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**Items of Importance**

**\* IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS\***  
*~April, May, and June 2007~*

Between now and September 3, 2007, WPS Medicare Provider Customer Service will be closed for the following holidays and federal holidays:

- July 4, 2007 (Independence Day)
- September 3, 2007 (Labor Day)

At these times, the Interactive Voice Response (IVR) and CMS Secure Net Access Pilot (C-SNAP) will continue to be available for your use to check eligibility and claim status. The IVR's standard hours of operation are Monday - Friday 6:00 am - 6:00 pm CT; Saturday 7:00 am - 12:00 pm CT.

C-SNAP is available 24 hours a day. For more information regarding C-SNAP, please call the C-SNAP support line Monday – Friday 8:00 am -4:00 pm CT 1-877-476-8116, or visit our Website at <https://medicareinfo.com/apps/cms/home.do>

For more information regarding the IVR, please visit our Website at: <http://www.wpsmedicare.com/provider/pdfs/ivr.pdf>

Alternatively, to use the IVR, call:

IL: (877) 908-9499 MI: (877) 567-7201 MN: (877) 908-8470 WI: (877) 567-7176

Thank you for your patience and for allowing us this opportunity to serve you better.

**2007 MEDICARE PARTICIPATING PHYSICIAN/SUPPLIER DIRECTORY NOW AVAILABLE**  
*~April 2007~*

The new Medicare Part B Participating Physician/Supplier Directory (MEDPARD) for 2007 is now available on the WPS Website at: [http://www.wpsmedicare.com/benefind\\_a\\_doctor.shtml](http://www.wpsmedicare.com/benefind_a_doctor.shtml)

Please review this site for the most up-to-date information. If you have questions about a specific provider's participation status, please call our Customer Service Center at:

WI: (866) 359-1599 IL: (866) 234-7340 MI: (866) 234-7331 MN: (866) 359-1598

**APPROPRIATE DOCUMENTATION FOR SERVICES OF SUPERVISING PHYSICIANS IN TEACHING SETTINGS**  
*~June 2007~*

Insufficient documentation by providers acting as supervising physicians in a teaching setting could cause Medicare to deny your services.

Documentation **may be** dictated and transcribed, hand-written, typed or computer-generated.

Documentation **must be** dated and include a legible signature.

The attending physician who bills Medicare **must personally document**:

- The services furnished
- His/her participation in providing the service and
- Whether he/she were physically present

The billing provider cannot simply co-sign the resident's documentation. He/she must indicate whether they were physically present during the Resident's services or separately performed key portions of the Evaluation and Management (E/M) service as required in the Medicare Policy PHYS-024.

You can view and download a copy of Medicare policy PHYS-024 at the following Wisconsin Physicians Service (WPS) Medicare address: <http://www.wpsmedicare.com/policies/wisconsin/phys024.pdf>

**Additional resources:**

Guidelines for Teaching Physicians, Interns, and Residents at the following Centers for Medicare & Medicaid Services (CMS) address:

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

**ATTENTION PHYSICIAN'S ASSISTANTS, OTHER PRACTITIONERS, AND THEIR EMPLOYERS***~June 2007~*

Are you a Physician's Assistant (PA)? Do you employ a PA? Are you a practitioner who currently bills under an organizational Medicare Provider Identification Number (PIN)? Under NPI, PAs and other practitioners may need to enroll in the Medicare program separately. Now is the time to verify if you need to enroll separately in Medicare. Medicare enrollment has identified over 450 practitioners who may not be payable after the implementation of NPI on May 23, 2007.

How does a practitioner enroll in Medicare? Complete the CMS 855I Provider Enrollment Form. Also, complete the CMS 855R Provider Enrollment Form to reassign benefits to the organizations.

If you need help completing the form or wonder if you need to complete the form, call the WPS Medicare provider enrollment department at:

WI, MI, IL (877) 908-8476

MN (866) 380-4744

**CHIROPRACTIC DEMONSTRATION ENDED MARCH 31, 2007***~April 2007~*

All providers should be aware that the Chiropractic Demonstration, which has been in place since April 1, 2005, ended on March 31, 2007. The Medicare Chiropractic Demonstration, as mandated by Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA,) has been conducted in our state for the last two years.

Brandeis University, under contract with CMS to conduct an independent evaluation of the Demonstration, is currently compiling data regarding patient survey responses, service utilization, and provider participation. Additionally, Brandeis is interviewing key players in the Demonstration to obtain their impressions. An interim report of Brandeis' findings will be sent to Congress in Spring, 2008. The final report is due in late 2009.

When the demonstration ends, no other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order will be covered. This means that if a chiropractor orders, takes, or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test can be used for claims processing purposes, but Medicare coverage and payment are not available for those services. This prohibition does not affect the coverage of x-rays or other diagnostic tests furnished by other practitioners under the program. For example, an x-ray or any diagnostic test taken for the purpose of determining or demonstrating the existence of a subluxation of the spine is a diagnostic x-ray test covered under §1861(s)(3) of the Act if ordered, taken, and interpreted by a physician who is a doctor of medicine or osteopathy. Additionally, chiropractors may not certify or recertify plans of care for therapy services.

If you have a patient receiving ongoing care referred or ordered by a chiropractor on or after April 1, 2007, you should know that your services will not be covered by Medicare unless a physician or other nonphysician practitioner (other than a chiropractor) takes over the responsibility as the referring or ordering provider. Please remember that any provider that is noted as the referring or ordering provider must have seen the patient and maintain documentation that the referred or ordered services are medically necessary and appropriate for the individual patient.

**CONSULTATIONS***~June 2007~*

Medicare has specific guidelines on what is and what is not a consultation. Wisconsin Physicians Service (WPS) Medicare is responsible for correct payment of claims. The Comprehensive Error Rate Testing (CERT) program shows an increase in payment errors on consultations from 29 to 37. The WPS Medicare Medical Review (MR) Department is looking at data on Consultation services.

The Common Procedural Terminology (CPT) book defines a consultation as "a type of service provided by a physician whose opinion or advice regarding an evaluation and/or management of a specific problem is requested by another physician or appropriate source."

This definition shows that the requesting physician (physician or non-physician practitioner) is asking another physician who has more expertise or knowledge of a particular area for his/her opinion on the treatment needs of the patient. The requesting physician anticipates continuing to treat the patient condition. The documentation includes the request for the consultation from the originating physician, the need for the consultation, and a written report back to the referring physician.

A consultation is different from a referral or transfer of care. When the originating physician determines another office or specialty is better equipped to treat the patient's condition, this is a referral or transfer of care. The originating physician is not asking for advice or an opinion, they are referring the patient to the second physician for treatment. They do not anticipate continuing to treat this condition. In this case, the performing physician bills the services using a new or established patient code as appropriate.

A referral may also have a written request and the performing physician may respond to the originating physician as a courtesy. However, Medicare will look for documentation to support the request for advice or opinion and will look for the intent of the originating physician.

Documentation must support the use of the Consultation procedure codes. The documentation includes the request for the consultation from the originating physician, the need for the consultation, and a written report back to the referring physician. In addition, the documentation must meet the requirements for Evaluation and Management (E/M) services.

The following analogy may help provider offices determine whether the service is a consultation or a visit.

**Your car engine has a problem. There are three applicable situations.**

1. You are unsure of how to treat this problem. You request someone with expertise in car engines to look at the car and provide you their advice and opinion on treating the car engine. You then treat the engine. In this case, the expert has a consultation.
2. You know that the engine has a problem and you are not equipped to treat the problem. You ask the expert to treat the car engine. The expert does not have a consultation; they have a new or established patient visit.
3. You ask the expert their advice or opinion on treating the car engine. Once you hear their advice, you determine the expert should treat the engine. In this case, the expert has a consultation followed by treatment.

We are asking the provider community to perform a self-audit on their internal processes for submitting consultation services. Documentation must support the use of the consultation code billed and the medical necessity of the service. The following chart indicates the current provider norms for our area.

**Outpatient Consultation Services**

IL, MI, MN, WI Peer Group 99241 - 99245 All Specialties

Procedure Codes	Peer Group Allowed Services	Percent of Total Allowed Services	Average Allowed Services/Patient
99241	36,555	4.16%	0.99
99242	126,731	14.42%	1.03
99243	296,602	33.75%	1.07
99244	308,985	35.16%	1.10
99245	109,880	12.50%	1.06
	878,753	100.00%	

**Inpatient Consultation Services**

IL, MI, MN, WI Peer Group 99251 - 99255 All Specialties

Procedure Codes	Peer Group Allowed Services	Percent of Total Allowed Services	Average Allowed Services/Patient
99251	20,347	2.39%	1.04
99252	64,895	7.63%	1.12
99253	210,520	24.75%	1.38
99254	371,319	43.66%	1.70
99255	183,467	21.57%	1.44
	850,548	100.00%	

National Coverage Provision (NCP) PHYS-006 – Consultations discusses Medicare's information on consultation services. The following Website will provide information:

**<http://www.wpsmedicare.com/policies/wisconsin/phys006.pdf>**

The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) has two different sections that discuss consultations.

- Pub. 100-04 Claims Processing, Chapter 12 – Physician/Practitioner Services, Section 30.6.10 at the following Website: <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>
- Pub. 100-02 Benefit Policy Manual, Chapter 15, Covered Medical and Other Health Services, Section 30.C. You can access this at the following Website:  
<http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf>

Please watch our Website for more extensive information on consultation services.

## DO YOU HAVE QUESTIONS CONCERNING INTERNET ANTI-VIRUS SOFTWARE, SPAM, OR INTERNET SECURITY?

~May 2007~

WPS Medicare developed a Website and E-Mail Security Fact Sheet to help answer your questions. Read it today at: <http://www.wpsmedicare.com/provider/pdfs/security.pdf>

## EYE EXAMINATIONS IN DIABETICS

~May 2007~

This article is to serve as a reminder that diabetic patients qualify for an annual eye examination as they are considered at high risk for diabetic retinopathy. This exam is covered when the examination is furnished **by, or under direct supervision of, an ophthalmologist or optometrist**, who is legally authorized to perform the services under State law (IOM – Pub 100-02, Ch 15, §280.1).

Retinal photography alone, including “telescreening,” in the absence of a concurrent personal examination by an ophthalmologist or optometrist, is a screening test and, as such, is not covered by Medicare. Fundus photography is considered medically reasonable and necessary, and, therefore, covered, when furnished by an ophthalmologist or optometrist in the course of ocular evaluation and/or treatment (IOM – Pub 100-03, Ch 1, §80.6) Therefore, the digital imaging systems used for the detection of diabetic retinopathy, which acquire images and transmits them to a remote area for interpretation are considered screening and do not meet Medicare’s reasonable and necessary criteria for reimbursement.

## HOW CAN I BE COMFORTABLE WITH MY E/M DOCUMENTATION?

~May 2007~

Evaluation & Management (E/M) services are the majority of services billed by physicians and non-physician practitioners (NPP). Wisconsin Physicians Service (WPS) Medicare and the Comprehensive Error Rate Testing (CERT) contractor have identified documentation as the number one reason why Medicare either denies claims or requests refunds. So how do you know your documentation is OK? Look at the following scenarios:

You are on a dark street late at night and a police car pulls out behind you. You can react in several ways.

1. If you are speeding, you can continue to speed hoping the police officer will not notice or will let you pass. This equates to providers justifying the regular use of high-level procedure codes based on statements such as "I'm a level 1 Trauma Center" or "I'm a specialist" or "Other doctors refer their sicker patients to me." Medicare does not consider any of these types of statements when evaluating documentation. Remember the documentation must support the medical necessity of the service and the level of service billed.
2. You can hit your brakes and suddenly start driving 10 miles under the speed limit. This equates to providers billing a lower level of service than what they performed and documented for the patient. Medicare's responsibility is to pay claims appropriately. We should reimburse you for the medically necessary services you provide. Providers believe that by billing a lower level of code, Medicare will not request documentation. It is an error when Medicare pays a procedure incorrectly, whether that is under or over the services documented.
3. You can turn off the road. This equates to providers who do not believe they should be required to provide this information. They are so frustrated with the documentation requirement that they stop seeing Medicare patients. A provider has a right, obviously, to see the patient population he or she chooses. However, for most specialties, the Medicare population is a big percentage of a physician's practice. Accurate documentation supports the provider in numerous ways, not only for Medicare reimbursement.
4. If in the above situations, the officer stops your car, you would be required to produce the paperwork such as license, registration, and insurance. When you reach into your glove box and all the necessary documents

are there, it will not be long before you are on your way. If you were unable to produce these documents, then you have a problem. This equates to Medicare requesting documentation and the documentation is either not received or does not support the service. Make sure your front office staff can recognize requests for documentation and that you have a procedure in place for sending the information to Medicare. Please keep in mind that Medicare does not know your patients. The only information we have to make our determination is the documentation you submit. Medicare does not expect providers to write a book. We simply expect the information to show the medical necessity of the service and that the documentation supports the level of service billed.

5. What about when the police officer decides that today is the day to stop all white mini-vans? You pull over to the side of the road and provide your license, registration, and insurance. This equates to audits that Medicare performs on particular procedure codes. We will request documentation from multiple providers for the identified codes. If your documentation supports the medical necessity and the level of care code billed, then you do not have anything to worry about. Medicare will look at the documentation and determine that you billed and we paid correctly.

WPS Medicare has published multiple articles concerning documentation. These include the following:

- The National Coverage Provision (NCP) PHYS-001  
<http://www.wpsmedicare.com/policies/wisconsin/phys001.pdf>
- CERT Error Update - Insufficient Documentation  
[http://www.wpsmedicare.com/provider/cert\\_error.shtml](http://www.wpsmedicare.com/provider/cert_error.shtml)
- Correct use of the checklist in E&M documentation  
[http://www.wpsmedicare.com/provider/em\\_checklist.shtml](http://www.wpsmedicare.com/provider/em_checklist.shtml)

The Centers for Medicare & Medicaid Services (CMS) has multiple resources to assist providers in understanding the need for documentation.

