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Items of Importance

2009 MEDICARE PHYSICIAN FEE SCHEDULES NOW AVAILABLE

The 2009 Medicare Physician Fee Schedules are now available on the WPS Medicare Website:

http://www.wpsmedicare.com/part_b/fees/fees_2009.shtml

Fee information will not be available on the Participation and Enrollment CD-ROM this year; however, we have provided the schedules in Excel and Adobe format in order to meet your needs. To access the Excel files, you need software that can open ZIP files. If you do not currently have unZIP software, please talk to your Systems department for recommendations.

These fees will be valid as of January 1, 2009, and serve as important resources. Please visit the Fees Page for more information.

Important Note: To ensure accuracy, effective with the 2009 fees, WPS Medicare will post those fees to our Website that are required per the Centers for Medicare & Medicaid Services (CMS). For all other fees, we now link to the appropriate CMS Web pages.

2009 PARTICIPATION/ENROLLMENT CD-ROM

In mid-November, WPS Medicare mailed the 2009 Participation/Enrollment CD-ROM to our Part B providers. This CD-ROM provides you with 2009 Medicare participation information, as well as some other helpful Medicare resources.

On this CD, you will find the following information:

- Information on where to find the 2009 Medicare Physician Fee Schedules
- An article about the CMS Medicare Learning Network
- Medicare Participation Announcement for Calendar Year 2009
- Medicare Participating Physician or Supplier Agreement
- Information regarding unsolicited or voluntary refunds
- WPS Medicare Part B Refund Form
- Provider survey on the 2009 Participation/Enrollment CD-ROM

To access the information on the CD-ROM, simply put the CD into your CD-ROM drive, and the CD menu will automatically pop-up.

Troubleshooting

- If the menu does not automatically pop-up on your computer screen, open the CD-ROM drive on your computer, and:
 - PC Users: Open the file titled "autorun.exe"
 - MAC Users: Open the file titled "MAC_USERS_START_HERE.pdf"
- The CD-ROM is presented in Adobe Acrobat and we included Adobe Reader software on the CD to ensure that all users can access the CD-ROM, whether they have Adobe installed on their computer or not. If, however, the CD menu is not opening for you, try launching the

Adobe Reader manually. The Adobe Reader software is located in the folder titled "Acrobat_Reader." Open the file titled "AdbeRdr811_en_US.exe" and the Adobe Reader software will download. You should then be able to launch the CD. You can also download Adobe Reader from free from the Adobe Website, <http://www.adobe.com>.

- If you have questions about using the CD-ROM, or do not have a CD drive, please contact Customer Service.

INFLUENZA PANDEMIC EMERGENCY: THE MEDICARE PROGRAM PREPARES

~ Revised CMS Special Edition MLN Matters ~

MLN Matters Number: SE0836 **Revised**
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

Note: This article was revised on November 6, 2008, to include a link to recently-issued CR 6146 and to update the link to CR6174, which was recently revised by CMS. All other information remains the same.

Provider Types Affected

In the event of a pandemic flu, all physicians and providers who submit claims to Medicare Part C or Part D plans or to Medicare contractors (Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), carriers or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries

Impact on Providers

This article is informational only and is alerting providers that the Centers for Medicare & Medicaid Services (CMS) has begun preparing emergency policies and procedures that may be implemented in the event of a pandemic or national emergency.

Background

As part of its preparedness efforts for influenza pandemic, CMS has begun developing certain emergency policies and procedures that **may** be implemented for the Medicare program in the event of a pandemic or other emergency.

Decision to implement would occur if:

1. The President declares an emergency or disaster under the National Emergencies Act or the Stafford Act; **and**
2. The Secretary of the Department of Health and Human Services declares – under § 319 of the Public Health Service Act – that a public health emergency exists; **and**
3. The Secretary elects to waive one or more requirements of Title XVIII of the Social Security Act (Act) pursuant to § 1135 of such Act.

In the event of a pandemic or other national emergency, CMS will issue communications to Medicare providers to specify which policies and procedures will be implemented and other relevant information.

This article includes links to policy documents that have been released by CMS. As additional policy becomes available, CMS will revise this article to include links to all available influenza pandemic policy documents.

Dedicated CMS Web Page Now Available

Providers should be aware that all relevant materials will be posted on a CMS dedicated "Pandemic Flu" Web page at http://www.cms.hhs.gov/Emergency/10_PandemicFlu.asp on the CMS Website. That page will contain all important information providers need to know in the event of an influenza pandemic, including the policy documents discussed above.

Additional Information

Additional CMS influenza pandemic policy documents include:

- CR 6146, which can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R386OTN.pdf> on the CMS Website;
- CR 6164, which can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R379OTN.pdf> on the CMS Website; and
- CR 6174, which can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R396OTN.pdf> on the CMS Website.

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

**INFLUENZA VACCINE AND THE PNEUMOCOCCAL VACCINE
PAYMENT ALLOWANCES BASED ON 95 PERCENT OF THE AVERAGE
WHOLESALE PRICE (AWP)
~ Revised CMS MLN Matters ~**

MLN Matters Number: MM6153 Revised
Related CR Release Date: October 31, 2008
Related CR Transmittal #: R1623CP

Related Change Request (CR) #: 6153
Effective Date: September 1, 2008
**Implementation Date: No later than
December 1, 2008**

Note: This article was revised on November 7, 2008, to reflect the correct payment amount for CPT code 90669. The correct amount is \$78.803. All other information remains the same.

Provider Types Affected

Physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), 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) 6153 which provides the updated payment allowances, effective as of September 1, 2008, for influenza and pneumococcal vaccines when payment is based on 95 percent of the average wholesale price (AWP).

Background

The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year. The payment allowances for pneumococcal vaccines are updated on a quarterly basis. Change Request (CR) 6153 provides the payment allowances for the following influenza virus vaccines: Current Procedural Terminology (CPT) codes 90655, 90656, 90657, 90658, and 90660 as well as the pneumococcal vaccines (CPT codes 90732 and 90669) when payment is based on 95 percent of the average wholesale price (AWP).

Effective September 1, 2008, these Medicare Part B payment allowances for influenza vaccines are as follows:

CPT Code	Allowance
90655	\$16.879
90656	\$18.198
90657	\$6.609
90658	\$13.218

CPT 90660 (FluMist, a nasal influenza vaccine) may be covered if the local Medicare claims processing contractor determines its use is medically reasonable and necessary for the beneficiary. When payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for CPT 90660 is \$22.316 (effective September 1, 2008).

The Medicare Part B payment allowance for the pneumococcal vaccine CPT code 90732 is \$32.703, and for CPT code 90669 is \$78.803. These payment allowances were published as a part of the July 2008 Quarterly Average Sales Price (ASP) Drug Pricing Files, as specified in CR6049. See <http://www.cms.hhs.gov/MLNMArticles/downloads/MM6049.pdf> on the CMS Website to view the article related to CR 6049.

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, rural health clinic, or federally qualified health center, in which cases, payments for the vaccines are based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply to these vaccines. All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Medicare Contractors will not search their files to adjust payment on claims paid incorrectly prior to implementing CR6153. However, they will adjust such claims that you bring to their attention.

Additional Information

The official instruction, CR 6153, issued to your carrier, FI, and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1623CP.pdf> on the CMS Website.

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

UPDATE TO MEDICARE DEDUCTIBLE, COINSURANCE, AND PREMIUM RATES FOR 2009

~ Revised CMS MLN Matters ~

MLN Matters Number: MM6258 Revised
Related CR Release Date: November 17, 2008
Related CR Transmittal #: R56GI

Related Change Request (CR) #: 6258
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Note: This article was revised on November 18, 2008, to reflect changes made to CR6258, which was re-issued on November 17. The CR transmittal number and release date (see above) were revised and the Web address for accessing CR6258 was changed. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (fiscal intermediaries (FI), regional home health intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC), Durable Medical Equipment Medicare Administrative Contractors (DME MAC) and carriers) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 6258, which provides the Medicare rates for deductible, coinsurance and premium payment amounts for calendar year (CY) 2009.

2009 Part A - Hospital Insurance (HI)

A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount that the Medicare program pays the hospital for inpatient hospital services it furnishes in an illness episode. When a beneficiary receives such services for more than 60 days during an illness encounter, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Please note that an individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during an illness episode. The 2009 deductible and coinsurance amounts are in the following table.

Table 1

2009 Part A – Hospital Insurance (HI)			
Deductible	\$1,068.00		
Coinsurance	Hospital		Skilled Nursing Facility
	Days 61-90	Days 91-150 (Lifetime Reserve Days)	Days 21-100
	\$267.00	\$534.00	\$133.50

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

Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2009 Part A premiums are listed in table 2, below.

Table 2

Voluntary Enrollees Part A Premium Schedule	
Base Premium (BP)	\$443.00 per month
Base Premium with 10% Surcharge	\$487.30 per month
Base premium with 45% Reduction	\$244.00 per month (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	\$268.40 per month

2009 Part B - Supplementary Medical Insurance (SMI)

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2009, the standard premium for SMI services is \$96.40 a month; the deductible is \$135.00 a year; and the coinsurance is 20%. The Part B premium is influenced by the beneficiary's income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 6258, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R56GI.pdf> on the CMS Website.

Additional Information

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

Claim Submission

**2009 ANNUAL UPDATE TO THE THERAPY CODE LIST
~ CMS MLN Matters ~**

MLN Matters Number: MM6254
Related CR Release Date: October 31, 2008
Related CR Transmittal #: R1625CP

Related Change Request (CR) #: 6254
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

Physicians, therapists, and providers of therapy services billing Medicare Carriers, Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs) or Part A/B Medicare Administrative Contractors (A/B MACs) for outpatient rehabilitation therapy services.

What Providers Need to Know

This article is based on Change Request (CR) 6254 and alerts providers to updates to Medicare’s therapy code list with two “sometimes” therapy codes for CY 2009. Note that these codes always represent therapy services and require the use of a therapy modifier when performed by therapists. The two codes added are:

1. **95992** – Standard Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day.
2. **0183T** – Low frequency, non-contact, non-thermal ultrasound, including topical applications(s), when performed, wound assessment, and instruction(s) for ongoing care, per day.

Note: If billed by a hospital subject to Outpatient Prospective Payment System (OPPS) for an outpatient service, CPT code 0183T will be paid under the OPPS when the service is not performed by a qualified therapist and it is inappropriate to bill the service under a therapy plan of care. In addition, no Medicare Physician Fee Schedule (MPFS) amount exists for this code. Since the local carrier (or A/B MAC) determines the coverage and pricing for this code, the FI or A/B MAC contacts the local contractor to obtain the appropriate fee schedule amount.

Background

This instruction updates the list of codes that sometimes or always describe therapy services. The additions, changes, and deletions to the therapy code list reflect those made in the CY 2008 and 2009 HCPCS/CPT-4.

Therapy services, including “always therapy” services, must follow all the policies for therapy services detailed in the *Medicare Claims Processing Manual*, Chapter 5 which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c05.pdf> on the Centers for Medicare & Medicaid Services (CMS) website and the *Medicare Benefit Policy Manual*, Chapter 12, which is available at <http://www.cms.hhs.gov/manuals/Downloads/bp102c12.pdf> on the CMS Website.

Additional Information

The official instruction (CR6254) issued to your Medicare FI, A/B MAC, carrier or RHHI, which is at <http://www.cms.hhs.gov/Transmittals/downloads/R1625CP.pdf> on the CMS Website.

