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Items of Importance**BILLING FOR POSTOPERATIVE WOUND INFUSION PUMPS****~September 2007~**

We have had several inquiries concerning the proper billing for the insertion of pain pumps placed at the end of major thoracic and orthopedic cases. Some of the better-known devices are the ON-Q Pain Buster, the Stryker Pain Pump System, and the DonJoy Pain Control Device. These provide pain management by a continuous infusion of a local anesthetic through a catheter directly into the patient's surgical site. The four main arguments for payment that we have heard are: 1) the pump insertion is not inclusive to the main procedure; 2) there is more work in putting in the pump; 3) the patient is more uncomfortable without it; and 4) the hospital stay may be lengthened without the device.

1. We agree that there is some additional work in inserting the pump. However, the real issues are whether the procedure is standard, whether it is truly a separate procedure, whether it is allowed by Medicare regulations, and whether it requires a significant amount of additional work. After reviewing many operative reports, manufacturers' Websites, and the medical literature, any additional work appears to be very minimal.
2. Per the National Coverage Provisions (and also found on GSURG-001 on our Website), a global surgery package includes "Postsurgical Pain Management - By the surgeon." Thus, the insertion of such a pump is included in the overall surgeon's payment.
3. While the hospital stay may be shortened, this is not an issue.

We have seen these pumps being billed under several CPT and HCPCS codes including A4306, 11981, 23929, and 32999. Billing for these pumps under these or other CPT/HCPCS codes is not appropriate. They should not be billed separately.

CARRIER JURISDICTION FOR AMBULANCE SUPPLIER CLAIMS**~CMS MLN Matters – August 2007~**

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

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

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

Note: The Centers for Medicare & Medicaid Services rescinded CR5203 on June 19, 2007. As a result, this article was rescinded on that date as well.

CMS-855 TO REPORT NATIONAL PROVIDER IDENTIFIERS**~September 2007~**

It is not generally required that providers submit a CMS-855 to report their NPIs to us. If, however, claim payment delays or rejections occur because your National Provider Identifier(s) (NPI) is not properly cross-walked to your legacy Medicare provider identification number(s), you may be asked to report your National Provider Identifier(s) to the Provider Enrollment Department as a change of information.

When doing so, be sure to complete each applicable Medicare Identification Number and NPI field on the appropriate CMS-855 enrollment form:

- Individuals and sole proprietors should submit a CMS-855I form, completing Sections 1, 2.A.1., 3, 4.C., 4.F. (if applicable), 13, and 15. (Complete a separate Section 4.C. for each legacy Medicare Identification Number.)
- Individuals who are the sole owner of a professional corporation, professional association, or limited liability company should submit a CMS-855I form, completing Sections 1, 2.A.1., 3, 4.A., 4.C., 13, and 15. (If there are multiple legacy Medicare Identification Numbers, complete Section 4.C. for each legacy Medicare Identification Number.)
- Clinics and other organizations should submit a CMS-855B form, completing Sections 1, 2.B.1, 3, 4.A, and either 15, or 16. (A separate Section 4.A. should be completed for each practice location.)

A copy of each NPI notification must be included with the CMS-855. This may be a copy of an e-mail or letter received from the NPI Enumerator or Electronic File Interchange Organization (EFIO), or it may be a "Welcome

to the National Provider System” screen print from the National Plan and Provider Enumeration System (NPPES) Web site.

When you are submitting a CMS-855 to report your NPI because of claims processing issues, please enclose a cover letter explaining that this is the case.

Note: If we do not have current enrollment information on file for you, you may need to submit a complete CMS-855 in order to report your NPI(s). If you have questions about what is needed, please contact our Provider Enrollment Department: (866) 564-0315 for Minnesota and (877) 908-8476 for Illinois, Michigan, and Wisconsin.

DISCONTINUANCE OF THE UNIQUE PHYSICIAN IDENTIFICATION NUMBER (UPIN) REGISTRY

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5584
Related CR Release Date: May 31, 2007
Related CR Transmittal #: R207PI

Related Change Request (CR) #: 5584
Effective Date: May 29, 2007
Implementation Date: June 29, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5584.pdf>

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5584 which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning Unique Physician Identification Numbers (UPINs) on June 29, 2007.

CAUTION – What You Need to Know

The National Provider Identifier (NPI) is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.) Information on that contingency plan is at http://www.cms.hhs.gov/NationalProvidentStand/downloads/NPI_Contingency.pdf on the CMS site.)

GO – What You Need to Do

If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the National Plan and Provider Enumeration System (NPPES) website at <https://nppes.cms.hhs.gov/>. See the Background and Additional Information Sections of this article for further details.

Important Note: Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007. For more information on this contingency plan, please visit the NPI dedicated Website: <http://www.cms.hhs.gov/NationalProvidentStand/>. This contingency plan does not affect CMS plans to discontinue assigning UPINs on June 29, 2007 or to disable the UPIN “look-up” functionality as of September 30, 2007.

The CMS will discontinue assigning on June 29, 2007, but CMS will maintain its UPIN public “look-up” functionality and Registry Website (<http://www.upinregistry.com/>) through September 30, 2007.

HEALTHCARE PROVIDER TAXONOMY CODE (HPTC) UPDATE

~August 2007~

Change Requests (CR) 5436 and 5673 advises your carrier to use the most cost effective means to obtain the Healthcare Provider Taxonomy Code (HPTC) lists for April and October 2007 and update their HPTC tables as necessary.

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim. Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears.

The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. Although the NUCC generally posts their updates on the Washington Publishing Company (WPC) Web page 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs.

The HPTC list is available from the Washington Publishing Company (WPC) at <http://www.wpc-edi.com/codes/taxonomy> in two forms. The first form is a free Adobe PDF download. The second form, available for purchase, is an electronic representation of the code set that facilitates automatic loading of the codes.