- Documentation Guidelines for E&M Services  
[http://www.cms.hhs.gov/mlnedwebguide/25\\_emdoc.asp](http://www.cms.hhs.gov/mlnedwebguide/25_emdoc.asp)
- Medicare Physician Guide  
<http://www.cms.hhs.gov/mlnproducts/downloads/physicianguide.pdf>
- Evaluation and Management Services Guide  
[http://www.cms.hhs.gov/mlnproducts/downloads/eval\\_mgmt\\_ser\\_guide.pdf](http://www.cms.hhs.gov/mlnproducts/downloads/eval_mgmt_ser_guide.pdf)

### **INTERACTIVE VOICE RESPONSE (IVR) ENHANCEMENTS EFFECTIVE 03/03/2007**

*~April 2007~*

As previously communicated, WPS upgraded the IVR with added features and new security requirements. The new IVR changes took effect on March 3, 2007. Outlined below are the detailed descriptions of the modifications. The new IVR brochure was available for download on March 5, 2007.

[http://www.wpsmedicare.com/provider/prov\\_resources.shtml](http://www.wpsmedicare.com/provider/prov_resources.shtml)

#### **Eligibility changes -**

- Gender authentication. The IVR no longer authenticates or prompts the caller for the beneficiary's gender.
- Corrected Health Insurance Claim Number (also known as the HICN or Medicare number). The IVR now voices back to the caller the corrected HICN if a previously assigned HICN is used by the caller to obtain eligibility. (The caller also hears the corrected HICN while in the claim status menu option).
- Date of death. The IVR now provides the beneficiary's date of death in the general eligibility section.
- Eligibility details. After general eligibility is played, there is a new option for the caller to request eligibility details. The information listed below is what is heard in the eligibility details section.
- Medicare Secondary Payer (MSP). The MSP type (working aged, liability, etc.) is played to the caller as well as effective and term dates if applicable. Up to two valid records are played.
- Health Maintenance Organization (also known as an HMO or Medicare Advantage Plan). The HMO plan ID is played as well as effective and term dates if applicable. Up to two valid records are played. The HMO name and type (cost versus risk) are played as before. Providers are reminded to submit their claims to the proper payer. Please note that if a beneficiary is enrolled in an HMO, the IVR states that Medicare is primary. It is important that the provider listen to whether the IVR states the HMO is a risk-type HMO or cost-type HMO. If the HMO is a risk-type, providers may only bill the HMO. If the HMO is a cost-type, providers may bill the HMO or WPS as the Medicare Part B Carrier. Please refer to Chapter 1 of Publication 100-04 on the Centers

for Medicare and Medicaid Service's (CMS's) website for further details on claim submission (<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>).

- Crossover. The crossover company name is played for up to two valid records. Note that the caller may hear the same name twice; this is due to constraints in programming. Note also, the name is voiced back to the caller using text-to-speech technology and may not be pronounced properly.
- Home Health. The home health information has been moved to the "details" section and plays as before – whether the beneficiary is receiving home health and the date home health was discontinued.

#### Claim status changes -

- Patient name as an added validation element. The IVR now asks for and verifies the patient's name in the claim status menu option as an added security layer.
- Non-assigned claims. For security reasons, the IVR only provides the following information on non-assigned claims - whether the claim has been received, date it finalized or if it's in process, and whether the claim crossed over.
- Deported and incarcerated beneficiaries. The IVR now checks to see if a beneficiary has either an incarcerated or deported record on CWF. In the extremely rare instance that there is a valid record, the IVR cannot release any claim information for that beneficiary. The IVR will play a message - "I'm sorry, we are unable to provide claim information for this beneficiary." The IVR then refers the caller to a Customer Service Representative (CSR) as CSR's can provide claim information in these situations.
- Corrected HICN. If the caller gives a HICN that has been corrected/changed, the IVR voices back to the caller the corrected number. The IVR uses the corrected number to obtain claim status.

#### Deductibles changes -

- Gender authentication. The IVR no longer authenticates or prompts the caller for the beneficiary's gender.

#### Overall menu changes and the "I have a question" prompt -

- Phone numbers, addresses, and the appeal rights message have been moved to a new section called "I have a question." The menu looks as follows.
  1. Eligibility
  2. Claim Status
  3. Provider Summary
  4. Checks
  5. Deductibles
  6. Pricing
  7. I Have a Question
    1. Medicare News (Up to 9 messages determined and maintained by WPS)
    2. Appeal Rights
    3. Phone Numbers
    4. Addresses
- There is a new submenu option within "I have a question" called Medicare News. This plays up to nine informational messages and is controlled and updated by WPS.
- Changed HICNs. In certain situations when a Medicare number has changed, and the IVR is unable to retrieve the new number, the IVR voices a message to tell the caller that the Medicare number has possibly changed and to contact the beneficiary for the new number.

### IVR TIP - ENTERING PATIENT NAMES USING YOUR PHONE'S TOUCH-TONE KEYPAD

~May 2007~

If you are having trouble with the Interactive Voice Response (IVR) recognizing patient names when you speak them, simply touch-tone the name instead. This is a quick and simple process.

To enter the patient's name using the touch-tone, you must use the numbers on the telephone keypad that corresponds to the letters in the name. Note that there is an exception - to enter letters Q and Z, use the 1 key.

\*\*\* You only need to enter the patient's last name followed by the first initial \*\*\*

For example:

John Smith would be entered as 764845;

S = 7, M = 6, I = 4, T = 8, H = 4, J = 5

Juan Espinosa would be entered as 377466725;  
E = 3, S = 7, P = 7, I = 4, N = 6, O = 6, S = 7, A = 2, J = 5

Manqi Xiong would be entered as 946646;  
X = 9, I = 4, O = 6, N = 6, G = 4, M = 6

Marcial Deguzman Jr. would be entered as 33481626576  
D = 3; E = 3; G = 4; U = 8; Z = 1; M = 6; A = 2; N = 6; J = 5; R = 7; M = 6

Joan Jones-Pastrick would be entered as 56637727874255  
J = 5; O = 6; N = 6; E = 3; S = 7; P = 7; A = 2; S = 7; T = 8; R = 7; I = 4; C = 2; K = 5; J = 5

Please note that a different process exists for using the touch-tone to key alpha characters in Medicare and provider numbers. For a comprehensive list of IVR instructions, please refer to our Website:  
<http://www.wpsmedicare.com/provider/pdfs/ivr.pdf>

**MEDICARE FEE-FOR-SERVICE (FFS) NATIONAL PROVIDER IDENTIFIER (NPI)  
IMPLEMENTATION CONTINGENCY PLAN  
~REVISED CMS MLN Matters – June 2007~**

MLN Matters Number: MM5595 Revised  
Related CR Release Date: April 24, 2007  
Related CR Transmittal #:R1227CP

Related Change Request (CR) #: 5595  
Effective Date: May 23, 2007  
Implementation Date: May 23, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf>**

**Note:** This article was revised on April 24, 2007, to reflect changes made to CR5595, which CMS re-issued on April 24. The article was changed to reflect in **bold print** on page 2 that “As long as covered entities, including health plans and covered health providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs, they may establish contingency plans to facilitate the compliance of their trading partners”. The article also has a revised transmittal number, release date, and Web address for accessing CR5595. All other information remains the same.

**Impact to You:** As early as July 1, 2007, Medicare fee for service (FFS) contractors may begin rejecting claims that do not contain an NPI for the primary providers.

**What You Need to Know:** CR 5595, from which this article is taken, announces that (effective May 23, 2007) Medicare fee for service (FFS) is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007.

**What You Need to Do:** If you have not yet done so, you should obtain your NPI now. You can apply on line at <https://nppes.cms.hhs.gov/> on the CMS Website. You should also make sure that your billing staffs begin to include your NPI on your claims as soon as possible.

**Background**

The 1996 Health Insurance Portability and Accountability Act (HIPAA) required that each physician, supplier, and other health care provider conducting HIPAA standard electronic transactions, be issued a unique national provider identifier (NPI). CMS began to issue NPIs on May 23, 2005; and to date, has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only,
- Medicare legacy only, or
- An NPI and legacy combination.

On April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance to covered entities regarding contingency planning for NPI implementation. **As long as covered entities, including health plans and covered health providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs, they may establish contingency plans to facilitate the compliance of their trading partners.** (You can find this guidance on the CMS Website at: [http://www.cms.hhs.gov/NationalProvdentStand/Downloads/NPI\\_Contingency.pdf](http://www.cms.hhs.gov/NationalProvdentStand/Downloads/NPI_Contingency.pdf).)

In CR 5595, from which this article is taken, Medicare fee for service (FFS) announces that it is establishing a contingency plan that follows this DHHS guidance. For some period after May 23, 2007, Medicare FFS will:

- Allow continued use of legacy numbers on transactions;
- Accept transactions with only NPIs; and
- Accept transactions with both legacy numbers and NPIs.

**After May 23, 2008, legacy numbers will NOT be permitted on ANY inbound or outbound transactions.**

As part of this plan, Medicare FFS has been assessing health care provider submission of NPIs on claims. As soon as the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is determined sufficient (and following appropriate notice to providers), Medicare will begin rejecting claims that do not contain an NPI for primary providers following appropriate notification. (See *Important Information* below.)

In May 2007, Medicare FFS will evaluate the number of submitted claims containing a NPI. If this analysis demonstrates a sufficient number of submitted claims contain a NPI, Medicare will begin to reject claims without NPIs on July 1, 2007. If, however, there are not sufficient claims containing NPIs in the May analysis, Medicare FFS will assess compliance in June 2007 and determine whether to begin rejecting claims in August 2007.

CMS also recognizes that the National Council of Prescription Drug Programs (NCPDP) format only allows for reporting of one identifier. Thus, NCPDP claims can contain either the NPI or the legacy number, but not both, until May 23, 2008.

In addition, in regards to the 835 remittance advice transactions and 837 Coordination of Benefits (COB) transactions, Medicare FFS will do the following until May 23, 2008:

- If a claim is submitted with an NPI, the NPI will be sent on the associated 835 remittance advice; otherwise, the legacy number will be sent on the associated 835.
- If a claim is submitted with an NPI, the associated 837 COB transaction will be sent with both the NPI and the legacy number; otherwise, only the legacy number will be sent.

By May 23, 2008, the X12 270/271 eligibility inquiry/response supported by CMS via the Extranet and Internet must contain the NPI.

**Important Information**

CR 5595 also provides specific important information that you should be aware of:

- Once a decision is made to require NPIs on claims, Medicare FFS will notify (in advance) providers and Medicare contractors about the date that claims without NPIs for primary providers will begin to be rejected. **That date will supersede all dates announced in previous CRs and *MLN Matters* articles.**
- In editing NPIs, Medicare considers billing, pay-to and rendering providers to be primary providers who must be identified by NPIs, or the claims will be rejected once the decision is made to reject.
- All other providers (including referring, ordering, supervising, facility, care plan oversight, purchase service, attending, operating and “other” providers) are considered to be secondary providers. Legacy numbers are acceptable for secondary providers until May 23, 2008. If a secondary provider’s NPI is present, it will only be edited to assure it is a valid NPI.

**NATIONAL PROVIDER IDENTIFIER (NPI) FOR A SERVICE FACILITY**

*~April 2007~*

Does the “requirement” to indicate the service facility’s NPI on your Medicare claim submissions confuse you? You are not alone.

Claim form instructions in the Centers for Medicare & Medicaid Services’ (CMS) Internet-Only Manual (IOM), Publication 100-04, Chapter 26, Section 10.4, state the following for item 32A:

*Item 32A Form CMS-1500 (08-05) – Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007, and must be reported May 23, 2007, and later.*

CMS defines a service facility as a hospital, clinic, laboratory, or facility other than the patient’s home or physician’s office.

CMS recently clarified that although you are *not required* to submit a service facility NPI in item 32A, it must be an NPI if you choose to enter a service facility identifier on any Form CMS-1500 submitted on or after May 23, 2007.

You can view CMS Publication 100-04 at the following CMS Website address:  
<http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>

### **NPI: THE LATEST NEWS**

*~June 2007~*

Over 2 million providers have their NPIs - do you have your NPI yet? Covered entities (including health plans, covered health care providers, and clearinghouses) across the country are making decisions regarding their need for contingency plans for NPI implementation. It is more important than ever to obtain an NPI as soon as possible and begin testing it on claims, as directed by your health plan.

Medicare providers should pay special attention to the Medicare information section below for important news on the Medicare FFS Contingency Plan.

#### **New Compliance Contingency Guidance FAQs**

CMS has posted new FAQs related to the previously posted NPI Compliance Contingency Guidance. Questions include:

- What are the exact dates for the National Provider Identifier (NPI) contingency plan?
- If a complaint is filed against me for not being in compliance with the National Provider Identifier (NPI) after May 23, 2007, what will happen?
- What happens if a complaint for not being in compliance with the National Provider Identifier (NPI) is filed against me after May 23, 2008?
- Is it acceptable for a health plan to announce their National Provider Identifier (NPI) contingency now?
- Is the National Provider Identifier (NPI) contingency plan voluntary?
- Am I allowed to give my National Provider Identifier (NPI) to other providers as well as to the health plans with whom I exchange transactions?

To view these FAQs, you should:

1. Go to the CMS dedicated NPI Web page at <http://www.cms.hhs.gov/NationalProviderStand>
2. Scroll down to the section that says "Related Links Inside CMS"
3. Click on NPI Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated." Look for the word "NEW" in red font to appear beside the most recent FAQs.

#### **Obtain Information on Contingency Plans**

CMS strongly urges providers to pay attention to information from the health plans they bill so that they are aware if, and when, a specific health plan announces its own contingency plan.

#### **Reminder - Sharing NPIs**

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business, and with health plans that request their NPIs. In fact, as outlined in current regulation, providers who are covered entities under HIPAA must share their NPIs with any entities that need them for billing purposes -- including those who need them for designation of ordering or referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their NPIs for them.