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

**ANNUAL UPDATE OF HEALTHCARE COMMON PROCEDURE CODING
SYSTEM (HCPCS) CODES USED FOR HOME HEALTH
CONSOLIDATED BILLING ENFORCEMENT
~CMS MLN Matters~**

MLN Matters Number: MM6262

Related CR Release Date: November 7, 2008

Related CR Transmittal #: R1633CP

Related Change Request (CR) #: 6262

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, 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 during an episode of home health care.

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

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS).

CAUTION – What You Need to Know

This article is based on Change Request (CR) 6262 which provides the annual HH consolidated billing update effective January 1, 2009.

GO – What You Need to Do

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

Background

The Social Security Act (Section 1842(b)(6); see http://www.ssa.gov/OP_Home/ssact/title18/1842.htm on the Internet) requires that payment for home health services provided under a home health plan of care is made to the home health agency (HHA). This requirement is found in Medicare regulations at 42 CFR 409.100 (see http://edocket.access.gpo.gov/cfr_2005/octqtr/42cfr409.100.htm on the Internet and in the Medicare Claims Processing Manual (Chapter 10, Section 20.1), available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Website.

The home health consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (i.e., 'K' codes) throughout the calendar year.

The following HCPCS code is **added** to the home health consolidated billing supply code list, and it is a new code that does not replace any prior HCPCS code on the list:

Added HCPCS Code	Descriptor
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mmHg, each.

The following HCPCS code is **deleted** from the home health consolidated billing supply code list, and this code is being removed because it is non-covered by Medicare statute.

Deleted HCPCS Code	Descriptor
A6413	Adhesive Bandage, First-Aid Type, any size, each

Additional Information

The official instruction, CR 6262, issued to your carrier, FI, A/B MAC, RHHI, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1633CP.pdf> on the CMS Website.

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

**LABORATORY NATIONAL COVERAGE DETERMINATION (NCD)
EDIT SOFTWARE FOR OCTOBER 2008
~ Revised CMS MLN Matters ~**

MLN Matters Number: MM6213 Revised
Related CR Release Date: October 2, 2008
Related CR Transmittal #: R1606CP

Related Change Request (CR) #: 6213
Effective Date: October 1, 2008
Implementation Date: October 6, 2008

Note: This article was revised on October 21, 2008, to correct the reference to the NCD from 190.18 to 190.19 on the bottom of page 3. A code for Gamma Glutamyl Transferase was corrected to 571.42 on page 5. It also corrected two codes on page 6 for FOBT, by adding a zero to correct the ICD-9-CM codes to 209.40 and 209.50. All other information remains the same.

Provider Types Affected

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

What You Need to Know

This article is based on Change Request (CR) 6213, which announces the changes that will be included in the October 2008 release of the edit module for clinical diagnostic laboratory

National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in July 2008. CR 6213 incorporates all changes from July 2008 to the present.

Background

The National Coverage Determination (NCDs) for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in the shared systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective January 1, 2003.

In accordance with the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 16, Section 120.2 (see <http://www.cms.hhs.gov/manuals/downloads/clm104c16.pdf> on the Centers for Medicare & Medicaid Services (CMS) Website), the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR 6213 announces changes to the laboratory edit module, for changes in laboratory NCD code lists for October 2008 as described below. These changes become effective for services furnished on or after October 1, 2008.

For Bacterial Urine Culture:

- Add ICD-9-CM codes 038.12, 599.70, 599.71, 599.72, 780.60, 780.61, 780.62, 780.63, 780.64, 780.65, 788.91, and 788.99 to the list of ICD-9-CM codes covered by Medicare for the Urine Culture, Bacterial (190.12) NCD.
- Delete ICD-9-CM codes 599.7, 780.6, and 788.9 from the list of ICD-9-CM codes covered by Medicare for the Urine Culture, Bacterial (190.12) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Urine Culture, Bacterial (190.12) NCD.

For HIV Testing:

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the HIV Testing (Prognosis Including Monitoring (190.13)) NCD.
- Add ICD-9-CM codes 078.12, 136.21, 136.29, 780.60, 780.61, 780.62, 780.63, 780.64, and 780.65 to the list of ICD-9-CM codes covered by Medicare for the HIV Testing (Diagnosis) (190.14) NCD.
- Delete ICD-9-CM codes 136.2 and 780.6 from the list of ICD-9-CM codes covered by Medicare for the HIV Testing (Diagnosis) (190.14) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the HIV Testing (Diagnosis) (190.14) NCD.

For Blood Counts:

- Add ICD-9-CM codes 078.12, V45.11, V45.12, V49.83, V51.0, V51.8, V61.01, V61.02, V61.03, V61.04, V61.05, V61.06, V61.09, V62.21, V62.22, V62.29, and V72.42 to the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Blood Counts (190.15) NCD.
- Delete ICD-9-CM codes V45.1, V51, V61.0, and V62.2 from the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.

For Partial Thromboplastin Time (PTT):

- Add ICD-9-CM codes 275.5, 238.77, 571.42, 599.70, 599.71, 599.72, and 611.89 to the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
- Delete ICD-9-CM codes 599.7 and 611.8 from the list of ICD-9-CM codes covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.

For Prothrombin Time (PT):

- Add ICD-9-CM codes 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 238.77, 511.81, 511.89, 571.42, 599.70, 599.71, 599.72, 611.89, and 999.89 to the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.
- Delete ICD-9-CM codes 511.8, 599.7, 611.8, and 999.8 from the list of ICD-9-CM codes covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Prothrombin Time (PT) (190.17) NCD.

For Serum Iron Studies:

- Add ICD-9-CM codes 199.2, 209.40, 209.41, 209.42, 209.43, 209.50, 209.51, 209.52, 209.53, 209.54, 209.55, 209.56, 209.57, 209.60, 209.61, 209.62, 209.63, 209.64, 209.65, 209.66, 209.67, 209.69, 209.30, 238.77, 571.42, 999.89, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.
- Delete ICD-9-CM codes 999.8 and V15.2 from the list of ICD-9-CM codes covered by Medicare for the Serum Iron Studies (190.18) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Serum Iron Studies (190.18) NCD.

For Collagen Crosslinks:

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Collagen Crosslinks, Any Method (190.19) NCD.

For Blood Glucose Testing:

- Add ICD-9-CM codes 038.12, 707.20, 707.21, 707.22, 707.23, 707.24, 707.25, 780.72, V23.85, and V23.86 to the list of ICD-9-CM codes covered by Medicare for the Blood Glucose Testing (190.20) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Blood Glucose Testing (190.20) NCD.

For Glycated Hemoglobin/Glycated Protein:

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.

For Thyroid Testing:

- Add ICD-9-CM codes 275.5, 780.72, 780.60, 780.61, 780.62, 780.63, 780.64, and 780.65 to the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.
- Delete ICD-9-CM code 780.6 from the list of ICD-9-CM codes covered by Medicare for the Thyroid Testing (190.22) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Thyroid Testing (190.22) NCD.

For Lipid Testing:

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Lipids Testing (190.23) NCD.

For Digoxin Therapeutic Drug Assay:

- Add ICD-9-CM codes 275.5, 339.3, and 780.72 to the list of ICD-9-CM codes covered by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD.

For Alpha-Fetoprotein:

- Add ICD-9-CM codes 571.42, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM codes covered by Medicare for the Alpha-Fetoprotein (190.25) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Alpha-Fetoprotein (190.25) NCD.

For Carcinoembryonic Antigen:

- Add ICD-9-CM codes 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, and 209.29 to the list of ICD-9-CM codes covered by Medicare for the Carcinoembryonic Antigen (190.26) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Carcinoembryonic Antigen (190.26) NCD.

For Human Chorionic Gonadotropin:

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Human Chorionic Gonadotropin (190.27) NCD.

For Tumor Antigen by Immunoassay-CA125:

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Tumor Antigen by Immunoassay-CA125 (190.28) NCD.

For Tumor Antigen by Immunoassay-CA15-3/CA27.29:

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Tumor Antigen by Immunoassay-CA15-3/CA27.29 (190.29) NCD.

For Tumor Antigen by Immunoassay-CA19-9:

- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Tumor Antigen by Immunoassay-CA19-9 (190.30) NCD.

For Prostate Specific Antigen (PSA):

- Add ICD-9-CM codes 599.70, 599.71, and 599.72 to the list of ICD-9-CM codes covered by Medicare for the Prostate Specific Antigen (PSA) (190.31) NCD.
- Delete ICD-9-CM code 599.7 from the list of codes covered by Medicare for the Prostate Specific Antigen (PSA) (190.31) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the (PSA) (190.31) NCD.

For Gamma Glutamyl Transferase:

- Add ICD-9-CM codes 275.5, 038.12, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 238.77, 558.41, 558.42, and 571.42 to the list of ICD-9-CM codes covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.

For Hepatitis Panel/Acute Hepatitis Panel:

- Add ICD-9-CM code 780.72 to the list of ICD-9-CM codes covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.

For Fecal Occult Blood Test (FOBT):

- Add ICD-9-CM codes 209.40, 209.41, 209.42, 209.43, 209.50, 209.51, 209.52, 209.53, 209.54, 209.55, 209.56, 209.57, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 530.13, 558.41, 558.42, 569.44, 571.42, and 780.72 to the list of ICD-9-CM codes covered by Medicare for the Fecal Occult Blood Test (FOBT) (190.34) NCD.
- Delete ICD-9-CM codes V28.8 and V68.0 from the list of ICD-9-CM codes denied by Medicare for the FOBT (190.34) NCD.

For All 23 NCDs (190.12-190.34):

- Add ICD-9-CM codes V28.81, V28.82, V28.89, V68.01, and V68.09 to the list of denied ICD-9-CM codes for all 23 Lab NCDs.

Additional Information

The official instruction, CR 6213, issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1606CP.pdf> on the CMS Website.

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

**REPORTING NATIONAL PROVIDER IDENTIFIERS (NPI) ON
CLAIMS FOR OUT-OF-JURISDICTION PURCHASED
MAMMOGRAPHY PREVENTIVE SCREENING AND DIAGNOSTIC
SERVICES**
~CMS MLN Matters~

MLN Matters Number: MM6237
Related CR Release Date: October 31, 2008
Related CR Transmittal #: R1624CP

Related Change Request (CR) #: 6237
Effective Date: December 1, 2008
Implementation Date: December 1, 2008

Provider Types Affected

Physicians and other Part B providers/suppliers who submit bills to Medicare carriers and Medicare Administrative Contractors (A/B MAC) for mammography services provided to Medicare beneficiaries.

What You Need to Know

CR 6237, from which this article is taken, provides billing instructions for using the NPI on paper, or electronically-submitted, Medicare claims for purchased mammography screening and diagnostic services when the service is performed **outside** of the carrier's or A/B MAC's claims processing jurisdiction. In this situation, billing providers should report their own NPI as the performing provider and also provide the name, address, and zip code of the performing physician/supplier.

You should be aware that carriers and AB MACs will return your out-of-jurisdiction, purchased mammography screening or diagnostic service claims as unprocessable if you submit them without the billing provider's NPI; and the name, address, and ZIP code of the performing physician/supplier.

