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**Medical Director's Corner****CONFUSING CONCEPTS:  
THE "REGS" AND MEDICAL NECESSITY**

I am frequently asked, often in exasperation, "Where do these rules come from, who's responsible for this." The short answer is the Congress of the United States. In general, the laws of Congress are interpreted and codified in the CFR (the Code of Federal Regulations). The CFR is then further interpreted and operationalized, by various government agencies, into the various Program Manuals, the contents of which are used to *finally* apply the laws (of Congress). The CFR is available on the internet.

On Oct 1, 2003 a project was undertaken by CMS to transition from the paper based Medicare Carrier Manual (MCM) to an *Internet-Only-Manual* system, fondly known as the IOM. This allows for easier access on everyone's part, and for an accurate and timely revisions (which occur daily) process. The IOM can be accessed through the CMS website (< <http://www.cms.hhs.gov/manuals> >).

CMS Pub 100 serves as a sort of "*bible*" for CMS contractors in applying the Medicare regulations to the beneficiary and provider communities. One might think after these various steps (law to CFR to IOM) taken to interpret the, often broad, laws of Congress, that the regulations would finally be crystal clear. But, alas, much is still left to the discretion of the Medicare contractors to define and apply. This is where the Carrier/contractor system for the development and application of Local Coverage Decisions (LCDs) takes over.

The LCD is the instrument used by the Carrier to establish the criteria for, and limitations of, the coverage of the various services, which are not addressed specifically in the IOM, and there are many. An LCD defines the conditions (ICD codes) under which applicable services (CPT codes) are covered, i.e., are *medically necessary*. "*Medical necessity*" has become a ubiquitous term in a vast array of Medicare documents (CMS regulations, LCDs, claim explanations, CMS educational materials, etc.) as well as throughout the commercial medical insurance realm.

I feel that "medical necessity" is an unfortunate term in that it evokes the implication that a diagnostic or therapeutic service that is provided by a physician and referred to as *not medically necessary*, is, in some way, unnecessary, superfluous or even bad; and this confuses patients and angers physicians. The words evolved directly from the Social Security Act of 1965 (1862 [a] [1] [A]) which states that "*...no payment may be made....for any expenses incurred for items or services which are **not reasonable and necessary** ...*"

What we need to remember is that Medicare is a **defined benefit program** and that *not medically necessary* simply means that the service in question is not a benefit under **this** defined benefit plan, for this diagnosis, at this time. *Diagnosis* and *time* are the key words in that neither is immutable. Any given service may become *medically necessary*, for a given diagnosis, at a future time and vice versa. Coverage decisions and the Medicare program, in general, are constantly evolving.

Dr. Rosenberg  
Carrier Medical Director

**Items of Importance****2007 FEE INFORMATION NOW AVAILABLE!**

~December 2006~

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**

~December 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 – December 2006~

MLN Matters Number: MM5345  
Related CR Release Date: October 27, 2006  
Related CR Transmittal #: R41G1

Related Change Request (CR) #: 5345  
Effective Date: January 1, 2007  
Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5345.pdf>

**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.

## BE READY IN CASE OF EMERGENCY - SIGN UP FOR WPS E-NEWS TODAY!

~ November 2006 ~

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

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

## CHANGES TO PROVIDER CUSTOMER SERVICE PROGRAM

~ October 2006 ~

The CMS Internet Only Manual (IOM), Pub 100-09, *Medicare Contract Beneficiary and Provider Communications*; Chapters 3 and 6 are being revised to reflect:

- Changes in contractor requirements for handling provider inquiries included in the Fiscal Year (FY) 2006 Budget & Performance Requirements (BPRs) and FY 2007 BPRs,
- Updates to the provider inquiry standardization categories and report submission,
- Contractor assistance to CMS in implementing provider satisfaction surveys and miscellaneous clarifications and corrections.

Additionally, Chapter 6 is being revised to include revisions to provider outreach and education requirements, including FY 06 and 07 BPR changes and provider education resulting from medical review referrals. Also, Chapter 6 is being reorganized into a more logical arrangement.

Effective 10/1/2006, Chapter 4 is being deleted in its entirety. Contractors shall adhere to the requirements in IOM 100-9, Chapter 6, for provider outreach and education requirements (sections 20, 40.1, 50.2, 50.3 and 60.1.) To view this Change Request in its entirety, go to

[http://www.wpsmedicare.com/provider/pdfs/chngs\\_cs.pdf](http://www.wpsmedicare.com/provider/pdfs/chngs_cs.pdf)

## COMPETITIVE ACQUISITION PROGRAM (CAP) FOR PART B DRUG: APPEALS – MMA

~CMS MLN Matters – December 2006~

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5207.pdf>

### 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.

**DO YOU HAVE YOUR NPI?**

~December 2006~

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.

**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>

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

~December 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 PARTICIPATION INFORMATION AVAILABLE VIA CD-ROM FOR 2007 ~ October 2006 ~**

The Centers for Medicare & Medicaid Services (CMS) is requesting Medicare Part B carriers distribute the Calendar Year (CY) 2007 Medicare Participation (PAR) Agreement and other materials to providers via CD-ROM.

In addition to enrollment information, the CD-ROM will feature supplementary educational tools, focusing on electronic resources. On the CD-ROM, you will find:

- Electronic Data Interchange (EDI) resources
- National Provider Identifier (NPI) information
- Enrollment form tutorials
- The latest HIPAA data
- Downloadable forms
- Helpful hints for using the CD-ROM
- And much more!

The fee schedule will not be on the CD-ROM this year. Instead, it will be conveniently located on the WPS Medicare Website.

Keep reading the *Communiqué* and WPS Medicare e-News for more updates on the CD-ROM and the fee schedule.

### **MESSAGE TO MEDICARE PROVIDERS, BILLERS, CLEARINGHOUSE, AND VENDORS ~ November 2006 ~**

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

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

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

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

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

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

### **NOVICE KNOW HOW - HOW CAN YOU RECOGNIZE A SERVICE THAT IS ALWAYS "BUNDLED"?** ~ November 2006 ~

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

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

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

### **NOVICE KNOW-HOW – MEDICAL REVIEW-RELATED DENIALS: NEW PATIENT VERSUS ESTABLISHED PATIENT** ~ October 2006 ~

"New patient" is defined as a patient who has not received any professional services from the physician within the previous three years. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If no face-to-face encounter has previously occurred between the physician and the patient, then the patient may be coded as a new patient the first time a face-to-face encounter does occur. **(National Coverage Provision, General Coverage for Physician Services, PHYS-001, Section E.) You can view this policy at the following Website:**  
<http://wpsmedicare.com/policies/wisconsin/phys001.pdf>

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.