#### **Reminder - Enumerating a Group Practice**

A group practice that conducts any of the HIPAA standard transactions is a covered healthcare provider (a covered entity under HIPAA) and, as such, must obtain an NPI. The physicians employed by the group practice, on the other hand, are furnishing services at the group office(s) but they are not conducting any of the HIPAA standard transactions (such as submitting claims, checking eligibility and claim status). As such, the physicians would not be covered health care providers and are not required by the NPI Final Rule to obtain NPIs. However, as the employer, the group could require these physicians to obtain NPIs and use the NPIs to identify them as the rendering providers in the claims that the group submits. If these physicians prescribe medication, the pharmacies may require their NPIs in the claims that the pharmacies submit to health plans. Additionally, health plans can require enrolled physicians to obtain NPIs in order to participate in that plan. Medicare is an example of a health plan with this requirement.

**Reminder - Applying for an NPI Does Not Enroll a Health Care Provider in a Health Plan**

Applying for an NPI and enrolling in a health plan are two completely separate activities. Having an NPI does not guarantee payment by any health plan.

**When to Contact the NPI Enumerator for Assistance**

Providers should remember that the NPI Enumerator can only answer/address the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter (i.e., for those providers enumerated via paper or Web-based applications)
- Trouble accessing NPDES
- Forgotten password/User ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at [CustomerService@NPIenumerator.com](mailto:CustomerService@NPIenumerator.com).

Please Note: The NPI Enumerator's operation is closed on federal holidays. The federal holidays observed are: New Year's Day, Independence Day, Veteran's Day, Christmas Day, Martin Luther King's Birthday, Washington's Birthday, Memorial Day, Labor Day, Columbus Day, and Thanksgiving.

**Important Information for Medicare Providers***Medicare Fee-For-Service (FFS) Contingency Plan Announced!*

FFS Medicare has announced its contingency plan. View the associated Change Request at <http://www.cms.hhs.gov/transmittals/downloads/R1227CP.pdf>, as well as the related MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS Website. Please note that these materials were recently revised; please be sure to visit the links above for the latest information. This information will also be available shortly on CMS' dedicated NPI Web page.

*Reporting a Group Practice NPI on Claims*

Medicare has identified instances where the Multi-Carrier System (MCS) is correcting billing or pay-to provider data on Part B claims submitted by group practices. As of May 18, 2007, the MCS Part B claims processing systems will no longer correct claims submitted by group practices that are reporting the individual rendering Provider Identification Number (PIN) or individual rendering NPI in either the billing or pay-to provider identifier fields. Groups should enter either their group NPI or group NPI and legacy PIN number pair in either of these fields.

*Reminder - Medicare Extending Date for Accepting Form CMS-1500 (12-90)*

While Medicare began to accept the revised Form CMS-1500 (08-05) on January 1, 2007 and was positioned to completely cutover to the new form on April 1, 2007, it has recently come to our attention that there are incorrectly formatted versions of the revised form being sold by the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized forms designer were improperly formatted. The error resulted in the sale of both printed forms and negatives which do not comply with the form specifications. However, not all of the new forms are in error.

Given the circumstances, CMS is extending the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, we are targeting June 1, 2007 as that date. During the interim, contractors will be directed to return, not manually key, any Form CMS-1500 (08-05) forms received which are not printed to specification. By returning the incorrectly formatted claim forms back to providers, we are able to make them aware of the situation so they can begin communications with their form suppliers.

For more details, and to learn how to identify the proper version of the new form, visit a recent MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5568.pdf> on the CMS Website.

**Still Confused?**

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found at the CMS NPI page <http://www.cms.hhs.gov/NationalProvidentStand> 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.

**Getting an NPI is free - not having one can be costly.**

**PROVIDER AUTHENTICATION REQUIREMENTS FOR TELEPHONE AND WRITTEN INQUIRES DURING THE MEDICARE FFS NPI CONTINGENCY PLAN**

*~Special Edition CMS MLN Matters – June 2007~*

MLN Matters Number: SE0721  
 Related CR Release Date: N/A  
 Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A  
 Effective Date: N/A  
 Implementation Date: N/A

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf>**

Due to the Medicare FFS NPI contingency plan, the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare Fee-for-Service provider contact centers (PCCs), will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and the written inquiries units.

**Medicare FFS will give sufficient notice to providers of the contingency plan end date. Until the date, you will need to provide the following:**

- **For Inquiries to the IVR:**
  - PTAN / Legacy Number, depending upon the contractor
- **For Inquiries to a CSR and Written Inquiries:**
  - PTAN / Legacy Number, depending upon the contractor, and
  - Provider Name

Remember, if you make inquiries to more than one contractor, you may hear the provider identification number referred to as either the legacy number or PTAN. On the date that the NPI is required to be on all claim transactions, the provider authentication elements required by all contractors will be both the NPI and PTAN.

If you have not yet done so, **you should obtain your NPI now**. You can apply on line at <https://nppes.cms.hhs.gov> on the CMS Website. Once CMS ends the contingency plans, your claims and inquiries will not be processed without NPIs.

**TEMPORARY ADDITION TO THE ADMINISTRATIVE SIMPLIFICATION COMPLIANCE ACT (ASCA) EXCEPTION LIST FOR MEDICARE SECONDARY PAYER (MSP) CLAIMS**

*~CMS MLN Matters – April 2007~*

MLN Matters Number: MM5488  
 Related CR Release Date: March 9, 2007  
 Related CR Transmittal #: R1194CP

Related Change Request (CR) #: 5488  
 Effective Date: April 9, 2007  
 Implementation Date: July 1, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5488.pdf>**

An exception has been created in CR 5488 that instructs carriers and A/B MACs, who use the Medicare Multi-Carrier System (MCS) for claims processing, to grant a temporary ASCA waiver (until July 1, 2007) for Electronic Media Claim (EMC) MSP claims to allow processing of MSP claims for reimbursement of a beneficiary for co-payment paid to the provider when the primary payer is an employer Managed Care Organization (MCO).

Participating Medicare providers must not accept from the beneficiary any co-payment, or coinsurance, upon services rendered when the primary payer is an employer MCO insurance, or any other type of primary payer insurance. Providers must follow the Medicare Secondary Payer rules and bill Medicare as the secondary payer after the primary payer has made payment. Medicare will inform you on its remittance advice the amount you may collect from the beneficiary.

## UNSOLICITED/VOLUNTARY REFUNDS

~June 2007~

The acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

## WPS MEDICARE OFFERS NEW EDUCATIONAL TOOL

~April 2007~

WPS recently acquired Mediasite, an educational tool that gives you the opportunity to attend a presentation when your schedule allows.

### What is Mediasite?

Mediasite is an on-line webinar tool used to record a presentation, including the speaker and the visual aids (such as PowerPoint presentations). The entire presentation is then streamed over the Internet. Mediasite presents several advantages:

- Presentations will be available both live and on-demand (recorded)
- An unlimited number of users can watch a session
- Users do not need to download special software to view a presentation
- Because the entire presentation is on-line, your office will not need to tie up phone lines

What do I need to view a WPS Medicare Mediasite presentation?

- A computer with Internet access and a sound card
- A desire to learn more about Medicare Part B



Mediasite recordings will be marked on our Website with a special icon: Please note that when you click on a Mediasite link, the URL will change from wpsmedicare.com to wps.mediasite.com. You will still be on the WPS Medicare Website.

Want to learn more? View our recording of a Mediasite presentation at [http://www.wpsmedicare.com/provider/eye\\_mediasite.shtml](http://www.wpsmedicare.com/provider/eye_mediasite.shtml)

## Claim Submission

### CLARIFICATION OF BARIATRIC SURGERY BILLING REQUIREMENTS ISSUED IN CR 5013

~REVISED CMS MLN Matters – June 2007~

MLN Matters Number: MM5477 Revised  
 Related CR Release Date: April 27, 2007  
 Related CR Transmittal #: R1233CP

Related Change Request (CR) #: 5477  
 Effective Date: February 21, 2006  
 Implementation Date: May 29, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5477.pdf>

**Note:** This article was revised on May 4, 2007, to clarify the types of Medicare contractors that will deny certain claims as opposed to rejecting claims.

This article is based on Change Request (CR) 5477 which clarifies the claims processing instructions contained in CR 5013 (Transmittals R931CP and R54NCD; titled Bariatric Surgery for Morbid Obesity).

On April 28, 2006, the Centers for Medicare & Medicaid Services (CMS) issued CR 5013 providing coverage for certain bariatric surgical procedures. CMS found that some claims not involving bariatric surgery are being denied in error while some covered bariatric surgery claims are being held rather than paid.

**CODING CHANGE FOR LUMBAR ARTIFICIAL DISC REPLACEMENT (LADR)**

*~REVISED CMS MLN Matters – April 2007~*

MLN Matters Number: MM5462 Revised  
 Related CR Release Date: January 26, 2007  
 Related CR Transmittal #: R1164CP

Related Change Request (CR) #: 5462  
 Effective Date: January 1, 2007  
 Implementation Date: March 13, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5462.pdf>**

**Note:** This article was revised on February 1, 2007, to show the correct code of 0163T in the last bullet point on page 2. The article had incorrectly reflected 0263T. All other information remains the same.

**Impact to You:** Effective for services on or after January 1, 2007, the CPT codes for billing LADR are changing.

**What You Need to Know:** No change in Medicare policy results from this coding change. But, be sure billing staff use the correct codes to assure prompt and correct payment of your claims.

**What You Need to Do:** For services on or after January 1, 2007, use CPT code 22857 in place of CPT Category III code 0091T for LADR. Also, use new CPT Category III code 0163T in place of CPT Category III code 0092T for services on or after January 1, 2007. CPT Category III codes 0091T and 0092T are still appropriate for services on or before December 31, 2006, but are discontinued as of December 31, 2006.

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

*~ REVISED CMS MLN Matters – May 2007 ~*

MLN Matters Number: MM5347 Revised  
 Related CR Release Date: April 18, 2007  
 Related CR Transmittal #: R1221CP

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>**

**Note:** This article was revised on April 20, 2007, to show that important new information on this issue is available in MLN Matters article MM5468 (<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5468.pdf>). In essence, according to MM5468, qualifying independent laboratories may continue to bill Medicare for the TC of physician pathology services furnished to Medicare patients of a covered hospital stay during calendar year 2007. Be sure to view MM5468 for details.

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.

**EXTENSION FOR ACCEPTANCE OF FORM CMS-1500 (12-90)**

*~CMS MLN Matters – May 2007~*

MLN Matters Number: MM5568  
 Related CR Release Date: March 19, 2007  
 Related CR Transmittal #: R1208CP

Related Change Request (CR) #: 5568  
 Effective Date: April 1, 2007  
 Implementation Date: April 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5568.pdf>**

Be aware that some of the new Form CMS-1500 (08-05) forms have been printed incorrectly. Recently it came to the attention of CMS that there are incorrectly formatted versions of the revised form being sold by print vendors. After reviewing the situation, CMS determined that the source files received from the authorized forms designer were improperly formatted. This resulted in the sale of printed forms and negatives which do not comply with the form specifications. Therefore, CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. The specific formatting issue involves top and bottom margins only, but may not be isolated to only top and/or bottom.

## INVALID SKILLED NURSING FACILITY (SNF) INFORMATIONAL UNSOLICITED RESPONSES (IURS) FROM MEDICARE'S COMMON WORKING FILE (CWF) SYSTEM

~CMS MLN Matters – June 2007~

MLN Matters Number: MM5587  
 Related CR Release Date: April 27, 2007  
 Related CR Transmittal #: R274OTN

Related Change Request (CR) #: 5587  
 Effective Date: April 27, 2007  
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5587.pdf>

Medicare systems may have inadvertently rejected outpatient, Part B, and DME claims that overlapped periods of a SNF stay by a beneficiary, whose Medicare SNF benefits were exhausted and for whom a non-pay SNF claim was submitted to Medicare. This problem may have affected some of your claims processed by Medicare from October 2, 2006 until January 29, 2007, when Medicare systems were fixed. You need not take any action as your Medicare contractor will take steps to adjust any claims affected and to reverse or stop any payment recovery actions.

## QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI) EDITS, VERSION 13.1, EFFECTIVE APRIL 1, 2007

~CMS MLN Matters – April 2007~

MLN Matters Number: MM5492  
 Related CR Release Date: March 9, 2007  
 Related CR Transmittal #: R1201CP

Related Change Request (CR) #: 5492  
 Effective Date: April 1, 2007  
 Implementation Date: April 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5492.pdf>

CR 5492, from which this article is taken, gives your carriers and A/B MACs the latest package of Correct Coding Initiative (CCI) edits. These edits (Version 13.1), which include all previous versions and updates from January 1, 1996, will be effective on April 1, 2007.

## REQUIREMENT FOR PROVIDING ROUTE OF ADMINISTRATION CODES FOR ERYTHROPOIESIS STIMULATING AGENTS (ESAS)

~REVISED CMS MLN Matters – June 2007~

MLN Matters Number: MM5480 Revised  
 Related CR Release Date: March 30, 2007  
 Related CR Transmittal #: R1212CP

Related Change Request (CR) #: 5480  
 Effective Date: January 1, 2007  
 Implementation Date: June 29, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5480.pdf>

Note: This article was revised April 30, 2007, to replace one of the HCPCS codes on page 2 (Q4055) with J0886.

CR 5480, from which this article is taken, instructs all providers and suppliers on the voluntary reporting of route of administration modifiers on claims for Erythropoiesis Stimulating Agents (ESAs) for ESRD beneficiaries. Route of administration modifiers were published and effective January 1, 2007, for reporting on Medicare claims submitted on or after February 1, 2007, for dates of service on or after January 1, 2007. Please see the background section for details.

## REVISIONS TO FORM CMS-1500 SUBMISSION REQUIREMENTS

~CMS MLN Matters – May 2007~

MLN Matters Number: MM5489  
 Related CR Release Date: March 30, 2007  
 Related CR Transmittal #: R1215CP

Related Change Request (CR) #: 5489  
 Effective Date: April 1, 2007  
 Implementation Date: April 30, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5489.pdf>

The language contained in the *Medicare Claims Processing Manual*, Chapter 26, regarding the Form CMS-1500 is being updated to reflect current processing guidelines and incorporate recent data collection decisions made by CMS. CR5489 makes the following updates to the CMS-1500 requirements:

- The requirement to submit the provider's Social Security Number in Box 25 has been removed;
- The requirement to report the PIN of the Skilled Nursing Facility in Box 23 has been removed; and
- Clarification language was added to Box 17a, indicating the qualifier 1G precedes the Unique Physician Identification Number (UPIN).