Additional Information

You can find more information about the reporting of the NPI on claims for out-of-jurisdiction purchased mammography preventive screening and diagnostic services by going to CR 6237, located at <http://www.cms.hhs.gov/Transmittals/downloads/R1624CP.pdf> on the Centers for Medicare & Medicaid (CMS) Website.

For claims processing instructions on the CMS-1500 form and electronic form *ANSI X12 837P* you can refer to the *Medicare Claims Processing Manual*, Chapter 1 (General Billing Requirements), Section 10.1.1.1. (Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004). That manual is available at <http://www.cms.hhs.gov/Manuals/IOM/list.asp> on the CMS Website. To learn more about the NPI in general, visit <http://www.cms.hhs.gov/NationalProvidentStand> on the CMS Website.

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

Coverage – General

**CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) THERAPY
FOR OBSTRUCTIVE SLEEP APNEA (OSA)**

~ Revised CMS MLN Matters ~

MLN Matters Number: MM6048 **Revised**
 Related CR Release Date: October 15, 2008
 Related CR Transmittal #: R96NCD

Related Change Request (CR) #: 6048
 Effective Date: March 13, 2008
 Implementation Date: August 4, 2008

Note: This article was revised on October 16, 2008, to reflect changes to CR 6048, which CMS revised on October 15, 2008. The CR release date, transmittal number, and the Web address for accessing CR6048 were revised. In addition, some language in item 3, on page 3 was clarified. All other information remains the same.

Provider Types Affected

Physicians, providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Durable Medical Equipment (DME) MACs) for OSA-related services provided to Medicare beneficiaries.

Impact on Providers

Providers need to be aware that effective for claims with dates of service on and after March 13, 2008, Medicare will allow for coverage of CPAP therapy based upon a positive diagnosis of OSA by home sleep testing (HST), subject to the requirements of CR6048.

Background

The Centers for Medicare & Medicaid Services (CMS) reconsidered its 2005 National Coverage Determination (NCD) for CPAP Therapy for OSA to allow for coverage of CPAP based upon a diagnosis of OSA by HST.

Medicare previously covered the use of CPAP only in beneficiaries who had been diagnosed with moderate to severe OSA when ordered and prescribed by a licensed treating physician and confirmed by polysomnography (PSG) performed in a sleep laboratory in accordance with Section 240.4 of the *Medicare NCD Manual* (see the *Additional Information* section of this article for the official instruction and the revised section of the NCD). Following the reconsideration of its coverage policy, CMS is revising the existing NCD on CPAP therapy for OSA as well as allowing coverage of CPAP based on a positive diagnosis of OSA by HST, subject to all the requirements of the new NCD, as outlined in CR6048. (Note that billing guidelines for capped rental equipment are contained in the *Medicare Claims Processing Manual*, Chapter 20, Section 30.5, which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf> on the CMS Website.)

As part of the NCD, apnea is defined as a cessation of airflow for at least 10 seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% oxygen desaturation. The apnea hypopnea index (AHI) is equal to the

average number of episodes of apnea and hypopnea per hour. The respiratory disturbance index (RDI) is equal to the average number of respiratory disturbances per hour.

Key Points of CR6048

1. Coverage of CPAP is initially limited to a 12-week period for beneficiaries diagnosed with OSA as described below. CPAP is subsequently covered for those beneficiaries diagnosed with OSA whose OSA improves as a result of CPAP during this 12-week period.

NOTE: DME Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are required to provide beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively (42 CFR 424.57(c)(12)). Failure to meet this standard may result in revocation of the DMEPOS supplier's billing privileges (42 CFR 424.57(d)).

2. CPAP for adults is covered when diagnosed using a clinical evaluation and a positive:
 - Polysomnography (PSG) performed in a sleep laboratory; or
 - Unattended home sleep monitoring device of Type II; or
 - Unattended home sleep monitoring device of Type III; or
 - Unattended home sleep monitoring device of Type IV, measuring at least 3 channels

NOTE: In general, pursuant to 42 CFR 410.32(a), diagnostic tests that are not ordered by the beneficiary's treating physician are not considered reasonable and necessary. Pursuant to 42 CFR 410.32(b), diagnostic tests payable under the Medicare physician fee schedule that are furnished without the required level of supervision by a physician are not reasonable and necessary.

3. A positive test for OSA is established if either of the following criteria using the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) are met:
 - AHI or RDI greater than or equal to 15 events per hour of sleep or continuous monitoring, or
 - AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour of sleep or continuous monitoring with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

As previously stated, the AHI is equal to the average number of episodes of apnea and hypopnea per hour of sleep. The RDI is equal to the average number of respiratory disturbances per hour of continuous monitoring. However, there is variability in the published medical literature about the definition of the events that constitute a respiratory disturbance. The technology assessment that supported this NCD recognized this variability and defined RDI in the context of the specific sleep test technology under review. For the purposes of this NCD, a respiratory disturbance is defined in the context of the sleep test technology of interest and does not require direct measurement of airflow. Local contractors will, as needed, determine, based on their review of the published, peer-reviewed medical literature, the equivalent test result criteria corresponding to the required AHI or RDI for Type IV devices measuring 3 or more channels that do not measure AHI or RDI directly.

4. The AHI or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing is at least the number of events that would have been required in a 2-hour period.
5. CMS is deleting the distinct requirements that an individual have moderate to severe OSA and that surgery is a likely alternative.
6. CPAP based on clinical diagnosis alone or using a diagnostic procedure other than PSG or Type II, Type III, or a Type IV HST measuring at least 3 channels is covered only when provided in the context of a clinical study and when that study meets the standards outlined in the NCD manual revision attached to CR6048. Medicare will process claims according to Coverage with Evidence Development (CED)/clinical trials criteria at Section 310.1 of the *NCD Manual* and Chapter 32 and Sections 69.6-69.7 (Pub 100-04) of the *Medicare Claims Processing Manual*. These manuals are available at <http://www.cms.hhs.gov/manuals/IOM/list.asp> on the CMS Website.

Note: The following HST portable monitoring G codes effective March 13, 2008, are provided for your information only, are not included in the CPAP for OSA NCD at section 240.4 of the NCD Manual, and do not necessarily convey coverage, which is determined at local contractor discretion.

G0398: Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation.

G0398 Short Descriptor: Home sleep test/type 2 Porta

G0399: Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation

G0399 Short Descriptor: Home sleep test/type 3 Porta

G0400: Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

G0400 Short Descriptor: Home sleep test/type 4 Porta

Additional Information

To see the official instruction (CR6048) issued to your Medicare A/B MAC, FI, carrier, or DME MAC, visit <http://www.cms.hhs.gov/Transmittals/downloads/R96NCD.pdf> on the CMS Website.

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

MIST THERAPY™ SYSTEM 5.0 WOUND TREATMENT DEVICE

The MIST Therapy™ System is a wound care product designed to impact key areas of the wound repair process. Multiple providers have asked WPS Medicare if this service is covered using Current Procedural Terminology (CPT) code 0183T. The following is in response to these inquires:

Ultrasonic Wound Debridement (CPT code 0183T) is a system that uses continuous low frequency ultrasonic energy to atomize a liquid and deliver continuous low frequency ultrasound to the wound bed. Medicare does not consider this cleansing method to be a significantly separately payable coverable service. Therefore, Mist Therapy™ (CPT code 0183T) is included in the payment for the Evaluation and Management (E/M) or wound care services.

OPEN LOCAL COVERAGE DETERMINATIONS MEETING

Wisconsin Physicians Service (WPS), the Medicare Part B contractor for Wisconsin, Illinois, Michigan, and Minnesota, will hold an open Local Coverage Determinations (LCD) meeting for persons wishing to provide input concerning LCDs that are currently in the development process.

The next Open Policy Meeting will be held Wednesday, December 17, 2008, at 1:00 p.m. CT, 2:00 p.m. ET.

WPS Medicare will hold the open meeting to allow the submission of scientific evidence and other information from members of the general public relating to draft policies.

Details on the meeting are on the WPS Medicare Website at:
http://www.wpsmedicare.com/part_b/policy/policy_openmtg.shtml

TEMPORARY PROSTATIC URETHRAL STENT

WPS Medicare will cover the insertion of a temporary prostatic urethral stent when used for up to a 30 day temporary use to maintain urine flow and allow voluntary urination in men following minimally invasive treatment for benign prostatic hypertrophy and after initial post-treatment catheterization. The medical record must document these requirements.

Claims for this insertion should bill **CPT code 0084T**, Insertion of a temporary prostatic urethral stent. Only FDA approved stents (e.g. Spanner™) should be used. Place the name of the FDA-approved stent in item 19 of the CMS-1500 claim form or its electronic equivalent. Claims must also have the ICD-9 code for urethral obstruction 599.60. By definition, since this is a temporary stent, payment for 0084T also includes payment for the removal of the stent. Coverage for this procedure is effective 12/01/2008.

UPDATE TO THE INITIAL PREVENTIVE PHYSICAL EXAMINATION (IPPE) BENEFIT

~CMS MLN Matters~

MLN Matters Number: MM6223
Related CR Release Date: October 24, 2008
Related CR Transmittal #: R1615CP

Related Change Request (CR) #: 6223
Effective Date: January 1, 2009
Implementation Date: January 5, 2009

Provider Types Affected

Physicians and providers who submit claims to Medicare Fiscal Intermediaries (FIs), Carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs) for the IPPE provided to Medicare beneficiaries

What You Need to Know

This article is based on Change Request (CR) 6223, which announces that, effective January 1, 2009, the Centers for Medicare & Medicaid Services (CMS) is expanding coverage for the IPPE benefit.

This expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, no later than 12 months (rather than 6 months as previously required) after the date the individual's first coverage period begins under Medicare Part B. However, this expanded coverage only applies if the IPPE is performed on or after January 1, 2009.

The IPPE has been expanded to include measurement of an individual's body mass index, and end-of-life planning as mandatory services (upon an individual's consent). The screening electrocardiogram (EKG) is no longer a mandatory part of the IPPE, but it may be performed as an optional one-time service as a result of a referral arising out of the IPPE. Be sure your billing staff is aware of these changes.

Background

Pursuant to Section 101 (b) of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), CMS is amending section 410.16 and related regulation provisions of the Code of Federal Regulations. Effective January 1, 2009, this expanded coverage is subject to certain eligibility and other limitations that allow payment for an IPPE, also known as the "Welcome to Medicare Visit", not later than 12 months after the date the individual's first coverage period begins under Medicare Part B.

Changes to IPPE

The Initial Preventive Physical Examination

- Effective for services performed on or after January 1, 2009, MIPPA changes the IPPE as follows:
 - Waives the deductible for the IPPE.
 - Adds the measurement of body mass index as part of the IPPE,
 - Adds end-of-life planning to the IPPE (upon an individual's consent), and
 - Removes the mandatory requirement of the screening electrocardiogram (EKG). The screening EKG is optional and is permitted as a one-time screening service as a result of a referral arising out of the IPPE.

Eligibility

- Effective January 1, 2009, the MIPPA of 2008 extends the eligibility period from 6 months after Part B enrollment to 12 months after enrollment.
- Effective for IPPEs performed on or after January 1, 2009, a beneficiary is eligible for the extended IPPE benefits of MIPPA when he/she first enrolls in Medicare Part B and receives the IPPE benefit within the first 12 months of the effective date of the initial Part B coverage period.
- For IPPEs performed on or after January 1, 2009, the Medicare deductible does not apply to the IPPE.
- The waived deductible is applicable to the IPPE (code G0402) only, but the coinsurance still applies. Prior to January 1, 2009, the deductible was not waived.