No distinction is made between new and established patients in the emergency department. Evaluation and Management services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department. **(CPT 2006 (Current Procedural Terminology), American Medical Association Publication, pg.1.)**

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

~December 2006~

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)

## **PROVIDERS RESPONSIBLE FOR KNOWING GUIDELINES**

~ October 2006 ~

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

According to the *Medicare Claims Processing Manual*, Chapter 30, Section 40.1:

“In accordance with regulations at **42 CFR 411.406**, evidence that the provider, practitioner, or other supplier did, in fact, know or should have known that Medicare would not pay for a service or item includes:

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

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

The provider is responsible to know the rules and regulations that are made available through publications from the Medicare carriers and fiscal intermediaries, which include, but are not limited to, the WPS Medicare newsletter (the *Communiqué*), information published on the WPS Medicare Website, WPS Medicare e-News (Listserv), The Internet-Only Manual (IOM), the CMS Website, and mailings sent periodically to all or individual providers. The WPS Medicare monthly newsletter, the *Communiqué*, is available electronically through the WPS Medicare Website at

[http://www.wpsmedicare.com/provider/pub\\_home.shtml](http://www.wpsmedicare.com/provider/pub_home.shtml)

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

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

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

~CMS MLN Matters – December 2007~

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5289.pdf>**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.

**THE INTERACTIVE VOICE RESPONSE (IVR) ENHANCEMENTS HAVE ARRIVED!**

~October 2006~

**Background**

Last year, WPS Medicare rolled out a new speech IVR allowing providers to obtain eligibility and check status in addition to claim status. The innovative IVR offers a wealth of information that previously was not available. Through provider and customer service feedback, WPS identified areas where we could update and improve the IVR to accommodate some frequently asked questions from providers. Based upon your feedback, these enhancements will make it easy to obtain provider summary details. The IVR will also provide for clearer detail regarding primary or secondary status under eligibility. Additionally, claim status will now indicate if WPS sent the claim on to a secondary insurer

**Provider Summary**

As of October 2nd, a new menu option will appear called "provider summary." The claim status function will no longer play claim counts. Earnings will no longer be available in the checks function. We have combined both of these to create a provider summary function, which, in a single request, will now provide all previously available information plus more!

After selecting "provider summary" and entering your provider number, the IVR will speak back the following information:

- Number of pending claims
- Dollar amount of pending claims
- Total number of approved to pay claims
- Total dollar amount of approved to pay claims
- Number of approved to pay claims less than 14 days old
- Dollar amount of approved to pay claims less than 14 days old
- Last check issued for provider number including check date, check amount, and check number

The IVR will then prompt for further details, to repeat the above information, or to enter a different provider number. If you would like further details, say "details" and the IVR will play the following:

- Number of month to date claims
- Dollar amount of month to date claims
- Number of year to date claims
- Dollar amount of year to date claims

### **Eligibility**

We have also updated the eligibility information you will receive. The IVR will now indicate whether Medicare is primary or secondary on every eligibility request. Currently, the IVR remains silent when Medicare is primary. Now the IVR will actually state Medicare is primary or secondary, making the eligibility data more straightforward to the caller.

### **Claim Status**

Finally, the IVR will now indicate when a claim was forwarded to the supplemental insurer (crossed over). At this time, the IVR is unable to provide the name of the insurance company the claim crossed to.

### **Moving Forward**

We believe these new improvements will make the IVR a better self-service tool for providers. WPS will continue to identify provider needs within the IVR and initiate improvements to meet those needs in the future.

## **WPS MEDICARE'S MESSAGE ON PROVIDER ENROLLMENT APPLICATIONS**

~October 2006~

### **National Provider Identifier**

The National Provider Identifier (NPI) is a required data element on the CMS 855 Medicare enrollment forms.

- For individual providers, a copy of the NPI notification received from the NPI Enumerator or Electronic File Interchange Organization (EFIO) via E-mail or letter must be included with each application submitted for the provider's initial enrollment, reassignment of benefits, and changes. (A screen print from the National Plan and Provider Enrollment System (NPPES) Website, "Welcome to the National Provider System," can also be submitted as documentation of the provider's NPI.)
- Groups and organizations must submit a copy of the group or organization's NPI notification, received from the NPI Enumerator or Electronic File Interchange Organization (EFIO) via E-mail or letter, with the group organization's initial CMS-855B enrollment application, as well as with CMS-855B enrollment forms submitted to report changes of information. (A screen print from the NPPES Website, "Welcome to the National Provider System," can also be submitted as documentation of the provider's NPI.)
- Individual providers who are reassigning their benefits to a group or organization are required to include the group or organization's NPI on their CMS 855I and/or CMS 855R applications. A copy of the group or organization's NPI notification is not required.

**Note:** Individuals, groups, and organizations are **NOT** required to report their NPIs to WPS Medicare when no change is being made to their enrollment information.

### **Reasons for Return and Development of Applications**

The Centers for Medicare & Medicaid Services (CMS) require Medicare contractors to return Medicare enrollment applications for the following reasons and to take no further action on them:

- 1) The application is not signed.
- 2) The signature on the application is stamped or copied.
- 3) The signature on the application is not dated.
- 4) The application was signed by someone other than the practitioner applying for enrollment.
- 5) We did not receive all the required forms needed to process a reassignment package within 15 calendar days of receipt.
- 6) The application was submitted to the wrong contactor.
- 7) The application was completed in pencil. (It must be either typed or completed in ink.)
- 8) The wrong CMS 855 application was submitted.
- 9) The application does not appear to have been downloaded from CMS' Website.
- 10) The application was not mailed.
- 11) The Authorized Official is not on file. Please complete sections 1, 2B1, 3, 6, 13, and 15 of the CMS 855B to establish the Authorized Official with Medicare.

Enrollment applications that cannot be processed for other reasons are developed for the needed information or documentation. WPS Medicare is currently returning or developing on 40-50% of all submitted provider enrollment applications, causing delays in processing and additional work for both the provider and WPS Medicare. For a listing of the most common reasons, WPS Medicare is currently returning or developing applications please visit our Website at:

[http://www.wpsmedicare.com/provider/pdfs/pe\\_applications.pdf](http://www.wpsmedicare.com/provider/pdfs/pe_applications.pdf)

### **YOU CAN MAKE A CHANGE**

~ October 2006 ~

WPS Medicare is currently participating in a Website Satisfaction Survey initiated by the Centers for Medicare & Medicaid Services (CMS). Foresee Results, an on-line customer satisfaction management company, is conducting this survey to determine potential improvement areas for the WPS Medicare Website.