HELP US REDUCE CONSULTATION SERVICE ERRORS

~September 2007~

Wisconsin Physicians Service (WPS) Medicare identified concerns with provider billing of Consultation services. The Comprehensive Error Rate Testing (CERT) program report shows an increase in payment errors for Consultation services. WPS Medicare created education materials to give you accurate information to determine correct billing. We encourage your office to access this material, compare the instructions to your individual office practices, and decide if you need to make any necessary changes. You can access this information at: http://www.wpsmedicare.com/provider/pdfs/consultation_presentation.pdf

HOW DO I SHARE MY NPI WITH MEDICARE?

~August 2007~

Please share your NPI with Medicare by submitting it on Medicare claims. Unlike some health plans, there is no fax number, phone number, or special Website you need to use to communicate your NPI to Medicare. As stated previously, Medicare is now asking that submitters send a small number of claims using only the NPI. If no claims are rejected due to provider number errors, the submitter can gradually increase the volume.

IMPORTANT NPI ANNOUNCEMENT REGARDING DATA DISSEMINATION AND UPIN REGISTRY

~July 2007~

The NPI is here. The NPI is now. Are you using it?

CMS Publishes National Plan and Provider Enumeration System (NPPES) Data Dissemination Notice

On May 30, 2007, CMS published the Data Dissemination Notice in the Federal Register. The final copy of the notice is posted at <http://www.cms.hhs.gov/NationalProvidentStand/Downloads/DataDisseminationNPI.pdf> on the CMS NPI Website

Data Dissemination Roundtable to be held on June 14, 2007

CMS will host a national roundtable on the Data Dissemination Notice on June 14, 2007 from 2-3:30PM EDT. Registration information will be available shortly.

New Data Dissemination FAQs Available

CMS has posted new FAQs related to the recently published Data Dissemination Notice. Questions include:

- Where is the National Plan and Provider Enumeration System (NPPES) data dissemination policy conveyed?
- What National Plan and Provider Enumeration System (NPPES) data will CMS disclose?
- How will CMS make the Freedom of Information Act (FOIA)-disclosable National Plan and Provider Enumeration System (NPPES) data available?
- Is there a charge to obtain the Freedom of Information Act (FOIA)-disclosable National Plan and Provider Enumeration System (NPPES) health care provider data?
- I want Freedom of Information Act (FOIA)-disclosable data for only the physicians in New York and I want the data on a CD. How do I go about having my request fulfilled?
- When will the Freedom of Information Act (FOIA)-disclosable National Plan and Provider Enumeration System (NPPES) health care provider data be available?

To view these FAQs, you should:

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

Important Information for Medicare Fee-For-Service (FFS) Providers

CMS Discontinues the Unique Physician Identifier Number (UPIN) Registry

Effective June 29, 2007, CMS will discontinue assigning UPINs to Medicare providers. For further details, visit the Change Request on this subject at <http://www.cms.hhs.gov/transmittals/downloads/R207PI.pdf> and the associated MLN Matters article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5584.pdf> on the CMS Website.

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

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

INTEREST RATE ON CLEAN CLAIMS NOT PAID TIMELY

~August 2007~

Per Change Request (CR) 3557, carriers and fiscal intermediaries (FIs) that do not pay clean claims in a timely manner (i.e., 30 days after the day of receipt of a claim) must pay interest. Interest accrues until and including the day of late payment 002E

For the period beginning July 1, 2007, and ending December 31, 2007, the rate of interest applicable for the purpose of the cited sections is 5.75% (5.75 per centum) per annum. This rate of interest was published in the Federal Register, Volume 71, Number 250, pages 78513-78514 on Friday, December 29, 2006.

To read more about how the Centers for Medicare & Medicaid Services (CMS) define a clean claim and how to calculate interest payments, please refer to Transmittal 416, available at:

<http://www.cms.hhs.gov/transmittals/Downloads/R416CP.pdf>

MAMMOGRAPHY REMINDER FOR IDTF'S

~September 2007~

Failure to report the new mammography codes for screening and diagnostic mammography services in the appropriate sections of the 855B will cause your claims to be returned and not processed.

CMS assigned new 2007 Current Procedural Terminology (CPT) mammography codes for screening and diagnostic mammography services.

Effective January 1, 2007, codes were replaced; however, the code descriptors for the services remain unchanged. Failure to report the new codes in the appropriate sections of the 855B will cause your claims to be returned and not processed.

The following table displays the new (and old) replacement codes and their description.

2007 Screening and Diagnostic Mammography CPT codes		
New Code	Old Code	Description
77051	76082	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, diagnostic mammography. (list separately in addition to code for primary procedure)
77052	76083	Computer aided detection (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation, with or without digitization of film radiographic images, screening mammography. (list separately in addition to code for primary procedure)
77055	76090	Diagnostic mammography, unilateral
77056	76091	Diagnostic mammography, bilateral
77057	76092	Screening mammography, bilateral (two view film study of each breast)

MAKE SURE YOUR BILLING STAFF IS AWARE OF THE CPT CODES CHANGES.

To read the Medicare Learning Network Matters articles in its entirety please visit the CMS Website at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5327.pdf>

NATIONAL PROVIDER IDENTIFIER (NPI): PAPER CLAIMS SUBMITTERS

~August 2007~

Paper Claim Submitters: The following are billing reminders when submitting NPI Numbers and old Legacy Numbers for groups and their members on the CMS-1500 form.

The NPI assigned to a group is to be reported in the billing provider portion of the CMS-1500 (Section 33) along with the group's Legacy Number. The NPI of the member of a group who furnished the care being billed is to be reported in the rendering provider section of the CMS-1500 (Section 24J) along with the member's Legacy Number.

- Group NPI (Section 33-A)
- Group Legacy (Section 33-B Shaded Area)
- Member NPI (Section 24J-NPI)
- Member Legacy (Section 24J-Shaded Area)

Electronic Data Interchange fields are Loops 2310B and 2420A.