Billing Requirements

Codes Used to Bill the IPPE

- Effective January 1, 2005, the physician or qualified non-physician practitioner will bill for IPPEs performed on or before December 31, 2008, using HCPCS code G0344 with one of the following HCPCS codes for the mandatory EKG: G0366, G0367, or G0368.
- Effective January 1, 2009, the screening EKG is billable with HCPCS code(s) G0403, G0404, or G0405, when it is a result of a referral from an IPPE.
- For an IPPE performed during the global period of surgery refer to Section 30.6.6, Chapter 12 of the Medicare Claims Processing Manual for reporting instructions at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> on the CMS Website.

The following HCPCS codes have been developed for the IPPE benefit effective January 1, 2009:

HCPCS Code	Short Descriptor
G0402: Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	Initial Preventive Exam
G0403: Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report	EKG for initial prevent exam
G0404: Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination	EKG tracing for initial prev
G0405: Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination	EKG interpret & report preve

Professional Claims Processed by Carriers/MACs

- The type of service (TOS) for each of the new codes is as follows:
 - G0402: TOS = 1
 - G0403: TOS = 5
 - G0404: TOS = 5
 - G0405: TOS = 5
- The HCPCS codes for an IPPE and screening EKG are paid under the Medicare Physician Fee Schedule (MPFS). The appropriate deductible and coinsurance applies to codes G0344, G0366, G0367, G0368, G0403, G0404, and G0405.

- The deductible is waived for code G0402 after January 1, 2009, but the coinsurance still applies.

Institutional Claims Processed by FIs/MACs

- FIs/MACs will pay for code G0402 for the IPPE and code G0404 for the screening EKG, tracing only when those services are submitted on a TOB 12X or 13X for hospitals subject to the outpatient prospective payment system (OPPS). Codes G0403 and G0405 are not payable under the OPPS. Hospitals not subject to OPPS will be paid under current methodologies.
- For inpatient or outpatient services in hospitals in Maryland, payment is made according to the State Cost Containment System.
- For services performed on a 12X, Indian Health Services (IHS) hospitals, payment is made based on an all-inclusive ancillary per diem rate.
- For services performed on a 13X, IHS hospitals, payment is made based on the all-inclusive rate (AIR).
- For services performed on an 85X, IHS critical access hospitals (CAHs), payment is made based on an all inclusive facility specific per visit rate. For other CAHs billing on the 85X, payment is based on reasonable cost.
- For services billed by Skilled Nursing Facilities (SNFs) on the 22X, payment for the technical component of the EKG is based on the MPFS.

NOTE: HCPC code G0405 is a professional component and is only allowable on 71x, 73x and 85x (**CAH Method II**) TOBs. In addition, G0404 is a Technical component HCPCS code that can only be submitted on 12x, 13x, 22x, OR 85x(Method I and II) TOBs.

Rural Health Clinics/Federally Qualified Health Centers (RHCs/FQHCs) Special Billing Instructions

- Payment for the professional services will be made under the all-inclusive rate. Encounters with more than one health professional and multiple encounters with the same health professionals that take place on the same day and at a single location constitute a single visit.

OPPS Hospital Billing

- Hospitals subject to OPPS (TOBs 12X and 13X) must use modifier 25 when billing the IPPE G0344 along with technical component of the EKG, G0367, on the same claim. **The same is true when billing IPPE code G0402 along with the technical component of the screening EKG, code G0404.**

Reporting a Medically Necessary Evaluation and Management (E/M) at Same IPPE Visit

- When the physician or qualified NPP provides a medically necessary E/M service in the same visit as the IPPE, CPT codes 99201 – 99215 may be used depending on the clinical appropriateness of the circumstances. CPT modifier –25 will be appended to the medically necessary E/M service identifying this service as a significant, separately identifiable service from the IPPE code **reported (G0344 or G0402, whichever applies based on the date of service).**

Documentation

- Physicians and qualified NPPs are required to use the 1995 and 1997 E/M documentation guidelines to document the medical record with the appropriate clinical information. The guidelines may be reviewed at http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp on the CMS Website.

Medicare Notices and Messages**Remittance Advice Remark Codes and Claim Adjustment Reason Codes**

- Your Medicare contractors will use the appropriate Remittance Advice Remark Code, i.e., N117 (This service is paid only once in a patient's lifetime) when denying additional claims for an IPPE and/or a screening EKG.
- Your Medicare contractors will use the appropriate Claim Adjustment Reason Code, i.e., 149 (Lifetime benefit maximum has been reached for this service/benefit category) when denying additional claims for an IPPE and/or a screening EKG.

Advance Beneficiary Notice (ABN) as Applied to the IPPE

- Effective for beneficiaries whose IPPE is provided on January 1, 2005, through December 31, 2008, an ABN will be issued for all IPPEs conducted after the beneficiary's statutory 6-month period has lapsed.
- Effective for IPPEs performed **on or after January 1, 2009**, an ABN will be issued for all IPPEs conducted after the beneficiary's statutory 12-month period has lapsed since based on Social Security Act Section 1862(a)(1)(K),

Medicare is statutorily prohibited from paying for an IPPE outside the initial 12-month period under the MIPPA of 2008.

Medicare Summary Notices (MSNs)

- When denying additional claims for G0402, Medicare contractors will use MSN message 20.91 - This service was denied. Medicare covers a one-time initial preventive physical exam (Welcome to Medicare physical exam) if you get it within the first 12 months of the effective date of your Medicare Part B coverage.
- When denying additional claims for screening EKG codes G0403, G0404 and G0405, contractors will use MSN message 20.12 - This service was denied because Medicare only covers this service once a lifetime.

Additional Information

The official instruction (CR6223) issued to Medicare Carriers, FIs and A/B MACs regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1615CP.pdf> on the CMS Website.

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

Coverage – Policies

INFORMATION ON WEBSITE

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

http://www.wpsmedicare.com/part_b/policy/index.shtml

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

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



Revised Policies for December 2008

Policy	Title	NCD/NCP/LCD	Web	Communiqué Page
GSURG-037	<i>Application of Bioengineered Skin Substitutes and Skin Grafting</i>	LCD	Click here to view	25
GSURG-050	<i>Stereotactic Computer Assisted Volumetric and/or Navigational Procedure</i>	LCD	Click here to view	25
PHYS-042	<i>Drugs and Biologicals - Coverage and Payment</i>	NCP	Click here to view	25
RAD-027	<i>Positron Emission Tomography (PET) Scan</i>	NCD	Click here to view	28
RAD-036	<i>Brachytherapy</i>	LCD	Click here to view	28
RAD-039	<i>Stereotactic Body Radiation Therapy</i>	LCD	Click here to view	31

Coverage – Revised Policies**LCD Title**

Application of Bioengineered Skin Substitutes and Skin Grafting

Contractor's Determination Number

GSURG-037

Effective for claims submitted with dates of service on or after 10/01/2008, WPS will cover the new 2009 ICD-9-CM codes:

List 1B Secondary diagnoses:

- *249.60 Secondary diabetes mellitus with neurological manifestations; not stated as uncontrolled, or unspecified
- *249.70 Secondary diabetes mellitus with peripheral circulatory disorders; not stated as uncontrolled, or unspecified

**Contractor's Policy Number**

GSURG-050

LCD Title

Stereotactic Computer Assisted Volumetric and/or Navigational Procedure

Primary Geographic Jurisdiction

Wisconsin, Illinois, Michigan, Minnesota

Revision Effective Date

11/16/2008

Indications and Limitations

Deleted, statement "when billed with CPT code 61795" from sentence that read "Therefore, CPT codes 20986, 20987, 20985 or other such CPT codes will be denied as not proven effective, when billed with CPT code 61795." Sentence now reads, "Therefore, CPT codes 20986, 20987, 20985 or other such CPT codes will be denied as not proven effective."

**Subject Number:**

PHYS-042

Subject Name:

Drugs and Biologicals - Coverage and Payment

II. Off-Label Use of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen

- 50.4.5-

(Rev.96, Issued: 10-24-08, Effective: 06-05-08 NCCN/06-10-08 Thomson
Micromedex/07-02-08 Clinical Pharmacology, Implementation: 11-25-08)

A. Overview

Effective January 1, 1994, off-label, medically accepted indications of Food and Drug Administration-(FDA) approved drugs and biologicals used in an anti-cancer chemotherapeutic regimen are identified under the conditions described below. A regimen is a combination of anti-cancer agents clinically recognized for the treatment of a specific type of cancer. Off-label, medically accepted indications are supported in either one or more of the compendia or in peer-reviewed medical literature. The contractor may maintain its own subscriptions to the listed compendia or peer-reviewed publications to determine the medically accepted indication of drugs or biologicals used off-label in an anti-cancer chemotherapeutic regimen. Compendia documentation or peer-reviewed literature supporting off-label use by the treating physician may also be requested of the physician by the contractor.

B. Recent Revisions to the Compendia List

Do not deny coverage based solely on the absence of FDA-approved labeling for the use, if the use is supported by any of the following compendia and the use is **not** listed as unsupported, not indicated, not recommended, or equivalent terms, in any of the following compendia:

- Existing - American Hospital Formulary Service-Drug Information (AHFS-DI)
- Effective June 5, 2008 - National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
- Effective June 10, 2008 - Thomson Micromedex DrugDex
- Effective July 2, 2008 - Clinical Pharmacology

The listed compendia employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium. In general, a use is identified by a compendium as **medically accepted** if the:

1. indication is a Category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or,
2. narrative text in AHFS-DI or Clinical Pharmacology is supportive.

A use is **not medically accepted** by a compendium if the:

1. indication is a Category 3 in NCCN or a Class III in DrugDex; or,
2. narrative text in AHFS or Clinical Pharmacology is “not supportive.”

The complete absence of narrative text on a use is considered neither supportive nor non-supportive.

C. Use Supported by Clinical Research That Appears in Peer-Reviewed Medical Literature

Contractors may also identify off-label uses that are supported by clinical research under the conditions identified in this section. Peer-reviewed medical literature may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication. In-house publications of entities whose business relates to the manufacture, sale, or distribution of pharmaceutical products are excluded from consideration. Abstracts (including meeting abstracts) are excluded from consideration.

In determining whether an off-label use is supported, the contractors will evaluate the evidence in published, peer-reviewed medical literature listed below. When evaluating this literature, they will consider (among other things) the following:

1. *Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence*
2. *Whether the administered chemotherapy regimen is adequately represented in the published evidence.*
3. *Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.*
4. *Whether the study is appropriate to address the clinical question. The contractor will consider:*
 - a. *whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover.);*
 - b. *that non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and,*
 - c. *that case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.*

The contractor will use peer-reviewed medical literature appearing in the regular editions of the following publications, not to include supplement editions privately funded by parties with a vested interest in the recommendations of the authors:

- *American Journal of Medicine;*
- *Annals of Internal Medicine;*
- *Annals of Oncology;*
- *Annals of Surgical Oncology;*
- *Biology of Blood and Marrow Transplantation;*
- *Blood;*
- *Bone Marrow Transplantation;*
- *British Journal of Cancer;*
- *British Journal of Hematology;*
- *British Medical Journal;*
- *Cancer;*
- *Clinical Cancer Research;*
- *Drugs;*
- *European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology);*
- *Gynecologic Oncology;*
- *International Journal of Radiation, Oncology, Biology, and Physics;*
- *The Journal of the American Medical Association;*
- *Journal of Clinical Oncology;*
- *Journal of the National Cancer Institute;*
- *Journal of the National Comprehensive Cancer Network (NCCN);*
- *Journal of Urology;*
- *Lancet;*

- *Lancet Oncology;*
- *Leukemia;*
- *The New England Journal of Medicine; or*
- *Radiation Oncology*

D. Generally

FDA-approved drugs and biologicals may also be considered for use in the determination of medically accepted indications for off-label use if determined by the contractor to be reasonable and necessary.