In addition, language has been added regarding the completion of Item 25 (the provider of service or supplier federal tax identification number). Medicare providers are not required to complete this item for crossover claim purposes, since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the Coordination of Benefits (COB) outbound claim. However, tax identification information is used in the determination of accurate National Provider Identification (NPI) reimbursement. Thus, reimbursement of claims submitted without tax identification information may be delayed.

**REVISIONS TO INCOMPLETE OR INVALID CLAIMS INSTRUCTIONS NECESSARY TO IMPLEMENT THE REVISED HEALTH INSURANCE CLAIM FORM CMS-1500 (VERSION 8/05)**

*~REVISED CMS MLN Matters – April 2007~*

MLN Matters Number: MM5391 Revised  
 Related CR Release Date: February 23, 2007  
 Related CR Transmittal #: R1187CP

Related Change Request (CR) #: 5391  
 Effective Date: May 23, 2007  
 Implementation Date: May 23, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5391.pdf>**

**Note:** This article was revised on March 20, 2007, to eliminate the words “electronically submitted” from the bullet point at the top of page 3. All other information remains the same.

This article is based on CR 5391 which revises the *Medicare Claims Processing Manual* (Publication 100-04; Chapter 1, Section 80.3.2) relating to the handling of incomplete and invalid claims to reflect the changes in reporting items for the National Provider Identifier (NPI) on the revised Form CMS-1500 version 08/05 and updates the references to remark codes in the instructions and revises the instructions to indicate what is consistent with HIPAA guidelines. These changes apply to claims received on or after May 23, 2007.

**VENTRICULAR ASSIST DEVICES (VADS)**

*~CMS MLN Matters – May 2007~*

MLN Matters Number: MM5516  
 Related CR Release Date: April 13, 2007  
 Related CR Transmittal #: R68NCD

Related Change Request (CR) #: 5516  
 Effective Date: March 27, 2007  
 Implementation Date: May 14, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5516.pdf>**

This article is based on Change Request (CR) 5516 which announces that, effective March 27, 2007, new facility criteria are established and hospitals must receive certification from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under their Disease Specific Certification Program for Ventricular Assist Devices (VADs). The new criteria apply to hospitals that implant VADs for the destination therapy indication.

**Coverage**

**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



**New Policies**

Policy	Title	Policy Type	Published
PHYS-078	Independent Diagnostic Testing Facilities (IDTFs)	LCD	May 2007
PHYS-080	Intracranial Percutaneous Transluminal Angioplasty (PTA) With Stenting	NCP	May 2007
RAD-037	3D Interpretation and Reporting of Imaging Studies	LCD	May 2007

**Policy Revisions**

Policy	Title	Policy Type	Published
AMB-001	Ambulance Services	NCP	May 2007
ASC-001	Ambulatory Surgical Centers (ASC)	NCP	June 2007
CV-039	Percutaneous Transluminal Angioplasty (PTA) (Carotid and Intracranial Stents)	NCD	June 2007
DERM-004	Mohs' Micrographic Surgery (MMS)	LCD	April 2007
DERM-008	Removal of Benign Skin Lesions	LCD	April 2007
FT-001	Foot Care	NCP	April 2007
GI-008	Colorectal Cancer Screening Benefit	NCD	April 2007
GI-009	Telemetric Gastrointestinal Capsule Imaging	LCD	May 2007
GSURG-042	Bariatric Surgery for Morbid Obesity; Coding and Billing Guidelines	NCD	June 2007
HONC-002	Chemotherapy and Drug Administration	NCP	April 2007
HONC-010	Antineoplastics and their Adjuncts	LCD	April 2007
OPHTH-025	Corneal Pachymetry	LCD	June 2007
PHYSMED-009	Physical Medicine and Rehabilitation	LCD	April 2007
PHYS-067	Medical Devices	NCD	May, June 2007
PSYCH-015	Health and Behavior Assessment/Intervention	LCD	April 2007



### BILLING FOR MAZE PROCEDURE PERFORMED CONCURRENTLY WITH OTHER OPERATIVE HEART PROCEDURES

~April 2007~

It is not correct to bill one of the three new (2007) CPT codes (33254, 33255, 33256) for operative tissue ablation and reconstruction of the cardiac atria (MAZE) when performed with other operative cardiac procedures. In this situation, providers should use the NOC code 33999. In Item 19 of the CMS 1500 claim form (or the equivalent field of an electronic claim form), providers should put one of the following descriptions which best describes the 33999 service performed when another operative cardiac procedure was performed:

- 1) 33254 concurrent MAZE
- 2) 33255 concurrent MAZE
- 3) 33256 concurrent MAZE

Please note that you cannot actually bill 33999 AND CPT 33254, CPT 33255, or CPT 33256. The use of CPT 33254, 33255, or 33256 in item 19 is for describing the extent of the MAZE service performed. It is only informational. The choice of code depends on whether the procedure was *limited*, *extensive*, or *extensive with cardiopulmonary bypass*. This coding instruction is effective January 1, 2007.

**BLOOD BRAIN BARRIER OSMOTIC DISRUPTION FOR TREATMENT OF BRAIN TUMORS**

*~CMS MLN Matters – May 2007~*

MLN Matters Number: MM5530  
 Related CR Release Date: April 6, 2007  
 Related CR Transmittal #: R67NCD

Related Change Request (CR) #: 5530  
 Effective Date: March 20, 2007  
 Implementation Date: May 7, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5530.pdf>**

Effective for claims with dates of service on or after March 20, 2007, the use of osmotic blood brain barrier disruption is not considered reasonable and necessary when it is used as part of a treatment regimen for brain tumors in Medicare patients.

**BONE MASS MEASUREMENTS (BMMs)**

*~CMS MLN Matters – June 2007~*

MLN Matters Number: MM5521  
 Related CR Release Date: May 11, 2007  
 Related CR Transmittal #: R1236BP,R70BP, R69NCD

Related Change Request (CR) #: 5521  
 Effective Date: January 1, 2007  
 Implementation Date: July 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5521.pdf>**

Effective for dates of service on or after January 1, 2007, Medicare will pay for BMM services for dual-energy x-ray absorptiometry (CPT code 77080) when this procedure is used to monitor osteoporosis drug therapy. In addition, new CPT were assigned to BMMs.

Medicare edits will deny claims that are not consistent with revised BMM policy and providers may be liable for noncovered BMMs unless they have issued an advanced beneficiary notice (ABN) as required. This article explains the changes as a result of the CY2007 Physician Fee Schedule Final Rule.

**CANALOPLASTY FOR THE TREATMENT OF GLAUCOMA**

*~June 2007~*

Several new approaches to glaucoma surgery have been devised over the last decade. One new approach for primary glaucoma surgery, the canaloplasty procedure, uses unique microcatheter techniques to dramatically reduce intraocular pressure (IOP) by reestablishing normal aqueous outflow for the eye.

Canaloplasty was granted two new Category III surgical CPT codes in 2006

- 0176T – Dilation of aqueous outflow canal: without retention of device or stent
- 0177T – with retention of device or stent

CMS has taken the following action effective as of January 1, 2007: In the hospital outpatient setting it was assigned to APC 0673 level IV Anterior Segment. In the ASC setting: It was listed in group 9.

Canaloplasty will be covered if it is medically necessary, for example in those patients where pharmacotherapy is no longer effective, not tolerated or contraindicated. The payable ICD-9 codes would be:

- Primary open angle glaucoma
- Chronic closed-angle glaucoma
- Pseudoexfoliation glaucoma
- V45.69 Other states following surgery of the eye or adnexa

Coverage for this procedure will become effective June 1, 2007.

**CAVERNOUS NERVES ELECTRICAL STIMULATION WITH PENILE PLETHYSMOGRAPH**

*~REVISED CMS MLN Matters – April 2007~*

MLN Matters Number: MM5294 Revised  
 Related CR Release Date: November 24, 2006  
 Related CR Transmittal #: R61NCD

Related Change Request (CR) #: 5294  
 Effective Date: August 24, 2006  
 Implementation Date: January 8, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5294.pdf>**

**Note:** This article was changed on December 6, 2006 to correct the HCPCS code for the test. The article had incorrectly stated to use HCPCS code 58899 (page 3), but it should have stated HCPCS code 55899. The reference to carriers and FIs was also changed to add a reference to A/B MACs.

**Impact to You:** Effective for claims with dates of service on or after August 24, 2006, Medicare will not pay for performing Cavernous Nerves Electrical Stimulation with Penile Plethysmography in Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

**What You Need to Know:** Change Request (CR) 5294, from which this article is taken, announces the results of a national coverage determination (NCD) addressing Cavernous Nerves Electrical Stimulation with Penile Plethysmography performed for Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures. It states that CMS, after reviewing the evidence, has determined that this test is not reasonable and necessary for Medicare beneficiaries undergoing these procedures.

## COVERAGE OF ERYTHROPOIESIS STIMULATING AGENTS (ESAs)

~April 2007~

**Coverage of Erythropoiesis Stimulating Agents (ESAs) for anemia of cancer will be terminated March 19, 2007 based on new evidence that indicates this may not be safe and effective treatment.**

Due to the results of a recent study, the *USPDI* has removed coverage for this condition. There are now new boxed warnings for these drugs. WPS, like all other Medicare contractors, is bound by the Medicare Benefit Policy Manual (CMS Pub 100 -02). Section 50.4.5 of this national document states:

"If a use is identified as not indicated by CMS or the FDA, or it's use is specifically identified as not indicated in one or more of the three compendia mentioned or if the carrier determines, based on peer reviewed literature, that a particular use of the drug is not safe and effective, the off-label use is not supported and, therefore, the drug is not covered."

Similarly, in the Program Integrity Manual (CMS Pub 100-08) the following section indicates that Medicare carriers can restrict coverage without going to a Carrier Advisory Committee (CAC) if they receive CMS Regional Office approval. Our regional office, has approved this restriction of coverage.

**PIM 13.7.3 - LCDs That Do Not Require a Comment and Notice Period (Rev. 71, 04-09-04)  
Revised LCD Being Issued for Compelling Reasons - SHALL OBTAIN RO (for PSCs, the GTL, Co-GTL, and SME) APPROVAL - For example, a highly unsafe procedure/device.**

WPS Medicare revised LCD INJ-023, Erythropoiesis Stimulating Proteins, Epoetin alfa (EPO), Darbepoetin alfa (DPA), based on the above information.

## EXTRACORPOREAL PHOTOPHERESIS

~CMS MLN Matters – May 2007~

MLN Matters Number: MM5464

Related CR Release Date: March 16, 2007

Related CR Transmittal #: R1206CP and R66NCD

Related Change Request (CR) #: 5464

Effective Date: December 19, 2006

Implementation Date: April 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5464.pdf>

CR 5464, from which this article is taken, announces (effective December 19, 2006), the expansion of coverage of extracorporeal photopheresis to include patients with acute cardiac allograft rejection and chronic graft versus host disease whose disease is refractory to standard immunosuppressive drug treatment.

## GSURG-037 APPLICATION OF BIOENGINEERED SKIN SUBSTITUTES AND SKIN GRAFT

~May 2007~

WPS has received multiple inquiries regarding updates made to the local coverage decision GSURG-037 Application of Bioengineered Skin Substitutes and Skin Grafting \*(Wound Care).

- Does this new Local Coverage Decision (LCD) apply to wound care that provides removal of necrotic tissue for patients who are not candidates for a skin substitute or graft?**  
Yes, LCD GSURG-037 now includes all wound care. Since wound care is closely related to skin substitutes and/or grafting, this information was added to LCD GSURG-037.
- LCD GSURG-037 has different information in the actual policy and the Billing and Coding Guidelines regarding covered place of service for CPT codes 11043 and 11044. Which is correct?**

11043	Debridement; skin, subcutaneous tissue, and muscle
11044	Debridement; skin, subcutaneous tissue, muscle, and bone

Both the LCD and Billing and coding guidelines have been updated to reflect that CPT codes 11043 and 11044 may be rendered in places of services inpatient hospital, outpatient hospital and ambulatory care centers (ASC). If the service is rendered in another place of service, please request an appeal with a copy of the operative report and plan of care.

**3. Why is WPS denying CPT code 11043 when the chronic nature of these wounds is that debilitated elderly patient frequently requires multiple debridements of necrotic tissue and slough, which is beneficial to wound healing, and prevents morbidity and mortality from wound progression and generalized sepsis?**

WPS agrees that the chronic nature of these wounds in the debilitated elderly patient frequently requires multiple debridements of necrotic tissue and slough, which is beneficial to wound healing, and prevents morbidity and mortality from wound progression and generalized sepsis. However, the correct coding to bill for these services with rare exception is CPT code 97597 or 97598.

97597 Removal of devitalized tissue from wound(s), selective debridement without anesthesia (e.g., high pressure water jet with/without suction, sharp debridement with scissors, scalpel and forceps), with/without use of whirlpool, topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 20 square centimeters.

97598 Removal of devitalized tissue from wound(s), selective debridement without anesthesia (e.g., high pressure water jet with/without suction, sharp debridement with scissors, scalpel and forceps), with/without use of whirlpool, topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 20 sq. cm.

CPT codes 11043 and 11044 are codes that describe deep debridement of the muscle and bone. Once the initial debridement of muscle and or bone has been performed, there typically is no true necrotic muscle or bone there to be subsequently debrided. Thus, the CPT codes 97597 and 97598 are what typically are performed for subsequent debridement services. Similarly, it is expected that with any debridement, especially in a long-term facility, that daily wound care would be performed by the nursing staff.

**4. The majority of the ulcers I treat are either Stage III or Stage IV wounds. I have to bill these services using CPT codes 11043 or 11044**

The issue in this LCD is not the stage of the wound; it is what procedure is actually being performed. A Stage III wound is not automatically billed with CPT code 11043 nor is a Stage IV wound automatically billed with a CPT code 11044.