PHYSICIAN QUALITY REPORTING INITIATIVE (PQRI) CODING & REPORTING PRINCIPLES

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5640
 Related CR Release Date: May 18, 2007
 Related CR Transmittal #: R277OTN

Related Change Request (CR) #: 5640
 Effective Date: May 18, 2007
 Implementation Date: May 18, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5640.pdf>

What Providers Need to Know

CR 5640, from which this article is taken, provides information about, and instructions for, the coding and reporting of, quality measures in the CMS PQRI. The current PQRI reporting period is for claims with dates of service from July 1, 2007 through December 31, 2007. **Prompt submission of claims with quality measures is imperative as the claims will only be included in the PQRI analysis (and the associated bonus payment calculation) if received by Medicare's National Claims History (NCH) file on or before February 29, 2008.**

Background

CMS (authorized under Title 1, Section 101 of the 2006 Tax Relief and Health Care Act of 2006 (TRHCA)), created the 2007 Physician Quality Reporting Initiative (PQRI), which establishes a financial incentive for eligible professionals to participate in a voluntary quality-reporting program.

These eligible professionals, who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment (subject to a cap) of 1.5% of total allowed charges for covered Medicare physician fee schedule services during that same period.

PRIOR AUTHORIZATION, PRIOR APPROVAL, AND PREDETERMINATION OF BENEFITS REQUESTS

~September 2007~

WPS Medicare often receives requests for prior authorization, prior approval, or a predetermination of benefits. Unfortunately, while a proposed treatment plan could offer insight into a patient's condition, the actual service and follow-up care provided may differ based on the patient's condition at the time the service is rendered. For this reason, the Original Medicare program does not give prior authorization, prior approval, or a predetermination of benefits for any service.

You can find general coverage guidelines for many services using the Medicare Coverage Database (MCD). This searchable database, which is maintained by the Centers for Medicare & Medicaid Services (CMS), is located on the CMS Website at the following address: <http://www.cms.hhs.gov/mcd>

Providers can also find WPS Medicare's coverage and billing guidelines for many services using our Local Coverage Determinations (LCDs). You can locate our policies on our Website at the following address: http://www.wpsmedicare.com/policies/pol_home.shtml

In the absence of a local or national coverage policy, WPS Medicare determines whether coverage is available for a service on a case-by-case basis using the documentation submitted with the claim for payment. WPS Medicare may also request additional medical documentation at the time the claim is processed.

REDETERMINATIONS AND THE ADVANCE BENEFICIARY NOTICE (ABN)

~August 2007~

When you are appealing a claim, the first level of appeal is a Redetermination. The form can be found at: <http://www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf>. Along with the redetermination form, it is helpful if you attach a copy of your remittance advice, any documentation to support the services being appealed, and a copy of the Advance Beneficiary Notice (ABN). If you had the patient sign the ABN before rendering the service, enclose a copy of that form with your redetermination request. You can find more information on the ABN at: <http://www.wpsmedicare.com/provider/what-is-abn.shtml>.

If you have questions about the ABN form, contact Provider Customer Service or perform a search of the WPS Medicare Website for the term "ABN."

REVISED INFORMATION ON PET SCAN CODING

~CMS MLN Matters – September 2007~

MLN Matters Number: MM5665 Revised
Related CR Release Date: July 20, 2007

Related Change Request (CR) #: 5665
Effective Date: January 28, 2005 and January 1, 2008 (per article)

Related CR Transmittal #: R1301CP

Implementation Date: January 7, 2008

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5665.pdf>

Note: This article was revised on August 1, 2007, to correctly list HCPCS code A4641, instead of A4691, in two places within the article and to correct one code shown in Table 2 related to physicians/practitioners billing for CPT 78491 and 78492. All other information remains the same.

Background

The Centers for Medicare & Medicaid Services (CMS) recently learned that the Medicare Claims Processing Manual, Chapter 13 (Radiology Services), Sections 60.30.1 (Appropriate CPT Codes Effective for PET Scans for Services Performed on or After January 28, 2005) and 60.30.2 (Tracer Codes Required for PET Scans), and CR 3747 (transmittal 527, dated April 15, 2005), contain incorrect information regarding CPT code 78609 (PET for brain perfusion imaging) and HCPCS code A4641.

- In Section 60.3.1, CPT code 78609 is incorrectly listed as a covered service by Medicare, and in Section 60.3.2 is incorrectly included in terms of the applicability of certain tracer codes. Similarly, Section 60.30.2 incorrectly lists HCPCS code A4641 as an applicable tracer for PET Scans.

CR 5665, from which this article is taken, corrects these errors. It updates the manual by removing HCPCS code 78609 from the list of covered codes and HCPCS code A4641 from the list of applicable tracer codes for PET scans. In so doing, it also corrects the erroneous information that was originally issued in CR 3747.

Notes: 1) All Positron Emission Tomography (PET) Scans services (codes 78459, 78491, 78492, 78608, and 78811-78816) require the use of a radiopharmaceutical diagnostic imaging agent (tracer). Therefore, the applicable tracer code should always be used when billing for a PET scan service.
2) The correct PET Scan CPT codes and tracer HCPCS codes are listed in Tables 1 and 2, below.

Key points in CR 5665

- Effective January 28, 2005, CPT 78609 became a non-covered service for Medicare;
- Carriers, FIs, and A/B MACS will deny claims submitted with CPT code 78609 (effective January 28, 2005);
- When denying these claims, they will use:
- Medicare Summary Notice (MSN) 16.10 "Medicare does not pay for this item or service."
- Claim Adjustment Reason Code 96: "Non-covered charge."
- Remittance Advice Remark Codes N386: —"This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at <http://www.cms.hhs.gov/mcd/search.asp>. If you do not have Web access, you may contact the contractor to request a copy of the NCD."
- Effective January 1, 2008, HCPCS code A4641 is not an applicable tracer for
- You should not report HCPCS code A4641 when submitting claims for PET Scans for services on or after January 1, 2008. Instead, as of that time, when submitting claims for PET Scans containing CPT code 78491 or 78492 you should use only tracer code A9555 or A9526; and, when submitting claims for PET Scans containing CPT code 78459, 78608, or 78811-78816, you should use only tracer code A9552 (see table 2, below).
- Carriers, FIs, and A/B MACs will not search for, and adjust, claims that have been paid prior to the implementation date, but they will adjust claims brought to their attention.