If a use is identified as not indicated by the Centers for Medicare & Medicaid Services (CMS) or the FDA, or if a use is specifically identified as not indicated in one or more of the compendia listed, or if the contractor determines, based on peer-reviewed medical literature, that a particular use of a drug is not safe and effective, the off-label usage is not supported and, therefore, the drug is not covered.

(This instruction was last reviewed by CMS in September 2008.)



Subject Number:

RAD-027

Subject:

Positron Emission Tomography (PET) Scan

Coding Guidelines

The following code is not covered and is being removed from the coding document:

78609	Brain imaging, positron emission tomography (PET); perfusion evaluation
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The Q0 modifier replaces modifiers QA and QR and the Q1 modifier replaces modifier QV.

Effective Date: January 1, 2008; Implementation Date: No Later Than April 7, 2008.



Contractor's Determination Number

RAD-036

LCD Title

Brachytherapy

CPT/HCPCS Codes

Codes 77781, 77782, 77783 and 77784 will be discontinued as of 01/2008 and replaced by the following new codes 77785, 77786, 77787:

- *77785 Remote afterloading high dose rate brachytherapy; 1 channel
- *77786 Remote afterloading high dose rate brachytherapy; 2-12 channels
- *77787 Remote afterloading high dose rate brachytherapy; Over 12 channels
- *Q3001 Radioelements for brachytherapy, any type each (discontinued 12/30/2007 for ASC billing)

Brachytherapy Sources Payable as of 01/01/2008 in the ASC setting

A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie
C1716	Brachytherapy source, non-stranded, Gold-198, per source
C1717	Brachytherapy source, non-stranded, High Dose Rate Iridium-192, per source
C1719	Brachytherapy source, non-stranded, Non-High Dose Rate Iridium-192, per source
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source
C2634	Brachytherapy source, non-stranded, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source
C2635	Brachytherapy source, non-stranded, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM
C2638	Brachytherapy source, stranded, Iodine-125, per source
C2639	Brachytherapy source, non-stranded, Iodine-125, per source
C2640	Brachytherapy source, stranded, Palladium-103, per source
C2641	Brachytherapy source, non-stranded, Palladium-103, per source
C2642	Brachytherapy source, stranded, Cesium-131, per source
C2643	Brachytherapy source, non-stranded, Cesium-131, per source
C2698	Brachytherapy source, stranded, not otherwise specified, per source
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source

Coding Guidelines
Coding guidance in relation to where the service is rendered.
***Radioelements**

In all cases, the radioisotope must be billed by the provider licensed and trained in nuclear materials use. **The date of service for the radioelement claim must match the date of service for the procedure performed.**

1. The expendable source Q3001 is only reimbursed when billed in an office or free-standing radiological facility (11), independent clinic (49).
For electronic billing in item 19 narrative, list iodine (I-125); palladium (Pd-103); and cesium (Cs-131), the number of seeds ordered, invoice price and the number of seeds used in the procedure. It is recognized that a small number of additional seeds is ordered and billed to cover plan changes or intra-operative loss.
2. In the OPPS setting use the source specific C code that best describes the radioelement should be used and it is priced off the OPPS fee schedule. Note that when billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand.
3. In the ASC (24) setting, effective 01/01/2008, use the source specific C code that best describes the radioelement should be used. Prior to 01/01/2008 Code Q3001 was used in the ASC.
Payment for Brachytherapy Sources in an ASC.
The Medicare Improvement for Patients and Providers Act of 2008 requires CMS to pay for brachytherapy sources for the period of July 1, 2008 through December 31, 2009, at

hospitals' charges adjusted to costs. As a result of the legislative amendment, there is no prospective rate under the OPPS for that period. Therefore, contrary to the payment policy, payment indicators and payment rates included in previous guidance, including Addendum BB to the November 27, 2007 OPPS/ASC final rule, for dates of service July 1, 2008 through December 31, 2009, payment for brachytherapy sources will be made at contractor-priced amounts, consistent with payment policy for the revised ASC payment system when no OPPS prospective rate is available. CR-6205

Note that when billing for stranded sources, providers should bill the number of units of the appropriate source HCPCS C-code according to the number of brachytherapy sources in the strand, and should not bill as one unit per strand.

For electronic billing in item 19 narrative, list iodine (I-125); palladium (Pd-103); and cesium (Cs-131), the number of seeds ordered, invoice price and the number of seeds used in the procedure. It is recognized that a small number of additional seeds is ordered and billed to cover plan changes or intra-operative loss.

Until standard pricing can be established, the contractor will request by mail additional documentation (operative note and seed invoice) to confirm billed amount and number of seeds used.

4. In the hospital setting (21 or 22) the radioelement is covered by source specific C-codes. The code C1717 code should be billed for each fraction of HDR given (77781-4).

Radioelements inserted in the in-patient or outpatient setting should not be billed to Medicare Part B but to Part A under OPPS or Inpatient billing rules.

Billing and Coding of Prostate Brachytherapy Performed in an Ambulatory Surgical Center (ASC)

Please refer to CMS payment rules for ASCs, which can be found at:
<http://www.cms.hhs.gov/ASCPayment/>

Brachytherapy performed for the treatment of prostate cancer includes low dose rate (permanent seed) and high dose rate (HDR) brachytherapy. This addresses the treatment of prostate cancer utilizing low dose rate (permanent seed) brachytherapy performed at an ASC- an entity approved by Medicare as a supplier of certain ambulatory surgery services that bills the Part B carrier and is licensed by the state.

CPT 55875 [formerly 55859] (Transperineal placement of needles or catheters into prostate for interstitial radio element application, with or without cystoscopy) was added to the list of Medicare-approved ASC procedures effective July 1, 2003. Other ASC approved codes are 19296, 19297 and 19298 for breast, 57155 and 58346 for gynecological, 31643 pulmonary, and 43241 for esophageal applicator insertions. As of 01/01/2008 there are new CMS ASC billing instructions.

The previous instructions for ASC billing have been removed from the coding and billing section because of new payment rules governing ASCs for these services.



Contractor's Determination Number

RAD-039

LCD Title

Stereotactic Body Radiation Therapy

CPT/HCPCS Codes

(77373 and 77435 are used in free standing facilities only (i.e. clinic or ASC))

77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to one or more lesions, including image guidance, entire course not to exceed 5 fractions

*In the Hospital Outpatient Setting use the following codes

G0339	Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment
G0340	Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment
G0251	Linear accelerator based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, maximum five sessions per course of treatment

Electronic Data Interchange (EDI)

EDI HOTLINE

Providers and submitters who send their Medicare claims electronically occasionally need to contact the Medicare Part B EDI Hotline. In order to make your experience with the Hotline more beneficial, here are a few tips you can use.

You should have your Submitter ID ready to give us either when we answer your call or when you leave a voicemail message. The Submitter Number is known by several names, including: Submitter ID, Sender ID, User ID, or Billing Location Code (for providers sending to us through Blue Cross of Michigan.) This number tells us how you are billing – whether through a clearinghouse or directly to us. If you are billing directly to us, your submitter ID will be five (5) numeric characters. The Submitter ID is the number you use to connect direct to the WPS Bulletin Board System to transmit.

The EDI Hotline will never ask you for your tax ID number. We do not have any system access using your tax ID number.

What we may ask for, however, is your NPI number. This is the number assigned to identify you as a provider by National Plan and Provider Enumeration System (NPES). You will use this number for all Medicare Part B billing whether the claim is sent electronically or on paper.

When you call, we will need your submitter ID, your NPI and usually the date you submitted the file about which you are inquiring. If you have received a report indicating your claims have deleted, we will also ask you for the "Processed Date" of the report. This will enable us to look at the same report you are seeing so we can give you valid information.

Earlier in this article, we referenced your need to know whether you bill directly to Medicare or through a clearinghouse. If you bill directly to Medicare, your computer will dial in through a modem to our Bulletin Board System. Your claims will only go to Medicare Part B, not through any other party. If you use a clearinghouse, your claims will be sent from your office to the clearinghouse then the clearinghouse will send your claims on to Medicare Part B. You might send all your electronic claims (Public Aid, Commercial insurances, Medicare, Blue Cross, etc) to the clearinghouse and they in turn will forward the Medicare claims to us and the other insurances to their proper parties. It is important to know the name of your clearinghouse for efficient response to your questions.

Sometimes the Medicare acronyms make it difficult for you to reach the right department at Medicare. One area in which we see particular problems is ERA/EFT. These two items are distinctly different. The ERA is the electronic remittance advice – your payment voucher in electronic format (also called your electronic Explanation of Medicare Benefits or EOMB. It has nothing to do with actual issuing of checks or transfer of funds. The ERA tells you how your payment was applied to each Medicare beneficiary. You can request ERA access or make changes to your ERA setup with the EDI Hotline in the Marion, Illinois office for providers in Illinois, Michigan and Wisconsin, and Minnesota.

The EFT or Electronic Funds Transfer is the direct deposit of your Medicare payment into your bank. EFT for all of the states we process (IL, MI, WI, and MN) are handled by the Minnesota

EDI staff at the numbers listed below. You can also reach them by calling the IL, MI, WI, and MN EDI Hotline and asking for the EFT staff. These two items, ERA and EFT, are not interchangeable. CMS strongly recommends all providers utilize ERAs and EFTs. If at some time in the future they become mandatory, your Medicare Part B Communiqué will have the details.

You may never have problems with electronic billing, but if you do and you need to contact us, hopefully these tips will make your experience more pleasant. Our contact numbers are:

Illinois, Michigan, Wisconsin, and MN: 877-567-7261

E-mail: EDIMedicareB@wpsic.com

For EFTs:

866-380-4742

952-885-2811

952-885-2881

952-885-2882

PC-ACE PRO32 BILLING SOFTWARE UPGRADE VERSION 1.96 NOW AVAILABLE ONLINE

If you are currently using PC-Ace Pro32 billing software, you can now download the latest upgrade online at <http://www.wpsic.com/edi/pcacepro32.shtml>.

Now available online is:

- The upgrade to the latest version of PC-Ace, version 1.96
- Instructions related to the upgrade
- Users Guides/Manuals

If you are not using the version listed above, it is very important that you update your software immediately.

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

If you are NOT currently using this program but you are interested in using this HIPAA-compliant software, please contact our EDI Hotline at 877-567-726 or download the PC-Ace request form from <http://www.wpsic.com/edi/pdf/medbpcace.pdf>.

