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**Medical Director's Corner**
**INAPPROPRIATE USE OF MODIFIERS 25 AND 59**

In December of 2005, the Office of the Inspector General (OIG) issued two reports. The first report concerned the use of modifier 25. Medicare payments for medical procedures include payments for certain evaluation and management (E/M) services that are necessary prior to the performance of a procedure. Medicare does not normally allow additional payments for separate E/M services performed by a provider on the same day as a procedure. However, if a provider performs an E/M service on the same day as a procedure that is significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure, modifier 25 may be attached to the claim to allow additional payment for the for the separate E/M service. In calendar year 2002, Medicare allowed \$1.96 billion for approximately 29 million claims using modifier 25. The OIG randomly selected 450 claims billed in the calendar year 2002 using modifier 25 for medical review. Thirty-five percent of claims using modifier 25 that Medicare allowed did not meet program requirements. Extrapolating this error rate to the total number of claims paid resulted in \$538 million in improper payments.

The second report concerned the use of modifier 59. The National Correct Coding Initiative (CCI) edits began in January 1996. This initiative was developed to promote correct coding by providers and to prevent Medicare payments for improperly coded services. The CCI edits contain code pairs that generally should not be billed together by a provider for a beneficiary on the same date of service. Under certain circumstances, a provider may bill for two services in a CCI code pair and include a modifier on the claim that would bypass the edit and allow both services to be paid. Modifier 59 is one of these modifiers. Modifier 59 is used to indicate that a provider performed a distinct procedure or service for a beneficiary on the same day as another procedure or service. It may represent a different session, different procedure or surgery, or different anatomical site or organ system, separate incision or excision, or separate injury. OIG selected a random sample of 350 code pairs for services that bypassed CCI edits using modifier 59 in fiscal year 2003. Forty percent of code pairs billed with modifier 59 did not meet program requirements. Extrapolating this error rate to the total number of claims paid resulted in \$59 million in improper payments.

As a result of these findings, The Centers for Medicare & Medicaid services is encouraging all contractors, including carriers and Program Safeguard Contractors (PSCs) to conduct prepayment and postpayment reviews of the use of modifiers 25 and 59.

In another effort to combat fraud and abuse in the Medicare program, the Tax Relief and Health Care Act of 2006 required the expansion of Recovery Audit Contractors (RACs) to all 50 states by 2010. The RACs currently operate as a demonstration project in Florida, New York, and California. The three existing RACs recovered \$303 million in overpayments in 1 ½ years.

With the continued rapidly increasing costs of the Medicare program, improper payments, whether due to fraud or abuse, hurt all Medicare providers and beneficiaries. All contactors are redoubling their efforts to eliminate these improper payments.

- Kenneth L. Bussan, MD  
Carrier Medical Director - Wisconsin

## Items of Importance

### 2007 FEE SCHEDULE NOW AVAILABLE

~ January 2007 ~

Congress recently passed the Tax Relief and Health Care Act of 2006, which among other things updated the 2007 conversion factor for services paid under the Medicare Physician Fee Schedule. The President signed the Tax Relief and Health Care Act of 2006 on December 20, 2006, and the changes are effective January 1, 2007.

Since there is a change to the 2007 MPFS rates, CMS is extending the participation enrollment period to February 14, 2007. Therefore, the participation enrollment period runs from November 15, 2006, through February 14, 2007. The effective date for any participation change is January 1, 2007.

### NEW FEES AVAILABLE ON WEBSITE

We posted the new fee schedules for our jurisdiction at  
[http://www.wpsmedicare.com/provider/pricing\\_fees.shtml](http://www.wpsmedicare.com/provider/pricing_fees.shtml)

These fees will be effective January 1, 2007. Please see CMS' article below for more information.

### 2007 MEDICARE PHYSICIAN FEE SCHEDULE – LEGISLATIVE CHANGE TO THE UPDATE FACTOR FOR THE 2007 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) AND EXTENSION OF THE PARTICIPATING ENROLLMENT PERIOD

~CMS MLN Matters – January 2007~

MLN Matters Number: MM5448

Related CR Release Date: December 15, 2006

Related CR Transmittal #: R1131CP

Related Change Request (CR) #: 5448

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5448.pdf>

#### Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), including regional home health intermediaries (RHHIs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries, which are paid based on the MPFS.

#### What You Need to Know

This article is based on Change Request (CR) 5448. The Tax Relief and Health Care Act of 2006 changes the update to the 2007 conversion factor for services paid under the MPFS, and this change is effective for services provided on or after January 1, 2007.

The Tax Relief and Health Care Act of 2006 set the 2007 conversion factor for physician payment at the same level as in 2006 (\$37.8975), reversing the statutorily mandated 5.0 percent negative update. However, it does not maintain 2007 physician payments at 2006 levels. There are a number of other factors that affect payment rates for 2007.

Other changes adopted in the physician fee schedule final rule that affect 2007 payment rates include changes in the practice expense RVU-setting methodology, refinements to the practice expense RVUs, re-weighting of geographic adjustment factors, limits on payments for imaging services required by the Deficit Reduction Act, and other annual refinements including coding changes.

Both the Centers for Medicare & Medicaid Services (CMS) and your local Medicare contractor will display the resulting new fees on its Web site no later than December 31, 2006. (Carriers' Web sites will display the new fees including the PAR/NONPAR, and limiting charge rates.) The revised fees under the 2007 MPFS will be effective for services provided on or after January 1, 2007.

The change to the 2007 MPFS will also result in an extension of the participation enrollment period to February 14, 2007. Therefore, the participation enrollment period runs from November 15, 2006, through February 14, 2007. The effective date for any participation change is January 1, 2007.

Physicians who wish to sign an agreement and become Participating (Par) physicians can access the Par

Agreement (CMS-460 form) from the CD which was mailed to all physicians last November. Physicians can also request the CMS-460 form from their local Medicare contractor. Existing Par physicians who no longer wish to be Par must notify their Medicare contractor in writing of their decision to terminate their Par agreement. Physicians who change their Par status during the extension period should begin to submit claims based on their new Par status.

## **ANNUAL MEDICARE CONTRACTOR PROVIDER SATISFACTION SURVEY: MAKE YOUR VOICE HEARD!**

~CMS MLN Matters – February 2007~

MLN Matters Number: SE0702  
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/SE0702.pdf>**

### **Provider Types Affected**

All Medicare FFS providers, especially those receiving the 2007 Medicare Contractor Provider Satisfaction Survey.

### **Provider Action Needed**

The Centers for Medicare & Medicaid Services (CMS) is publishing this Special Edition (SE) article to alert providers that in early January 2007 CMS will disseminate the 2007 Medicare Contractor Provider Satisfaction Survey (MCPSS) to a new sample of Medicare providers. If you receive the survey, CMS encourages you to respond because your input is NEEDED and will be used to support claims processing improvement by Medicare fee-for-service (FFS) contractors and to reform the Medicare Program.

## **CLAIM STATUS REQUESTS**

~January 2007~

WPS Medicare frequently receives telephone calls and written correspondence from providers, billing services, etc. requesting the status of a Medicare claim they filed to WPS Medicare for a beneficiary. These requests are often referred to as "claim status requests" or "insurance tracers." WPS Medicare does not verify the status of a claim by telephone or through written correspondence. However, WPS Medicare offers alternative resources to providers, billing services, etc. for obtaining claim status information.

The first resource is the Interactive Voice Response (IVR) telephone system. The IVR provides Medicare-related information 24 hours a day, including claim status information. The IVR also allows you to access information on beneficiary eligibility, provider summary (payment) information, checks, deductibles, pricing, telephone numbers, addresses, and appeals. For additional information on the IVR, please visit the WPS Medicare Website below:  
<http://www.wpsmedicare.com/provider/pdfs/ivr.pdf>

The second resource is the CMS (Centers for Medicare & Medicaid Services) Secure Net Access Pilot (C-SNAP). C-SNAP offers patient eligibility and claim status information in a secure Internet environment. C-SNAP is available 24 hours a day, 7 days a week. For additional information on C-SNAP, please visit the Website <http://www.medicareinfo.com>, or contact C-SNAP Support at 877-476-8116.

We also have an article available on our Website that provides additional information on these resources. To view the article, please refer to our Website below:

[http://www.wpsmedicare.com/provider/bene\\_claim\\_status.shtml](http://www.wpsmedicare.com/provider/bene_claim_status.shtml)

## **DID YOU DOWNLOAD ILLINOIS LOCALITY 16 FEES BETWEEN 02/12/07 - 02/20/07 FROM THE WPS WEBSITE? IF SO, THE FOLLOWING INFORMATION MAY AFFECT YOU**

~March 2007~

### **ALERT**

WPS Medicare inadvertently posted the incorrect fees for **Illinois Locality 16** affecting the downloadable file version only on 02/12/07. We posted the correct fees to the Website on 02/20/07.

### **MOST PROVIDERS NOT AFFECTED**

If you sent in claims for Illinois Locality 16 for 2007 dates of service, **AND** you only billed the allowed amount

based upon the fee schedule allowed amounts, **AND** you used the fees from the version of the downloadable file for Illinois Locality 16 posted between 02/12/07 - 02/20/07, you may be affected.

Please note this **DOES NOT AFFECT YOU IF:**

- You did not download IL locality 16 fees from our Website between February 12-20, 2007
- You used the "Download All States" feature
- You used the viewable PDF for Illinois Locality 16
- You used the downloadable Illinois Locality 16 feature previous to or after February 12-20, 2007

If you submit your claims with actual billed amounts, and do not adjust your billed amount to reflect the Medicare allowed amount, this error will not affect you. In other words, if you do not bill based on the Medicare Physician Fee Schedule Relative Value File allowed amount, but rather on your own individually determined pricing, this error will not have affected your reimbursement. You will have received the correct allowed amount when your claim processed. This error only affects providers who bill the Medicare allowed amounts based upon the allowed amounts for Illinois Locality 16 posted to the WPS Medicare Website February 12, 2007 - February 20, 2007.

#### **WHAT SHOULD I DO IF I AM AFFECTED?**

Please call 877-867-3418 and request a telephone reopening in order to receive your correct reimbursement amount. Please mention that you are requesting a telephone reopening based on the "Website fee error" and that you need to change the amount you billed. This is carrier error and we will reprocess it to reflect the correct reimbursement level. If you prefer to request a reopening in writing, please submit our new reopening request form found at <http://www.wpsmedicare.com/provider/appeals.shtml> on our Website.

#### **BACKGROUND**

The Centers for Medicare & Medicaid Services (CMS) requested WPS Medicare update our Medicare Physician Fee Schedules to reflect the current American Medical Association (AMA) copyright statement. WPS Medicare made the AMA copyright statement update to all of the fee schedules on February 12, 2007. We mistakenly loaded an incorrect previous version of the fees for Illinois Locality 16 from February 12-20, 2007.

### **DO YOU WANT TO MAKE THE MOST OF THE "CONTACT US" FUNCTION ON THE WPS MEDICARE WEBSITE?**

~ March 2007 ~

WPS Medicare has found that in most cases the most efficient way to answer these inquiries is to call with the response. We need your help to make this process as simple as possible.

Follow these simple tips to help WPS Medicare respond to your "Contact Us" request.

- 1) Always include your first and last name
- 2) Be sure the e-mail address included is correct
- 3) Include the provider/supplier name in the field named "Street (line 1)"
- 4) Include the physical street location in the field named "Street (line 2)"
- 5) Include the City, State, and ZIP code
- 6) Include a phone number with area code. (We recommend the following format: 608-555-1234.)
- 7) If you have an extension that should go with your phone number, include it in the same area the question is typed. Please include either Ext. or Extension in front of the number.

