEMENTATION OF REVISED FEE SCHEDULE AMOUNTS FOR NEW HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES FOR POWER MOBILITY DEVICES (PMDs)

The Centers for Medicare & Medicaid Services (CMS) has revised fee schedule amounts for codes K0857 and K0859, and these revised fees will soon be available. WPS Medicare will adjust previously processed claims for codes K0857 and K0859 with dates of service on or after November 15, 2006, if they are resubmitted as adjustments.

In addition, suppliers should be aware that they can bill separately for expandable controllers furnished with power wheelchair codes K0841-K0843, K0861-K0864, K0884-K0886, and K0891, using code E2399 for claims with dates of service from November 15, 2006, through December 31, 2006, and new code E2377 for claims with dates of service on or after January 1, 2007.

**OCTOBER 2006 DMEPOS FEE SCHEDULE UPDATE**

The Centers for Medicare & Medicaid Services (CMS) has issued revised fee schedule amounts for Durable Medical Equipment, Prosthetics and Orthotics and Supplies (DMEPOS) codes processed by WPS. Reimbursement below is effective for dates of service January 1, 2006 and after.

Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

<b>Code</b>	<b>Narrative</b>	<b>Illinois</b>	<b>Michigan</b>	<b>Minnesota</b>	<b>Wisconsin</b>
A7043	Vacuum drainage bottle and tubing for use with implanted catheter	\$ 26.88	\$ 26.88	\$ 26.88	\$ 26.88
L8689	External Recharging System for Implanted Neurostimulator, Replacement Only	\$1,391.39	\$1,391.39	\$1,391.39	\$1,391.39

**SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM  
FACT SHEET NOW AVAILABLE**

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 print format from the Centers for Medicare & Medicaid Services **Medicare Learning Network**. To place your order, visit <http://www.cms.hhs.gov/mlngeninfo>, scroll down to “Related Links Inside CMS,” and select “MLN Product Ordering Page.”



## **WPS MEDICARE PROVIDER SERVICES**

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

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

## **WPS MEDICARE e-NEWS MESSAGES**

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***<http://www.wpsmedicare.com/listserv>***

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