Please read this entire article for the tables that list the currently covered PET Scan CPT codes (on or after January 28, 2005) and tracer HCPCS codes, as of January 1, 2008).

WPS MEDICARE WRITTEN CORRESPONDENCE

~August 2007~

Do you send written correspondence to WPS Medicare? If so, we need your help to process your correspondence quickly and accurately.

When sending any written correspondence to WPS Medicare, please be sure to include the provider's name and Medicare Provider Identification Number (PIN) or National Provider Identification (NPI) number. It also helps us if you write to us on your official letterhead and include a contact name and telephone number. If your inquiry concerns a specific Medicare beneficiary, please include the beneficiary's name, Medicare Health Insurance Claim Number (HICN), date of birth, and date of service (if applicable). WPS Medicare cannot release any claim-specific or beneficiary-specific information without verifying all of these elements.

In addition, when sending any written correspondence to WPS Medicare, please be sure to indicate your reason for sending us the material. This is especially true when sending medical records. If you receive a request for

medical records from WPS Medicare, please return a copy of our request along with the documentation. This helps us route the records to the appropriate department, and it helps you avoid claim denials and payment delays. Keep in mind that WPS Medicare generally does not need additional documentation to process a claim unless we request it. If you have additional documentation you would like WPS Medicare to consider when processing your claim, please include the documentation along with your paper claims. If you submit your claims electronically, please be sure to indicate that you have documentation available upon request. WPS Medicare will request the documentation only if it is needed to process the claim.

If you send medical records in order to appeal the determination on a processed claim, please make sure you specifically state you are requesting an appeal. Medicare cannot accept implied appeal requests. You can find instructions for appealing a Medicare claim determination on our Website at the following address:

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

You can also help us by addressing your letters correctly. We have published a list of addresses, broken down by state and department, which you should use when sending us correspondence. When sending an inquiry to a specific department, please be sure to include the name of the department on both the envelope and the letter. You can find the list of WPS Medicare addresses at the following Website:

http://www.wpsmedicare.com/provider/pdfs/cs_address.pdf

If WPS Medicare cannot determine the reason for your correspondence, we will return your request to you. You can help us help you best by ensuring your letters are addressed correctly, and your issues are identified completely.

Claim Submission

CLAIM STATUS CATEGORY CODE AND CLAIM STATUS CODE UPDATE

~CMS MLN Matters – September 2007~

MLN Matters Number: MM5687
Related CR Release Date: July 23, 2007
Related CR Transmittal #: R1314CP

Related Change Request (CR) #: 5687
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5687.pdf>

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction. These codes indicate the general category of a claim's status (accepted, rejected, additional information requested, and so on). The national Code Maintenance Committee maintains the Claim Status Category and Claim Status codes.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at <http://www.wpc-edi.com/content/view/180/223/>. This page has previously been referenced by the following URL address: <http://www.wpc-edi.com/codes>.

Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2007 committee meeting were posted on that site on July 9, 2007. One of the decisions made during this June meeting by this Maintenance Committee was to allow the industry more lead time for implementation of code changes. At least 6 months lead time will be allowed for industry implementation of all Claim Status-related code changes as well as Claim Adjustment Reason Code changes (the same committee maintains these code sets). As result, changes approved in June 2007 will be effective January 1, 2008.

CLAIMS PROCESSING CHANGE FOR SERVICES SUBMITTED WITH THE HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) MODIFIERS QB OR QU FOR CLAIMS WITH DATES OF SERVICE ON OR AFTER JANUARY 1, 2006

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5629
 Related CR Release Date: June 29, 2007
 Related CR Transmittal #: R1275CP

Related Change Request (CR) #: 5629
 Effective Date: January 1, 2006
 Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5629.pdf>

STOP – Impact to You

For dates of service on or after January 1, 2006, when a modifier is required to bill for the HPSA bonus, use the **AQ modifier** for physician services provided in HPSAs. **Claims will be returned as unprocessable if submitted with the QB or QU modifiers**, when submitted for dates of service on or after January 1, 2006.

CAUTION – What You Need to Know

Make certain that services eligible to receive a HPSA bonus for dates of service on or after January 1, 2006, are billed with the **AQ modifier, when a modifier is required**.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes.

CLARIFICATION OF THE NATIONAL PROVIDER IDENTIFIER (NPI) REPORTING REQUIREMENTS FOR AMBULANCE SERVICE CLAIMS

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5564
 Related CR Release Date: May 25, 2007
 Related CR Transmittal #: R1251CP

Related Change Request (CR) #: 5564
 Effective Date: July 1, 2007
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5564.pdf>

Section 1833(q) of the Social Security Act (the Act), requires that the ordering/referring physician's name be provided on all claims for Medicare covered services and items resulting from a physician's order or referral. In addition, when the NPI reporting requirements go into effect according to the Medicare fee-for-service NPI contingency plan, the ordering/referring physician's NPI will also be required on these claims; except, however, on claims for ambulance services (as explained in the paragraphs below). (See MLN Matters article, MM5595, available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS Website for details about the NPI contingency plan.)

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. In response to this mandate, the Centers for Medicare and Medicaid Services (CMS) in the National Provider Identifier (NPI) final rule (published on January 23, 2004) established the NPI as this standard.

Although providers/suppliers may begin reporting the NPI as early as January 1, 2007, all health care providers covered under HIPAA must comply with the requirements of the NPI final rule in accordance with Medicare's NPI contingency plan. At the appropriate date, Medicare will reject claims in which the appropriate name and NPI are not entered in the required fields of the Form CMS-1500 paper claim format, version 08-05 (fields 17 and 17B, respectively), and the ANSI X12 837-P electronic claim format, version 4010A (NM1 segment of the 2310A and/or 2420E loop, respectively).