By including all of the information above, you will ensure that WPS Medicare will be able to locate you, the requestor, within your organization. Please remember we have 45 business days to respond to an inquiry, so be patient; you will hear from us.

#### **FIND INFORMATION WITH EASE**

~ January 2007 ~

Wisconsin Physicians Service (WPS) Medicare is currently participating in a Website Satisfaction Survey initiated by the Centers for Medicare & Medicaid Services (CMS) and presented by Foresee Results. The goal of this survey is to determine potential areas of improvement within the WPS Medicare Website.

WPS Medicare thoroughly reviews feedback received from the Website satisfaction survey and discovered that providers would really benefit from a search engine that offered additional functionality. On October 31, WPS responded to these concerns by implementing a new search engine powered by Google.

This Google Mini search engine gives more user-friendly results. It also allows providers to refine their searches so the results are not so overwhelming. Our new search engine still gives users the ability to organize search results by date or to search for specific words or phrases. For more information, please visit our Website at: <http://www.wpsmedicare.com/provider> and search for a topic of your choice. We recommend you take advantage of our helpful hints by selecting the "Search tips" option offered after completing your search.

If you have never completed a WPS Website Satisfaction Survey, or if you have not recently completed a survey, please provide us with your opinion of our new search engine by visiting the WPS Medicare Website at <http://www.wpsmedicare.com>. The survey randomly presents after a few clicks. If you are not interested in completing the survey, simply select the close box, marked with an "X" in the upper right hand corner. The survey only takes a few moments of your time and provides valuable feedback to WPS Medicare staff. With your input, we will continue to improve our WPS Medicare Website and endeavor to provide you with the best possible customer service.

### **IMPORTANT NOTICE REGARDING PROVIDER CUSTOMER SERVICE CLOSINGS**

**~January, February, & March 2007~**

WPS Medicare Provider Customer Service closes on occasion for brief periods so our Customer Service Representatives may participate in training sessions. Our representatives are eager to learn more in order to serve you better. For information on these closures, visit us at [http://www.wpsmedicare.com/misc/cust-serv\\_closings.shtml](http://www.wpsmedicare.com/misc/cust-serv_closings.shtml). At these times, the IVR and C-SNAP will continue to be available for your use to check eligibility and claim status. For more information regarding C-SNAP, call 1-877-476-8116. Thank you for your patience and for allowing us this chance to serve you better.

### **IVR ENHANCEMENTS COMING THIS MONTH**

**~March 2007~**

WPS Medicare will be implementing changes and enhancements to the IVR in March 2007. We feel these changes will better serve the provider community by offering much more information than what was previously available. Some of the highlights are as follows:

- Detailed patient eligibility information will be available to callers including the patient's date of death, MSP, HMO and crossover information, if applicable.
- The IVR will have the ability to recognize a reassigned Medicare number when it is available and voice back the new Medicare number to the caller.
- Callers will no longer need to provide the patient's gender as an authentication element.
- Callers will, however, now need to provide the patient's first and last name when requesting claim status in order to be compliant with privacy guidelines.
- The main menu will change slightly and will offer a new menu option called "General Information" where callers can listen to current Medicare News messages.

In the near future we will update our IVR instruction manual and brochure. Please refer to our Website at: [http://www.wpsmedicare.com/provider/prov\\_resources.shtml](http://www.wpsmedicare.com/provider/prov_resources.shtml)

### **MEDICARE NUMBERS: A REMINDER**

**~February 2007~**

Did you know the letter(s)/letter-numeric combination at the end of a Medicare number is considered part of the Medicare number?

WPS Medicare has received several calls in which the Medicare number providers are entering into the Interactive Voice Response (IVR) is invalid – because they are not entering the letter(s)/letter-numeric combination at the end of the Medicare number. Please remember when using the IVR, enter/speak the entire Medicare number into the IVR, including the letter(s)/letter-numeric combination at the end of the number. It can be confusing because the IVR asks for the Medicare number, but the Medicare number does include the letter(s)/letter-numeric combination at the end. For more information about the IVR and how to use it, visit us at: <http://www.wpsmedicare.com/provider/pdfs/ivr.pdf>

## NEW COMPUTER BASED TRAINING (CBT) MODULES AVAILABLE

~ March 2007 ~

Our growing library of training materials now includes new Computer-Based Trainings (CBTs) explaining how to avoid duplicate denials and unprocessable denials. Over 8% of the claims submitted to WPS Medicare deny as either duplicate or unprocessable. This costs Medicare and providers millions of dollars a year. Why not take a few minutes to complete the CBTs and learn easy ways to avoid these denials? You can access them at <http://www.wpsmedicare.com/provider/tutorials.shtml>

## NEW PERFORMANCE STANDARDS AND REQUIREMENTS FOR INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTFs) EFFECTIVE JANUARY 1, 2007

~ January 2007 ~

The Centers for Medicare & Medicaid Services has announced new performance standards and additional requirements that must be met by independent diagnostic testing facilities (IDTFs). These provisions, which revise the *Code of Federal Regulations* at 42 CFR §410.33, were published in the December 1, 2006, *Federal Register* and are re-printed at [http://www.wpsmedicare.com/provider/idtf\\_standard.shtml](http://www.wpsmedicare.com/provider/idtf_standard.shtml). They are effective January 1, 2007.

## NPI ALERT - COMMUNICATING NPIS TO MEDICARE

~ January 2007 ~

Medicare providers should know that there is no "special process" or need to call to communicate NPIs to the Medicare program. NPIs can be shared with the Medicare program by using them on your claims along with your legacy identifier. Secondly, for providers applying for Medicare enrollment, an NPI must be reported on the CMS-855 enrollment application (along with a photocopy of the NPI notification received by the provider from the NPPES or from an EFIO). Existing Medicare providers must provide their NPIs when making any changes to their Medicare enrollment information.

## NPI AND BILLING

~ January 2007 ~

You have your National Provider Identifier (NPI). You are ready to submit the NPI on a claim. There is just one catch: your software vendor is not ready or is recommending that you wait to submit the NPI. If your software vendor is not ready, no matter how much work you do as preparation, you are not ready. If the software vendor is recommending that you wait, how will you know if your claims will be paid after May 23, 2007? You have no way to be sure.

If you have your NPI and are filing electronically, begin to put the NPI on the submission today. Take advantage of the testing phase to ensure your claims transition will go smoothly. If you are filing paper, be prepared for January 2, 2007, and begin to submit your NPI on that date. Remember between now and May 23, 2007, to submit both your existing Medicare numbers and NPI on the claims.

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

~ CMS MLN Matters – February 2007 ~

MLN Matters Number: MM5441  
Related CR Release Date: January 19, 2007  
Related CR Transmittal #: R1157CP

Related Change Request (CR) #: 5441  
Effective Date: July 1, 2007  
Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5441.pdf>

### Provider Types Affected

All physicians and suppliers who submit claims for services provided to Medicare beneficiaries to carriers or A/B Medicare Administrative Contractors (MACs).

### Provider Action Needed

This article is derived from CR 5441, which announces the requirement that (effective for claims processed July 1, 2007 and later) the Part B standard systems and the carrier claims processing systems capture and process up to eight diagnosis codes on all of your claims (both paper and electronic). You should make sure that your billing staffs are aware of these changes that allow all eight diagnosis codes on Medicare claims effective, July 1, 2007.

**PROVIDER COLLECTIBLE AMOUNTS WHEN OTHER INSURANCE IS INVOLVED**

~ January 2007 ~

Providers choosing to sign the Medicare Participation agreement, providers required by Medicare rules to accept assignment on certain services (i.e. clinical laboratory, physician assistants, etc.) and non-participating providers choosing to accept assignment on a claim-by-claim basis should be aware of the following information.

Accepting assignment means accepting the Medicare allowed amount as payment in full. If a supplemental or secondary insurance reimbursement plus the Medicare reimbursement exceeds the Medicare allowed amount, the provider should refund the difference to the insurer. You can reference more information in the Participation Agreement in the Internet Only Manual (IOM) 100-04, *Claims Processing*, Chapter 1, Section 30.3 and 30.3.12.3 and Section 50.1. You can access this manual at

<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>

Non-participating providers who choose not to accept assignment on a particular claim are obligated to accept the Limiting Charge amount as payment in full. The provider should refund any amount received over the Limiting Charge.

Below are several examples.

1. When Medicare is **primary** and the supplemental insurance pays more than the Medicare coinsurance and/or deductible, can I keep the difference? Does it make a difference whether or not I accept assignment? For example, Medicare's co-insurance amount is \$11.50. The supplemental pays \$20.00. I know that I cannot collect anything above \$11.50 from the patient, but can I keep the entire \$20.00?
  - a. Physicians or suppliers who agree to accept assignment from Medicare cannot collect more than the appropriate Medicare deductible and coinsurance amounts from the beneficiary, his/her other insurance, or anyone else. Therefore, you cannot keep the \$20.00. You will need to refund \$8.50.
  - b. The Limiting Charge binds physicians/suppliers not accepting assignment. The provider/supplier cannot collect any amounts from Medicare, the patient and/or the supplemental insurance that exceeds the Medicare Limiting Charge.
2. When Medicare is **primary** and Medicare denies a charge as "non-covered," can I collect my total charge from the supplemental insurance and the patient or am I restricted to what would have been the Medicare allowed amount?
  - a. It is important to look at the denial message from Medicare. If the message indicates the provider can collect from the patient, then a provider can collect up to his/her billed amount. These denials will indicate "PR" along with the reason code. If the denial message indicates the provider cannot collect for his/her services, the patient is not responsible for any payment. These denials general indicate "CO" along with the reason code. Applying any payment from the supplemental insurance company does not violate the assignment agreement.
3. When Medicare is **primary** and Medicare denies a charge as "bundled", may I collect the amount from the supplemental insurance company. There are several examples of bundled services (this is not all-inclusive): ambulance supplies considered part of the base rate and not payable separately, services with a "B" indicator on the Medicare Physician Fee Schedule Relative Value File, services part of the Correct Coding Initiative (CCI), etc.
  - a. No. Medicare states through the denial that these services are not payable separately. Therefore, physicians may not collect amounts from the patient, the patient's supplemental insurance, or anyone else. The provider should not bill Medicare separately for the services.
4. When Medicare is **secondary**, can the provider keep payments made over the Medicare approved amount without violating the assignment agreement?
  - a. Yes. If the primary insurance payment amount exceeds the Medicare allowed amount, the physician/supplier may retain the primary payment amount in full without violating the assignment agreement.
  - b. This same is true for providers bound by the Limiting Charge.

**REVISITING THE AT MODIFIER**

~ March 2007 ~

The Centers for Medicare & Medicaid Services (CMS) introduced Change Request (CR) 3449 in October 2004. This CR requires Chiropractors to append the AT modifier to procedure codes 98940-98942 where they perform

active/corrective treatment. All services billed without the AT modifier would be considered “maintenance therapy” and not payable. This change now allowed providers to identify covered chiropractic services from non-covered maintenance services. The anticipation was that chiropractic services would decrease.

Medicare conducted an analysis to review the effects of CR 3449 and the use of the AT modifier for procedure codes 98940-98942. Jurisdictionally, the total billed services went up slightly (0.5%) from calendar year 2004 to 2005. While the percent of change in the billed services was nominal, the increase in the **allowed services** is over 8 percent for the same time. The number of **allowed services** jumped from 3,994,137 in 2004 to 4,313,910 in 2005. **Allowed amounts** for this jurisdiction in 2004 totaled \$129,143,868.41. That number spiked to \$142,475,826.34 in 2005. This is a 10.3% or \$13 million increase in **allowed amount** for Chiropractic services from 2004 to 2005. Again, the anticipation was that chiropractic services would decrease with the introduction of the AT modifier as providers could sort out covered services from non-covered services.