WPS Medicare thoroughly reviews all of the feedback received from the Website satisfaction survey in an effort to determine possible Website improvements. Recently, the left-hand navigation bar was altered based on feedback received from the Foresee Results Survey. The changes included altering headers to be more descriptive and inserting additional options to provide quick links to some of our most popular pages. We are hopeful that this recent change has increased your satisfaction when visiting the WPS Medicare Website.

If you have never completed a Website Satisfaction Survey, or if you have not recently completed a survey, please provide us with your opinion by visiting the WPS Medicare Website at <http://www.wpsmedicare.com>.

The survey randomly presents after a few clicks. If you are not interested in completing the survey, simply select the close box, marked with an "X" in the upper right hand corner.

The survey only takes a few moments of your time and provides valuable feedback to WPS staff. With your input, we plan to make the WPS Medicare Website exceed your expectations.

**Claim Submission**

**2007 ANNUAL UPDATE OF HCPCS CODES FOR SKILLED NURSING FACILITY (SNF)  
CONSOLIDATED BILLING (CB)  
~CMS MLN Matters – November 2006~**

MLN Matters Number: MM5283

Related CR Release Date: September 29, 2006

Related CR Transmittal #: R1068CP

Related Change Request (CR) #: 5283

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5283.pdf>

**Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare carriers, durable medical equipment regional carriers (DMERCs) or DME Medicare Administrative Contractors (DME MACs), and fiscal intermediaries (FIs) for services provided to Medicare beneficiaries in SNFs

**Provider Action Needed**

**STOP – Impact to You**

This article is based on Change Request (CR) 5283, which provides the 2007 annual update of HCPCS Codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

**CAUTION – What You Need to Know**

CR5283 provides updated to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

**ADDITIONAL REQUIREMENTS NECESSARY TO IMPLEMENT THE REVISED HEALTH  
INSURANCE CLAIM FORM CMS-1500  
~Revised CMS MLN Matters – December 2006~**

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf>

**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).

**ANNUAL UPDATE OF HCPCS CODES USED FOR HOME HEALTH CONSOLIDATED BILLING ENFORCEMENT**  
~ CMS MLN Matters – December 2006 ~

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5356.pdf>

**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.

**CARRIER JURISDICTION FOR AMBULANCE SUPPLIER CLAIMS**

~ CMS MLN Matters – December 2006 ~

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5203.pdf>

**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.

**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 – December 2006~

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5347.pdf>

**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.

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

~CMS MLN Matters – November 2006~

MLN Matters Number: MM 5308

Related CR Release Date: September 22, 2006

Related CR Transmittal #: R1063CP

Related Change Request (CR) #: CR 5308

Effective Date: October 1, 2006

Implementation Date: October 23, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5308.pdf>

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

**MODIFICATION OF NATIONAL PROVIDER IDENTIFIER (NPI) EDITING REQUIREMENTS IN CR4023 AND AN ATTACHMENT TO CR4320**

~CMS MLN Matters – October 2006~

MLN Matters Number: MM5229

Related CR Release Date: August 18, 2006

Related CR Transmittal #: R2340TN

Related Change Request (CR) #: 5229

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5229.pdf>

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

This article is based on CR5229, which corrects certain business requirements from CR4023 that relate to edits for National Provider Identifiers (NPIs) and provider legacy identifiers when reported on claims, particularly for **referring/ordering or other secondary providers**, effective October 1, 2006 and later. Additionally, CR5229 revises Attachment 1 to CR4320.

**CAUTION – What You Need to Know**

Some of those business requirements erroneously assumed that any provider for whom information is reported in a claim, including a referring/ordering or other secondary provider, would need to be enrolled in Medicare and therefore listed in the Medicare Provider Identifier Crosswalk. This is not always the case. CR5229 modifies those business requirements.

**GO – What You Need to Do**

These modifications will enable correct processing of affected claims in October 2006 and later, and will avoid the unnecessary rejection of many claims that involve a referring/ordering or other secondary provider. Please refer to the Background section of this article and to CR5229 for additional important information regarding these modifications.

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

~CMS MLN Matters – December 2006~

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4276.pdf>

**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.

## QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI) EDITS, VERSION 12.3, EFFECTIVE OCTOBER 1, 2006

~CMS MLN Matters – November 2006~

MLN Matters Number: MM5258

Related CR Release Date: September 15, 2006

Related CR Transmittal #: R1056CP

Related Change Request (CR) #: 5258

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5258.pdf>

**Provider Types Affected**

Physicians billing Medicare carriers

**Background**

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

**Key Points**

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice. The latest package of CCI edits, Version 12.3, is effective on October 1, 2006. This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables:

- Column 1/Column 2 Correct Coding Edits table; and
- MEC Edits table.

**REVISED CMS-1500 CLAIM FORM**  
~ Revised CMS MLN Matters – October 2006 ~

MLN Matters Number: MM4293  
Related CR Release Date: March 31, 2006  
Related CR Transmittal #: R899CP

Revised Related Change Request (CR) #: 4293  
Effective Date: See shaded note box below.  
Implementation Date: October 2, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf>**

**Note:** This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf> for more current information on the effective dates for using Form CMS 1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR5060, which is available at <http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf>

**Provider Types Affected**

Physicians, providers, and suppliers who are excluded from the mandatory electronic claims submission requirements and submit claims to Medicare carriers using the CMS-1500 paper claim form

**Important Points to Remember**

CR4293 describes the claim form **CMS-1500 (12-90)** that is being revised to accommodate the reporting of the National Provider Identifier (NPI) and will then be named **CMS-1500 (08-05)**. The following timeline outlines the schedule for using the revised CMS-1500 claim form:

- October 1, 2006: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised CMS-1500 (08/05) claim form.
- October 1, 2006 – January 31, 2007: Providers can use either the current CMS-1500 (12/90) version or the revised CMS-1500 (08/05) version of the claim form.
- February 1, 2007: The current CMS-1500 (12/90) version of the claim form is discontinued; only the revised CMS-1500 (08/05) form is to be used. All rebilling of claims should use the revised CMS-1500 (08/05) form from this date forward, even though earlier submissions may have been on the current CMS-1500 (12/90) claim form.