However, ambulance services (particularly transports provided in response to a 911 or 911-equivalent emergency call) are often ordered by someone other than a physician. In these situations, the name and the NPI of the ordering/referring physician are not available. Thus, CMS does not feel that it is appropriate to require that this information be submitted on the claim form. Therefore, CR 5564, from which this article is taken, instructs carriers and the Medicare Administrative Contractors (MACs) that the ordering/referring physician's NPI is not required on claims for ambulance services.

CORRECT REPORTING OF DIAGNOSIS CODES ON SCREENING MAMMOGRAPHY CLAIMS

~CMS MLN Matters – September 2007~

MLN Matters Number: MM5050 Revised
Related CR Release Date: April 28, 2006
Related CR Transmittal #: R916CP

Related Change Request (CR) #: 5050
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5050.pdf>

This article was revised on July 27, 2007 to add a reference to CR5377. MM5050 erroneously removed TOB 12X as an applicable TOB for diagnostic mammography services (page 1) supplied to Medicare inpatients and billable under Medicare Part B. CR5377 announced that effective April 1, 2007, TOB 12X is acceptable by FIs and A/B MACS as an appropriate bill type for such services.

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

~CMS MLN Matters – September 2007~

MLN Matters Number: MM5675
Related CR Release Date: July 13, 2007
Related CR Transmittal #: R1295CP

Related Change Request (CR) #: 5675
Effective Date: April 1, 2007
Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5675.pdf>

STOP – Impact to You

Previously the Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5347 that established duplicate claims edits, which included consideration of the admission and discharge dates of a hospital stay in identifying duplicate claims for radiology and pathology services.

CAUTION – What You Need to Know

Effective with implementation of CR5675 on October 1, 2007, claims with dates of service on or after April 1, 2007, **will be paid that provide** radiology and pathology services to Medicare beneficiaries on **the day of admission and the day of discharge during an inpatient hospital stay**.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes.

MEDICARE CONTRACTOR ANNUAL UPDATE OF THE INTERNATIONAL CLASSIFICATION OF DISEASES, NINTH REVISION, CLINICAL MODIFICATION (ICD-9-CM)

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5643
Related CR Release Date: June 15, 2007
Related CR Transmittal #: R1269CP

Related Change Request (CR) #: 5643
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5643.pdf>

ICD-9- CM codes, became mandatory as follows:

- In 1979 for use in reporting provider services on Form CMS-1450;
- On April 1, 1989, for use by all physician services submitted on Form CMS-1500; and
- On October 1, 2003 for all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59).

The ICD-9-CM codes are updated annually as stated in the *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service).

CMS issued CR 5643 as a reminder that the annual ICD-9-CM coding update will be effective for dates of service on or after October 1, 2007 (for institutional providers, effective for discharges on or after October 1, 2007).

You should remember that an ICD-9-CM code is required for all professional claims (including those from physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs)), and for all institutional claims; but is not required for ambulance supplier claims.

NEW DEADLINE FOR REQUIRED SUBMISSION OF THE FORM CMS-1500 (08-05)
 ~CMS MLN Matters – July 2007~

MLN Matters Number: MM5616
 Related CR Release Date: May 25, 2007
 Related CR Transmittal #: R1247CP

Related Change Request (CR) #: 5616
 Effective Date: July 1, 2007
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5616.pdf>

CR 5616, from which this article is taken announces that, beginning July 2, 2007, you must use the Form CMS-1500, version (08-05) for paper claims submission to Medicare. Claims received on or after July 2, 2007, using Form CMS-1500, version (12-90) will be rejected.

Make sure that your billing staffs use Form CMS-1500 (08-05) for your claims, beginning July 2, 2007.

Note: CR5616 addresses submission of the revised Form CMS-1500 paper claim form only, and has no bearing on the implementation of the National Provider Identifier (NPI), nor does CR5616 mandate the submission of the NPI by July 1, 2007.

OCTOBER QUARTERLY UPDATE TO 2007 ANNUAL UPDATE OF HCPCS CODES USED FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB) ENFORCEMENT
 ~CMS MLN Matters – July 2007~

MLN Matters Number: MM5636
 Related CR Release Date: June 15, 2007
 Related CR Transmittal #: R1266CP

Related Change Request (CR) #: 5636
 Effective Date: April 1, 2007
 Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5636.pdf>

Periodically, the Centers for Medicaid & Medicare Services (CMS) updates the lists of HCPCS codes (for FIs carriers and DME/MACs) that are subject to the consolidated billing provision of the SNF PPS. This particular update, however, applies to providers who bill for NTIOLs furnished in ASCs as well as providers billing Medicare FIs for Major Category IV. A. Mammography Screening. The mammography codes for screening and diagnostic mammography services that are **no longer valid as of January 1, 2007 are:**

- Diagnostic mammography, unilateral—CPT code **77055**
- Diagnostic mammography, bilateral—CPT code **77056**

NTIOLs that are now reimbursable separately by the carrier/MAC for dates of service prior to June 30, 2005 are:

- **Q1001** (Category 1, AMO Array Multifocal lens: Model # SA40N); and
- **Q1002** (Category 2, Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Lens).

In addition, Medicare edits allow the payment of the \$50 additional fee for Category 3 NTIOLs for dates of service prior to January 1, 2007, when billed with HCPCS code **Q1003**. (See MM4361 for additional information about NTIOLs and **Q1003** and the article may be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4361.pdf> on the CMS Website.)

Remember that:

- With the exception of SNFs, Medicare will not pay providers for services appearing on the list of services included in SNF CB.
- Conversely, Medicare will pay non- SNF providers for beneficiary services excluded from SNF PPS and CB, even when in a SNF stay.
- SNF CB applies to non-therapy services only when furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.
- FIs, carriers and A/B MACs will not search their files for claims affected by this change to either retract payment for claims already paid or to retroactively pay claims, but will adjust such claims that you bring to their attention.

**QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI) EDITS, VERSION 13.2,
EFFECTIVE JULY 1, 2007**

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5604
Related CR Release Date: May 18, 2007
Related CR Transmittal #: R1243CP

Related Change Request (CR) #: 5604
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5604.pdf>

This article is based on Change Request (CR) 5604 which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The latest package of CCI edits, Version 13.2, effective July 1, 2007, and the current Mutually Exclusive Code (MEC) edits will be available at <http://www.cms.hhs.gov/NationalCorrectCodInitEd/> on the Centers for Medicare & Medicaid Services (CMS) Website.

The National Correct Coding Initiative developed by CMS helps promote national correct coding methodologies and controls improper coding. The coding policies developed are based on coding conventions defined in:

- The American Medical Association's (AMA's) Current Procedural Terminology (CPT) manual,
- National and local policies and edits,
- Coding guidelines developed by national societies,
- Analysis of standard medical and surgical practice, and
- Review of current coding practice.

The latest package of CCI edits, Version 13.2, includes all previous versions and updates from January 1, 1996, to the present and will be organized in two tables:

- Column 1/ Column 2 Correct Coding Edits, and
- Mutually Exclusive Code (MEC) Edits.

**QUARTERLY UPDATE TO MEDICALLY UNLIKELY EDITS (MUES), VERSION 1.2, EFFECTIVE
JULY 1, 2007**

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5603 Revised
Related CR Release Date: June 12, 2007
Related CR Transmittal #: R1265CP

Related Change Request (CR) #: 5603
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5603.pdf>

Note: This article was revised on June 12, 2007, to reflect the changes made to CR5603 on that date. The CR release date, transmittal number and Web address for accessing CR5603 were changed. All other information remains the same.

In order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to below as MUEs. The National Correct Coding Initiative (NCCI) contractor develops and maintains MUEs. Key points of CR5603 are as follows:

- CR5603 announces the upcoming release of the next version of the MUEs, which is version 1.2.
- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- CR5603 states that Medicare carriers and A/B MACs will **deny** the entire claim line from providers with units of service that exceed MUE criteria and pay the other services on the claims, where the claims are processed by either Medicare's DME system (VMS) or carriers system (MCS).
- FIs and A/B MACs will RTP claims from institutional providers with units of service that exceed MUE criteria and which are processed by Medicare's fiscal intermediary shared system (FISS).

With regard to MUEs, providers are reminded of the following:

- An appeal process will not be allowed for RTP'ed claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the National Correct Coding Contractor.

- Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"), and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

RESPONSE TO COMPETITIVE ACQUISITION PROGRAM (CAP) FOR PART B DRUGS AND BIOLOGICALS CLAIMS WHEN THE MEDICARE SYSTEM COMMON WORKING FILE (CWF) 69XD ERROR CODE IS RECEIVED

~CMS MLN Matters – September 2007~

MLN Matters Number: MM5658
Related CR Release Date: July 23, 2007
Related CR Transmittal #: R1313CP

Related Change Request (CR) #: 5658
Effective Date: August 23, 2007
Implementation Date: August 23, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5658.pdf>

Carriers and A/B MACs receive an error code when the same prescription order number is submitted more than once on a CAP claim. This inclusion of duplicate prescription order numbers on a single claim can happen, for example, when:

In response to this error code, carriers and A/B MACs will return the claims as unprocessable, using the following Remittance Advice Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) messages:

- CARC 16: Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate. This change to be effective 4/1/2007. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
- Message MA130: Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
- RARC M16: Please see our Website, mailings, or bulletins for more details concerning this policy/procedure/decision.

In order to resolve the issue of units that exceed 999, the Centers for Medicare & Medicaid Services (CMS) will be working with the approved CAP vendor to issue additional prescription order numbers when the units of the drug exceed 999.

Finally, CR 5658 rescinds (from CR 4309, issued on February 17, 2006) the instructions that addressed applying the unused drug modifier (JW) to indicate billing for the unused portion of a single-use drug product under the CAP. Claims for drugs provided under CAP submitted with the JW modifier will be treated as unprocessable. This CR does not affect the use of the JW modifier for non CAP claims.

REVISED HCPCS CODES RELATING TO IMMUNE GLOBULIN

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5635 Revised
Related CR Release Date: June 1, 2007
Related CR Transmittal #: R1261CP

Related Change Request (CR) #: 5635
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5635.pdf>

Note: This article was corrected on June 20, 2007, to show the correct HCPCS code for Flebogamma Injection in Table 1 of page 2 is Q4091. All other information remains the same.

CR 5635, from which this article is taken, implements HCPCS coding changes for Immune Globulin. **On and after July 1, 2007:**

- **HCPCS code J1567** (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg)) **will no longer be payable by Medicare.**
- **In its place, the following HCPCS codes are payable: Q4087 (Octagam Injection), Q4088 (Gammagard Liquid Injection), Q4091 (Flebogamma Injection), and Q4092 (Gamunex Injection);**
- **In addition, for services on or after July 1, 2007, two new codes are payable:**

- **Q4089 (Rhopylac injection).** Note that currently, Rhophylac® is the only product that should be billed using code Q4089. If other products under the Food and Drug Administration's (FDA) approval for Rhophylac® become available, code Q4089 would be used to bill for such products.
 - **Q4090 (HepaGam B injection).** Note that currently, HepaGam BTM, when given intramuscularly, is the only product that should be billed using code Q4090. If other products under the FDA's approval for HepaGam BTM IM become available, code Q4090 would be used to bill for such products. HepaGam BTM when given intravenously should be billed using an appropriate Not Otherwise Classified code in the absence of a specific HCPCS code.
 - For institutional claims, revenue code 0636 should be used for billing codes Q4087, Q4088, Q4089, Q4090, Q4091, and Q4092.
 - As described in CR 5428, Medicare contractors will pay for pre-administration-related services (G0332) associated with intravenous Immune Globulin administration when Q4087, Q4088, Q4091, or Q4092 is billed in lieu of J1567.
- Make sure that your billing staffs are aware of these Immune Globulin HCPCS code changes.