At this time, WPS Medicare would like to issue this reminder. **The AT modifier is only to be appended to services that are part of active/corrective treatment. The AT modifier should not be appended to services that are part of maintenance therapy.**

Chiropractic **maintenance therapy** is not considered medically reasonable or necessary, and is therefore not payable under the Medicare program. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. For more information regarding the Medicare Chiropractic benefit, please refer to the policy Local Coverage Determination (LCD) CHIRO-001. You can view this policy at the Website address below.

<http://www.wpsmedicare.com/policies/wisconsin/chiro001.pdf>

The full text of this article is available in the March 2007 *Communiqué*:

<http://www.wpsmedicare.com/provider/pdfs/0307comm.pdf>

## RULES OF BEHAVIOR GOVERNING MEDICARE ELIGIBILITY INQUIRIES

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5431

Related CR Release Date: January 5, 2007

Related CR Transmittal #: R1149CP

Related Change Request (CR) #: 5431

Effective Date: January 1, 2007

Implementation Date: April 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMArticles/downloads/MM5431.pdf>

### Provider Types Affected

All providers and suppliers, including their third party billing agents or clearinghouses, who submit eligibility inquiries to Medicare

### Provider Action Needed

#### STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. If you, or your biller, do not adhere to these rules of behavior and/or other CMS data privacy and security rules, you could incur revocation of access to the data as well as other penalties.

### CAUTION – What You Need to Know

CR 5431, from which this article is taken, restates your responsibilities in obtaining, disseminating, and using beneficiary's Medicare eligibility data; and also delineates CMS' expectations for provider and clearinghouse use of the HIPAA 270/271 Extranet application.

### GO – What You Need to Do

Read the key points from CR 5431 in the Background section, below, and make sure that your staffs read the manual section (Medicare Claims Processing Manual (100-04), Chapter 31 (ANSI X12N Formats Other than Claims or Remittance), Section 10.3 (Eligibility Rules of Behavior), attached to CR5431.

**THERAPY CAPS EXCEPTION PROCESS**

~CMS MLN Matters – February 2007~

MLN Matters Number: MM4364 Revised  
 Related CR Release Date: February 15, 2006  
 Related CR Transmittal #: R52BP, R140PI, R855CP

Related Change Request (CR) #: 4364  
 Effective Date: January 1, 2006  
 Implementation Date: No later than March 13, 2006

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4364.pdf>**

**Important Note:** Recent legislation extended the therapy cap exceptions for calendar year 2007. For details on the 2007 exceptions and process, see the MLN Matters article MM5478 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5478.pdf> on the CMS site.

**Provider Types Affected**

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

**UPDATE ON CMS ACTIONS TO REVERSE INVALID OVERPAYMENTS GENERATED BY MANAGED CARE INFORMATIONAL UNSOLICITED RESPONSES (MCIURS) - (INVALID MCIURS FROM THE COMMON WORKING FILE (CWF))**

~CMS MLN Matters – March 2007~

MLN Matters Number: MM5507  
 Related CR Release Date: January 26, 2007  
 Related CR Transmittal #: R262OTN

Related Change Request (CR) #: 5507  
 Effective Date: January 26, 2007  
 Implementation Date: April 26, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5507.pdf>**

**Provider Types Affected**

Physicians, suppliers, and providers who submit claims to Medicare contractors (fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), and/or DME Medicare Administrative Contractors (DME/MACs)).

**Provider Action Needed**

This article provides information regarding overpayment recovery actions that may be taken by your Medicare contractor and the circumstances that have caused these recovery actions. We estimate that between 150,000 – 300,000 claims may be affected by these actions. If, due to the conditions stated below, an overpayment recovery action has occurred for your claims, your Medicare contractor is in the process of correcting the payment. **You need not take any action at this time.** Because these actions will affect Medicare contractors in varying degrees, you should stay tuned to your Medicare contractor's web site for additional details.

**WHAT RESOURCES ARE AVAILABLE FOR CODING ASSISTANCE?**

~ January 2007 ~

Coding questions are best handled by coding professionals. The Medical Policy staff and Provider Outreach and Education staff at Wisconsin Physicians Service (WPS) Medicare are not professional coders. We do from time to time help providers with coding questions as they relate to Medicare Policy and/or claim denial(s); however, the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) 100-9, Chapter 6, Section 30.1 explains that providers should seek professional guidance for their coding questions. To reference this publication, please refer to the CMS Website link below:

**<http://www.cms.hhs.gov/manuals/downloads/com109c06.pdf>**

Here are examples of inquiries that require professional coding assistance:

1. Susie from the Sunshine Clinic calls Medicare regarding how to code a surgical service for Dr. Fall. Marge, a Customer Service Representative from WPS Medicare answers the telephone inquiry. Marge explains to Susie that she wishes she could help, but is unable to give coding advice, as she is not a professional coder.
2. Is it appropriate to report XXXXX to Medicare when only one of the descriptors is done?
3. Mary from Blue Sky Radiology calls Medicare regarding how to code an X-Ray read by radiologist Lucy Spring. Lucas, a Customer Service Representative from WPS Medicare answers the telephone inquiry. Lucas explains to Mary that he wishes he could help, but is unable to give coding advice, as he is not a

- professional coder.
4. What is the proper code to use when Computed Tomography (CT) scans are done for the evaluation of coronary arteries?
  5. I need to know if we are able to charge for a (insert your description here). If so, is there a CPT code and do you pay for it.

To read this article in full, including a list of coding resources, please visit:  
[http://www.wpsmedicare.com/provider/coding\\_assistance.shtml](http://www.wpsmedicare.com/provider/coding_assistance.shtml)

## Claim Submission

### ASSIGNMENT OF DEDICATED MEDICARE SECONDARY PAYER MODIFIER INTRODUCED IN CHANGE REQUEST (CR) 5332 (TRANSMITTAL 1088)

~CMS MLN Matters – February 2007~

MLN Matters Number: SE0703  
 Related CR Release Date: October 27, 2006  
 Related CR Transmittal #: R57MSP & R1088CP

Related Change Request (CR) #: 5332  
 Effective Date: January 1, 2007  
 Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/Downloads/SE0703.pdf>

#### Provider Types Affected

Physicians who bill Medicare Carriers and Part A/B Medicare Administrative Contractors (A/B MACs) for drugs paid under the Competitive Acquisition Program (CAP).

#### Key Information

In CR 5332 (Transmittal 1088) "Instructions for the Coordination of Medicare Secondary Payer (MSP) claims for the Competitive Acquisition Program (CAP)", issued October 27, 2006, the Center for Medicare & Medicaid Services (CMS) indicated that, under certain circumstances, a participating CAP physician may procure a CAP drug from a source other than the CAP vendor because of a mistake in identifying the patient's primary insurer. Under these unusual circumstances, CR5332 instructed CAP physicians to use the J3 modifier to receive payment for the drug at the non-CAP rate.

However, the M2 "Medicare secondary payer" modifier was created for the purpose described in CR5332 and was included in the 2007 Alpha-Numeric HCPCS File posted to the CMS website in November 2006.

**Participating CAP physicians must note that, effective January 1, 2007, the M2 modifier will be the dedicated modifier for the unusual circumstances identified above, and Medicare will no longer accept the J3 modifier for this purpose.**

### CLAIMS SUBMITTED WITH ONLY A NATIONAL PROVIDER IDENTIFIER (NPI) DURING THE STAGE 2 NPI TRANSITION PERIOD

~CMS MLN Matters – January 2007~

MLN Matters Number: MM5378  
 Related CR Release Date: November 13, 2006  
 Related CR Transmittal #: R249OTN

Related Change Request (CR) #: 5378  
 Effective Date: October 1, 2006  
 Implementation Date: November 20, 2006

Read this entire article at <http://www.cms.hhs.gov/mlnmattersarticles/downloads/mm5378.pdf>

#### Provider Types Affected

Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries, with Medicare.

#### Provider Action Needed

##### STOP – Impact to You

Beginning October 1, 2006 and until further notice, claims that you submit containing only an NPI will be returned to you as unprocessable if a properly matching legacy number cannot be found.

#### CAUTION – What You Need to Know

From the beginning of Medicare's Stage 2 NPI transition period on October 1, 2006 and until further notice, you should submit both NPIs and legacy provider numbers on your Medicare claims to ensure that they are properly

processed.. During this period, claims submitted with only a NPI that Medicare systems are unable to properly match with a legacy number (e.g., PIN, OSCAR number), may be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

**GO – What You Need to Do**

You should make sure that when submitting Medicare claims with dates of service on or after October 1, 2006, your billing staff submit both your NPI and legacy provider numbers until further notice from CMS.

**COMPETITIVE ACQUISITION PROGRAM (CAP) – CLAIM PROCESSING FOR NOT OTHERWISE CLASSIFIED (“NOC”) DRUGS  
~CMS MLN Matters – January & March 2007~**

MLN Matters Number: MM5259 Revised  
Related CR Release Date: August 18, 2006  
Related CR Transmittal #: R1034CP

Related Change Request (CR) #: CR5259  
Effective Date: January 1, 2007  
Implementation Date: January 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5259.pdf>**

**Note:** This article was revised on January 29, 2007, to alert participating physicians that the dose of the drug should be coded also in item 19 of paper claims or Loop 2300 segment NTE on electronic claims. All other information remains the same.

**Provider Types Affected**

Physicians participating in the Medicare Part B Drug CAP.

**Impact on Providers**

This article is based on Change Request (CR) 5259, which describes the process for adding Not Otherwise Classified (NOC) Drugs to the CAP beginning in 2007. It provides additional details, information and instructions for the implementation of the CAP as outlined previously in CRs 4064, 4306, 4309 and 5079 and the MLN Matters articles related to those CRs.

**DIRECT BILLING AND PAYMENT FOR NON-PHYSICIAN PRACTITIONER (NPP) SERVICES FURNISHED TO HOSPITAL INPATIENTS AND OUTPATIENTS  
~CMS MLN Matters – March 2007~**

MLN Matters Number: MM5221  
Related CR Release Date: January 26, 2007  
Related CR Transmittal #: R1168CP

Related Change Request (CR) #: 5221  
Effective Date: April 26, 2007  
Implementation Date: April 26, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5221.pdf>**

**Provider Types Affected**

All hospitals, clinical nurse specialists (CNSs), nurse practitioners (NPs), and the employers of physician assistants (PAs) who bill Medicare for hospital inpatient and outpatient services.

**Background**

Section 4511(a)(2)(B) of the Balanced Budget Act of 1997 amended section 1861(b)(4) of the Social Security Act to **exclude the professional services of NPs, CNSs and PAs from hospital inpatient services**. Accordingly, upon the effective date of Change Request (CR) 5221, NPs and CNSs are authorized to bill Medicare carriers directly for their professional services when furnished to hospital patients, both inpatients and outpatients. The **employer of a PA, rather than the hospital, must bill the carrier for their professional services when furnished to hospital patients. Hospitals should not bill for the professional services of a PA, unless the PA is employed by the hospital.**

**ELIMINATION OF CMS-1491 AND CMS-1490U FORMS  
~CMS MLN Matters – February 2007~**

MLN Matters Number: MM5390 Revised  
Related CR Release Date: December 29, 2006  
Related CR Transmittal #: R1144CP

Related Change Request (CR) #: 5390  
Effective Date: April 2, 2007  
Implementation Date: April 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5390.pdf>**

**Note:** This article was revised on January 18, 2007, to reflect the correct title. All other information remains the same.

### Provider Types Affected

Suppliers of ambulance services who submit claims to Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for ambulance services to Medicare beneficiaries.