## SCREENING, FECAL-OCCULT BLOOD TESTS (FOBT), 1-3 SIMULTANEOUS DETERMINATIONS

~CMS MLN Matters – November 2006~

MLN Matters Number: MM5292

Related CR Release Date: September 22, 2006

Related CR Transmittal #: R1062CP

Related Change Request (CR) #: 5292

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5292.pdf>

### Provider Types Affected

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

### Provider Action Needed

#### STOP – Impact to You

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

#### CAUTION – What You Need to Know

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

#### GO – What You Need to Do

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

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

~CMS MLN Matters – November 2006~

MLN Matters Number: MM4316

Related CR Release Date: September 1, 2006

Related CR Transmittal #: R1049CP

Related Change Request (CR) #: 4316

Effective Date: July 1, 2006

Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4316.pdf>

### Provider Types Affected

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

### Key Points

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

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

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

#### Claims Paid at Nonfacility Rate

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

**New Code Does Not Supersede Medicare Policy**

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

Carriers will continue to abide by current policy that does not allow for payment for Medicare services in a penal institution in most cases. This policy is supplied in the Medicare Claims Processing Manual, Chapter 1, Section 10.4, located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage> on the CMS site.

**Comprehensive Error Rate Testing (CERT)****CERT ERROR FOCUS – INPATIENT AND OUTPATIENT INITIAL CONSULTATIONS - CPT  
99241-99255  
~ October 2006 ~**

In previous *Communiqué* articles, we have focused on Comprehensive Error Rate (CERT) errors received by specific provider specialties. In our continuing effort to increase the awareness of all Medicare providers regarding documentation issues found as a result of CERT reviews, we have begun to focus on specific services that contribute to our CERT error rate. Our focus this month is on incorrect coding issues related to initial consultation services, Current Procedural Terminology (CPT) procedure codes 99241-99255.

Analysis of current CERT error findings (claims submitted 04/01/05-03/31/06) show that these services accounted for nearly 20% of our errors assessed for incorrect coding. The majority of these cases involved services that were billed at a higher level than what was documented in the medical records. Below are examples of actual CERT review comments regarding these claims.

- Submitted documentation supports down code of 99254 to 99252 with detailed history, Expanded Problem Focused (EPF) exam, and Moderate complexity medical decision-making (MDM). The consulting MD was unable to communicate verbally due to "confused" beneficiary due to dementia; and was unable to examine the beneficiary due to "severe psychomotor agitation"
- Billed CPT 99254 requires 3/3 components of Comprehensive history and exam, and Moderate MDM with typically spending 80 minutes at patient bedside or on hospital unit with the presenting problem of moderate to high severity. Documentation submitted supports down-code to 99253 with detailed history and exam, and Moderate MDM with no time element documented. Cardiology consultant states, "Stable cardiac condition."
- Documentation supports down code from 99245 which requires 3 of 3, comprehensive history, comprehensive exam, and high complexity to 99243 by meeting 3 of 3 components with comprehensive history, detailed exam, and moderate complexity MDM.

Providers must be aware of documentation requirements when billing consultation services to Medicare Part B. The patient's medical records should be legible, contain the relevant history, physical findings conforming to the criteria stated in the "Indications and Limitation of Coverage" section of the Consultation NCP, and must be made available to the Carrier or CERT contractor upon request.

In addition, the consultant's written report should be legible, and should include the key components for the category, level, and location of service for the consultation performed. The Evaluation and Management (E/M) Documentation Guideline requirements for the consultation performed also must be met. Either the 1995 or the 1997 E/M Documentation Guidelines may be utilized, but the elements from each set of guidelines may not be mixed. The report should identify the referring physician/non-physician practitioner (NPP) and the reason for the consultation.

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

For more information regarding the CERT program and other issues related to CERT review findings, please visit our Website at <http://www.wpsmedicare.com/provider/cert.shtml>. If you have questions related to the CERT process or a specific CERT sampled claim, you may 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 (HICN).

For more information regarding Medicare coverage of consultation services, please refer to National Coverage Provision (NCP) - PHYS-006 on our WPS Medicare Website at [http://www.wpsmedicare.com/policies/pol\\_home.shtml](http://www.wpsmedicare.com/policies/pol_home.shtml)

**CERT ERROR FOCUS – PHYSICAL MEDICINE AND REHABILITATION PROCEDURES  
AND MODALITIES - CPT 97001-97546  
~ November 2006 ~**

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

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

To review examples of actual CERT review comments received for these claims please visit our Website at: [http://www.wpsmedicare.com/provider/cert\\_97001-97546.shtml](http://www.wpsmedicare.com/provider/cert_97001-97546.shtml)

**CERT ERROR FOCUS – PROVIDER REPORTED BILLING ERRORS  
~ December 2006 ~**

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 e-mail us at [medicareadmin@wpsic.com](mailto:medicareadmin@wpsic.com). Be sure to include "CERT Question" in the subject line. Please also include your full name, telephone number, and Provider Identification Number (if available) in the body of the e-mail. This will assure a prompt and accurate reply to your question. When e-mailing WPS Medicare, please do not include sensitive information. If your question pertains to a specific claim, include the Internal Control Number, not your patient's Medicare Health Insurance Claim Number.

**Coverage**

**2007 ICD-9-CM COVERAGE - POLICY REVISIONS**

~ October 2006 ~

Effective for claims submitted with dates of service on or after 10/01/2006, WPS will cover the new 2007 ICD-9-CM codes for the policies and procedures listed below. The listed changes to these effected policies will be posted to the Website after 10/01/2006. This is a correction to what was published in the September 2006 *Communiqué*.