REVISIONS TO THE MEDICARE CLAIMS PROCESSING MANUAL, CHAPTER 17, SECTIONS 40 AND 100, REGARDING DISCARDED DRUGS AND BIOLOGICALS AND SUBMISSION OF CLAIMS WITH THE MODIFIER JW, "DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT"

~ CMS MLN Matters – July 2007 ~

MLN Matters Number: MM5520
 Related CR Release Date: May 25, 2007
 Related CR Transmittal #: R1248CP

Related Change Request (CR) #: 5520
 Effective Date: July 1, 2007
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5520.pdf>

What You Need to Know

CR 5520, from which this article is taken, revises the Medicare Claims Processing Manual, Chapter 17, Sections 40 and 100.2.9 to include language that references payment for administering (and discarding) both single use vials and single use packages. Specifically, the change is to clarify that Medicare will cover the amount of a single use vial or single use package of a drug or biological that was discarded along with the amount of that single use vial/package that was administered to the Medicare patient.

Background

CR 5520, from which this article is taken revises the Medicare Claims Processing Manual, Chapter 17 (Drugs and Biologicals), Sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) to ensure the proper billing of discarded drugs and biologicals in both single use vials and single use packages.

These revisions are summarized as follows:

- The Centers for Medicare and Medicaid Services (CMS) encourages physicians, hospitals and other providers to schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.
- Section 40 of Chapter 17 is amended to address single use vials/packages of drugs and biologicals. If after administering a dose/quantity of the drug or biological to a Medicare patient, a physician, hospital or other provider must discard the remainder of a single use vial or other single use package, the program provides payment for the amount of drug or biological administered and the amount discarded, up to the total amount of the drug or biological as indicated on the vial or package label.
- Section 100.2.9 is amended to show that CMS will reimburse physicians, providers and suppliers for the amount of a drug or biological administered (and for the amount discarded) when:
 - The participating competitive acquisition program (CAP) physician has made a good faith effort to minimize the unused portion of the CAP drug or biological in scheduling patients and in ordering, accepting, storing, and using the drug or biological;
 - In its process of supplying the drug or biological to the participating CAP physician, the approved CAP vendor has made a good faith effort to minimize the unused portion of the drug or biological.

NOTE: Multi-use vials are not subject to payment for discarded amounts of drug or biological.

STAGE 2 NATIONAL PROVIDER IDENTIFIER (NPI) CHANGES FOR TRANSACTION 835, AND STANDARD PAPER REMITTANCE ADVICE, AND CHANGES IN MEDICARE CLAIMS PROCESSING MANUAL, CHAPTER 22 – REMITTANCE ADVICE
~CMS MLN Matters – July 2007~

MLN Matters Number: MM5081 Revised
Related CR Release Date: June 30, 2006
Related CR Transmittal #: R996CP

Related Change Request (CR) #: 5081
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5081.pdf>

Special note regarding remittance advice transactions: Just as it is important to understand when and where to report NPIs in claim transactions, it is crucial that providers understand and be ready to accept the provider identifiers as reported on remittance advice transactions. This article discusses what provider identifiers Medicare will report on remittances under Stage 2 of Medicare’s NPI implementation. However, the processes will change as Medicare moves to Stage 3 implementation of the NPI. A key difference is that NPIs will be returned in many remittance transactions as the payee and the TIN as the additional payee identifier rather than the current practice of reporting TIN and legacy number respectively, even though the provider may have included the legacy number and the NPI on their claim. Providers need to review, and understand the impact of, Stage 3 on remittances as discussed in the MLN Matters article MM5452, which is at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf> on the CMS site.

Also, note that this article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS Website.

STAGE 3 NATIONAL PROVIDER IDENTIFIER (NPI) CHANGES FOR TRANSACTION 835, AND STANDARD PAPER REMITTANCE ADVICE (RA)
~CMS MLN Matters – July 2007~

MLN Matters Number: MM5452
Related CR Release Date: May 18, 2007
Related CR Transmittal #: R1241CP

Related Change Request (CR) #: 5452
Effective Date: July 2, 2007
Implementation Date for DME suppliers: July 2, 2007
Implementation Date for other providers: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf>

This article discusses Stage 3 of Medicare’s fee-for-service (FFS) processes for the NPI and reflects Medicare processing of claims submitted with NPIs. Submitted NPIs will be crosswalked to the Medicare legacy number(s) for processing. Medicare’s internal provider files will continue to be based upon records established in relation to the legacy identifiers. The crosswalk may result in:

Scenario I	Single NPI	Cross walked to	Single Medicare legacy number
Scenario II	Multiple NPIs	Cross walked to	Single Medicare legacy number
Scenario III	Single NPI	Cross walked to	Multiple Medicare legacy numbers

CMS will adjudicate Medicare FFS claims based upon a unique NPI/Legacy combination for Scenarios II and III, but the remittance advice, both electronic and paper, and any output using PC Print or Medicare Remit Easy Print (MREP) will have only NPI as the primary provider identification. The TIN will be used as the secondary identifier for the Payee. The NPI regulation permits continued use of Taxpayer Identification Number (TIN) for tax purposes if the implementation guide allows it.

The Companion Documents and Flat Files for both Part A and B will be updated to reflect these changes and the updated documents will be posted at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage on the CMS Website.

The following three scenarios refer to Medicare reporting of NPIs in remittance advice processes.

Note that current requirements concerning the reporting of provider names and addresses still apply.

Scenario I – Single NPI cross walked to single legacy number:

- **Electronic Remittance Advice (ERA)** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (Employer Identification Number (EIN) Social Security Number (SSN) (EIN/SSN)) in the REF segment as Payee Additional ID. Medicare will report any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will also report relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, there will be one remittance advice, and one check/Electronic Funds Transfer (EFT) per NPI.
- **Standard Paper Remittance (SPR)** - Medicare will insert the appropriate Payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** - Medicare will show the Payee NPI at the header level and add the relevant Rendering Provider NPI at the claim level if different from the Payee NPI.
- **MREP Software** - Medicare will show the Payee NPI at the header level and add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI, and any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI.