### Impact on Providers

Ambulance suppliers should submit their paper ambulance claims using the Form CMS-1500 on or after April 2, 2007 (see Additional Information section for the CMS-1500 web address). **Note: The April 2, 2007, date actually refers to the date your carrier or A/B MAC receives the claim. So, be sure the claims you send that will be received on or after April 2, 2007, are sent on the Form CMS-1500.**

## HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES SUBJECT TO AND EXCLUDED FROM CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA) EDITS ~CMS MLN Matters – March 2007~

MLN Matters Number: MM5457  
Related CR Release Date: January 26, 2007  
Related CR Transmittal #: R1165CP

Related Change Request (CR) #: 5457  
Effective Date: January 1, 2007  
Implementation Date: April 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5457.pdf>

### Provider Types Affected

Clinical diagnostic laboratories billing Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for laboratory tests.

### Provider Action Needed

#### STOP – Impact to You

If you do not have a valid, current, CLIA certificate and submit a claim to your Medicare carrier or A/B MAC for a HCPCS code that is considered to be a laboratory test, your Medicare payment may be impacted.

#### CAUTION – What You Need to Know

The Clinical Laboratory Improvement Amendments of 1998 (CLIA) requires that for each test it performs, a laboratory facility must be appropriately certified. The HCPCS codes that CMS considers to be laboratory tests under CLIA (and thus requiring certification) change each year. CR 5457, from which this article is taken, informs carriers and A/B MACS about the new HCPCS codes for 2007 that are subject to CLIA edits and also about those that are now excluded from CLIA edits.

#### GO – What You Need to Do

Make sure that your billing staffs are aware of these CLIA-related HCPCS changes for 2007 and that you remain current with certification requirements.

## INSTRUCTIONS FOR THE COORDINATION OF MEDICARE SECONDARY PAYER (MSP) CLAIMS FOR THE COMPETITIVE ACQUISITION PROGRAM (CAP) ~CMS MLN Matters – February 2007~

MLN Matters Number: MM5332 REVISED  
Related CR Release Date: October 27, 2006  
Related CR Transmittal #: R57MSP & R1088CP

Related Change Request (CR) #: 5332  
Effective Date: January 1, 2007  
Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5332.pdf>

**Important Note:** See special edition article SE0703, which contains important information regarding the M2 (Medicare Secondary Payer) modifier that must be used in certain circumstances. The information in SE0703 overrides the information in this article relating to the use of the M2 modifier, instead of J3, in those circumstances, effective January 1, 2007. SE0703 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0703.pdf> on the CMS site.

### Provider Types Affected

Physicians who bill Medicare Carriers and Part A/B Medicare Administrative Contractors (A/B MACs) for drugs paid under the CAP program.

### Background

This article and related change request (CR) 5332 provides additional details, information and instructions for

CAP MSP claims and instances in which a beneficiary's MSP status is incorrectly determined. Section 303 (d) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 established section 1847B of the Social Security Act requiring the implementation of a competitive acquisition program (CAP) for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Beginning with drugs administered on or after July 1, 2006, physicians are given a choice between buying and billing these drugs for beneficiaries with Medicare as their primary insurer under the average sales price (ASP) system or obtaining these drugs from vendors selected through a competitive bidding process.

Participating CAP physicians agree to obtain all drugs included in the CAP drug category for Medicare beneficiaries who do not have another primary insurer from the approved CAP vendor. However, Medicare statutes allow for limited exceptions to this requirement.

One such exception includes Medicare Secondary Payer (MSP) situations. Section 1862(b) establishes provisions for Medicare as a secondary payer that are codified in 42 CFR Part 411. Section 1862(b) (6) specifically instructs physicians and other suppliers to identify, from information obtained from the beneficiary, payers primary to Medicare and to bill such payers prior to billing Medicare.

This CR instructs carriers to continue allowing CAP physicians to obtain physician administered drugs from entities approved by the primary plan and bill the primary payer outside the CAP vendor when Medicare beneficiaries have other insurance primary to Medicare.

**Note:** the term "carrier" also refers to A/B MACS as those entities replace carriers as part of Medicare's contracting reform implementation.

**NEW 2007 CURRENT PROCEDURAL TERMINOLOGY (CPT) MAMMOGRAPHY CODES  
~CMS MLN Matters – January 2007~**

MLN Matters Number: MM5327  
Related CR Release Date: September 29, 2006  
Related CR Transmittal #: R1070CP

Related Change Request (CR) #: 5327  
Effective Date: January 1, 2007  
Implementation Date: January 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5327.pdf>**

**Provider Types Affected**

All physicians and providers who bill Medicare carriers, fiscal intermediaries (FI), or Part A/B Medicare Administrative Contractors (A/B MACs) for providing mammography services.

**Provider Action Needed**

**STOP – Impact to You**

As part of the annual HCPCS update, CMS has assigned new 2007 Current Procedural Terminology (CPT) mammography codes for screening and diagnostic mammography services. Effective January 1, 2007, these codes ((77051, 77052, 77055, 77056, and 77057) will replace the current CPT codes; however the CPT code descriptors for the services are unchanged.

**CAUTION – What You Need to Know**

Failure to submit the correct codes will cause your claims to be returned and not processed.

**GO – What You Need to Do**

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

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

~CMS MLN Matters – March 2007~

MLN Matters Number: MM5456  
Related CR Release Date: January 26, 2007  
Related CR Transmittal #: R1163CP

Related Change Request (CR) #: 5456  
Effective Date: April 1, 2007  
Implementation Date: April 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5456.pdf>**

**Provider Types Affected**

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs),

durable medical equipment regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs)) for services.

#### Provider Action Needed

CR 5456, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective April 2, 2007. Be sure billing staff are aware of these changes.

### TAX RELIEF AND HEALTH CARE ACT OF 2006 CHANGES TO INDEPENDENT LABORATORY BILLING FOR THE TECHNICAL COMPONENT (TC) OF PHYSICIAN PATHOLOGY SERVICES ~CMS MLN Matters – February 2007~

MLN Matters Number: MM5468  
Related CR Release Date: January 5, 2007  
Related CR Transmittal #: R1148CP

Related Change Request (CR) #: 5468  
Effective Date: January 1, 2007  
Implementation Date: February 5, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5468.pdf>

#### Provider Types Affected

Independent laboratories submitting claims to Medicare contractors (carriers and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries

#### Provider Action Needed

This article is based on Change Request (CR) 5468 which directs Medicare contractors to notify independent laboratories that those independent laboratories qualifying to bill under the Tax Relief and Health Care Act of 2006 (Section 104) may continue to bill their carrier or A/B MAC for the TC of physician pathology services furnished to patients of a covered hospital, regardless of the beneficiary's hospitalization status (inpatient or outpatient) on the date that the service was performed, through December 31, 2007.

### USE OF NINE-DIGIT ZIP CODES FOR DETERMINING THE CORRECT PAYMENT LOCALITY FOR SERVICES PAID UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE (MPFS) AND ANESTHESIA SERVICES ~CMS MLN Matters – March 2007~

MLN Matters Number: MM5208  
Related CR Release Date: January 26, 2007  
Related CR Transmittal #: R1167CP

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>

#### Provider Types Affected

Physicians and providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors (MACs)) for services paid under the MPFS and for anesthesia services

#### Provider Action

##### Needed STOP – Impact to You

Effective for dates of service on or after October 1, 2007, for services rendered in the ZIP code areas displayed in Table 1 (below), 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.

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.

#### CAUTION – What You Need to Know

Effective October 1, 2007, for services rendered in the areas defined by the ZIP codes in Table 1, Medicare will require that you provide the nine-digit ZIP code for the location where services were rendered on your claims for services paid by carriers/MACs under the MPFS and for anesthesia services. CMS is implementing this requirement to prevent payment issues generated by ZIP codes that cross payment localities.







## CARDIAC OUTPUT MONITORING BY THORACIC ELECTRICAL BIOIMPEDANCE (TEB)

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5414 Revised  
 Related CR Release Date: December 15, 2006  
 Related CR Transmittal #: R63NCD

Related Change Request (CR) #: 5414  
 Effective Date: November 24, 2006  
 Implementation Date: January 16, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5414.pdf>

**Note:** This article was revised on December 29, 2006, to correct, on page 2, the Web address for accessing CR5414. All other information remains the same.

### Provider Types Affected

Physicians who bill Part A/B Medicare Administrative Contractors (A/B MACs), or Medicare carriers for services to Medicare beneficiaries.

### Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered the Medicare coverage policy for TEB for drug-resistant hypertension and decided to retain current coverage as written in section 20.16 of the National Coverage Determinations (NCD) Manual. Effective for dates of service on and after November 24, 2006, the current policies for cardiac output monitoring by TEB listed at section 20.16 of the NCD Manual will remain the same. Medicare A/B MACs and carriers will continue to make reasonable and necessary determinations for the use of TEB related to drug-resistant hypertension only. All other coverage and non-coverage policies at section 20.16 remain in effect.

## CAVERNOUS NERVES ELECTRICAL STIMULATION WITH PENILE PLETHYSMOGRAPH

~CMS MLN Matters – January 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. All other information remains the same.

### Provider Types Affected

Physicians and hospitals who bill Medicare fiscal intermediaries (FI) and carriers for performing Cavernous Nerves Electrical Stimulation with Penile Plethysmography in Medicare beneficiaries undergoing nerve-sparing prostatic or colorectal surgical procedures.

### Provider Action Needed

#### STOP – 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.

#### CAUTION – What You Need to Know

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.

#### GO – What You Need to Do

Make sure that your billing staffs are aware of this NCD.

**IMPLEMENTATION OF A ONE-TIME ONLY ULTRASOUND SCREENING FOR ABDOMINAL AORTIC ANEURYSMS (AAA), RESULTING FROM A REFERRAL FROM AN INITIAL PREVENTIVE PHYSICAL EXAMINATION**

~CMS MLN Matters – January 2007~

MLN Matters Number: MM5235 Revised

Related CR Release Date: November 17, 2006

Related CR Transmittal #: R1113CP

Related Change Request (CR) #: 5235

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

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

**Note:** This article was changed on December 8, 2006 to add emphasize that this coverage is for a one-time only service and it must also be as a result of a referral from an initial preventive physical exam and is also subject to other limitations as discussed in this article and in CR5235.

**Provider Types Affected**

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

**Background**

This article and related CR5235 highlight the fact that section 5112 of the Deficit Reduction Act (DRA) of 2005 allows for one ultrasound screening for Abdominal Aortic Aneurysms (AAA) under Medicare Part B, effective for services furnished on or after January 1, 2007, as a result of a referral from an Initial Preventive Physical Examination (IPPE) and subject to certain eligibility and other limitations. This provision also waives the annual Part B deductible for the AAA screening test.

**INFRARED THERAPY DEVICES**

~CMS MLN Matters – February & March 2007~

MLN Matters Number: MM5421

Related CR Release Date: February 9, 2007

Related CR Transmittal #: R1183CP and R62NCD

Related Change Request (CR) #: 5421

Effective Date: October 24, 2006

Implementation Date: January 16, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5421.pdf>**

**Note:** This article was revised on February 9, 2007, to correct the range of ICD-9 codes shown in bold print on page 2. The range is 880.00-887.7. Originally, CR5421 and the related article incorrectly showed 880.00-887.79 for that range. The CR transmittal number, release date, and Web address for accessing CR5421 are also revised, but all other information remains the same.

**Provider Types Affected**

Physicians, suppliers, and providers who submit claims to Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME/MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs), for the use of infrared therapy devices for treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

**Impact on Providers**

This article is based on Change Request (CR) 5421. Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services (CMS) has made a National Coverage Determination (NCD) stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), **is non-covered for the treatment**, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

**INJECTION LIST**

~ January 2007 ~

Under Lidocaine HCL (J2001) ICD-9 code V68.89 for ambulance use only was removed. Ambulance providers can not bill for drugs as of 01/01/06.