General Information

**COMPENDIA AS AUTHORITATIVE SOURCES FOR USE IN THE DETERMINATION OF A "MEDICALLY ACCEPTED INDICATION" OF DRUGS AND BIOLOGICALS USED OFF-LABEL IN AN ANTI-CANCER CHEMOTHERAPEUTIC REGIMEN
~CMS MLN Matters~**

MLN Matters Number: MM6191

Related CR Release Date: October 24, 2008

Related Change Request (CR) #: 6191

Effective Date: June 5, June 10, and July 2, 2008

(see below)

Related CR Transmittal #: R96BP

Implementation Date: November 25, 2008

Provider Types Affected

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

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6191 which updates the list of compendia recognized as authoritative sources of information for the determination of drugs and biologicals used off-label in anti-cancer chemotherapeutic regimens.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is recognizing the following as authoritative compendia and listing them in the Medicare Benefit Policy Manual (Chapter 15, Section 50.4.5) for use in the determination of a “medically-accepted indication” of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service-Drug Information (AHFS-DI), (existing)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (effective June 5, 2008)
- Thomson Micromedex DrugDex, (effective June 10, 2008) and
- Clinical Pharmacology (effective July 2, 2008).

GO – What You Need to Do

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

Background

In the past, the following three compendia were recognized as authoritative sources for use in the determination of a "medically-accepted indication" of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen (unless the Secretary of the Department of Health and Human Services determined that the use was not medically appropriate or the use was identified as not indicated in one or more such compendia):

1. American Medical Association Drug Evaluations (AMA-DE),
2. United States Pharmacopoeia-Drug Information (USP-DI) or its successor publication, and

3. American Hospital Formulary Service-Drug Information (AHFS-DI).

Because the AMA-DE and the USP-DI are no longer published (due to changes in the pharmaceutical reference industry), the AHFS-DI became the only remaining statutorily-named compendia available for the CMS to use as a reference. Consequently, CMS received requests from the stakeholder community for a process to revise the list of recognized authoritative compendia.

In the Medicare Physician Fee Schedule final rule for calendar year 2008, CMS established:

- A process for revising the list of compendia. (Section 1861(t)(2) of the Social Security Act; [http://www.ssa.gov/OP_Home/ssact/title18/1861.htm], and
- A definition for “compendium.” (72 FR 66222 [<http://edocket.access.gpo.gov/2007/07-5506.htm>], 72 FR 66303-66306 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiapreamble.pdf>], and 72 FR 66404 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf>].

A compendium is defined “as a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example, a compendium of anti-cancer treatment.” (42 CFR 414.930(a) [<http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf>].

In addition, a compendium:

- (1) Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases; and,
- (2) Is indexed by drug or biological. (42 CFR 414.930(a) [<http://edocket.access.gpo.gov/2007/pdf/07-3274.pdf>], 72 FR 66222 [<http://edocket.access.gpo.gov/2007/07-5506.htm>], and 72 FR 66404 [<http://www.cms.hhs.gov/CoverageGenInfo/Downloads/compendiareg.pdf>].

During a public meeting on March 30, 2006, the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) generated a list of desirable characteristics to use when reviewing a compendium. Subsequently, the MedCAC advised CMS of their findings and recommendations regarding the desirable characteristics of compendia for use in the determination of medically-accepted indications of drugs and biologicals in anti-cancer therapy.

After CMS conducted a review of specific compendia and compared their characteristics with the MedCAC list of desirable characteristics, CMS determined the following are recognized as authoritative compendia and is listing them in the Medicare Benefit Policy Manual (Chapter 15, Section 50.4.5) for use in the determination of a “medically-accepted indication” of drugs and biologicals used off-label in an anti-cancer chemotherapeutic regimen:

- American Hospital Formulary Service - Drug Information (AHFS-DI),
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium,
- Thomson Micromedex DrugDex, and
- Clinical Pharmacology.

The above listed compendia employ various rating and recommendation systems that may not be readily cross-walked from compendium to compendium. In general, a use is identified by a compendium as **medically accepted** if the:

- Indication is a Category 1 or 2A in NCCN, or Class I, Class IIa, or Class IIb in DrugDex; or,
- Narrative text in AHFS-DI or Clinical Pharmacology is supportive.

A use is **not medically accepted** by a compendium if the:

- Indication is a Category 3 in NCCN or a Class III in DrugDex; or,
- Narrative text in AHFS or Clinical Pharmacology is “not supportive.”

The complete absence of narrative text on a use is considered neither supportive nor non-supportive.

Medicare contractors may also identify off-label uses that are supported by clinical research under the conditions identified in Section 50.4.5 of the Medicare Benefits Policy Manual, as amended by CR6191. Peer-reviewed medical literature may appear in scientific, medical, and pharmaceutical publications in which original manuscripts are published, only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased, independent experts prior to publication.

In-house publications of entities whose business relates to the manufacture, sale, or distribution of pharmaceutical products are excluded from consideration. Abstracts (including meeting abstracts) are excluded from consideration.

In determining whether an off-label use is supported, Medicare contractors will evaluate the evidence in published, peer-reviewed medical literature listed in the revised Section 50.4.5.C, which is attached to CR6191. When evaluating this literature, Medicare contractors will consider (among other things) the following:

- Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence.
- Whether the administered chemotherapy regimen is adequately represented in the published evidence.
- Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients.
- Whether the study is appropriate to address the clinical question.

Additional Information

The official instruction, CR 6191, issued to your carrier, FI, A/B MAC, and DME MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R96BP.pdf> on the CMS Website. The revised sections of the Medicare Benefit Policy Manual are attached to CR 6191.

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

MEDICARE BENEFICIARIES IN STATE OR LOCAL CUSTODY

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

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

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

Exclusion from Coverage

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

Claims Processing Procedures

Providers and suppliers rendering services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact with the use of the **QJ modifier** *Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b)*. This modifier indicates the state or local government agency requesting the healthcare items or services provided to the patient has notified the provider that the prisoner or patient is responsible to repay the cost of Medical services. Furthermore, the agency will pursue the collection of debts for furnishing such items and services with the same vigor and in the same manner as any other debt.

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

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

Appeals

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

Program Safeguards**MEDICAL RECORDS REQUESTS**

Wisconsin Physicians Service (WPS) is authorized to access any records deemed necessary for the processing of Medicare claims. Furthermore, Medicare requires that the services are verifiable in order to be paid. WPS, as a Medicare contractor, has the responsibility of conducting random internal audits to verify services reported to the Medicare program against what is contained in the patient's medical record information.

When a provider receives a request for medical records from WPS, it is the responsibility of the provider to comply with the request within 45 business days from the date of the request. Failure to submit the requested records may result in the identification of a total overpayment for the services billed for the patient(s) in question. Additionally, further action could be taken to suspend all payments made to the billing provider from the Medicare program.

Provider Education**DO YOU BILL PSYCHOTHERAPY SERVICES FOR PATIENTS IN A NURSING FACILITY?**

Federal legislation has set forth requirements for Skilled Nursing Facilities (SNF) to participate in the Medicare program, and for Nursing Facilities (NF) to participate in the Medicaid program. One requirement is that each SNF or NF resident have an initial and a periodic comprehensive assessment, in order to institute a comprehensive care plan that meets the residents medical, nursing, mental, and psychological needs. The care plan must be developed and revised by an interdisciplinary team that includes the attending physician and a registered nurse who has responsibility for the resident. The components of the care plan are documented on the physician's order sheet, which is signed by the physician and the nurse.

Please be aware that Medicare will not cover psychotherapy services that are performed for residents of a skilled nursing facility or nursing facility, unless one of the following criteria is met:

1. The resident's attending physician evaluates the resident and authorizes the order for the psychotherapy, or the referral of the resident to another provider specialty.
or
2. A named physician, whose attendance is required by the resident or the residents interested family member, legal guardian, or power of attorney for health care, evaluates the resident and authorizes the order for the psychotherapy services. The attending physician must be notified of any change in the resident's physical, mental, or psychosocial status, or of the need to alter the resident's treatment significantly.

A "PRN" or standing order for psychotherapy is not acceptable.

To view additional information about Coverage of Services and Procedures in Nursing Facilities, refer to WPS Medicare policy PHYS-068. It is located at the following Website address:

http://www.wpsmedicare.com/part_b/policy/phys068.pdf

EDUCATION SCHEDULE

Be sure to visit the WPS Medicare Education Schedule at http://www.wpsmedicare.com/part_b/education/education_schedule.shtml to learn more about the educational events we have scheduled for the upcoming months.

We hope you can join us to learn more about the Medicare program.

Reimbursement

FEE SCHEDULE UPDATE FOR 2009 FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

~CMS MLN Matters~

MLN Matters Number: MM6270

Related CR Release Date: November 7, 2008

Related CR Transmittal #: R1630CP

Related Change Request (CR) #: 6270

Effective Date: January 1, 2009

Implementation Date: January 5, 2009

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, 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 DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6270 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) has issued instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). Be sure your billing staffs are aware of these changes.

Background

The update process for the DMEPOS fee schedule is contained in section 60, Chapter 23 of the Medicare Claims Processing Manual, which is located at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Website. Other information on the fee schedule, including access to the DMEPOS fee schedules is at http://www.cms.hhs.gov/DMEPOSFeeSched/01_overview.asp on the CMS Website. The key points of CR6270 are as follows:

- The following codes are being deleted from the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2009, and are therefore being removed from the DMEPOS fee schedule files:

L5993	L5994	L5995	L7611	L7612	L7613
L7614	L7621	L7622			

- For gap-filling purposes, the 2008 deflation factors by payment category are:

0.500 for Oxygen	0.504 for Capped Rental	0.505 for Prosthetics and Orthotics	0.641 for Surgical Dressings	0.697 for Parental and Enteral Nutrition
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- The fee schedule amounts for HCPCS code **K0672** (Addition to Lower Extremity Orthosis, Removable Soft Interface, All Components, Replacement Only, Each) are added to the fee schedule file on January 1, 2009, and are effective for claims submitted with dates of service on or after January 1, 2009.

- HCPCS code E2295 (Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features) is added to the HCPCS file on January 1, 2009. Due to low claims volumes expected, your Medicare contractor will establish local fee schedule amounts to pay claims for E2295.
- Fee schedule amounts for L3905, L3806, and L3808 were revised in the July 2008 Quarterly Update. However, CMS has determined that the gap-filled fees originally established for these three codes were correct and the fee amounts will revert back to what was in place prior to the July update. Claims already processed for dates of service on or after July 1, 2008, through December 31, 2008 will not be adjusted.

2009 Fee Schedule Updates following the Enactment of the Medicare Improvements for Patients and Providers Act (MIPPA)

- MIPPA of 2008 mandates a fee schedule covered item **update of -9.5% for 2009 for items included in round 1 of the DMEPOS Competitive Bidding Program**. The reduction applies to items furnished on or after January 1, 2009, in any geographical area.
- Items selected for competitive bidding in 2008 will receive a **-9.5%** update for 2009 with the **exception of HCPCS codes E1392, K0738, E0441, E0442, E0443 and E0444**. These 6 oxygen generating portable equipment (OGPE) and oxygen contents codes will receive a 0% update for 2009 as the fees for these items are not adjusted by the covered item update specified in 1834(a)(14), and are not reduced by the -9.5%, even though they are competitive bid items.
- Non-competitive bid items will receive a 5.0% covered item update for 2009.

New KE Modifier and the KL Modifier

A new HCPCS modifier was added to the HCPCS on January 1, 2009, and is effective for claims with dates of service on or after January 1, 2009. The new modifier is KE (Bid Under Round One of the DMEPOS Competitive Bidding Program for use with Non-Competitive Bid Base Equipment).