Policy Name/Number	Policy Procedure Code	2007 ICD-9-CM Changes
Flow Cytometry PATH-016	88184-88189	238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 288.09  Delete: 238.7, 288.0, 288.5, 288.6
Cytogenetic Studies PATH-027	88230, 88245, 88248, 88249, 88283, 88237, 88239, 88262, 88271- 88275, 88283	284.01, 284.09, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 284.01, 284.09, 288.09, 288.59, 288.69  Delete: 238.7, 284.0, 288.0
Non- Invasive Vascular Testing CV-033	93965, 93970, 93971, 93875-93882	289.83, 377.43
Erythropoiesis Stimulating Proteins Epoetin alfa (EPO), Darbepoetin alfa (DPA) INJ-023	J0881 and J0885	238.72, 238.73, 238.74 , 238.75, 995.20

**CHANGES TO THE LABORATORY NATIONAL COVERAGE DETERMINATION (NCD) EDIT SOFTWARE FOR JANUARY 2007**

~CMS MLN Matters – December 2006~

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

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5384.pdf>**

**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.

**CHANGES TO THE LABORATORY NATIONAL COVERAGE DETERMINATION (NCD) EDIT SOFTWARE FOR OCTOBER 2006**  
~CMS MLN Matters – October 2006~

MLN Matters Number: MM5293

Related CR Release Date: September 7, 2006

Related CR Transmittal #: R1050CP

Related Change Request (CR) #: 5293

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5293.pdf>

**Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare carriers and fiscal intermediaries (FIs) for clinical diagnostic laboratory services provided for Medicare beneficiaries

**Impact on Providers**

This article is based on Change Request (CR) 5293, which announces the changes that will be included in the October 2006 release of the edit module for clinical diagnostic laboratory services.

**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 23 national coverage determinations can be found within the full article.*

**CLARIFICATION ON BILLING REQUIREMENTS FOR PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY (PTA) CONCURRENT WITH THE PLACEMENT OF AN FDA-APPROVED CAROTID STENT**

~Revised CMS MLN Matters – October 2006~

MLN Matters Number: MM5022

Related CR Release Date: August 25, 2006

Related CR Transmittal #: R1042CP and R53NCD

Revised Related Change Request (CR) #: 5022

Effective Date: March 17, 2005

Implementation Date: October 2, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5022.pdf>

**Note:** This article was revised on August 28, 2006, to reflect changes made to CR5022, which CMS reissued on August 25. The transmittal number, CR release date, and web address for accessing CR5022 were changed. All other information remains the same.

**Provider Types Affected**

Providers, physicians, and suppliers that bill Medicare contractors (fiscal intermediaries (FIs) and carriers) for their services

**Key Points**

- This article is based on CR5022, which contains instructions (summarized below) that must be implemented to correctly process carotid stenting claims.
- The Centers for Medicare & Medicaid Services (CMS) has additionally updated the carotid artery stenting (CAS) facilities “approved facilities” web site link in Publication 100-03, *The National Coverage Determinations Manual*. The list is now available at <http://www.cms.hhs.gov/MedicareApprovedFacilitie/CASF/list.asp> on the CMS Website.

- Claims that are being billed for Category B IDE studies and post-approval studies, per CR1660 (effective July 1, 2001) and CR3489 (effective October 12, 2004), respectively, are not subject to the same billing requirements as indicated in CR3811 (Effective March 17, 2005). The links to CR1660 and the Medicare Learning Network (MLN) articles relating to CR3489 and CR3811 can be found in the *Related Links* section below.
- CMS created a new section in the Medicare Claims Processing Manual specific to carotid stents. Please refer to this new section in the manual attachment to CR5022, (Publication 100-04, Chapter 32, Sections 160.1-160.3) for more information about PTA for implanting the carotid stent. (This includes information on CR660, CR 3489 and CR3811.)

## **CODING FOR STRIPPING KERATOPLASTY PROCEDURES**

~December 2006~

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 IOM, 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 – December 2006~

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

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5235.pdf>**

**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.

**INFORMATION ON WEBSITE**

WPS publishes LMRPs, LCDs, NCPs, and NCDs, and retired LMRPs/LCDs 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 LMRP by writing to our Freedom of Information (FOI) Unit.

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

**Policy Revisions**

<b>Policy</b>	<b>Title</b>	<b>Policy Type</b>	<b>Published</b>
ALRG-001	<i>Allergy Testing and Allergy Immunotherapy</i>	LCD	November 2006
CV-006	<i>Cardiac Catheterization and Coronary Angiography (CV-006) Billing and Coding Guidelines</i>	LCD	December 2006
CV-016	<i>Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring)</i>	LCD	December 2006
CV-026	<i>Transthoracic Echocardiography</i>	LCD	October 2006

Policy	Title	Policy Type	Published
CV-028	<i>Non-Coronary Vascular Stents/Endovascular Graft Placement</i>	LCD	October 2006
CV-033	<i>Noninvasive Vascular Testing (N.I.V.T.) [Revision]</i>	LCD	October 2006
ENT-012	<i>Surgical Treatment of Obstructive Sleep Apnea (OSA)</i>	LCD	November 2006
GI-008	<i>Colorectal Cancer Screening Benefit</i>	NCD	November 2006
GSURG-032	<i>Cosmetic and Reconstructive Surgery</i>	LCD	November 2006
GSURG-033	<i>Cryosurgery for Liver Tumors</i>	LCD	November 2006
GSURG-035	<i>*Pancreas Transplants with Kidney Transplant and Pancreas Transplant Alone</i>	NCD	October 2006
HONC-010	<i>Antineoplastics and their Adjuncts</i>	LCD	October 2006
HONC-010	<i>Antineoplastics and their Adjuncts</i>	LCD	November 2006
HONC-010	<i>Antineoplastics and their Adjuncts</i>	LCD	December 2006
<i>Injection List</i>		LCD	November 2006
INJ-019	<i>Human Granulocyte/Macrophage Colony Stimulating Factors</i>	LCD	October 2006
INJ-019	<i>Human Granulocyte/Macrophage Colony Stimulating Factors</i>	LCD	December 2006
INJ-023, PATH-016, PATH-027	<i>2007 ICD-9-CM Coverage</i>	LCD	October 2006
INJ-023	<i>Erythropoiesis Stimulating Proteins Epoetin alfa (EPO), Darbepoetin alfa (DPA) Billing and Coding Guidelines</i>	LCD	December 2006
OPHTH-025	<i>Corneal Pachymetry</i>	LCD	November 2006
PHYS-006	<i>Consultations</i>	NCP	November 2006
PHYS-064	<i>Care Plan Oversight (CPO)</i>	NCP	October 2006
PHYS-073	<i>Diabetic Peripheral Neuropathy with Loss of Protective Sensation (LOPS)</i>	NCD	December 2006
PHYSMED-001	<i>Outpatient Physical Therapy, Occupational Therapy and Speech- Language Pathology</i>	NCP	December 2006
PHYSMED-009	<i>Physical Medicine Rehabilitation Procedures and Modalities</i>	LCD	December 2006