Ranibizumab (Lucentis™) (J3490) dosage amount was changed to .5 mg. This is the unit of measure used by CMS on the ASP drug pricing file.

## INTRACRANIAL PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY (PTA) WITH STENTING

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5432  
 Related CR Release Date: January 5, 2007  
 Related CR Transmittal #: R64NCD and R1147CP

Related Change Request (CR) #: 5432  
 Effective Date: November 6, 2006  
 Implementation Date: February 5, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5432.pdf>

### Provider Types Affected

Physicians and providers who may wish to submit claims to Medicare carriers, fiscal intermediaries (FIs) and Part A/B Medicare Administrative Contractors (A/B MACs) for PTA Stenting.

### Provider Action Needed

Be aware that The Centers for Medicare & Medicaid Services (CMS) has reviewed the evidence and determined that, effective for discharges on or after November 6, 2006, Medicare will cover PTA with stenting of intracranial arteries for treatment of cerebral artery stenosis  $\geq 50\%$  in patients with intracranial atherosclerotic disease when furnished in accordance with FDA-approved protocols governing Category B IDE clinical trials. Payment for intracranial PTA with stenting is considered reasonable and necessary under §1862(a)(1)(A) of the Social Security Act under these circumstances. All other indications for intracranial PTA with or without stenting to treat obstructive lesions of the vertebral and cerebral arteries remain non-covered.

## OUTPATIENT THERAPY CAP EXCEPTIONS CLARIFICATIONS

~CMS MLN Matters – January & February 2007~

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

Related Change Request (CR) #: 5271  
 Effective Date: December 9, 2006  
 Implementation Date: December 9, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5271.pdf>

**Important Note:** Recent legislation extended the therapy cap exceptions for calendar year 2007. For details on the 2007 exceptions and process, see the MLN Matters article MM5478 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5478.pdf> on the CMS site.

### Provider Types Affected

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

### Provider Action Needed

CR 4364, released February 15, 2006, described the exception process to the caps set on outpatient therapy services (physical therapy and occupational therapy). CR 5271, upon which this article is based, clarifies questions (below) that have arisen about this exception process. Thus, the article is meant primarily for informational purposes. It also reminds you that the exception process stops after December 31, 2006.

## OUTPATIENT THERAPY CAP EXCEPTION PROCESS FOR 2007

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5478 Revised  
 Related CR Release Date: December 29, 2006  
 Related CR Transmittal #: R1145CP, R181PI, R63BP

Related Change Request (CR) #: 5478  
 Effective Date: January 1, 2007  
 Implementation Date: January 29, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5478.pdf>

**Note:** This article was revised on January 11, 2007, to eliminate a reference to Cedaron. All other information remains the same.

### Provider Types Affected

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

### Provider Action Needed

Be sure you are aware of the requirements for the therapy cap exceptions for calendar year 2007, especially the use of the KX modifier and the rules governing the exceptions.

**PERCUTANEOUS INTRADISCAL ELECTROTHERMAL ANNULOPLASTY (INTRADISCAL  
ELECTROTHERMAL THERAPY)****~ January 2007 ~**

Original Article Effective Date  
07/01/2002

Article Revision Effective Date  
01/01/2007  
Article Text

CPT 2007 introduces two new Interdiscal Electrothermal Annuloplasty (IDET) codes: CPT 22526 and CPT 22527. Intradiscal electrothermal annuloplasty is performed by inserting a needle or catheter, which is subsequently heated, into a disc, to effect a thermal change in the annular tissue, which modulates the nerve fibers in a disrupted disc's annulus, and stabilizes the collagen of the annulus as a treatment for back pain. The related "nucleoplasty procedure" involves the percutaneous removal of disc material by using a low-temperature resister probe to disintegrate and evacuate disc material, followed by thermal treatment of adjacent residual disc material.

Previously the Category II codes 0062T (Percutaneous intradiscal annuloplasty, any method, unilateral or bilateral including fluoroscopic guidance; single level) and 0063T (; one or more additional levels [List separately in addition to 0062T for primary procedure]) were used to describe this service.

Proponents of this service feel that it is a minimally invasive procedure, and thus is safer than standard back surgery and allows a much quicker healing time. They argue that it gives good results in the alleviation of pain. Unfortunately, the peer-reviewed, published medical literature at this time is meager and the long term results concerning its safety/efficacy are not apparent.

At present, after review of the published literature it is this carrier's medical opinion that currently there are insufficient studies or clinical trials to support the safety and effectiveness of IDET.

Thus, at present, this treatment is considered experimental/investigational and will not be covered under Medicare B in Illinois, Michigan, Minnesota, or Wisconsin. As more peer-reviewed medical literature appears on the PubMed, they will be reviewed and the status of IDET will be reevaluated.

Providers should not bill Medicare for Intradiscal Electrothermal annuloplasty or Intradiscal Electrothermal Therapy since it has been determined to be experimental/investigational and thus not medically necessary and therefore not covered by Medicare B. An advanced beneficiary notice (ABN) needs to be signed since experimental/investigational treatments are not medically necessary or payable. Unless an ABN is signed, the beneficiary will not be responsible for the charges. If the beneficiary wishes that a bill be sent to Medicare for the purpose of obtaining a denial, CPT code 22526/22527 should be used with the GA modifier (Item or service expected to be denied as not reasonable and necessary and the physician has an ABN signed by the beneficiary on file.). It is not appropriate to bill 64999 (Unlisted procedure, nervous system) or CPT 62287 (Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar [eg, manual or automated percutaneous discectomy, percutaneous last discectomy]). (reference: article A3439)

**PODIATRY CODE LIST****~ January 2007 ~**

Effective 01/01/2007 the following CPT/HCPCS codes are removed from the Podiatry Code List:  
J7343, J7344, 15000, 15001, 15040, 15100, 15101, 15115, 15116, 15120, 15121, 15135, 15155, 15156, 15157, 15175, 15176, 15220, 15221, 15240, 15241.

**POLICY 2007 PROCEDURE CODE UPDATE****~ January 2007 ~**

The following Procedure Codes have been added or deleted from the listed Local Coverage Determination (LCD) Policies for 2007. The new codes are effective for services performed on or after 01/01/2007; the deleted are effective 12/31/2006 and will not include a 90 day grace period.

**Editors' Note:** J3490, J3590, and J9999, 22899, 92499 are valid codes to identify not otherwise classified (NOC) drugs/procedures that have not been assigned a true CPT/HCPCS code. They are listed in the table below to indicate that the NOC code is no longer valid for the drugs/procedure codes for which a true CPT/HCPCS code have been assigned.

Policy Name & Number	Added Codes	Deleted Codes	Description Changed
Automatic Implantable Cardioverter Defibrillator (AICD or ICD) CV-014	33202, 33203  33225	33245, 33246	33225 is not a new code but is new to policy
Moh's Micrographic Surgery (MMS) DERM-004	17311, 17312, 17313, 17314, 17315	17304, 17305, 17306, 17307, 17310	
Removal of Benign Skin Lesions DERM-008			17000, 17004
Treatment of Actinic Keratosis DERM-009			17000, 17004
Cosmetic and Reconstructive Surgery GSURG-032	15830, 19300	15831, 19140	
Cryosurgery for Liver Tumors GSURG-033			76940
Application of Bioengineered Skin Substitutes and Skin Grafting GSURG-037	15002, 15003, 15004, 15005  J7345, J7346	15000, 15001  J7350	
Antineoplastics and Their Adjuncts HONC-010	J0894, J9261	J9999 for Dacogen	J9264
Hemophilia Clotting Factors INJ 003	J7187	J7188	
Bisphosphonate Drug Therapy INJ-025	J1740		
Intra-articular Injection of Hyaluronate for Treatment of Osteoarthritis of Knee INJ-033	Q4083-Q4086	J7317, J7320 J3590 for Orthovisc	
Bone Mineral Density Studies MS-004	77078, 77079, 77080, 77081, 77083	76070, 76071, 76075, 76076, 76078	
Vagus Nerve Stimulation NEURO-004			64590, 64959
Optometrist Services OPHTH-003	92025		
Computerized Corneal Topography OPHTH-014	92025	92499	
Consultations PHYS-006			99251, 99252, 99253, 99254, 99255
Magnetic Resonance Imaging (MRI) RAD-024	77058, 77059	76093, 76094	
Diagnostic Mammogram RAD-005	77051, 77055 77056	76082, 76090 76091	
Screening Mammogram RAD-016	77051, 77052, 77055, 77056, 77057	76082, 76083, 76090, 76091, 76092	
Radiopharmaceutical Agents RAD-026	A9568, A9527 78707, 78708, 78709, 78710, 78761	A9549 78704, 78715 78760	

Policy Name & Number	Added Codes	Deleted Codes	Description Changed
Percutaneous Image-Guided Breast Biopsy RAD 028	77002, 77012, 77021, 77031, 77032	76095, 76096, 76360, 76393	
Vertebroplasty (Percutaneous) and Kyphoplasty RAD-032	72291, 72292	76012, 76013	
Brachytherapy RAD 036	55875, 55876	55859	
Injection List	J0129, J0364	J3590 for Abatacept J3490 for Apokyn	
Podiatry Code List	28055, 77002, 77071, 77073	J2912, 15000, 15001, 28030, 76003, 76006, 76040	

**PRIVATE CONTRACTING- DEFINITION OF PHYSICIAN/PRACTITIONER  
~CMS MLN Matters – February 2007 ~**

MLN Matters Number: MM5426

Related CR Release Date: December 22, 2006

Related CR Transmittal #: R62BP

Related Change Request (CR) #: 5426

Effective Date: November 13, 2006

Implementation Date: April 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5426.pdf>

**Provider Types Affected**

Registered dietitians or nutrition professionals providing services to Medicare beneficiaries.

**Provider Action Needed**

This article is based on Change Request (CR) 5426 which updates the Medicare Benefit Policy Manual (Publication 100-02, Chapter 15, Section 40.4) to include registered dietitians and nutrition professionals in the list of practitioners who can opt out of Medicare if certain conditions are met, and to provide services through private contracts that would otherwise be covered by Medicare.

**UPDATE: BILLING END STAGE RENAL DISEASE (ESRD) RELATED SERVICES FOR  
TRANSIENT DIALYSIS PATIENTS  
~February 2007 ~**

The November 2004 *Communiqué* contained an MLN Matters article published by the Centers for Medicare & Medicaid Services (CMS) titled, "Payment for Outpatient End Stage Renal Disease (ESRD) Related Services." The purpose of the article was to assist physicians and practitioners billing for outpatient ESRD-related services.

The article advised physicians and practitioners to bill with the unlisted dialysis Current Procedural Terminology (CPT) code 90999, when managing outpatient ESRD-related services for transient dialysis patients (patients traveling away from home - less than full month). HCPCS codes G0324-G0327 were not appropriate for these situations, as the original narrative descriptions for G0324-G0327 contained the words "home dialysis."

WPS Medicare has recently been working with CMS to clarify the original instructions, and to ensure proper billing for these situations. CMS recently clarified to WPS Medicare that the unlisted dialysis code (90999) was only intended to be used for Outpatient ESRD-related services (transient patients) on a temporary basis. CMS published Change Request (CR) 3595, "Emergency Update to the 2005 Medicare Physician Fee Schedule Database," after the MLN Matters article that clarified "home dialysis" should not be included in the narrative descriptions of these codes. Therefore, in lieu of billing 90999 for these situations, physicians, and practitioners managing Outpatient ESRD-related services for transient dialysis patients (patients traveling away from home - less than full month) can utilize HCPCS codes G0324-G0327 accordingly.