To accommodate the fee schedule updates required per the MIPPA, CMS is adding the KE modifier to the fee schedule for all power mobility device (PMD) accessory items selected for competitive bidding in 2008 as part of this update. The KE modifier is a pricing modifier that suppliers must use to identify when the same accessory HCPCS code can be furnished in multiple competitive and non-competitive bidding product categories. For example, HCPCS code E0981 *Wheelchair Accessory, Seat Upholstery, Replacement Only, Each* can be used with both competitively bid standard and complex rehabilitative power wheelchairs (K0813 thru K0829 and K0835 thru K0864), as well as with non-competitively bid manual wheelchairs (K0001 thru K0009) or a miscellaneous power wheelchair (K0898).

All fee schedules for PMD accessory codes with the KE modifier will receive a 5% covered item update for 2009, whereas the fee schedules for the PMD accessory codes without the KE modifier will receive the MIPPA-required 9.5% reduction for 2009. Suppliers need to know that if a competitively bid PMD accessory code is used with a competitively bid standard PMD base code (K0813 thru K0829) or complex rehabilitative PMD base code (K0835 thru K0864), claims for the PMD accessory code should be submitted without the KE modifier. If such claims are submitted with the KE modifier, they will be rejected with message M78 (Missing/incomplete/invalid HCPCS modifier) and 125 (Submission/billing error (s)).

Suppliers should bill the accessory code with the KE modifier when the accessory is used in conjunction with a non-competitively bid manual wheelchair (K0001 through K0009) or a miscellaneous PMD (K0898). In the case of the complex rehabilitative only PMD accessory code E2373 KC, suppliers should bill for the replacement only of E2373 without the KE modifier, but with the KC modifier when the accessory is used with a competitively bid complex rehabilitative PMD base code (K0835 thru K0864). When the replacement only code E2373 is used with a non-competitively bid manual or miscellaneous wheelchair, suppliers should bill code E2373 without the KC modifier, but with the KE modifier.

For the aforementioned reasons, CMS is also adding the KE modifier to the fee schedule for the following competitively bid HCPCS codes: A4636, A4637, A7000, and E0776. If codes A4636 and A4637 are used in conjunction with a competitively bid walker code (E0130, E0135, E0140, E0141, E0143, E0144, E0147, E0148, and E0149), claims for the replacement handgrip (A4636) or tip (A4637) should be submitted without the KE modifier. Suppliers should bill codes A4636 and A4637 with the KE modifier when the codes are used with non-competitively bid cane or crutch codes. Likewise, suppliers should bill the disposable canister code A7000 without the KE modifier when this code is used in conjunction with the competitively bid negative pressure wound therapy pump code E2402. When code A7000 is used with a non-competitively bid respiratory or gastric suction pump, suppliers should bill code A7000 with the KE modifier. Similarly when an IV pole (E0776) is used in conjunction with competitively bid enteral nutrient codes (B4149, B4150, and B4152 thru B4155), suppliers should bill code E0776 with the BA modifier, but without the KE modifier. When code E0776 is used with non-competitively bid parenteral nutrient codes, suppliers should bill code E0776 without the BA modifier, but with the KE modifier.

Further instruction on the use of the KE modifier with codes competitively bid in 2008 is available in Attachment B of CR 6270, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Website.

Note: Suppliers should not use the KE modifier on any claims for payment for items that were included under Round 1 such as an accessory for a standard power wheelchair.

With CR 6270, CMS is also adding the KL modifier to the fee schedule for the following diabetic supply HCPCS codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259. As indicated in CR 5641 (July Quarterly Update for 2007 DMEPOS Fee Schedule, discussed in MLN Matters article MM5641 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5641.pdf>), suppliers began using the KL modifier as an informational modifier to identify diabetic supplies (HCPCS codes A4233-A4236, A4253, A4256, A4258 and A4259) furnished via mail order on or after July 1, 2007. Effective January 1, 2009, the KL modifier has been changed from an informational modifier to a pricing modifier in the HCPCS file. Suppliers must use the KL modifier on all claims for the aforementioned diabetic supply codes that are furnished via mail order to beneficiaries. The KL modifier is not used with diabetic supply codes that are not delivered to the beneficiary's residence and are obtained from local supplier storefronts.

Note: Inappropriate use of a competitive bidding modifier on a competitive bidding claim is in violation of the law and may lead to claims denial and/or other corrective actions. The use of a competitive bidding modifier does not supersede existing Medicare modifier use requirements for a particular code, but rather should be used in addition, as required.

Competitive Bidding Items from 2008 Impacted by 2009 Pricing

The following product lists of the HCPCS codes that were selected for competitive bidding in 2008 are subject to the - 9.5% covered item update for 2009. The detailed descriptions of the listed HCPCS codes (for product categories 1-10) are not repeated in this article, but are available in **Attachment A** of CR 6270, which is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Website.

Product Category 1—Oxygen, Supplies and Equipment (for the detailed product description of each HCPCS code see **Attachment A**)

E1390	E1391	E0424	E0439	E0431
E0434	A4608	A4615	A4616	A4617
A4620	E0560	E0580	E1353	E1355

As part of this update, CMS is implementing the 2009 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2009. CMS is revising the fee schedule file to include the new national 2009 monthly payment rate of \$175.79 for stationary oxygen equipment. This revised 2009 monthly payment rate of \$175.79 includes the 9.5% covered item reduction ascribed to items selected for competitive bidding in 2008. The previously announced payment amount for 2009 of \$193.21 did not include the 9.5% reduction and assumed a higher shift to oxygen generating portable equipment (OGPE).

As a result of the above adjustments, CMS is also revising the fee schedule amounts for HCPCS codes E1405 and E1406 as part of this update. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

Product Category 2—Standard Power Wheelchairs, Scooters, and Related Accessories (for the detailed product description of each HCPCS code see **Attachment A**)

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1016	E1020	E1028
E2208	E2209	E2210	E2361	E2363	E2365	E2366	E2367
E2368	E2369	E2370	E2371	E2381	E2382	E2383	E2384
E2385	E2386	E2387	E2388	E2389	E2390	E2391	E2392
E2394	E2395	E2396	E2601	E2602	E2603	E2604	E2605
E2606	E2607	E2608	E2611	E2612	E2613	E2614	E2615
E2616	E2619	E2620	E2621	K0015	K0017	K0018	K0019
K0020	K0037	K0038	K0039	K0040	K0041	K0042	K0043
K0044	K0045	K0046	K0047	K0050	K0051	K0052	K0053
K0098	K0195	K0733	K0734	K0735	K0736	K0737	K0800
K0801	K0802	K0806	K0807	K0808	K0813	K0814	K0815
K0816	K0820	K0821	K0822	K0823	K0824	K0825	K0826
K0827	K0828	K0829					

Product Category 3—Complex Rehabilitative Power Wheelchairs and Related Accessories (for the detailed product description of each HCPCS code see **Attachment A**)

E0950	E0951	E0952	E0955	E0956	E0957	E0960	E0973
E0978	E0981	E0982	E0990	E0995	E1002	E1003	E1004
E1005	E1006	E1007	E1008	E1010	E1016	E1020	E1028
E1029	E1030	E2208	E2209	E2210	E2310	E2311	E2321
E2322	E2323	E2324	E2325	E2326	E2327	E2328	E2329
E2330	E2351	E2361	E2363	E2365	E2366	E2367	E2368
E2369	E2370	E2371	E2373 KC	E2374	E2375	E2376	E2377
E2381	E2382	E2383	E2384	E2385	E2386	E2387	E2388
E2389	E2390	E2391	E2392	E2394	E2395	E2396	E2601
E2602	E2603	E2604	E2605	E2606	E2607	E2608	E2611
E2612	E2613	E2614	E2615	E2616	E2619	E2620	E2621
K0015	K0017	K0018	K0019	K0020	K0037	K0038	K0039
K0040	K0041	K0042	K0043	K0044	K0045	K0046	K0047
K0050	K0051	K0052	K0053	K0098	K0195	K0733	K0734
K0735	K0736	K0737	K0835	K0836	K0837	K0838	K0839
K0840	K0841	K0842	K0843	K0848	K0849	K0850	
K0851	K0852	K0853	K0854	K0855	K0856	K0857	K0858
K0859	K0860	K0861	K0862	K0863	K0864		

Product Category 4—Mail-Order Diabetic Supplies (for the detailed product description of each HCPCS code see **Attachment A**)

A4233 KL	A4234 KL	A4235 KL	A4236 KL	A4253 KL	A4256 KL	A4258 KL	A4259 KL
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Product Category 5—Enteral Nutrients, Equipment, and Supplies (for the detailed product description of each HCPCS code see **Attachment A**)

B4034	B4035	B4036	B4081	B4082	B4083	B4087	B4088
B4149	B4150	B4152	B4153	B4154	B4155	B9000	B9002
E0776							

Product Category 6—Continuous Positive Airway Pressure Devices, Respiratory Assist Devices, and Related Supplies and Accessories (for the detailed product description of each HCPCS code see **Attachment A**)

A4604	A7030	A7031	A7032	A7033	A7034	A7035	A7036
A7037	A7038	A7039	A7044	A7045	A7046	E0470	E0471
E0472	E0561	E0562	E0601				

Product Category 7—Hospital Beds and Related Supplies (for the detailed product description of each HCPCS code see **Attachment A**)

E0250	E0251	E0255	E0256	E0260	E0261	E0265	E0266
E0271	E0272	E0280	E0290	E0291	E0292	E0293	E0294
E0295	E0296	E0297	E0300	E0301	E0302	E0303	E0304
E0305	E0310	E0316	E0910	E0911	E0912	E0940	

Product Category 8—Negative Pressure Wound Therapy Pumps and Related Supplies and Accessories (for the detailed product description of each HCPCS code see **Attachment A**)

A6550	A7000	E2402
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Product Category 9—Walkers and Related Supplies (for the detailed product description of each HCPCS code see **Attachment A**)

A4636	A4637	E0130	E0135	E0140	E0141	E0143	E0144	E0147
E0148	E0149	E0154	E0155	E0156	E0157	E0158	E0159	

Product Category 10—Support Surfaces (for the detailed product description of each HCPCS code see **Attachment A**)

E0193	E0277	E0371	E0372	E0373
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Billing Instructions for Power Wheelchair Harness (HCPCS code E2313)

The April Quarterly Update for the 2007 DMEPOS Fee Schedule included instructions for suppliers to submit claims for the electronics necessary to **upgrade from a non-expandable controller to an expandable controller at initial issue using HCPCS code E2399. This instruction was intended as a temporary measure** until a new code could be added to describe the electronics/cables/junction boxes used when upgrading from a non-expandable controller at initial issue.

- HCPCS code E2313 (Power Wheelchair Accessory, Harness For Upgrade to Expandable Controller, Including all Fasteners, Connectors and Mounting Hardware, Each) was added to the HCPCS effective January 1, 2008, for use in paying claims for the electronics furnished when upgrading from a non-expandable controller at initial issue.
- Suppliers may submit claims for the electronics provided at initial issue using HCPCS code E2313 for dates of service on or after January 1, 2008, and must no longer use code E2399 for submission of such items.
- Claims submitted for the electronics necessary to upgrade from a non-expandable controller to an expandable controller using HCPCS code E2399 are invalid and will be denied as contractor/supplier responsibility. When such claims are denied, CMS will use message codes of M20 (Missing/incomplete/invalid HCPCS), 189 (Not otherwise classified or unlisted procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.), N211 (Alert: You may not appeal this decision.), and MA13 (You may be subject to penalties if you bill the patient for amount not reported with the PR (patient responsibility) group code.). These denials are made as CO-Contractual Obligation denials.