**5. The AMA CPT Assistant states that CPT codes 97597 or 97598 are non-physician codes and physicians should use CPT codes 11040-11044 when billing debridement of a wound.**

Medicare does not acknowledge *CPT Assistant* as a coding authority.

On page xiv of *CPT 2007*(professional edition), it states:

"It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any section of this book may be used to designate the service rendered by any qualified physician or other qualified health care professional."

Similarly, on page 416, there is no mention of any restrictions on this code to any specialty.

Medicare Part B covers medically necessary wound debridements performed by non-physician practitioners. CPT codes 97597-97606 should be used by all providers to bill active wound care. Most likely, when a beneficiary requires repeated debridement, CPT 97597 or 97598 is the service performed, although at times CPT 11040-11042 may also be the true service.

## INSTRUCTIONS FOR IMPLEMENTING THE CENTERS FOR MEDICARE & MEDICAID (CMS) RULING CMS 1536-R; ASTIGMATISM-CORRECTING INTRAOCULAR LENS (A-C IOLS)

~CMS MLN Matters – June 2007~

MLN Matters Number: MM5527  
Related CR Release Date: April 27, 2007  
Related CR Transmittal #: R1228CP

Related Change Request (CR) #: 5527  
Effective Date: January 22, 2007  
Implementation Date: May 29, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5527.pdf>**

This article is based on Change Request (CR) 5527 which discusses a recent Administrator Ruling from the Centers for Medicare & Medicaid Services (CMS) regarding astigmatism-correcting intraocular lenses (A-C IOLS) following cataract surgery (CMS-1536-R). **The new policy is effective for dates of service on and after January 22, 2007. Physicians and providers need to be aware that effective January 22, 2007:**

- Medicare will pay the same amount for cataract extraction with A-C IOL insertion that it pays for cataract extraction with conventional IOL insertion.
- **The beneficiary is responsible for payment of that portion of the hospital or ambulatory surgery center (ASC) charge for the procedure that exceeds the facility's usual charge for cataract extraction and insertion of a conventional IOL following cataract surgery, as well as any fees that exceed the physician's usual charge to perform a cataract extraction with insertion of a conventional IOL.**

In addition, CMS reminds physicians that they can be reimbursed for the conventional or A-C IOL (V2632) only when the service is performed in a physician's office. Also, when physicians perform cataract surgery in an ASC or hospital outpatient setting, the physician may only bill for the professional service because payment for the lens is bundled into the facility payment for the cataract extraction.

## INTERSPINOUS PROCESS DECOMPRESSION SYSTEM

~April 2007~

WPS Medicare Part B will cover the implantation of an Interspinous Process Decompression System in accordance to the 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 codes 0171T, *Insertion of posterior spinous process distraction device, lumbar; single level*, and 0172T, *Insertion of posterior spinous process distraction device, lumbar; each additional level*. These codes became effective 01/01/2007. 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 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.

## RETIRED NCDS/NCP

~June 2007~

The following National Coverage Determination (NCD) and National Coverage Provision (NCP) policy documents will be retired effective 06/30/2007.

- CV-031-External Counterpulsation (ECP) Therapy for Severe Angina
- GU-018-Cryosurgery of Prostate
- OPTH-024-Glaucoma Screening
- PHYS-074-Home Prothrombin Time (INR) Monitoring for Anticoagulation Management

The national coverage criteria and Medicare regulations for these services remain in place. Reference and note the following Medicare Internet-Only Manual (IOM) section for these services at:

**<http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>**

- External Counterpulsation (ECP) Therapy for Severe Angina, CMS Pub.100-03 §20.20; CMS Pub.100-04 Ch. 32 §§130-130.2
- Cryosurgery of Prostate, CMS Pub.100-03 §230.9; MCM §§4174-4174.4
- Glaucoma Screening, CMS Pub.100-02 Ch.15 §280.1; CMS Pub.100-04 Ch.18 §§70-70.3
- Home Prothrombin Time (INR) Monitoring for Anticoagulation Management, CMS Pub.100-03 §190.11; CMS Pub.100-04 Ch.32 §§60-60.8.1

**UPDATE TO MEDICARE CLAIMS PROCESSING MANUAL, PUBLICATION 100-04, CHAPTER 18, SECTION 60.1 REGARDING COLORECTAL SCREENING SERVICES**

*~CMS MLN Matters – May 2007~*

MLN Matters Number: MM5541  
 Related CR Release Date: March 30, 2007  
 Related CR Transmittal #: R1217CP

Related Change Request (CR) #: 5541  
 Effective Date: July 1, 2007  
 Implementation Date: July 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5541.pdf>**

The Centers for Medicare & Medicaid Services (CMS) is aware that Chapter 18, Section 60.1 of the *Medicare Claims Processing Manual* (Publication 100-04) needed clarification regarding application of the annual Part B deductible for **diagnostic** colorectal services. Section 5113 of the Deficit Reduction Act (DRA) of 2005 **waived** the requirement for the annual Part B deductible for **screening** colorectal services, **NOT diagnostic** colorectal services. CR5541 clarifies that portion of the manual.

The following are the key points of the revised portion of Chapter 18, Section 60.1 of the *Medicare Claims Processing Manual*, which is attached to CR5541.

- Prior to January 1, 2007, deductible and coinsurance apply to HCPCS codes G0104, G0105, G0106, G0120, and G0121. On or after January 1, 2007, the annual Part B deductible is waived for the listed HCPCS coded screening services. Coinsurance still applies.
- Coinsurance and deductible applies to the diagnostic colorectal service codes 45330, 45378, and 74280.

**Electronic Data Interchange (EDI)**

**ATTENTION ALL PROVIDERS: ARE YOU PREPARING FOR NPI?**

*~June 2007~*

All providers should be preparing for National Provider Identifier (NPI), getting enumerated, determining their vendor readiness, and preparing their billing systems.

How will you know if you have potential NPI issues? Start using your NPI as soon as you are able.

The Electronic Media Claims (EMC) system reviews every claim for a number of pre-pass edits to ensure that claim data is valid; this includes NPI validation and verification. Your Batch Detail Control Listing returns information regarding NPIs sent on your electronic claims; validating the structure of the NPI and verifying the NPI or NPI/legacy number combination are on the crosswalk.

Watch for pre-pass edits in the M340 - M351 range. The edits in this range indicate there is a problem with your NPI. Providers not receiving edits in M340 - M351 range do not have problems with NPI.

It is extremely important to use the Legal Business name when applying for the NPI. The Legal Business name is the name reported to the Internal Revenue Service (IRS). Also, be sure to add any of your current legacy ID numbers, Medicare PIN, UPIN, etc., when applying for an NPI or if you need to update your record within NPPES.

The NPI enumerator Website is: <https://NPPES.cms.hhs.gov/NPPES/Welcome.do>

Once you have updated NPPES if you still continue to receive the informational errors on your report, please contact the EDI Hotline for assistance at:

**Illinois/Michigan/Minnesota (877) 567-7261**  
**Minnesota (952) 885-2882, (952) 885-2881, or (952) 885-2811**

### ATTENTION ELECTRONIC BILLERS

~June 2007~

All forms being submitted to Electronic Data Interchange (EDI) must contain both the Medicare Part B legacy number and the National Provider Identifier (NPI) number. If the form you are using does not have fields for both of these items, please go to the WPS Website at [http://www.wpsic.com/edi/tools\\_p.shtml?mm=3](http://www.wpsic.com/edi/tools_p.shtml?mm=3) to download the most current forms.

Please keep in mind that only one set of paperwork should be turned in for the group provider number. Do not send in a separate form for each provider within the group. Once the group is signed up, all providers belonging to or joining that group in the future will already be set up.

### IMPORTANT NOTICE FOR ELECTRONIC MEDICARE SECONDARY PAYOR SUBMITTERS

~June 2007~

After a claim has been processed by the primary payer, you must include Claim Adjustment Reason Codes (CARC) when sending it to Medicare for processing. One very commonly used code is being deactivated as of June 1, 2007. Code 42 "Charges exceed our fee schedule or maximum allowable amount" will be deactivated on June 1, 2007. This has been replaced with code 45 "Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." Claims may be rejected if the codes you are submitting are not valid at the time the claim is submitted.

The CARC are updated three times a year, and are posted at <http://wpc-edi.com/codes>

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

**Illinois/Michigan/Minnesota (877) 567-7261**  
**Minnesota (952) 885-2882, (952) 885-2881, or (952) 885-2811**

### MEDICARE REMIT EASY PRINT

~May 2007~

The quarterly update to the Medicare Remit East Print (MREP) software has been released by the Centers for Medicare & Medicaid Services (CMS) on April 2, 2007. MREP Version 2.1 is now available at: <http://www.wpsmedicare.com/provider/provhome.shtml>

#### Medicare Remit Easy Print v2.1 (Production) Change Summary

1. Issues #20178: NDC (National Drug Code) not displaying correctly  
 A correction will be made to the MREP software to correctly display the NDC from the 2110.SVC01-2 data field when "N4" is present in the 2110.SVC01-1 data field when previewing/printing from the Claim Detail tab and Entire Remittance option.

To find out more about MREP and/or for information on receiving a HIPAA compliant ERA, please contact the EDI Hotline at:

**Illinois/Michigan/Minnesota (877) 567-7261**  
**Minnesota (952) 885-2882, (952) 885-2881, or (952) 885-2811**

### NATIONAL PROVIDER IDENTIFIER (NPI) READINESS – CRUCIAL TO PROVIDERS

~April 2007~

NPI is almost here – the requirement that only NPI numbers be used for Medicare claims processing. Have you taken all the steps you should to make sure there is no interruption in your cash flow? Here are some examples of actions you should take.

Make sure you have applied for your NPI number. Don't be caught without an NPI when the deadline arrives. Obtain your NPI by going on-line to: <https://NPPES.cms.hhs.gov/NPPES/Welcome.do> or calling 800-465-3203. Be sure to enter all of your Medicare legacy numbers to the NPPES Website to avoid problems later.

Begin using your NPI number on your electronic claims transmissions. We recommend you still use your Medicare legacy numbers in conjunction with the NPI, but give yourself plenty of time to make sure your NPI is correctly billed. Don't wait until the last minute then find you need programming changes. This could adversely affect your cash flow.

Don't forget to put your NPI number on any forms you submit to the EDI area – NPI is a condition for EDI Enrollment. Make sure you use the NPI number that corresponds with your provider number.

Check your electronic Medicare reports when you use the NPI number on your transmissions. Make sure your NPI is not receiving edits indicating that your number is not on the NPI Crosswalk. See our March 2007 *Communiqué* for steps to take if you are receiving these informational edits. One hint to avoid these edits is to be sure to add your Medicare legacy numbers on the NPPES Website.

**PC-ACE PRO32 SOFTWARE FOR AMBULANCE BILLING**

*~April 2007~*

Per CMS Change Request (CR) 5390, effective April 2, 2007, Form CMS-1491 will no longer be a valid format for submitting claims. As of April 2, 2007, suppliers are no longer permitted to submit paper claims on the CMS-1491 form. To read more about this CR, please see the CMS MLN Matters Article at the following Website <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5390.pdf>

WPS Medicare has a HIPAA-compliant software product available for all types of Medicare billing called PC-ACE Pro32. This software may be used for specialty billing, such as ambulance as well as regular office visits. This software will allow you to submit your Medicare claims electronically. The newest version of PC-ACE Pro32 also allows for your new NPI number.

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

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

PC-ACE Pro32 software can now be downloaded from our Website. If you are interested in using PC-ACE Pro32, download the PC-ACE request form from: <http://www.wpsic.com/edi/pdf/medbpcace.pdf> or call the EDI Hotline at the numbers below. If you are currently using the PC-ACE Pro32 billing software, you can now download the most current upgrade at: [http://www.wpsic.com/edi/pcacepro32\\_p.shtml](http://www.wpsic.com/edi/pcacepro32_p.shtml)

**YOUR 837 4010 EMC PRE-PASS REPORT**

*~May 2007~*

The Electronic Media Claims (EMC) system reviews every claim for a number of pre-pass edits to ensure that claim data is valid. It is very important that you review this report to ensure that your claims are being accepted into the Medicare processing system. Currently there are a number of edits set to informational regarding the National Provider Identifier (NPI). If you are sending NPIs along with your Medicare legacy numbers, the EMC system will verify that they are on the NPI crosswalk file. If a match is not found on the crosswalk file, an informational edit will set on your report. The edits are M340 through M351. Be sure to review your pre-pass reports. If an edit sets, verify the information on the report; e.g. if M340 sets, the field in error is the B00999.

H99RAR04	WISCONSIN PHYSICIANS SERVICE	PAGE 1
	PROFESSIONAL EMC PROGRAM	
PRODUCTION	MEDICARE-B EMC INPUT	
	BATCH DETAIL CONTROL LISTING	
SUBMITTER ID: 99999	SUBMITTER NAME: BUSINESSXX	
ADDRESS: STREETXX.		
CITY: CITYXX		
STATE/ZIP: STXX ZIPCODEXX		
PROCESS DATE: 05/01/07		
EMC PROVIDER : NPI#: 1234567890	PIN#: B00999	BATCH NUMBER : 9999
- PROV	PROV REFERENCE	REC TYPE DTL FIELD IN FIELD ERR MESSAGE ERROR
NPI#	PIN# NUMBER	NUM ERROR CONTENTS NUM SEVERITY
-----		
0 1710908058	B00999 9999	2010AAREF REF01 B00999 M340 PIN/NPI CROSSWALK ERROR
		INFORMATIONAL
0	EMC PROVIDER : NPI#: 1234567890	PIN: B00999 BATCH STATUS : ACCEPTED
110136	2310B REF REF01	L99999 M343 PIN/NPI CROSSWALK ERROR INFORMATIONAL
0	HIC FOR ABOVE CLAIM IN ERROR: 333333333A	ICN: 0907099999990

If an informational edit is in effect, the claim, batch, or file will process normally. The informational edit identifies the error and **alerts the submitter in order to correct** issue. Some of the most common crosswalk edits:

- M340 Billing provider PIN and NPI mismatch: The legacy provider number and the NPI reported in the 837 do not match the crosswalk. Verify that the NPI on the report (and in your 837) is the correct NPI for the legacy number listed.
- M343 Rendering provider PIN and NPI mismatch: The rendering provider PIN and NPI reported in the 837 do not match the crosswalk.