CR 3595 provided the following narrative descriptions for G0324-G0327:

- G0324-End stage renal disease (ESRD) related services less than full month, per day; for patients under two years of age
- G0325-End stage renal disease (ESRD) related services less than full month, per day; for patients between

- two and eleven years of age
- G0326-End stage renal disease (ESRD) related services less than full month, per day; for patients between twelve and nineteen years of age
- G0327-End stage renal disease (ESRD) related services less than full month, per day; for patients twenty years of age and over

To view a copy of CR 3595, please refer to the CMS Website below:

<http://www.cms.hhs.gov/transmittals/downloads/R414CP.pdf>

WPS Medicare does not routinely require supporting documentation (medical records) for G0324-G0327 on a pre-payment (claim level) basis. However, the medical records should be available to WPS Medicare upon request, and should include the following:

- Supporting and legible documentation for the service(s) provided
- Identity of the patient (e.g. name, address, Medicare number)
- Dates on which the billing provider was responsible for the beneficiary's outpatient ESRD-related services
- The name of the provider who was responsible for (supervising) the beneficiary's outpatient ESRD-related services during this time

## Electronic Data Interchange (EDI)

### ATTENTION SOLE PROPRIETORS: ARE YOU PREPARING FOR NPI?

~March 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.

A common issue in electronic claims occurs when the provider is a sole proprietor with Medicare Part B. The solo practice is incorporated, has a tax ID, and has obtained an organizational NPI as well as an individual NPI for the provider. If an individual provider has 2 NPIs (one for organization, one for provider) but only 1 Medicare Provider number, a new CMS 855 application may be necessary. Conversely, a sole proprietor who is unincorporated yet has a tax ID should enumerate only an individual NPI under their Social Security Number.

Another common issue occurs when there are multiple sole proprietors who share a common tax ID and pay-to name. If the pay-to organization has obtained an organizational NPI and each solo has their own NPI, a new CMS 855 application may be necessary to establish a group. Not sure if you need a new CMS 855 application? Call Provider Enrollment at: (877) 908-8476.

It is extremely important to use the Legal Business name used when applying for the NPI. The Legal Business name is the name reported to the 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 and you still continue to receive the informational errors on your report, please contact the EDI Hotline for assistance at:

**IL, MI, WI:** 877-567-7261

**MN:** 952-885-2811, 952-885-2881, or 952-885-2882.

**MEDICARE REMIT EASY PRINT JANUARY 2, 2007****~February 2007~**

The quarterly update to the Medicare Remit East Print (MREP) software has been released by the Center for Medicare and Medicaid Services (CMS) on January 2, 2007. MREP Version 2.0 is now available.

If you are an electronic biller who does not receive the ERA, please download the ERA information sheet at [http://www.wpsic.com/edi/pdf/edi\\_ern\\_medb.pdf](http://www.wpsic.com/edi/pdf/edi_ern_medb.pdf) and submit it to our office. If you already receive the ERA, please download the MREP software at <http://www.wpsmedicare.com/provider/provhome.shtml>. If you are not an electronic biller and still want to receive an ERA to use the MREP software, you will also need to submit an EDI enrollment form. Please label MREP only. You can download this form at [http://www.wpsic.com/edi/pdf/medb\\_enroll.pdf](http://www.wpsic.com/edi/pdf/medb_enroll.pdf)

Take advantage of this new software. Begin using MREP today!

To find out more about MREP and/or for information on receiving a HIPAA compliant ERA please contact the EDI Hotline for IL/MI/WI (877) 567-7261 For Minnesota, please contact (952) 885-2882, (952) 885-2881 or (952) 885-2811

**REMINDER: EDI QUESTIONS****~March 2007**

The WPS Medicare Electronic Data Interchange (EDI) Department frequently receives telephone calls to our EDI Hotline from providers, billing services, etc. These callers sometimes are requesting claim status, have questions regarding automatic crossover issues, requesting copies of paper remittance, pending and approved to pay claims, looking into check status, and have patient eligibility issues or need verification of patient birth dates. These are types of questions that can all be answered using the IVR (Interactive Voice Response). For more information on the IVR, visit the Website below:

<http://www.wpsmedicare.com/provider/pdfs/ivr.pdf>

**WHERE CAN I FIND..... EDI'S MOST FREQUENTLY REQUESTED WEBSITES****~January 2007~**

Electronic Data Interchange (EDI) Bulletin Board System (BBS)

[https://www.wpsic.com/edi/edi\\_bbs\\_p.shtml?mm=3](https://www.wpsic.com/edi/edi_bbs_p.shtml?mm=3)

EDI Enrollment

[https://www.wpsic.com/edi/pdf/medb\\_enroll.pdf](https://www.wpsic.com/edi/pdf/medb_enroll.pdf)

Electronic Funds Transfer (EFT)

[https://www.wpsic.com/edi/pdf/edi\\_medb\\_eft.pdf](https://www.wpsic.com/edi/pdf/edi_medb_eft.pdf)

Electronic Remittance Advice (ERA)

[https://www.wpsic.com/edi/pdf/edi\\_ern\\_medb.pdf](https://www.wpsic.com/edi/pdf/edi_ern_medb.pdf)

MCS 837 4010 Pre-pass Edit Listing

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

Medicare Remit Easy Print (MREP)

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

PC Ace Software-Free billing software for Medicare Part B

[https://www.wpsic.com/edi/pacepro32\\_p.shtml?mm=3](https://www.wpsic.com/edi/pacepro32_p.shtml?mm=3)

National Provider Identifier (NPI)

[https://www.wpsic.com/edi/npi\\_p.shtml?mm=3](https://www.wpsic.com/edi/npi_p.shtml?mm=3)

If you have any questions, please contact the EDI Hotline for IL/MI/WI (877) 567-7261

For Minnesota, please contact (952) 885-2882, (952) 885-2881 or (952) 885-2811

**YOUR 837 4010 EMC PRE-PASS REPORT****~February 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.

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. The NPI enumerator Website is:

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

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.

## General Information

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

~ Revised CMS MLN Matters – March 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>

**Note:** This article was revised on February 9, 2007, to clarify the language in the first bullet point under “Billing Guidelines” on page 2. All other information remains the same.

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

~ CMS MLN Matters – March 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.

#### Provider Types Affected

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

#### Provider Action Needed

##### STOP – 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.

##### CAUTION – 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.

**GO – What You Need to Do**

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

**ENHANCE THE MULTI-CARRIER SYSTEM (MCS) TO AVOID DUPLICATE PAYMENTS WHEN A FULL CLAIM ADJUSTMENT IS PERFORMED.**

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5424  
Related CR Release Date: January 12, 2007  
Related CR Transmittal #: R2600TN

Related Change Request (CR) #: 5424  
Effective Date: April 1, 2007  
Implementation Date: April 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5424.pdf>

**Provider Types Affected**

Physicians and other providers who bill Medicare carriers or Part A/B Medicare Administrative contractors (A/B MACS) for services.

**Provider Action Needed**

In CR5424, from which this article was taken, CMS announces the enhancement of the Multi-Carrier System (MCS). MCS is the system that Medicare carriers and A/B MACS use to process Part B claims for physician care and other outpatient services to avoid duplicate payments when performing a full claim adjustment. CR5424 rescinds and fully replaces CR 3878. This article is mainly for informational purposes.

**LABORATORY COMPETITIVE BIDDING DEMONSTRATION**

~CMS MLN Matters – January 2007~

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

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5359.pdf>

**Note:** This article was changed on December 19, 2006 to specify that the \$100,000 annual ceiling for passive laboratories must be exceeded by \$25,000 or more to be terminated, as described on page 3. All other information remains the same.

**Provider Types Affected**

Physicians and hospitals (TOB 14X only) who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical laboratory tests performed for Medicare Part B beneficiaries who live within the competitive bidding demonstration area (CBA) sites

**Background**

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

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

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

## MEDICALLY UNLIKELY EDITS (MUES)

~CMS MLN Matters – January 2007~

MLN Matters Number: MM5402  
 Related CR Release Date: December 8, 2006  
 Related CR Transmittal #: R178PI

Related Change Request (CR) #: 5402  
 Effective Date: January 1, 2007  
 Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5402.pdf>

### Provider Types Affected

Physicians, suppliers, and providers who bill Medicare fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare Administrative contractors (DME/MACs), and/or regional home health intermediaries (RHHIs).

### Background

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, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- The MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria or Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

## PART C PLAN TYPE DESCRIPTION DISPLAY ON MEDICARE'S COMMON WORKING FILE (CWF)

~CMS MLN Matters – March 2007~

MLN Matters Number: MM5349  
 Related CR Release Date: February 2, 2007  
 Related CR Transmittal #: R1175CP

Related Change Request (CR) #: 5349  
 Effective Date: July 1, 2007  
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5349.pdf>

### Provider Types Affected

Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through CWF eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).

### Provider Action Needed

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 will soon be published that contains the list of all active Medicare contracts and their corresponding plan type. The directory will be posted at the following URL no later than March 1, 2007:  
[http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02\\_EnrollmentData.asp#TopOfPage](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage)

## QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI) EDITS, VERSION 13.0, EFFECTIVE JANUARY 1, 2007

~CMS MLN Matters – January 2007~

MLN Matters Number: MM5422  
 Related CR Release Date: December 8, 2006  
 Related CR Transmittal #: R1124CP

Related Change Request (CR) #: 5422  
 Effective Date: January 1, 2007  
 Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5422.pdf>

### Provider Types Affected

Physicians who submit claims to Medicare carriers and A/B Medicare Administrative Contractors (A/B MACs).

### Background

This article and related Change Request (CR) 5422 provide a reminder for physicians to take note of the quarterly updates to the coding initiatives. The latest package of Correct Coding Initiative (CCI) edits, Version

13.0, effective January 1, 2007, will be available via the CMS Data Center (CDC).

Physicians may view the current CCI edits and the current Mutually Exclusive Code (MEC) edits at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> on the Centers for Medicare & Medicaid Services (CMS) web site.

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice, and review of current coding practice. The latest package of CCI edits, Version 13.0, is effective on January 1, 2007. This version will include all previous versions and updates from January 1, 1996 to the present and will be organized in two tables:

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

### **PHYSICIAN VOLUNTARY REPORTING PROGRAM (PVRP) REMINDERS ~February 2007~**

**Note:** The following article is based on Transmittal 259, Change Request (CR) 5409, located on the CMS Website at: <http://www.cms.hhs.gov/transmittals/downloads/R259OTN.pdf>

As part of its overall quality improvement efforts, the Centers for Medicare & Medicaid Services (CMS) launched the Physician Voluntary Reporting Program (PVRP) on January 1, 2006. This new program builds on Medicare's comprehensive efforts to substantially improve the health and function of our beneficiaries by improving the quality of care delivered.

Under the PVRP, physicians who choose to participate will help capture data about the quality of care provided to Medicare beneficiaries in order to identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care. Participating physicians will begin reporting quality data and not only be able to receive feedback on their reporting rates and performance, but also provide input on how quality reporting can be improved and less burdensome.

PVRP consists of evidence-based, clinically valid measures, which have been part of the guidelines endorsed by physicians and medical specialty societies, and are the result of extensive input from physicians and other quality care experts.

CR 4183 (Transmittal 35), dated November 2, 2005, contained the 16 measures to be reported by physicians using the existing Medicare claims system effective January 1, 2006. You may access CR 4183 on the CMS Website at: <http://www.cms.hhs.gov/Transmittals/Downloads/R35DEMO.pdf>

CR 5036 (Transmittal 43), dated March 24, 2006, added CPT Category II codes to 7 of the 16 measures effective April 1, 2006. You may access CR 5036 at:

<http://www.cms.hhs.gov/transmittals/downloads/R43DEMO.pdf>

**Please note the following important reminders regarding PVRP:**

1. PVRP codes are for voluntary reporting purposes only and physicians should not charge for these codes.
2. A note clarifying "not eligible" has been added to the instruction for each measure.