Additional Information

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

For complete details regarding this Change Request (CR) please see the official instruction (CR6270) issued to your Medicare A/B MAC, DME/MAC, carrier, FI or RHHI. That instruction may be viewed by going to <http://www.cms.hhs.gov/Transmittals/downloads/R1630CP.pdf> on the CMS Website.

MEDICARE PAYMENT FOR AIR AMBULANCE SERVICES UNDER SECTION 146(B)(1) OF THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008 (MIPPA)

~CMS MLN Matters~

MLN Matters Number: MM6214
Related CR Release Date: October 17, 2008
Related CR Transmittal #: R387OTN

Related Change Request (CR) #: 6214
Effective Date: July 1, 2008
Implementation Date: January 5, 2009

Provider Types Affected

Ambulance providers and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for air ambulance services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 6214, which alerts providers to the fact that any area that was designated as a rural area as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, will be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008, through December 31, 2009.

Be aware that upon the implementation date of January 5, 2009, in addition to the successful installation of the revised calendar year (CY) 2008 ZIP Code File, your Medicare contractor will mass-adjust all air ambulance claims with dates of service on or after July 1, 2008, through December 31, 2008, which were previously paid under an urban ZIP code that was considered rural on December 31, 2006. In addition, the revised ZIP Code File will be used to process such claims that were not already processed.

Key Points of CR6214

Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) further amends the designation of rural areas for air ambulance services.

- The statute specifies that any area that was designated as a rural area, as of December 31, 2006, for purposes of making payments under the ambulance fee schedule for air ambulance services, will be treated as a rural area for purposes of making payments under the ambulance fee schedule for air ambulance services furnished during the period July 1, 2008, through December 31, 2009.
- Accordingly, for areas that were designated rural on December 31, 2006, and were subsequently re-designated as urban, CMS has re-established the "rural" indicator on the ZIP code file for air ambulance services, effective July 1, 2008.
- Your Medicare contractor will process air ambulance transport and mileage claims (i.e., A0430, A0431, A0435, A0436), in accordance with these revised designations.

Background

The Ambulance Fee Schedule was implemented in April 2002 based on a Final Rule published in the Federal Register (67 Fed. Reg. 9100 (February 27, 2002)). The elements of this final rule allowed for payment for various ground ambulance services and rotary and fixed wing air ambulance services under a fee schedule. The payment for these services is based on the type of service provided and on the geographical points of pick up. The final

rule also establishes increased payment for services furnished in rural areas based on the location of the beneficiary at the time the beneficiary is placed on board the ambulance.

When the fee schedule was implemented, a rural area was defined as one that was outside any area defined by the Office of Management and Budget as a Metropolitan Statistical Area, (MSA) or a New England County Metropolitan Area (NECMA). The definition of “rural” also included the Goldsmith Modification. The Goldsmith Modification was developed because of the need to identify small towns and rural areas within large metropolitan counties. Some of these communities were isolated from central areas with health services because of distance or other physical features. The urban and rural areas were identified for payment purposes by a nexus of the ZIP code file and the ambulance fee schedule. The ZIP code file is updated quarterly.

Another final rule published in 71 Fed. Reg. 69713 (December 1, 2006), revised the geographic designations for urban and rural areas as set forth in OMB’s Core- Based Statistical Areas (CBSAs) standard. It added the definition of “urban area” as defined by the Executive Office of Management and Budget (OMB). In addition, it removed the definition of “Goldsmith modification” and amended the definition of “rural area” to include areas determined to be rural under the most recent version of the Goldsmith modification. Updating the MSA definition to conform with OMB’s CBSA-based geographic area designations, coupled with updating the Goldsmith Modification (that is, using the current Rural Urban Commuting Areas (RUCAs) version, as discussed in Section III.B.1.b of the final rule), more accurately reflected the contemporary urban and rural nature of areas across the country for ambulance payment purposes and made ambulance fee schedule payments more accurate. These changes became effective January 1, 2007.

Additional Information

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

To see the official instruction (CR6214) issued to your Medicare Carrier, FI, or A/B MAC visit <http://www.cms.hhs.gov/Transmittals/downloads/R387OTN.pdf> on the CMS Website.

**NEW 2008 MEDICARE PHYSICIAN FEE SCHEDULE (MPFS)
PAYMENT RATES EFFECTIVE FOR DATES OF SERVICE JULY 1,
2008, THROUGH DECEMBER 31, 2008**

~CMS MLN Matters~

MLN Matters Number: MM6212
Related CR Release Date: October 24, 2008
Related CR Transmittal #: R389OTN

Related Change Request (CR) #: 6212
Effective Date: July 1, 2008
Implementation Date: October 24, 2008,
unless otherwise noted below

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, 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 and paid under the MPFS

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 6212, which announces the new 2008 MPFS payment rates effective for dates of service July 1, 2008, through December 31, 2008. Please note that Medicare contractors have already implemented the actions annotated in this article.

CAUTION – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) directed Medicare contractors to revert back to the 0.5 percent payment rates that were previously in place until June 30, 2008, and to use those rates through December 31, 2008. In addition, carriers/Part B MACs are using the same rates as used for January 1 through June 30, 2008, to make payments, where appropriate, to Ambulatory Surgical Centers (ASCs) for services rendered from July 1 through December 31, 2008. This reflects a continuation of the payment policy for brachytherapy services at carrier/Part B MAC-priced amounts and the prospective rates for other ASC services. CMS also provided revised fees for selected mental health codes that had an increase in their fee schedule amounts. The effective date for the increase for the mental health codes was for dates of service on and after July 1, 2008.

GO – What You Need to Do

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

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15, 2008. The -10.6 percent Medicare Physician Fee Schedule (MPFS) that took effect on July 1, 2008, was changed back to the January-June 2008 rates, which reflect an update of 0.5 percent. CMS directed **Medicare contractors** to revert back to the 0.5 percent payment files that were previously in place until June 30, 2008. The new MPFS rates are retroactive to July 1, 2008.

Consistent with the new legislation, **carriers/Part B MACs** are using the same fees as used for January 1 through June 30, 2008, to make payments to **ambulatory surgical centers**

(ASCs) for July 1 through December 31, 2008. Those fees reflect the continuation of the payment policy for brachytherapy services at carrier/Part B MAC-priced amounts and the prospective rates for other ASC services.

Fiscal intermediaries/Part A MACs also have reverted back to the fees that were in effect from January 1, 2008, through June 30, 2008.

In addition, based on the new legislation, CMS provided Medicare contractors with new revised **fees for selected mental health codes** that had an increase in their fee schedule amounts. The effective date for the increase for the mental health codes was for dates of service on and after July 1, 2008, and Medicare contractors are currently paying the new fees.

After Medicare contractors began paying claims at the new rates, they began to identify any MPFS claims that were paid at the -10.6 percent rate for dates of service on and after July 1, 2008. Contractors are in the process of automatically adjusting those claims, and must complete the adjustments no later than September 30, 2008.

There may be some claims that cannot be automatically adjusted. Under the Medicare statute, Medicare pays the lower of submitted charges or the Medicare fee schedule amount. Claims with dates of service July 1, 2008, and later billed with a submitted charge at least at the level of the January 1 through June 30, 2008, fee schedule amount will be automatically reprocessed. Any lesser amount requires providers to contact their local contractor for direction on obtaining adjustments. Non-participating physicians who submitted unassigned claims at the reduced non-participation amount also will need to request an adjustment.

Contractors are following the normal process for transmitting the adjusted claims to supplemental insurers, where appropriate. Contractors disclosed the new MPFS rates on their Websites by July 23, 2008.

Additional Information

The official instruction, CR 6212, issued to your carrier, FI, A/B MAC, and RHHI regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R389OTN.pdf> on the CMS Website.

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

REASONABLE CHARGE UPDATE FOR 2008 FOR SPLINTS, CASTS, DIALYSIS SUPPLIES, DIALYSIS EQUIPMENT, AND CERTAIN INTRAOCULAR LENSES

~ Revised CMS MLN Matters ~

MLN Matters Number: MM5740 **Revised**
Related CR Release Date: September 28, 2007
Related CR Transmittal #: R1344CP

Related Change Request (CR) #: 5740
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Note: This article was revised on November 7, 2007 to change the title to the chart showing the payment limits. That chart should have read "2008" and not "2007." All other information is unchanged.

Provider Types Affected

Physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis equipment, and certain intraocular lenses.

Provider Action Needed

Affected providers may want to be certain their billing staffs know of these changes.

Background

For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change Request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: <http://www.gpoaccess.gov/cfr/retrieve.html> on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The MLN Matters article related to CR 5382 can be viewed at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf> on the CMS Website.

For intraocular lenses, payment is made **only on a reasonable charge basis for lenses implanted in a physician's office**. Change Request 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007. DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For

these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

Dialysis Supplies Billed With AX Modifier

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639
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Dialysis Equipment Billed Without AX Modifier

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes.

Contractors will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008 through December 31, 2008. **Those 2008 payment limits are in Attachment A at the end of this article.**

Additional Information

Detailed instructions for Calculating:

- Reasonable charges are located in Chapter 23 (Section 80) of the *Medicare Claims Processing Manual*;
- Customary and prevailing charge are located in Section 80.2 and 80.4 of Chapter 23 of the *Medicare Claims Processing Manual*; and
- The IIC (Inflation Indexed Charge) are located in Section 80.6 of Chapter 23 of the *Medicare Claims Processing Manual*. The IIC update factor for 2008 is 2.7 percent.

You can find Chapter 23 of the *Medicare Claims Processing Manual* at <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Website. For complete details regarding this Change Request (CR) please see the official instruction (CR5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to <http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf> on the CMS Website. If you have questions, please contact your Medicare FI, carrier, DME MAC, or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS Website.

Attachment A

2008 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit
A4565	\$7.38	Q4025	\$32.45
Q4001	\$42.01	Q4026	\$101.30
Q4002	\$158.81	Q4027	\$16.23
Q4003	\$30.18	Q4028	\$50.66
Q4004	\$104.49	Q4029	\$24.81
Q4005	\$11.12	Q4030	\$65.31
Q4006	\$25.08	Q4031	\$12.41
Q4007	\$5.58	Q4032	\$32.65
Q4008	\$12.54	Q4033	\$23.14
Q4009	\$7.43	Q4034	\$57.56
Q4010	\$16.72	Q4035	\$11.57
Q4011	\$3.71	Q4036	\$28.79
Q4012	\$8.36	Q4037	\$14.12
Q4013	\$13.52	Q4038	\$35.37
Q4014	\$22.81	Q4039	\$7.08
Q4015	\$6.76	Q4040	\$17.68
Q4016	\$11.40	Q4041	\$17.16
Q4017	\$7.82	Q4042	\$29.30
Q4018	\$12.47	Q4043	\$8.59
Q4019	\$3.91	Q4044	\$14.66
Q4020	\$6.24	Q4045	\$9.96
Q4021	\$5.78	Q4046	\$16.03
Q4022	\$10.44	Q4047	\$4.97
Q4023	\$2.91	Q4048	\$8.02
Q4024	\$5.22	Q4049	\$1.82

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