Policy	Title	Policy Type	Published
PSYCH-014	<i>Psychiatry and Psychology Services</i>	LCD	November 2006
PULM-003	<i>Sleep-Disorder Clinics and Diagnostic Tests</i>	NCP	December 2006
RAD-004	<i>Coding and Billing Guidelines for Radiologic Examination of the Chest, Including Portable</i>	LCD	October 2006
RAD-014	<i>Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT)</i>	LCD	December 2006
RAD-034	<i>Computed Coronary Tomography Angiography</i>	LCD	November 2006
RAD-035	<i>CT Colonography (Virtual Colonoscopy [VC])</i>	LCD	October 2006

### INTERSPINOUS PROCESS DECOMPRESSION SYSTEM

~ October 2006 ~

WPS Medicare Part B will cover the implantation of an Interspinous Process Decompression System in accordance to the Food and Drug Administration (FDA) approved indications. This system will be covered for the treatment of patients aged 50 or older suffering from neurogenic intermittent claudication secondary to a confirmed diagnosis of lumbar stenosis with x-ray, MRI and/or CT evidence of thickened ligamentum flavum, narrowed lateral recess and/or central canal narrowing. This system is indicated for those patients with moderately impaired physical function who experience relief in flexion from their symptoms of leg/buttock/groin pain, with or without back pain, and have undergone a regimen of at least 6 months of nonoperative treatment. This device may be implanted at one or two lumbar levels in patients in whom operative treatment is indicated at no more than two levels. The medical record must document the above requirements. Only FDA-approved systems (e.g. X STOP) will be covered.

Claims for the implantation of these systems should use the CPT code 22899, *Unlisted procedure, spine*, and place the name of the FDA-approved decompression system in item 19 of the CMS-1500 claim form or its electronic equivalent. The claim must also have both the ICD-9 diagnosis code for spinal stenosis 724.02, *Spinal stenosis, lumbar region*, and the ICD-9 code for neurogenic intermittent claudication, 349.9, *Unspecified disorders of the nervous system*. The effective date for this coverage is August 1, 2006.

Currently, this system is only approved for use on inpatients. However, approval for its use on outpatients is pending. In the event of approval for outpatient use, the device should be billed with the HCPCS code L8699, *Prosthetic implant, not otherwise specified*.

### PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTS

~CMS MLN Matters – November 2006~

**MLN Matters Number:** MM5204

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

**Related CR Transmittal #:** R55BP

**Related Change Request (CR) #:** 5204

**Effective Date:** January 1, 2006

**Implementation Date:** December 28, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5204.pdf>

#### Provider Types Affected

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

**Provider Action Needed**

**STOP – Impact to You**

Effective January 1, 2006, carriers and FIs will pay for diagnostic psychological and neuropsychological tests that are within the CPT code range of 96101 through 96120.

**CAUTION – What You Need to Know**

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

**UPDATE CONCERNING PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTS  
(PSYCH-014)  
~ November 2006 ~**

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

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

The updated policy is on WPS' website <http://www.wpsmedicare.com/policies/wisconsin/psych014.pdf>

**Electronic Data Interchange (EDI)**

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

~CMS Manual System - November 2006~

Read this entire article at [http://www.wpsmedicare.com/provider/pdfs/edi\\_media.pdf](http://www.wpsmedicare.com/provider/pdfs/edi_media.pdf)

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

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

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

**CORRECTION OF BUSINESS REQUIREMENT 4320.19 AS CONTAINED IN CR4320  
REGARDING NATIONAL PROVIDER IDENTIFIER INFORMATION**

~CMS MLN Matters – October 2006~

MLN Matters Number: MM5217  
Related CR Release Date: August 18, 2006  
Related CR Transmittal #: R235OTN

Related Change Request (CR) #: 5217  
Effective Date: January 1, 2006  
Implementation Date: November 20, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5217.pdf>

**Provider Types Affected**

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

**Impact on Providers**

This article is based on change request CR5217, which instructs your Medicare carrier/DMERC/DME MAC, or FI/RHHI to provide specific National Provider Identifiers (NPIs) for those providers identified in electronic claims, such as a billing, pay-to, rendering or other provider, that have already obtained NPIs.

Prior to May 23, 2007, providers should report the Medicare legacy identifiers of those providers enrolled to submit claims to Medicare, as well as their NPI.

**Note:** Pending Medicare implementation of the UB-04 and the revised CMS-1500, providers are not to report NPIs on the current paper claim forms.

If not already available, the following information will be posted on your local Medicare contractor's Website, or included in provider newsletters from your local Medicare contractor:

- Adjustments to edits to be applied when an NPI is included in an electronic data interchange (EDI) transaction; and
- Actions that can be taken by claim and 276 submitters to avoid rejection of their transactions as result of these edits, and information about how to correct and resubmit a transaction if the transactions are rejected as result of these edits.

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

~December 2006~

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.

**RETURNING PAPER CLAIMS RECEIVED FROM CLEARINGHOUSES**

~CMS MLN Matters – December 2006~

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5341.pdf>

**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.

**STAGE 2 REQUIREMENTS FOR USE AND EDITING OF NATIONAL PROVIDER IDENTIFIER (NPI) NUMBERS RECEIVED IN ELECTRONIC DATA INTERCHANGE TRANSACTIONS, VIA DIRECT DATA ENTRY SCREENS OR PAPER CLAIM FORMS**

~ Revised CMS MLN Matters – October 2006 ~

MLN Matters Number: MM4023

Related CR Release Date: November 3, 2005

Related CR Transmittal #: 190

Revised Related Change Request (CR) #: 4023

Effective Date: April 1, 2006

Implementation Date: April 3, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf>

**Note:** This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf> for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR5060, which is available at <http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf>.

**Provider Types Affected**

Physicians, providers, and suppliers who submit claims for services to Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), to include regional home health intermediaries (RHHIs)

**Provider Action Needed**

The requirements for Stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are not based on the date of receipt of a transaction, unless otherwise stated in a business requirement.

Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the NPI in Stage 2 is October 1, 2006.

**Background**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414)).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005.