### **REVISIONS TO PROCEDURES TO ESTABLISH GOOD CAUSE AND QUALIFIED INDEPENDENT CONTRACTOR (QIC) JURISDICTIONS ~CMS MLN Matters – February 2007~**

MLN Matters Number: MM5386  
Related CR Release Date: December 22, 2006  
Related CR Transmittal #: R1136CP

Related Change Request (CR) #: 5386  
Effective Date: January 1, 2007  
Implementation Date: April 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5386.pdf>**

#### **Provider Types Affected**

Physicians, providers and suppliers who bill Medicare contractors (A/B Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), durable medical

equipment regional carriers (DMERCs) or durable medical equipment Medicare administrative contractors (DME MAC)) for services provided to Medicare beneficiaries.

### Background

The purpose of CR 5386 is to notify providers and suppliers of the restructured Part B/DME QIC jurisdictions. Under the new jurisdictions, three QICs will process reconsiderations as follows:

- Two QICs will process reconsiderations of carrier and A/B MAC re-determinations effective November 15, 2006 for contractors that process claims in the North jurisdiction and January 1, 2007 for contractors that process claims in the South jurisdiction. Your contractor will reference the appropriate QIC in the Medicare Redetermination Notice (MRN). In order to expedite your request for appeal, please make sure you follow the instructions on your MRN regarding where to submit your request for reconsideration. If you have already submitted a reconsideration request with the incumbent QIC, please do not submit a duplicate request.; and
- The third QIC will process all reconsiderations of DMERC and DME MAC re-determinations effective December 1, 2006.

## TIMELINESS STANDARDS FOR PROCESSING OTHER-THAN-CLEAN CLAIMS

~ CMS MLN Matters – March 2007 ~

MLN Matters Number: MM5355  
Related CR Release Date: February 2, 2007  
Related CR Transmittal #: R1173CP

Related Change Request (CR) #: 5355  
Effective Date: July 1, 2007  
Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/Downloads/mm5355.pdf>

### Provider Types Affected

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

### Provider Action Needed

This article is intended as informational only and is based on Change Request (CR) 5355, which provides requirements for all carriers and MACs for timeliness for processing “other-than-clean” claims.

## WPS MEDICARE’S MESSAGE ON PROVIDER ENROLLMENT APPLICATIONS

~ January 2007 ~

The Centers for Medicare & Medicaid Services (CMS) requires the return of an application for seventeen reasons (we have added numbers below for your convenience). If WPS Medicare is unable to process an application and the reason is not listed below, we are required to develop for the information. This return or development could cause processing delays. WPS Medicare is currently returning or developing on 40-50% of all submitted provider enrollment applications.

CMS direction in IOM 100-08 Chapter 10 Section 4.1 states:

*Unless otherwise stated in this manual, the provider may only check one reason for submittal. Thus, suppose a supplier is changing its TIN. It must enroll as a new supplier while also requesting to terminate its existing billing number. The provider must submit two applications: (1) an initial CMS 855B for the new supplier, and (2) a CMS 855B change request/voluntary termination. Both transactions cannot be reported on the same application.*

If you have questions or need assistance completing the provider enrollment process, please check the following WPS Medicare Website for Computer Based Training (CBT):

<http://www.wpsmedicare.com/provenroll/enroll.shtml>

The following provider enrollment CBTs are available.

- Medicare Provider Enrollment Application CMS Form 855B
- Medicare Provider Enrollment Application CMS Form 855I
- Medicare Provider Enrollment Application CMS Form 855R

Or contact the Provider Enrollment Hotlines at:

**Minnesota** – (866) 564-0315

**Illinois, Michigan, or Wisconsin** – (877) 908-8476

The hotline hours are Monday through Friday 8:00 A.M. – 4:00 P.M. Central Time, 9:00 A.M. – 5:00 P.M. Eastern Time.

The full text of this article, including the top reasons WPS Medicare returns enrollment applications, is available at [http://www.wpsmedicare.com/provider/pdfs/wps\\_pe\\_apps.pdf](http://www.wpsmedicare.com/provider/pdfs/wps_pe_apps.pdf)

## **Program Safeguards**

### **SANCTIONED AND REINSTATED PROVIDERS**

~January, February, March 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**

### **ATTENTION! IF YOU READ THIS, YOU MAY SAVE MONEY! DUPLICATE CLAIMS RESULT IN UNNECESSARY COSTS FOR PROVIDERS AND MEDICARE ~March 2007~**

Duplicate claims continue to be one of the top denial reasons for both new and established providers, resulting in millions of dollars in unnecessary costs. Currently, 5.5% of all claims submitted to WPS Medicare deny as duplicates.

This article provides available resources to assist you in helping WPS Medicare reach our goal to reduce duplicate denials to 1% of all claims submitted. You can find helpful information on the WPS Medicare Website at the following Website addresses:

[http://www.wpsmedicare.com/provider/dup\\_claims.shtml](http://www.wpsmedicare.com/provider/dup_claims.shtml)

[http://www.wpsmedicare.com/provider/novice\\_know.shtml](http://www.wpsmedicare.com/provider/novice_know.shtml)

A new Computer-Based Training (CBT) module designed to help providers reduce duplicate claim denials will be available soon on the WPS Medicare tutorials homepage. You can visit the tutorials homepage at:

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

### **PROVIDER EDUCATION EVENTS AVAILABLE!**

~January, February, & March 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.

## **Reimbursement**

### **2007 ANNUAL UPDATE FOR CLINICAL LABORATORY FEE SCHEDULE AND LABORATORY SERVICES SUBJECT TO REASONABLE CHARGE PAYMENT**

~CMS MLN Matters – January 2007~

MLN Matters Number: MM5362  
Related CR Release Date: December 8, 2006  
Related CR Transmittal #: R1122CP

Related Change Request (CR) #: 5362  
Effective Date: January 1, 2007  
Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5362.pdf>

**Provider Types Affected**

Clinical laboratories billing Medicare carriers, intermediaries, or Part A/B Medicare Administrative Contractors (A/B MACs)

**Provider Action Needed**

This article and related CR5362 contain important information regarding:

- The 2007 annual updates to the clinical laboratory fee schedule
- Mapping for new codes for clinical laboratory tests, and
- Laboratory costs related to services subject to reasonable charge payments.

It is important that affected laboratories understand these changes to ensure correct and accurate payments from Medicare.

**2007 MEDICARE PHYSICIAN FEE SCHEDULE (MPFSDB) UPDATES**

~March 2007~

Fee changes are being made to the 2007 Medicare Physician Fee Schedule. These changes are effective for claims processed on and after February 5, 2007, for dates of service January 1, 2007, and after. WPS Medicare will adjust all affected claims. Providers do not need to contact us to request an adjustment. To read this article in full, including a table detailing the changes, please go to

[http://www.wpsmedicare.com/provider/pdfs/mpfsdb\\_07\\_updates.pdf](http://www.wpsmedicare.com/provider/pdfs/mpfsdb_07_updates.pdf)

**2007 PHYSICIAN FEE SCHEDULE PAYMENT POLICIES**

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5443

Related CR Release Date: December 22, 2006

Related CR Transmittal #: R258OTN

Related Change Request (CR) #: 5443

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5443.pdf>**

**Provider Types Affected**

Physicians and other providers who bill Medicare carriers, fiscal intermediaries (FI) and A/B MACs for services, including ambulance and telehealth services.

**What you Need to Know**

CR 5443, from which this article was taken: 1) Summarizes significant issues contained in the Medicare Physician Fee Schedule Regulation for 2007 (including publishing the Ambulance Inflation Factor (AIF) for CY 2007); and 2) Announces the telehealth originating site facility fee for 2007. CR5443 also discusses several provisions of the recently-enacted Tax Relief and Health Care Act of 2006. You should refer to the Background and Additional Information sections, below, for more details and information on how to find the background/reference documents.

**2007 UPDATE OF HCPCS CODES AND PAYMENTS FOR AMBULATORY SURGICAL CENTERS (ASCS)**

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5211 Revised

Related CR Release Date: December 20, 2006

Related CR Transmittal #: R1134CP

Related Change Request (CR) #: 5211

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5211.pdf>**

**Note:** This article was revised on December 21, 2006, to reflect changes made to CR5211. CR5211 was amended to provide the Web address for accessing the “2007 ASC Approved HCPCS Codes and Payment Rates”. That address is in the Additional Information section of this article. The article was also revised to reflect the new CR release date, transmittal number, and Web address for accessing the revised CR5211. All other information remains the same.

**Provider Types Affected**

Ambulatory surgical centers (ASCs) submitting claims to Medicare carriers or fiscal intermediaries (FIs) for ASC services provided to Medicare beneficiaries.

**Impact on Providers**

This article is based on Change Request (CR) 5211, which updates the 2007 HCPCS codes and ASC payment rates, effective for services furnished on or after January 1, 2007.

**ADDITIONAL CHANGES TO THE 2007 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE (MPFSDB)**

~CMS MLN Matters – March 2007~

MLN Matters Number: MM5498  
 Related CR Release Date: January 24, 2007  
 Related CR Transmittal #: R1161CP

Related Change Request (CR) #: 5498  
 Effective Date: January 1, 2007  
 Implementation Date: February 26, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5498.pdf>**

**Provider Types Affected**

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs)) for professional services paid under the Medicare Physician Fee Schedule (MPFS).

**Background**

This article and Change Request (CR) 5498 wants providers to know that payment files were issued to carriers based upon the December 1, 2006, MPFS Final Rule and Transmittal 1143, Change Request 5459, Emergency Update to the 2007 Medicare Physician Fee Schedule Database. (An MLN Matters, MM5459, is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf> on the CMS website.) This CR, 5498, amends those payment files and includes new outpatient prospective payment system (OPPS) payment amounts for codes subject to the OPPS cap and other miscellaneous corrections.

**ANESTHESIA INFORMATION - REVISED FSY 2007 ANESTHESIA CONVERSION FACTORS**  
 ~January 2007~

The chart below lists the REVISED FSY 2007 anesthesia participating, non-participating and limiting charge conversion factors (CFs) effective for dates of service January 1, 2007, and after. For physician-directed anesthesia services provided in 2007, the allowance for both the physician and the Certified Registered Nurse Anesthetist (CRNA) is 50 percent of the allowance for the anesthesia service if performed by the physician or CRNA alone. The Medicare approved amount for an anesthesia service is calculated as follows: (Base Units + Time Units) x Conversion Factor = Approved Amount To determine the medically directed rate, multiply the approved amount by 50%. See National Coverage Provision AN-001 on the WPS Website for detailed billing and payment guidelines.

State	Locality	Participating Physician and CRNA CF	Non-Participating Physician CF	Limiting Charge CF
Illinois	12	\$17.17	\$16.31	\$18.76
Illinois	15	\$17.63	\$16.75	\$19.26
Illinois	16	\$18.06	\$17.16	\$19.73
Illinois	99	\$16.18	\$15.37	\$17.68
Michigan	01	\$19.38	\$18.41	\$21.17
Michigan	99	\$16.78	\$15.94	\$18.33
Minnesota		\$15.67	\$14.89	\$17.12
Wisconsin		\$15.28	\$14.52	\$16.70

**CHIROPRACTIC DEMONSTRATION 2007 RATE CHANGE**  
 ~CMS MLN Matters – February 2007~

MLN Matters Number: MM5396  
 Related CR Release Date: January 10, 2007  
 Related CR Transmittal #: R52DEMO

Related Change Request (CR) #: 5396  
 Effective Date: January 1, 2007  
 Implementation Date: January 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5396.pdf>**

**Provider Types Affected**

Chiropractors who are allowed to bill Medicare carriers or Part A/B Medicare Administrative Contractors (A/B MACs) for services under the Expansion of Coverage for Chiropractic Services Demonstration.