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

Some common NPI billing experiences:

- Billing provider has an individual's NPI listed, rather than organization's NPI.
- Reporting same NPI at billing and rendering.
- Unincorporated solo provider has registered tax ID with NPPES and therefore obtained an organization NPI that they don't need.
- Reporting NPI for an individual provider at rendering but not referring level.
- Reporting incorrect EIN for NPI.
- NM102 with incorrect value for individual or organization; should = 1 for person and 2 for non person.

The first step in alleviating the error is to go to the NPI enumerator and add any of your current legacy ID numbers, Medicare PIN, UPIN, etc. If after you have added these, you continue to receive the informational errors on your report, please contact the EDI Hotline:

**Illinois/Michigan/Minnesota (877) 567-7261**  
**Minnesota (952) 885-2882, (952) 885-2881, or (952) 885-2811**

The NPI enumerator Website is:  
<http://NPPES.cms.hhs.gov/NPPES/Welcome.do>

**YOUR 837 4010 EMC PRE-PASS REPORT**  
 ~June 2007~

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

1. If an informational edit is in effect, the claim, batch, or file will process normally. The informational edit identifies the error and alerts the submitter in order to correct future claims.
2. If a delete edit is in effect, the claim, batch, or file will not process normally; it deletes from the claims processing system and alerts the submitter to the error.

It is very important that you review this report to ensure that your claims are being accepted into the Medicare processing system. Currently there are a number of edits set to informational regarding the National Provider Identifier (NPI). **These crosswalk edits will soon be batch and claim deletions!** Be sure to read your report and resolve issues as soon as possible. If you are sending NPIs along with your Medicare legacy numbers, the EMC system will verify that they are on the NPI crosswalk file. If a match is not found on the crosswalk file, an informational edit will set on your report. The edits are M340 through M351. Be sure to review your prepass reports. If an edit sets, verify the information on the report; e.g. if M340 sets, the field in error is the B00999.

```

H99R&R04
PRODUCTION
WISCONSIN PHYSICIANS SERVICE
PROFESSIONAL EMC PROGRAM
MEDICARE-B EMC INPUT
BATCH DETAIL CONTROL LISTING
SUBMITTER ID: 99999 SUBMITTER NAME: BUSINES3XX
ADDRESS: STREETXX
CITY: CITYXX
STATE/ZIP: STXX,ZIPCODEXX
PROCESS DATE: 05/01/07

EMC PROVIDER : NPI#: 1234567890 PIN#: B00999 BATCH NUMBER : 9999
- PROV PROX REFERENCE REC TYPE DTL FIELD IN FIELD ERR MESSAGE
  NPI# PIN# NUMBER NUM ERROR CONTENTS NUM
-----
0 1710908058 B00999 9999 2010A&REF REF01 B00999 M340 PIN/NPI CROSSWALK ERROR
0 EMC PROVIDER : NPI#: 1234567890 PIN: B00999 BATCH STATUS : ACCEPTED
0 110136 2310B REF REF01 L99999 M343 PIN/NPI CROSSWALK ERROR
||0 HLT FOR ABOVE CLAIM IN ERROR: 333333333A ICM: 0907099999990
    
```

If an informational edit is in effect, the claim, batch, or file will process normally. The informational edit identifies the error and **alerts the submitter in order to correct** the issue. Some of the most common crosswalk edits:

- M340 Billing provider PIN and NPI mismatch: The legacy provider number and the NPI reported in the 837 do not match the crosswalk. Verify that the NPI on the report (and in your 837) is the correct NPI for the legacy number listed.
- M343 Rendering provider PIN and NPI mismatch: The rendering provider PIN and NPI reported in the 837 do not match the crosswalk.

A complete list of current 4010A1 pre-pass edits, as well as a detailed description, is available in the WPS Bulletin Board in the EDI file library in the HIPAA directory (file name: 4010A1.doc) or on the WPS Website:

[http://www.wpsic.com/edi/pdf/hipaa\\_mcs837.pdf](http://www.wpsic.com/edi/pdf/hipaa_mcs837.pdf)

Some common NPI billing experiences:

- Billing provider has an individual's NPI listed, rather than organization's NPI.
- Reporting same NPI at billing and rendering.
- Unincorporated solo provider has registered tax ID with NPPES and therefore obtained an organization NPI that they don't need.
- Reporting NPI for an individual provider at rendering but not referring level.
- Reporting incorrect EIN for NPI.
- NM102 with incorrect value for individual or organization; should = 1 for person and 2 for non person.

The first step in alleviating the error is to go to the NPI enumerator and add any of your current legacy ID numbers, Medicare PIN, UPIN, etc. If after you have added these, you continue to receive the informational errors on your report, please contact the EDI Hotline for assistance at: for IL, MI and WI: 877-567-7261, or for MN: 952-885-2811, 952-885-2881, or 952-885-2882. The NPI enumerator Website is:

<https://NPPES.cms.hhs.gov/NPPES/Welcome.do>

If you fail to prepare, you may not be able to send electronic claims or receive electronic remittances or conduct any of the other HIPAA transactions, significantly impacting your business and cash flow.

## General Information

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

~REVISED CMS MLN Matters – June 2007~

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>

This article was revised on May 8, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS Website.

#### Key Points

- CMS is implementing the revised Form CMS-1500, which accommodates the reporting of the NP).
- 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).

### CENTRALIZED BILLING PERIOD FOR FLU, PPV

~April 2007~

According to the Centers for Medicare & Medicaid Services (CMS), the yearly enrollment period for centralized billing of influenza and Pneumococcal (PPV) immunizations is changed to September 1 through August 31, rather than October 1 through September 30. When an application for centralized billing from an individual or entity is approved, the approval is limited to the 12-month period from September 1 through the following August 31. The revised period more closely reflects the annual immunization pattern. It is the responsibility of the centralized biller to reapply to the CMS central office (CO) for approval each year by June 1. TrailBlazer Health Enterprises, which is the carrier selected to process the centralized billing claims, will not process claims for a centralized biller without permission from CMS CO.

Individuals and entities interested in centralized billing must contact the CMS CO, in writing, at the following address by June 1 of the year in which they wish to centrally bill.

Division of Practitioner Claims Processing, Provider Billing and Education Group, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop C4-10-08, Baltimore, Maryland, 21244

By agreeing to participate in the centralized billing program, providers agree to abide by the criteria located at [http://www.wpsmedicare.com/provider/central\\_bil\\_flu.shtml](http://www.wpsmedicare.com/provider/central_bil_flu.shtml)

### CHANGES TO THE LABORATORY NCD EDIT SOFTWARE FOR APRIL 2007

~CMS MLN Matters – April 2007~

MLN Matters Number: MM5514  
Related CR Release Date: March 9, 2007  
Related CR Transmittal #: R1200CP

Related Change Request (CR) #: 5514  
Effective Date: April 1, 2007  
Implementation Date: April 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5514.pdf>

This article and related Change Request (CR) 5514 announces the changes that will be included in the April, 2007 release of the edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). Effective for dates of service on or after April 1, 2007:

- The **new HCPCS code G0394** for Blood occult test (e.g., guaiac), feces, for single determination for colorectal neoplasm (i.e., patient was provided three cards or single triple card for consecutive collection) is added to the list of HCPCS codes for the Fecal Occult Blood Test NCD (190.34).

### DIFFERENTIATING MASS ADJUSTMENTS FROM OTHER TYPES OF ADJUSTMENTS AND CLAIMS FOR CROSSOVER PURPOSES AND REVISING THE DETAILED ERROR REPORT SPECIAL PROVIDER NOTIFICATION LETTERS

~REVISED CMS MLN Matters – April 2007~

MLN Matters Number: MM5472  
Related CR Release Date: February 28, 2007  
Related CR Transmittal #: R1189CP

Related Change Request (CR) #: 5472  
Effective Date: July 1, 2007  
Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5472.pdf>

**Note:** This article was revised on March 1, 2007, to reflect changes made to CR5472, which CMS revised on February 28, 2007. The CR transmittal number, release date, and Web address for accessing CR5472 have been revised. All other information remains the same.

**Impact to You:** This article is based on Change Request (CR) 5472, which implements changes to Medicare contractor systems so that their claim transmissions to the Coordination of Benefits Contractor (COBC) for mass adjustments and other kinds of adjustments may be differentiated from all other types of claims sent for crossover.

**What You Need to Know:** This will be accomplished through modifications to the 837 COB flat files and National Council for Prescription Drug Programs (NCPDP) Part B drug claim files, all of which are transmitted to the COBC on a daily basis.

Through CR5472, Medicare contractors' systems will be modified so that the COBC Detailed Error Report information that is printed on the outgoing special provider notification letters/report that you receive when claims will not be crossed over due to claim data errors will be modified to also include the error/trading partner rejection code and accompanying description. These changes to the special provider letters should enable your billing service to determine why claims that were previously selected by Medicare for crossover were not actually crossed over.

Without these changes, CMS would be unable to isolate mass adjustment claims as part of the national COBA crossover process. This change corrects a problem that the Centers for Medicare & Medicaid Services (CMS) encountered as part of its implementation of the Deficit Reduction Act (DRA). Also, providers would continue to be unaware of the specific reasons as to why their patients' claims were not crossed over.

### **INPATIENT, OUTPATIENT, OFFICE: WHERE IN THE WORLD IS MY PATIENT?**

*~April 2007~*

Choosing the correct place of service (POS) can be confusing when the patient is physically located at the hospital. The hospital can classify a patient in many different ways. The hospital can classify the patient as inpatient, outpatient, emergency room patient, or observation care patient. These classifications make a difference in the E&M services a physician may bill. Medicare only has two classifications – inpatient and outpatient.

There are special rules concerning patients registered with the hospital with either of the classifications listed above. There are three POS codes used when the patient is registered with the hospital. Discuss with the hospital the specific classification. Those POS codes are:

- 21 Inpatient Hospital
- 22 Outpatient Hospital – This would include Observation Care
- 23 Emergency Room

Physicians should bill professional services separately to Medicare Part B through the Part B contractor. Physician Professional services include the E/M service to treat the patient, the professional component of x-rays, cardiology services, etc. The physician or non-physician practitioner provides these services directly. Non-physician practitioners include nurse practitioners, clinical nurse specialists and physician assistants.

Medicare Part B cannot pay services as “incident to” when provided to a hospital inpatient or outpatient. The hospital includes the services of auxiliary personnel in the charges to Medicare Part A.

The hospital will bill technical services to Medicare Part A through the Fiscal Intermediary for Medicare payment. This is true whether hospital-employed personnel or other entities provide the service. Services provided by entities that lease space from the hospital to provide technical services would need to make arrangements with the hospital to receive payment. The hospital includes the technical service in their claim.

### **MEDICALLY UNLIKELY EDITS (MUEs)**

*~CMS MLN Matters – April 2007~*

MLN Matters Number: MM5495  
Related CR Release Date: March 9, 2007  
Related CR Transmittal #: R1202CP

Related Change Request (CR) #: 5495  
Effective Date: April 1, 2007  
Implementation Date: April 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5495.pdf>**

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as MUEs. The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs.

- An MUE is defined as an edit that tests claim lines for the same beneficiary, HCPCS code, date of service, and billing provider against a criteria number of units of service.
- For carrier claims, the MUEs will automatically deny or suspend claim line items containing units of service billed in excess of the MUE criteria and for FI claims, the MUEs will Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

### Key Points

- CR5495 announces the upcoming release of the next version of the MUEs, which is version 1.1.
- CR5495 states that Medicare carriers and A/B MACs will deny the entire claim line from non-institutional providers with units of service that exceed MUE criteria and pay the other services on the claims.
- FIs and A/B MACs will RTP claims from institutional providers with units of service that exceed MUE criteria.
- An appeal process will not be allowed for RTP'ed claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the National Correct Coding Contractor.
- Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"), and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

## MEDICARE PROVIDER ENROLLMENT: PHYSICIANS IN RESIDENCY AND FELLOWSHIP PROGRAMS

~June 2007~

For Medicare program purposes, the Centers for Medicare & Medicaid Services (CMS) defines "residents" as physicians participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools. Where a senior resident has a staff or faculty appointment or is designated, for example, a "fellow," it does not change the resident's status for the purposes of Medicare coverage and payment. As a general rule, the hospital's Medicare fiscal intermediary pays the hospital for services of residents as provider services.

### Services Furnished Within the Scope of Approved Training Programs

Medical and surgical services furnished by residents within the scope of their training program are covered as provider services. The term "provider services" includes services furnished within the provider setting and medical and surgical services furnished in a setting that is not part of the provider, where the hospital has agreed to incur all or substantially all of the costs of training in the nonprovider setting. Such services are reimbursed to the hospital by the hospital's Medicare fiscal intermediary and are not separately payable by Part B of the Medicare program. Resident physicians providing services only on this basis do not enroll in Part B of the Medicare program.

Note: Where the provider does *not* incur all or substantially all of the training costs in the nonprovider setting, and the services are performed by a licensed physician, the services are payable under Part B by the Medicare carrier, and the resident physician may enroll in Part B of the Medicare program.

### Services Furnished Outside the Scope of Approved Training Programs "Moonlighting" Services

Medical and surgical services furnished by residents that are *not* related to their training program, and that are performed outside the facility where they have their training program, e.g., in an urgent care clinic, are covered by Medicare Part B as physician services where both of the following requirements are met:

- The services are identifiable physician services, the nature of which requires performance by a physician in person and which contribute to the diagnosis or treatment of the patient's condition; and,
- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed.

When both of these requirements are met, the residents' services are considered to have been furnished by the residents in their capacity as physicians and not in their capacity as residents. Resident physicians meeting these requirements may enroll in Part B of the Medicare program for reimbursement based on the Medicare Physician Fee Schedule Database (MPFSDB).

Medical and surgical services furnished by residents that are *not* related to their training program, and that are *performed in an outpatient department or emergency room of the hospital where they have their training program*, are covered as physicians' services where all three of the following criteria are met:

- The services are identifiable physician services, the nature of which requires performance by a physician in person and which contribute to the diagnosis or treatment of the patient's condition;
- The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed; *and*,
- The services performed can be separately identified from those services that are required as part of the training program.