**General Information****COMMUNICATIONS INFRASTRUCTURE TESTING**

~CMS Manual System – November 2006~

**SUMMARY OF CHANGES:**

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

**Background:**

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

Please read this entire instruction on the CMS Website at:

<http://www.cms.hhs.gov/transmittals/downloads/R239OTN.pdf>

**CORRECTION TO SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB)  
CODING FILE**

~CMS MLN Matters – October 2006~

MLN Matters Number: MM5103

Related CR Release Date: August 18, 2006

Related CR Transmittal #: R1032CP

Related Change Request (CR) #: 5103

Effective Date: April 1, 2001

Implementation Date: September 18, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5103.pdf>

**Provider Types Affected**

Physicians and providers billing Medicare carriers for SNF services to Medicare beneficiaries

**What You Need to Know**

Because claims for the procedure codes in Table 1 below have been processing incorrectly, carriers will begin reopen and reprocess affected claims, when brought to their attention.

**Background**

CMS has become aware that claims for the procedure codes listed below, have not been processing correctly. In order to ensure that you receive payment for these procedure codes, CR 5103, from which this article is taken, instructs Medicare carriers to reopen and reprocess these claims, when brought to the carrier's attention.

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

~December 2006~

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."

## MMA - INDEPENDENT LABORATORY BILLING FOR THE TECHNICAL COMPONENT (TC) OF PHYSICIAN PATHOLOGY SERVICES

~CMS MLN Matters – October 2006~

MLN Matters Number: MM5210

Related CR Release Date: September 1, 2006

Related CR Transmittal #: R1046CP

Related Change Request (CR) #: 5210

Effective Date: December 1, 2006

Implementation Date: December 1, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5210.pdf>

### Provider Types Affected

Independent laboratories that bill Medicare carriers

### Impact of CR5210 on Independent Laboratories

Independent laboratories may not bill for the Technical Component (TC) of physician pathology services furnished to a patient of a hospital after December 31, 2006.

### Background

In CR5210, the Centers for Medicare & Medicaid Services' (CMS) proposes to implement the 1999 final physician fee schedule regulations (at 42 CFR § 415.130).

Prior to this proposal, any independent laboratory could bill the carrier under the physician fee schedule for the TC of physician pathology services for hospital inpatients.

Section 732 of the Medicare Modernization Act (MMA) extended, for 2005 and 2006, the provision of section 542 of the Benefits Improvement Act of 2000 (BIPA) that allowed certain independent laboratories to bill under the physician fee schedule for the technical component of physician pathology services furnished to patients of a covered hospital. CR5210 instructs Medicare carriers to notify all independent laboratories that they may no longer bill for these services after the MMA provision expires on December 31, 2006.

## PANCREAS TRANSPLANTS ALONE (PA)

~Revised CMS MLN Matters – November 2006~

MLN Matters Number: MM5093 REVISED

Related CR Release Date: May 19, 2006

Related CR Transmittal #: R56 NCD and R957CP

Related Change Request (CR) #: 5093

Effective Date: April 26, 2006

Implementation Date: July 3, 2006 for carriers,  
October 2, 2006 for FIs

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5093.pdf>

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

### Provider Types Affected

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

### Background

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

**REOPENINGS AND REVISIONS OF CLAIM DETERMINATIONS AND DECISIONS – MMA  
~CMS MLN Matters – December 2006~**

MLN Matters Number: MM4147  
Related CR Release Date: September 29, 2006  
Related CR Transmittal #: R1069CP

Related Change Request (CR) #: 4147  
Effective Date: November 29, 2006  
Implementation Date: November 29, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4147.pdf>**

**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, 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.

**Program Safeguards**

**SANCTIONED AND REINSTATED PROVIDERS**

**~October, November, and December 2006~**

The Medicare and Medicaid Patient and Program Protection Act provides the Department of Health and Human Services 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. WPS will not issue payments for services performed, ordered or referred by these providers after the indicated changes. Current listings of sanctioned and reinstated providers are published in the monthly *Communiqué*. Complete lists are available at:  
**<http://oig.hhs.gov/fraud/exclusions/listofexcluded.html>**

**Provider Education****A REMINDER ABOUT MEDICARE PREVENTIVE SERVICES PROVIDER EDUCATION PRODUCTS**

~December 2006~

**~ 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)

**PROVIDER EDUCATION EVENTS AVAILABLE!**  
~October 2006 ~ November 2006 ~ December 2006~

Take advantage of a Medicare Education event in your area. Provider Outreach and Education are offering free educational events. Sign up today by going to [http://www.wpsmedicare.com/provider/proved\\_seminar.shtml](http://www.wpsmedicare.com/provider/proved_seminar.shtml) and clicking on the course number for the seminar that you are interested in attending.

**SKILLED NURSING FACILITY CONSOLIDATED BILLING WEB-BASED TRAINING  
COURSE IS NOW AVAILABLE**  
~November 2006~

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

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

## **Reimbursement**

**AMBULANCE INFLATION FACTOR FOR CY 2007**  
~CMS MLN Matters – December 2006~

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5358.pdf>

### **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%.

**CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) NEW WAIVED TESTS**  
~October 2006~

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test.

CPT Code/ Modifier	Effective Date	Description
82274QW, G0328QW	March 22, 2006	immoCare Fecal Occult Blood Test
87804QW	April 19, 2006	BinaxNOW Influenza A & B Test {Nasopharyngeal (Np) Swab and Nasal Wash/Aspirate Specimens}, K053126
80101QW	May 1, 2006	First Check Diagnostics LLC, First Check Home Drug Test Marijuana
87899QW	May 31, 2006	Meridian Bioscience Immunocard STAT! HpSA {Stool}

For the complete listing of CLIA Waived Tests, visit our Website at:  
[http://www.wpsmedicare.com/provider/clia\\_tests.shtml](http://www.wpsmedicare.com/provider/clia_tests.shtml)

**COLLECTION OF FEE-FOR-SERVICE PAYMENTS MADE DURING PERIODS OF MANAGED CARE ENROLLMENT (PREVIOUSLY CR2801 PROGRAM MEMORANDUM TRANSMITTAL AB-03-101) - MANUALIZATION**

~ Revised CMS MLN Matters – October 2006 ~

MLN Matters Number: MM5105  
 Related CR Release Date: August 25, 2006  
 Related CR Transmittal #: R106FM

Revised Related Change Request (CR) #: 5105  
 Effective Date: October 1, 2003  
 Implementation Date: June 26, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5105.pdf>**

**Note:** This article was revised on August 28, 2006, to reflect revisions made to CR5105, which CMS released on August 25, 2006. The Transmittal number, CR release date, and web address for accessing CR5105 have been changed. All other information remains the same.

**Provider Types Affected**

Physicians, providers, and suppliers submitting fee-for-service claims to Medicare carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs) for services furnished to Medicare beneficiaries enrolled in Medicare Advantage (MA) Organizations.