**What These Providers Need to Know**

CR 5396, from which this article is taken, implements new 2007 fee rates for CPT 98943 (to replace the current 2006 rates), under the Expansion of Coverage for Chiropractic Services Demonstration. The 2007 rates are in the following table:

State/Area	Non-Facility Fee	Facility Fee
New Mexico	\$21.38	\$18.69
Iowa	\$21.11	\$18.47
Virginia	\$21.71	\$18.86
Dupage, Kane, Lake, and Will Counties, Illinois	\$23.82	\$20.43
Cook County, Illinois	\$24.08	\$20.67
Remaining Counties in Illinois	\$21.37	\$18.73
Cumberland and York Counties, Maine	\$22.33	\$19.26
Remaining Counties in Maine	\$21.28	\$18.59

**COLORECTAL CANCER SCREENING FLEXIBLE SIGMOIDOSCOPY AND COLONOSCOPY  
COINSURANCE PAYMENT CHANGE**

~CMS MLN Matters – February & March 2007~

MLN Matters Number: MM5387 Revised  
 Related CR Release Date: January 19, 2007  
 Related CR Transmittal #: R1160CP

Related Change Request (CR) #: 5387  
 Effective Date: January 1, 2007  
 Implementation Date: July 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5387.pdf>**

**Note:** This article was revised on January 26, 2007, to correct an effective date in the text (The effective date is January 1, 2007.) Also, the notice to beneficiaries mentioned on page 3 is the Medicare Summary Notice.

**Provider Types Affected**

Non-Outpatient Prospective Payment System (non-OPPS) Hospital Outpatient Departments and Ambulatory Surgical Centers (ASCs) who bill Medicare fiscal intermediaries (FIs), carriers, or Part A/B Medicare Administrative Contractors (A/B MACs) for Colorectal Cancer Screening Flexible Sigmoidoscopy, and Colonoscopy.

**Impact on Providers**

Effective for services on or after January 1, 2007, Medicare requires:

1. A 25% beneficiary coinsurance for colorectal cancer screening flexible sigmoidoscopies, and colonoscopies performed in the outpatient departments of non-Outpatient Prospective Payment System (non-OPPS) hospitals; and
2. A 25% beneficiary coinsurance for colorectal cancer screening colonoscopies performed in ambulatory surgery centers (ASC).

**EMERGENCY UPDATE TO THE 2007 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE  
(MPFSDB)**

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5459 Revised  
 Related CR Release Date: January 11, 2007  
 Related CR Transmittal #: R1152CP

Related Change Request (CR) #: 5459  
 Effective Date: January 1, 2007  
 Implementation Date: January 2, 2007

**Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf>**

**Note:** This article was revised on January 12, 2007 to reflect that CR5459 was revised by CMS. The article was revised to reflect the new CR release date, transmittal number, and the Web address for accessing CR5459. All other information remains the same.

**Provider Types Affected**

Physicians and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), or Part A/B Medicare administrative contractors (A/B MACs)) for professional services paid under the Medicare Physician Fee Schedule (MPFS).

**Background**

This article and related Change Request (CR) 5459 wants providers to know that payment files were issued to contractors based upon the December 1, 2006, MPFS Final Rule. CR5459 amends those payment files.

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

~CMS MLN Matters – January 2007~

MLN Matters Number: MM5417  
Related CR Release Date: December 8, 2006  
Related CR Transmittal #: R1125CP

Related Change Request (CR) #: 5417  
Effective Date: January 1, 2007  
Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5417.pdf>

**Provider Types Affected**

Physicians, suppliers, and providers who bill Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), carriers, and/or regional home health intermediaries (RHHs)), for services paid under the DMEPOS Fee Schedule.

**Provider Action Needed**

This article is based on Change Request (CR) 5417, and it provides specific information regarding the annual update for the 2007 DMEPOS Fee Schedule. Be sure billing staff are aware of this update.

**FSY 2007 FEES FOR DMEPOS CODES PROCESSED BY WPS**

~January 2007~

The Centers for Medicare & Medicaid Services (CMS) has issued fees for durable medical equipment, prosthetics and orthotics (DMEPOS) codes processed by WPS. Reimbursement is effective for dates of service January 1, 2007 and after. Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage. To read this article in full, including the list of fees, please go to:

[http://www.wpsmedicare.com/provider/pdfs/07\\_dmepos.pdf](http://www.wpsmedicare.com/provider/pdfs/07_dmepos.pdf)

**GUIDELINES FOR PAYMENT OF DIABETES SELF-MANAGEMENT TRAINING (DSMT)**

~CMS MLN Matters – March 2007~

MLN Matters Number: MM5433  
Related CR Release Date: January 19, 2007  
Related CR Transmittal #: R1158CP & R64BP

Related Change Request (CR) #: 5433  
Effective Date: July 1, 2007  
Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/Downloads/mm5433.pdf>

**Provider Types Affected**

Providers submitting claims to Medicare Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHs) for DSMT services provided in institutional settings to Medicare beneficiaries.

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

This article is based on Change Request (CR) 5433 which corrects, clarifies, and provides guidelines for the payment of DSMT services in various institutional provider settings.

**CAUTION – What You Need to Know**

Medicare Part B covers 10 hours of initial training for a beneficiary who has been diagnosed with diabetes, and beneficiaries are eligible to receive 2 hours of follow-up training each calendar year following the year in which they were certified as requiring initial training. **DSMT must be ordered by the physician or qualified non-physician practitioner who is managing the beneficiary's diabetic condition.**

**GO – What You Need to Do**

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

## HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) DESIGNATION CHANGES

~March 2007~

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

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

Only physicians furnishing services in a geographic, primary care HPSA are eligible to receive bonus payments. Eligible providers include medical doctors, including psychiatrists, doctors of osteopathy, dentists, doctors of podiatric medicine, licensed chiropractors, and optometrists. In addition, psychiatrists furnishing services in a geographic, mental health HPSA are also eligible to receive a bonus payment. Nonphysician practitioners, such as physician assistants and nurse practitioners, are not eligible for the bonus payment.

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

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

## JANUARY 2007 QUARTERLY AVERAGE SALES PRICE (ASP) MEDICARE PART B DRUG PRICING FILE, EFFECTIVE JANUARY 1, 2007, AND REVISIONS TO APRIL 2006, JULY 2006 AND OCTOBER 2006 QUARTERLY ASP MEDICARE PART B DRUG PRICING FILES

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5413

Related CR Release Date: December 15, 2006

Related CR Transmittal #: R1129CP

Related Change Request (CR) #: 5413

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5413.pdf>

### Provider Types Affected

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

### Provider Action Needed

This article is based on Change Request (CR) 5413 which informs Medicare contractors to download the January 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2006, April 2006, July 2006, and October 2006 files.

## MEDICARE PAYMENT FOR PREADMINISTRATION-RELATED SERVICES ASSOCIATED WITH IVIG ADMINISTRATION—PAYMENT EXTENDED THROUGH CY 2007

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5428

Related CR Release Date: December 22, 2006

Related CR Transmittal #: R1140CP

Related Change Request (CR) #: 5428

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5428.pdf>

### Provider Types Affected

Physicians and hospitals that bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for Intravenous Immune Globulin (IVIG) administration.

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

You may bill for preadministration-related services associated with Intravenous Immune Globulin (IVIG) administration (HCPCS code G0332) during calendar year 2007. The preadministration-related service must be billed on the same claim and have the same date of service, as the claim for the IVIG itself (codes J1566 and/or J1567) and the drug administration service.

**CAUTION – What You Need to Know**

CR 5428, from which this article was taken, extends payment of the preadministration-related service for IVIG through CY 2007 but only when submitted on the same claim as the IVIG and its administration.

**GO – What You Need to Do**

Make sure that your billing staff is aware that they must include your claim for the IVIG preadministration-related services on the same claim (and with the same date of service) as the IVIG and its administration.

**MULTIPLE PROCEDURE REDUCTION ON THE TECHNICAL COMPONENT (TC) OF CERTAIN DIAGNOSTIC IMAGING PROCEDURES AND CAP ON THE TC OF IMAGING PROCEDURES**

~CMS MLN Matters – January 2007~

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0665.pdf>

**Provider Types Affected**

Physicians and suppliers billing Medicare carriers for imaging supplies and services

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

This special edition article provides details regarding the Centers for Medicare & Medicaid Services (CMS) revised policies for the payment of the technical component (TC) of imaging procedures.

**CAUTION – What You Need to Know**

CMS has 1) modified the multiple procedure payment reduction to the TC of certain diagnostic imaging procedures and 2) implemented a procedure specific payment cap on the TC payment of imaging procedures effective January 1, 2007, as required by the Deficit Reduction Act of 2005.

**GO – What You Need to Do**

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

**NEW WAIVED TESTS**

~CMS MLN Matters – January 2007~

MLN Matters Number: MM5404

Related CR Release Date: November 24, 2006

Related CR Transmittal #: R1115CP

Related Change Request (CR) #: 54047

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5404.pdf>

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 5404 which informs carriers and A/B MACs of new waived tests approved by the Food and Drug Administration (FDA) under Clinical Laboratory Improvement Amendments of 1988 (CLIA).

**PAYMENT ALLOWANCES FOR THE INFLUENZA VIRUS VACCINE (CPT CODES 90655, 90656, 90657, AND 90658) AND THE PNEUMOCOCCAL VACCINE (CPT 90732) WHEN PAYMENT IS BASED ON 95 PERCENT OF THE AVERAGE WHOLESALE PRICE (AWP)**

~CMS MLN Matters – February 2007~

MLN Matters Number: MM5365

Related CR Release Date: December 22, 2006

Related Change Request (CR) #: 5365

Effective Date: September 1, 2006

Related CR Transmittal #: R256OTN

Implementation Date: January 22, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5365.pdf>

**Provider Types Affected**

Physicians, non-physician practitioners, providers and suppliers billing Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs) and carriers for the influenza and pneumococcal vaccines.

**Background**

This article and related change request (CR) 5365 provide the payment allowances for the following influenza virus vaccines: CPT codes 90655, 90656, 90657, and 90658 as well as the pneumococcal vaccine (CPT 90732) when payment is based on 95 percent of the AWP.

**REASONABLE CHARGE UPDATE FOR 2007 FOR SPLINTS, CASTS, DIALYSIS SUPPLIES,  
DIALYSIS EQUIPMENT, AND CERTAIN INTRAOCULAR LENSES**

~CMS MLN Matters – January 2007~

MLN Matters Number: MM5382

Related CR Release Date: November 24, 2006

Related CR Transmittal #: R1118CP

Related Change Request (CR) #: 5382

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf>

**Provider Types Affected**

Physicians, suppliers and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), or Part A/B Medicare Administrative Contractors (A/B MACs) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

**Provider Action Needed**

Affected providers may want to be sure their billing staff knows of these changes.

**REMITTANCE ADVICE REMARK CODE AND CLAIM ADJUSTMENT REASON CODE UPDATE**

~CMS MLN Matters – January 2007~

MLN Matters Number: MM5346

Related CR Release Date: October 27, 2006

Related CR Transmittal #: R1087CP

Related Change Request (CR) #: 5346

Effective Date: January 1, 2007

Implementation Date: January 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5346.pdf>

**Provider Types Affected**

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

**Provider Action Needed**

CR 5346, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective January 2, 2007. Be sure billing staff are aware of these changes.

**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  
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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  
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7. What information do you look for within the Communiqué?  
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Other: \_\_\_\_\_
8. Overall, how would you rate the paper copy of the Communiqué?  
Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Very Poor \_\_\_\_\_
9. If we could improve one thing, what would you suggest? \_\_\_\_\_

You may send us your comments via:

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

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

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

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