When these three criteria are met, the residents' hospital outpatient department and emergency room services are considered to have been furnished by the residents in their capacity as physicians and not in their capacity as residents. Resident physicians meeting these requirements may enroll in Part B of the Medicare program for reimbursement based on the MPFSDB.

Resident physicians eligible to enroll in Part B of the Medicare program do so by submitting a CMS 855I enrollment application and, where benefits are reassigned, a CMS 855R enrollment application. The entity to which benefits are reassigned must have enrolled with Medicare by completing a CMS 855B enrollment application. Medicare enrollment forms can be downloaded from the CMS Website:

**<http://www.cms.hhs.gov/CMSForms/>**

Resident physicians themselves, as well as academic medical institutions and other entities involved in enrolling resident physicians in the Medicare program, must ensure that CMS 855 enrollment application forms are complete and accurate when they are submitted; that they are submitted on the current version of the appropriate CMS-855 form(s); and that they contain all required supporting documentation, including a copy of the resident's license and copies of the National Provider Identifier (NPI) notifications received from the NPI Enumerator for both the resident and the entity to which the resident is reassigning Medicare benefits.

Note that the questions in CMS 855I Section 2.C. "Resident/Fellow Status" must be answered correctly and completely, and that the answers must be consistent both within Section 2.C. itself and with the information provided in Section 4, "Practice Location Information." The name and address of the *teaching hospital* ("facility") at which the physician is a resident or fellow must be reported in response to Question 1 in Section 2.C., and subsequent questions must be answered in light of the response to Question 1. When this section, or other required sections of the application, are not completed correctly, processing of the application is delayed because the needed information must be developed.

Questions regarding the provider enrollment process may be directed to our Provider Enrollment Department at these telephone numbers:

- 1-877-908-8476 for Wisconsin, Illinois, and Michigan; and,
- 1-866-564-0315 for Minnesota.

Completed enrollment applications for physicians practicing in Wisconsin, Illinois, and Michigan should be sent to:

Wisconsin Physicians Service Medicare Part B  
Provider Enrollment Department  
P.O. Box 8248  
Madison, WI 53708-8248

Applications being sent via courier should be delivered to  
1707 W Broadway  
Madison, WI 53713-1834

Completed enrollment applications for physicians practicing in Minnesota should be sent to  
Wisconsin Physicians Service Medicare Part B  
Provider Enrollment Department  
8120 Penn Avenue South, Suite 200  
Bloomington, MN 55431-1394

**MODIFICATION TO THE MODEL MEDICARE REDETERMINATION NOTICE (MRN) (FOR PARTLY OR FULLY UNFAVORABLE REDETERMINATIONS) AND THE ADMINISTRATIVE LAW JUDGE (ALJ) FILING LOCATIONS WHERE THE PLACE OF SERVICE WAS IN DELAWARE, KENTUCKY, PUERTO RICO, VIRGINIA, &/OR THE US VIRGIN ISLANDS**

~CMS MLN Matters – June 2007~

MLN Matters Number: MM5554  
Related CR Release Date: April 27, 2007  
Related CR Transmittal #: R1229CP

Related Change Request (CR) #: 5554  
Effective Date: July 2, 2007  
Implementation Date: July 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5554.pdf>**

The Centers for Medicaid & Medicare Services (CMS) issued change request (CR) 5554 in order to modify the Reconsideration Request Form and to amend the ALJ filing locations.

Providers and suppliers do not need to resubmit documentation when requesting a Qualified Independent Contractor (QIC) reconsideration if the documentation was previously submitted as part of the redetermination process. This documentation is forwarded to the QIC as part of the case file utilized in the reconsideration process. Make certain that any additional evidence is submitted prior to the reconsideration decision. If all additional evidence is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence to the ALJ or further appeal unless you can demonstrate good cause for withholding the evidence from the QIC.

Be aware that when the service was rendered in **Delaware, Kentucky, Virginia, Puerto Rico, and/or the US Virgin Islands**, the filing locations for ALJ requests **are modified** to identify the appropriate Office of Medicare Hearings and Appeals (OMHA) field office. All other jurisdictions remain unchanged.

**PART C PLAN TYPE DISPLAY ON THE MEDICARE'S COMMON WORKING FILE (CWF) - CR5538 RESCINDS AND FULLY REPLACES CR 5349**

~CMS MLN Matters – May 2007~

MLN Matters Number: MM5538  
Related CR Release Date: April 13, 2007  
Related CR Transmittal #: R1219CP

Related Change Request (CR) #: 5538  
Effective Date: July 1, 2007  
Implementation Date: July 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5538.pdf>**

Be aware of the expanded list of MA Plan Type Descriptions that are being displayed by Medicare's CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in Private Fee-For-Service (PFFS) plans. A plan directory, which is quite descriptive, is now available at <http://www.cms.hhs.gov/MCRAAdvPartDENroiData/>

**PROGRAM OVERVIEW: 2007 PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI)**

~CMS MLN Matters – April 2007~

MLN Matters Number: MM5558  
Related CR Release Date: March 9, 2007  
Related CR Transmittal #: R265OTN

Related Change Request (CR) #: 5558  
Effective Date: March 2, 2007  
Implementation Date: N/A

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5558.pdf>**

This article is based on Change Request (CR) 5558 which provides overview-level information on the Physician Quality Reporting Initiative (PQRI). The Centers for Medicare & Medicaid Services (CMS) encourages all physicians to be familiar with the PQRI, its importance, and benefits.

**PROVIDER NOTIFICATION REGARDING MEDICARE DURABLE MEDICAL EQUIPMENT PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) COMPETITIVE BIDDING PROGRAM**

~June 2007~

The Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Final Regulation is now published at the Federal Register at:

**<http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/Downloads/CMS-1270-F.pdf>**

CMS has also announced the first 10 metropolitan areas in which competition will occur, as well as the first items to be competitively bid. Visit the CMS Website at <http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/> to view the rule and for additional information.

### **QUARTERLY PROVIDER UPDATE**

*~April 2007~*

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

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update listserv (electronic mailing list) at: <http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1>

## **Program Safeguards**

### **SANCTIONED AND REINSTATED PROVIDERS**

*~April, May, and June 2007~*

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**

### **NATIONAL PROVIDER IDENTIFIER – FREQUENTLY ASKED QUESTION**

*~May 2007~*

#### **How is Medicare being informed of a provider's National Provider Identifier (NPI) number?**

Providers will supply NPIs to Medicare in one of two ways.

1. Providers should include existing Medicare numbers on the application for an NPI. The NPI will then be added to the Medicare crosswalk, and providers can simply submit a claim. If providers did not originally include their Medicare numbers on the NPI application, the Center for Medicare & Medicaid Services (CMS) is encouraging providers to enter into the National Plan and Provider Enumeration System (NPPES).
2. Providers who are not currently enrolled in Medicare or are updating any Medicare information are required to provide their NPI on the appropriate CMS Form 855 and attach a copy of the notification letter. Medicare will add the providers NPI into the national provider enrollment system. After providers receive notification of their finalized Medicare enrollment, no further action is required and they can submit claims with NPIs.

### **NEW: FIVE MINUTE "QUICK TIP" COMPUTER BASED TRAININGS (CBTs)**

*~May 2007~*

We are happy to announce that WPS Medicare's new "Mediasite" hybrid CBT (recorded video tutorial) has received tremendous positive response from our provider customers. **WPS Medicare is pleased to introduce a collection of short educational segments.** Each segment lasts only 1-5 minutes.

From your feedback, we know that many of our providers just do not have 45 minutes to spend during the work day to watch our recorded video seminars. In order to meet these needs, our Provider Outreach and Education staff are developing short messages on timely topics to get you the information you need, when you need it.

You can find our first three offerings; on the National Provider Identifier (NPI), C-SNAP (CMS Secure Net Access Pilot), and Appeals by visiting our Website at: <http://www.wpsmedicare.com/provider/tutorials.shtml>

Please try out one of these "Quick Tip" CBTs, and let us know what you think by using our **FEEDBACK** form found at the very bottom of each page of our Website (right next to our Privacy Statement).

### PROVIDER EDUCATION EVENTS AVAILABLE!

~April, May, and June 2007~

Take advantage of a Medicare Education event in your area, on-line, or via telephone. 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.

### PROVIDER EDUCATION FOR HANDLING ISSUES RELATED TO DECEASED PROVIDERS

~CMS MLN Matters – May 2007~

MLN Matters Number: MM5508  
Related CR Release Date: March 30, 2007  
Related CR Transmittal #: R1216CP

Related Change Request (CR) #: 5508  
Effective Date: May 23, 2007  
Implementation Date: April 30, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5508.pdf>

This article and related Change Request (CR) 5508 addresses NPI issues related to deceased providers.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Secretary of the Department of Health and Human Services adopt standards providing for a standard unique health identifier for each health care provider for use in the healthcare system and to specify the purpose for which the identifiers may be used.

Because deceased providers may not have NPIs, this article discusses what representatives of those providers need to do in order to submit claims that need to be paid.

## Reimbursement

### AMBULANCE FEE SCHEDULE - GROUND AMBULANCE SERVICES - MANUALIZATION REVISION TO THE SPECIALTY CARE TRANSPORT (SCT) DEFINITION

~CMS MLN Matters – May 2007~

MLN Matters Number: MM5533  
Related CR Release Date: March 30, 2007  
Related CR Transmittal #: R68BP

Related Change Request (CR) #: 5533  
Effective Date: January 1, 2007  
Implementation Date: April 30, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5533.pdf>

Providers and suppliers are reminded that the Centers for Medicare & Medicaid Services (CMS) expanded the interpretation of "interfacility" to include both hospitals and Skilled Nursing Facilities (SNFs) in the December 1, 2006 (71 FR 69716) final rule.

### AMBULANCE FEE SCHEDULE - MEDICAL CONDITIONS LIST - MANUALIZATION REVISIONS

~May 2007~

This Change Request (CR) 5442 furnishes the revised Ambulance Medical Conditions List to Contractors and Maintainers.

The revisions are being done to update the condition code list for 2007 because of the updated ICD-9-CM manuals that came out in October.

To read this entire transmittal, go to: <http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf>

**APRIL 2007 QUARTERLY AVERAGE SALES PRICE (ASP) MEDICARE PART B DRUG PRICING FILE, EFFECTIVE APRIL 1, 2007, AND REVISIONS TO THE JANUARY 2007 QUARTERLY ASP MEDICARE PART B DRUG PRICING FILES**

~CMS MLN Matters – May 2007~

MLN Matters Number: MM5517  
 Related CR Release Date: March 16, 2007  
 Related CR Transmittal #: R1204CP

Related Change Request (CR) #:5517  
 Effective Date: April 1, 2007  
 Implementation Date: April 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5517.pdf>**

This article is based on CR 5517 which informs Medicare contractors to download the April 2007 Average Sales Price drug pricing file for Medicare Part B drugs as well as the revised January 2007 ASP files.

**APRIL QUARTERLY UPDATE FOR 2007 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) FEE SCHEDULE**

~REVISED CMS MLN Matters – April 2007~

MLN Matters Number: MM5537 Revised  
 Related CR Release Date: March 9, 2007  
 Related CR Transmittal #: R1203CP

Related Change Request (CR) #: 5537  
 Effective Date: January 1, 2007  
 Implementation Date: April 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5537.pdf>**

**Note:** This article was revised on March 16, 2007, to show the correct effective date of January 1, 2007 above.

This article is based on Change Request (CR) 5537, which provides the April 2007 quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error.

The following are key changes in the April 2007 quarterly update of the DMEPOS fee schedule:

**L8690 and L8691**

The A/B MACs, Local Carriers, and FIs will adjust previously processed claims for L8690 (Auditory Osseointegrated Device, Includes All Internal and External Components) and L8691 (Auditory Osseointegrated Device, External Sound Processor, Replacement), with dates of service on or after January 1, 2007, if you resubmit such claims as adjustments.

**Code E1002 (Wheelchair accessory, Power Seating System, Tilt Only)**

Code E1002 was added to the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2004. The fee schedule amounts that were calculated and implemented for this code included systems with tilts less than 45 degrees from horizontal. As described in the November 2006 Policy Article for Wheelchair Options/Accessories, power tilt seating systems (falling under code E1002) must have the ability to tilt to greater than or equal to 45 degrees from horizontal. Therefore as part of this quarterly update, **the fee schedule amounts for code E1002 are being revised in order to remove pricing information for power seating systems with tilts less than 45 degrees.**

The DME MACs, and DMERCs will adjust previously processed claims for code E1002 with dates of service on or after January 1, 2007, if they are resubmitted as adjustments.

**Code E2377 (Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics and Mounting Hardware, Upgrade Provided at Initial Issue)**

Code E2377 was added to the HCPCS effective January 1, 2007, for use in paying claims for upgraded expandable controllers and mounting hardware provided at initial issue. The fee schedule amounts for code E2377 do not include payment for the proportional joystick and electronics/cables/junction boxes necessary to upgrade from a non-expandable controller. Suppliers need to submit claims for the upgraded proportional joysticks and electronics provided at initial issue for dates of service on or after January 1, 2007, using HCPCS code E2399.

**Further Changes for Power Wheelchairs**

CMS is in the process of making refinements to the fee schedule amounts for several HCPCS codes for power wheelchairs to be implemented as part of the April quarterly update for the 2007 DMEPOS fee schedule. Additional instructions regarding these changes will be issued in the near future under separate cover.