**Impact on Providers**

This article is based on Change Request (CR) 5105, which was issued to manualize the process that ensures that any duplicate payments for services rendered to Medicare beneficiaries are collected. CR5105 ensures that any fee-for-service claims that were approved for payment during a period when the beneficiary was enrolled in a Managed Care Organization are submitted to the normal collection process used by the Medicare contractors (carriers/DMERCs/FIs) for overpayments.

The Centers for Medicare & Medicaid Services (CMS) pays for a beneficiary's medical services more than once when a specific set of circumstances occurs. When CMS data systems recognize a beneficiary has enrolled in a MA Organization, the MA Organization receives capitation payments for the Medicare beneficiary. In some cases, enrollments with retroactive payments are processed.

The result is that Medicare may pay for the services rendered during a specific period twice:

- First, for the specific service that was paid by the fee-for-service Medicare contractor to the provider; and
- Second, by the MA Payment Systems in the monthly capitation rate paid to the MA plan for the beneficiary.

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

~ Revised CMS MLN Matters – November 2006 ~

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

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

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5079.pdf>**

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

**Provider Types Affected**

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

**Impact on Providers**

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

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

~ October 2006 ~ December 2006 ~

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>**

## OCTOBER 2006 DMEPOS FEE SCHEDULE UPDATE

~ December 2006 ~

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.

Code	Narrative	Illinois	Michigan	Minnesota	Wisconsin
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

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

~ Revised CMS MLN Matters – November 2006 ~

MLN Matters Number: MM5270

Related CR Release Date: September 22, 2006

Related CR Transmittal #: R1066CP

Related Change Request (CR) #: 5270

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5270.pdf>

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

### Provider Action Needed

#### STOP – Impact to You

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

#### CAUTION – What You Need to Know

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

## OCTOBER QUARTERLY UPDATE FOR 2006 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) FEE SCHEDULE

~ CMS MLN Matters – October 2006 ~

MLN Matters Number: MM5255

Related CR Release Date: August 25, 2006

Related CR Transmittal #: R1037CP

Related Change Request (CR) #: 5255

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5255.pdf>

**Provider Types Affected**

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment (DME) regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services paid under the DMEPOS Fee Schedule.

**Background**

This article and related CR5255 provide specific information regarding the quarterly update for the October 2006 DMEPOS Fee Schedule.

**OCTOBER UPDATE TO THE 2006 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)  
DATABASE**

~CMS MLN Matters – November 2006~

MLN Matters Number: MM5272

Related CR Release Date: September 1, 2006

Related CR Transmittal #: R1047CP

Related Change Request (CR) #: 5272

Effective Date: January 1, 2006

Implementation Date: October 2, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5272.pdf>**

**Provider Types Affected**

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

**What you need to know**

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

**REMITTANCE ADVICE REMARK CODE (RARC) AND CLAIM ADJUSTMENT REASON CODE  
(CARC) UPDATE**

~CMS MLN Matters – October 2006~

MLN Matters Number: MM5212

Related CR Release Date: August 18, 2006

Related CR Transmittal #: R1031CP

Related Change Request (CR) #: 5212

Effective Date: October 1, 2006

Implementation Date: October 2, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5212.pdf>**

**Provider Action Needed**

**STOP – Impact to You**

The November 2005 through February 2006 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes (RARCs) and the X12N 835 Health Care Claim Adjustment Reason codes (CARCs).

**CAUTION – What You Need to Know**

The Centers for Medicare & Medicaid Services (CMS) has developed a new web site located at <http://www.cmsremarkcodes.info/> on the CMS website, to provide information and help navigate the RARC database more easily. A helpful search tool is provided at this site if you need to find a specific category of code. This new website does not replace the Washington Publishing Company (WPC) Website, <http://www.wpc-edi.com/codes>, as the official site where the most current RARC list resides. Use the list posted at the **WPC Website** if there are any discrepancies between code text listed either on the new web site or in this article, and the code text provided on the WPC Website.

**QUARTERLY COMMUNIQUÉ SATISFACTION SURVEY**

The Quarterly Communiqué Satisfaction Survey is an effort by WPS Medicare to improve the quality of information provided to Medicare physicians and suppliers. The purpose of this survey is to measure and evaluate your ability to access information included within the Quarterly Communiqué. We would like to determine if it would be more beneficial to mail CD-ROM's with entire Communiqué's or if you would like to continue to receive paper copies of the Communiqué with partial articles and references to the Internet if further information is desired. The survey should take approximately five minutes to complete. Participation in this survey is strictly voluntary and all information is completely confidential. Please complete the following survey, fold, and return to the address indicated.

**WPS MEDICARE QUARTERLY COMMUNIQUÉ SATISFACTION SURVEY**

*We are currently evaluating the effectiveness of the Quarterly Communiqué. Please complete this survey. Your comments are important to us.*

1. Do you have access to a computer with a CD-ROM Drive?  Yes  No  
Comments: \_\_\_\_\_
2. Are you comfortable using a CD-ROM?  Yes  No  
If no, would you be interested in learning more about using a CD-ROM?  Yes  No  
Comments: \_\_\_\_\_
3. Would you be interested in receiving a CD-ROM each quarter that contains the monthly Communiqués in their entirety instead of the paper Quarterly summary Communiqué?  Yes  No  
Comments: \_\_\_\_\_
4. Do you have access to the Internet?  Yes  No  
If you are not connected to the Internet, what obstacles prevent you from accessing on-line resources?  
\_\_\_\_\_
5. Do you currently find the Communiqué to meet your needs?  Yes  No  
Comments: \_\_\_\_\_
6. Would you like the Communiqué to include complete articles?  Yes  No  
Comments: \_\_\_\_\_
7. What information do you look for within the Communiqué?  
 Policy/Coverage  Medlearn Matters Articles  Claim Submission  
Other: \_\_\_\_\_
8. Overall, how would you rate the paper copy of the Communiqué?  
Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Very Poor \_\_\_\_\_
9. If we could improve one thing, what would you suggest? \_\_\_\_\_

You may send us your comments via:

**WEBSITE:** "Contact Us" title at the top of our Website page at <http://www.wpsmedicare.com>

**FAX** your survey to: (608) 301-2775

**MAIL** to: WPS Medicare Quarterly Communiqué Satisfaction Survey, PO Box 4433, Marion, IL 62959

**Communiqué**

Wisconsin Physicians Service  
PO Box 7758  
Madison, WI 53708

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