**APRIL UPDATE TO THE 2007 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE (MPFSDB)**
*~CMS MLN Matters – April 2007~*

MLN Matters Number: MM5528  
 Related CR Release Date: February 26, 2007  
 Related CR Transmittal #: R1188CP

Related Change Request (CR) #: 5528  
 Effective Date: January 1, 2007  
 Implementation Date: April 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5528.pdf>

This article and related Change Request (CR) 5528 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS Final Rule. CR5528 amends those payment files. These changes are effective January 1, 2007. However, providers may wish to note that Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims. Contractors will adjust claims that you bring to their attention. The following table reflects the key changes from CR5528:

CPT/HCPCS	ACTION
17311	Multiple Procedure Indicator – 0
17313	Multiple Procedure Indicator – 0
36478	Transitional Non-Facility PE RVU = 41.71 Fully Implemented Non-Facility PE RVU = 26.53 <b>(Informational Only)</b>
37210	Transitional Non-Facility PE RVU = 79.88 Fully Implemented Non-Facility PE RVU = 79.88 <b>(Informational Only)</b>
77056 Global	Fully Implemented Non-Facility PE RVU = 1.96 <b>(Informational Only)</b> Fully Implemented Facility PE RVU = 1.96 <b>(Informational Only)</b>
77056 – TC	Fully Implemented Non-Facility PE RVU = 1.72 <b>(Informational Only)</b> Fully Implemented Facility PE RVU = 1.72 <b>(Informational Only)</b>
93225	Transitional Non-Facility PE RVU = 1.14 Fully Implemented Non-Facility PE RVU = 0.85 <b>(Informational Only)</b> Transitional Facility PE RVU = 1.14 Fully Implemented Facility PE RVU = 0.85 <b>(Informational Only)</b>
93226	Transitional Non-Facility PE RVU = 1.93 Fully Implemented Non-Facility PE RVU = 1.18 <b>(Informational Only)</b> Transitional Facility PE RVU = 1.93 Fully Implemented Facility PE RVU = 1.18 <b>(Informational Only)</b>
93231	Transitional Non-Facility PE RVU = 1.32 Fully Implemented Non-Facility PE RVU = 0.71 <b>(Informational Only)</b> Transitional Facility PE RVU = 1.32 Fully Implemented Facility PE RVU = 0.71 <b>(Informational Only)</b>
93232	Transitional Non-Facility PE RVU = 1.97 Fully Implemented Non-Facility PE RVU = 1.34 <b>(Informational Only)</b> Transitional Facility PE RVU = 1.97 Fully Implemented Facility PE RVU = 1.34 <b>(Informational Only)</b>
95991	Transitional Facility PE RVU = 0.17 Fully Implemented Facility PE RVU = 0.18 <b>(Informational Only)</b>

The codes in the following table are either bundled or not valid for Medicare purposes. Values for these codes have been established as a courtesy to the general public. These codes will remain bundled or not valid for Medicare purposes even though relative value units have been established.

CPT/HCPCS	ACTION
78351	Transitional Non-Facility PE RVU = 1.41 Fully Implemented Non-Facility PE RVU = 0.47 <b>(Informational Only)</b>
98960	Transitional Non-Facility PE RVU = 0.57 Fully Implemented Non-Facility PE RVU = 0.57 <b>(Informational Only)</b> Transitional Facility PE RVU = 0.57 Fully Implemented Facility PE RVU = 0.57 <b>(Informational Only)</b>
98961	Transitional Non-Facility PE RVU = 0.27 Fully Implemented Non-Facility PE RVU = 0.27 <b>(Informational Only)</b> Transitional Facility PE RVU = 0.27 Fully Implemented Facility PE RVU = 0.27 <b>(Informational Only)</b>
98962	Transitional Non-Facility PE RVU = 0.20 Fully Implemented Non-Facility PE RVU = 0.20 <b>(Informational Only)</b> Transitional Facility PE RVU = 0.20 Fully Implemented Facility PE RVU = 0.20 <b>(Informational Only)</b>

**CHANGE IN THE AMOUNT IN CONTROVERSY REQUIREMENT FOR FEDERAL DISTRICT COURT APPEALS**

~CMS MLN Matters – May 2007~

MLN Matters Number: MM5518  
 Related CR Release Date: March 30, 2007  
 Related CR Transmittal #: R1211CP

Related Change Request (CR) #: 5518  
 Effective Date: January 1, 2007  
 Implementation Date: July 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5518.pdf>**

This article is based on Change Request (CR) 5518 which notifies Medicare contractors of an increase in the Amount in Controversy Required to sustain Federal District Court appeal rights beginning January 1, 2007. CR 5518 announces that for ALJ hearing requests made on or after January 1, 2007, the amount that must remain in controversy did not change and remains at \$110. CR 5518 announces that for Federal District Court review requests made on or after January 1, 2007, the amount that must remain in controversy is increased to \$1,130.

**CMS PROPOSES PAYMENT, POLICY CHANGES FOR INPATIENT REHABILITATION FACILITIES IN FISCAL YEAR 2008**

~June 2007~

Inpatient rehabilitation facilities (IRFs) are projected to receive approximately \$6.3 billion in payments from the Medicare program in fiscal year (FY) 2008, under a proposed rule announced today by the Centers for Medicare & Medicaid Services (CMS). The proposed rule would update payment rates and modify payment policies for services furnished to Medicare beneficiaries for discharges occurring on or after October 1, 2007 through September 30, 2008. The rule's provisions are estimated to increase Medicare payments to approximately 1,234 IRFs in FY 2008 by approximately \$150 million.

To view the Press Release, please click here:

[http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)

To view the Display Copy, please click here:

<http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms1551P.pdf>

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

~April, May, and June 2007~

In accordance with Section 1833(m) of the Social Security Act, physicians who provide covered professional services in a geographic Health Professional Shortage Area (HPSA) are entitled to a 10 % 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.

For more information about HPSAs, and to access entire HPSA listings, visit us at:

<http://www.wpsmedicare.com/provider/hpsa.shtml>

**APRIL 2007 HPSA CHANGES**

**Illinois**

***Primary Care HPSA***

New eligibility for dates of service on and after September 20, 2006:

Washington County – Entire County (Please note: only a portion of the county was previously eligible)

**Michigan**

***Primary Care HPSA***

No longer eligible for dates of service on or after April 1, 2007:

Luce County

No longer eligible for dates of service on or after April 1, 2007:

Wayne County – MacKenzie/Brooks Service Area  
Census Tract 5466

New eligibility for dates of service on and after December 18, 2006:

Wayne County – MacKenzie/Brooks Service Area  
Census Tracts: 5302 – 5303, 5307, 5310, 5313 – 5316, 5334, 5357, 5369, 5375, 5377, 5423, 5426

#### ***Mental Health HPSA***

No longer eligible for dates of service on or after April 1, 2007:

Chippewa County

#### **Wisconsin**

##### ***Primary Care HPSA***

Dane County - Northeast Madison Service Area  
Census Tract 24.98 has been changed to 24.02  
Census Tract 25.98 has been changed to 25.00

#### **MAY 2007 HPSA CHANGES**

##### **Minnesota**

##### ***Mental Health HPSA***

The following counties are eligible as a Mental Health HPSA for dates of service on or after January 26, 2007.

Kittson	Mahnomen	Marshall	Norman
Pennington	Polk	Red Lake	Roseau

#### **JUNE 2007 HPSA CHANGES**

##### **Minnesota**

##### ***Mental Health HPSA***

The following county is eligible as a Mental Health HPSA for dates of service on or after March 5, 2007:  
Cass County

#### **MEDICARE PHYSICIAN FEE SCHEDULE FACT SHEET NOW AVAILABLE IN PRINT FORMAT**

*~May 2007~*

The *Medicare Physician Fee Schedule Fact Sheet*, which provides general information about the Medicare Physician Fee Schedule, is now available in print format.

To place an order for the fact sheet, visit the Medicare Learning Network at <http://www.cms.hhs.gov/mlngeninfo> on the Centers for Medicare & Medicaid Services Website and select "MLN Product Ordering Page" under the "Related Links Inside CMS" Section.

#### **NEW WAIVED TESTS**

*~CMS MLN Matters – April 2007~*

MLN Matters Number: MM5484  
Related CR Release Date: March 9, 2007  
Related CR Transmittal #: R1195CP

Related Change Request (CR) #: 5484  
Effective Date: April 1, 2007  
Implementation Date: April 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5484.pdf>**

Change Request (CR) 5484, from which this article is taken, notifies your carriers and A/B MACs of the new Food and Drug Administration (FDA)-approved tests (effective October 4, 2006) that are waived under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), so that they can accurately process your claims.

Note that each of the Current Procedural Terminology (CPT) codes for these new tests must have the modifier QW to be recognized as a waived test, and that these new waived tests are effective October 4, 2006.

#### **New FDA Waived Tests Under CLIA**

- CPT/HCPCS code, 82042QW, has been assigned for the albumin test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.

- CPT/HCPCS code, 82150QW, has been assigned for the amylase test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT/HCPCS code, 82247QW, has been assigned for the total bilirubin test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT/HCPCS code, 82977QW, has been assigned for the gamma glutamyltransferase (GGT) test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT/HCPCS code, 84075QW, has been assigned for the alkaline phosphatase test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT/HCPCS code, 84157QW, has been assigned for the total protein test performed using the Abaxis Piccolo Point of Care Chemistry Analyzer (Liver Panel Plus Reagent Disc){whole blood}.
- CPT/HCPCS code, 84520QW, has been assigned for the urea (BUN) test performed using the Arkray SPOTCHEM EZ Chemistry Analyzer.

### **NEW WAIVED TESTS: CORRECTION TO CR5404**

*~CMS MLN Matters – April 2007~*

MLN Matters Number: MM5482  
 Related CR Release Date: March 9, 2007  
 Related CR Transmittal #: R1197CP

Related Change Request (CR) #: 5482  
 Effective Date: April 1, 2007  
 Implementation Date: April 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5482.pdf>**

CR 5404, which informed carriers and A/B MACS about new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments of 1988 (CLIA), contained an incorrect Current Procedural Terminology (CPT) code for the Gryphus Diagnostics BVBlue test. The correct code for this test is 87999QW (Unlisted microbiology procedure).

### **NPI FOR AMBULANCE SUPPLIERS**

*~April 2007~*

**All providers/suppliers including Ambulance suppliers need to have a National Provider Identifier (NPI) by May 23, 2007.**

#### **What happens if you do not get an NPI?**

Medicare and health care payers will not be able to accept your claims. If we cannot accept your claim, we cannot pay your claim.

#### **What is the National Provider Identifier (NPI)?**

A single provider identifier used to bill all health care payers in the United States.

#### **When can I apply for my NPI?**

Apply today. Be sure to include your existing Medicare Provider Identification Numbers (PINs) on your applications. The Centers for Medicare & Medicaid Services (CMS) encourages providers to include the PIN to help ease the transition to the NPI.

#### **How do I get my NPI?**

You can apply on-line at <https://nppes.cms.hhs.gov/NPPES/Welcome.do>, which is the National Plan & Provider Enumeration System (NPPES) Website.

#### **When should I begin using the NPI?**

Ambulance suppliers can begin submitting the NPI to Medicare today.

CMS encourages all providers and suppliers to continue to submit their current Medicare PIN through May 22, 2007.

#### **Where do I find more information on the NPI?**

Find the answers to these important NPI questions and more by visiting our Website today at [http://www.wpsmedicare.com/provider/npi\\_resource.shtml](http://www.wpsmedicare.com/provider/npi_resource.shtml)

Find additional information by visiting the CMS NPI Website at [http://www.cms.hhs.gov/NationalProvidentStand/01\\_Overview.asp#TopOfPage](http://www.cms.hhs.gov/NationalProvidentStand/01_Overview.asp#TopOfPage)

## SERVICES NOT PROVIDED WITHIN UNITED STATES

~CMS MLN Matters – April 2007~

MLN Matters Number: MM5427  
 Related CR Release Date: February 23, 2007  
 Related CR Transmittal #: R66BP

Related Change Request (CR) #: 5427  
 Effective Date: November 13, 2006  
 Implementation Date: April 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5427.pdf>

Change Request (CR) 5427 clarifies that payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States.

### Take Note:

Payment may not be made for a medical service (or a portion of it) that was subcontracted to another provider or supplier located outside the United States.

For example, if a radiologist who practices in India analyzes imaging tests that were performed on a beneficiary in the United States, Medicare would not pay the radiologist or the U.S. facility that performed the imaging test for any of the services that were performed by the radiologist in India.

This article and related CR 5427 outlines the limited items and services that are reimbursable by Medicare outside the United States according to Section 1862(a)(4) of the Social Security Act.

The law specifies the following **exceptions** to the “foreign” exclusion:

- Inpatient hospital services for treatment of an emergency in a foreign hospital that is closer to, or more accessible from, the place the emergency arose than the nearest U.S. hospital that is adequately equipped and available to deal with the emergency, provided either of the following conditions exist:
  - emergency arose within the U.S.; or
  - emergency arose in Canada while the individual was traveling, by the most direct route and without unreasonable delay between Alaska and another State
- Inpatient hospital services at a foreign hospital that is closer to, or more accessible from, the individual’s residence within the U.S. than the nearest U.S. hospital that is adequately equipped and available to treat the individual’s condition, whether or not an emergency exists.
- Physician and ambulance services in connection with, and during, a foreign inpatient hospital stay that is covered in accordance with either of the above.

## USE OF NINE-DIGIT ZIP CODES FOR DETERMINING THE CORRECT PAYMENT LOCALITY FOR SERVICES PAID UNDER THE MPFS AND ANESTHESIA SERVICES

~REVISED CMS MLN Matters – April 2007~

MLN Matters Number: MM5208 Revised  
 Related CR Release Date: March 9, 2007  
 Related CR Transmittal #: R1193CP

Related Change Request (CR) #: 5208  
 Effective Date: October 1, 2007  
 Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5208.pdf>

**Note:** This article was revised on March 9, 2007, to reflect a revised CR Transmittal number and CR release date (see above). Also the Web address for accessing CR5208 has been changed. All other information remains the same.

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed in Table 1, if you do not include the full nine-digit ZIP code on your claims for services paid by Medicare carriers or MACs under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services, your claim will be treated as unprocessable.

CMS is implementing this requirement to prevent payment issues generated by ZIP codes that cross payment localities.

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed in Table 1, if a valid full nine-digit ZIP code is not present on the Provider Master File Address ZIP code, services paid by the FIs/MACs under the MPFS and for anesthesia services, your claim will be treated as unprocessable.

**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:

**E-Mail:** MedicareAdmin@wpsic.com

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

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

**Communiqué**

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