Scenario II: Multiple NPIs cross walked to Single Medicare legacy number:

- **ERA** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** - Medicare will insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** - Same as Scenario I.
- **MREP Software** - Same as Scenario I.

Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:

- **ERA** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then, Medicare will add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** - Insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional notes.
- **PC Print Software** - Same as Scenario I.
- **MREP Software** - Same as Scenario I.

Implementation

While these changes are effective for dates of service on or after July 2, 2007, the changes will be implemented as follows:

- For claims submitted to DMERCs and/or DME MACs, the changes will be implemented on July 1, 2007.
- For claims submitted to other Medicare contractors, the implementation will occur on October 2, 2007.

TRANSITIONING THE MANDATORY MEDIGAP ("CLAIM-BASED") CROSSOVER PROCESS TO THE COORDINATION OF BENEFITS CONTRACTOR (COBC)

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5601
 Related CR Release Date: May 18, 2007
 Related CR Transmittal #: R1242CP

Related Change Request (CR) #: 5601
 Effective Date: October 1, 2007
 Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf>

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5601, which outlines the Centers for Medicare & Medicaid Services (CMS) systematic requirements for the transitioning of its mandatory Medigap (“claim-based”) crossover process from its Part B contractors to the COBC. During the period from June through September 2007, CMS’ Coordination of Benefits Contractor (COBC) will sign national crossover agreements with Medigap claim-based crossover insurers and will assign new 5-digit Coordination of Benefits (COBA) Medigap claim-based crossover identifiers to these entities for inclusion on incoming Medicare claims. CMS is also preparing a separate change request (CR 5662) that includes the Website where provider billing staffs may go to obtain the listing of new COBA Medigap claim-based identifiers for purposes of initiating Medigap claim-based crossovers. Within the next few weeks, following the issuance of CR 5662, providers will also receive more detailed information regarding this change via their Medicare contractors’ provider newsletters/bulletins and Websites.

CAUTION – What You Need to Know

October 1, 2007 is the effective date for completing the transition of the Medigap crossover process to the COBC. At that time, CMS will then only support the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X-12N 837 professional COB (version 4010-A1) claim format and National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claim format for such crossovers. As CMS’ COBC assigns the new COBA Medigap claim-based ID to the Medigap insurers, it will populate this information on its COB Website so that provider billing staffs may access it for purposes of including the new identifiers on incoming Medicare Part B claims, claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and NCPDP Part B drug claims. By October 1, 2007, providers will exclusively be including the new identifiers on incoming claims to initiate Medigap claim-based crossovers.

GO – What You Need to Do

During June through September, 2007, CMS will gradually be moving Medigap insurers to the new process. Be certain that your billing staffs are aware of these changes and that claims are sent to Medicare contractors in a timely and correct manner.

UPDATE TO MEDICARE CLAIMS PROCESSING MANUAL (PUBLICATION 100-04), CHAPTER 18, SECTION 10 FOR PART B INFLUENZA BILLING

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5511
 Related CR Release Date: June 29, 2007
 Related CR Transmittal #: R1278CP

Related Change Request (CR) #: 5511
 Effective Date: July 1, 2007
 Implementation Date: July 30, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf>

Key Points of CR5511

It is important that providers who want to participate in centralized billing programs understand and follow the rules governing the program. Specifically, approval to participate in the CMS centralized billing program is a two part approval process. Individuals and corporations who wish to enroll as a CMS Mass Immunizer Centralized Biller must send their request to participate as a centralized biller in writing by June 1 of the year they wish to begin centralized billing. These written requests should be sent to the following address:

<p>Center for Medicare & Medicaid Services Division of Practitioner Claims Processing Provider Billing and Education Group 7500 Security Boulevard Mail Stop C4-10-07 Baltimore, Maryland 21244</p>

CO will complete Part 1 of the approval process by reviewing preliminary demographic information included in the request for participation letter. **Completion of Part 1 is not approval to set up flu clinics, vaccinate beneficiaries, and bill Medicare for reimbursement.**

All new participants must complete Part 2 of the approval process (Form CMS-855 Application) before they may set up flu clinics, vaccinate Medicare beneficiaries, and bill Medicare for reimbursement. **If an individual or entity's request is approved for centralized billing, the approval is limited to 12 months from September to August 31 of the next year. It is the responsibility of the centralized biller to reapply to CMS CO for approval each year.** The designated Medicare carrier for centralized billing will provide in writing to CMS CO and to approved centralized billers notification of completion and approval of Part 2 of the approval process. The designated carrier may not process claims for any centralized biller who has not completed Parts 1 and 2 of the approval process. If claims are submitted by a provider who has not received approval of Parts 1 and 2 of the approval process to participate as a centralized biller, the carrier must return the claims to the provider to submit to the local carrier for payment.

Before September 1 of every year, CMS CO provides the designated carrier with the names of the entities that are authorized to participate in centralized billing for the 12 month period beginning September 1 and ending August 31 of the next year.

Though centralized billers may already have a Medicare provider number, for purposes of centralized billing, they must also obtain a provider number from the processing carrier for centralized billing through completion of the Form CMS-855 (Provider Enrollment Application). **Providers/suppliers are encouraged to apply to enroll as a centralized biller early as the enrollment process takes 8 -12 weeks to complete. Applicants who have not completed the entire enrollment process and received approval from CMS CO and the designated carrier to participate as a Medicare mass immunizer centralized biller will not be allowed to submit claims to Medicare for reimbursement.**

Providers should note that the practice of requiring a beneficiary to pay for the vaccination upfront and to file their own claim for reimbursement is inappropriate. All Medicare providers are required to file claims on behalf of the beneficiary per §1848(g)(4)(A) of the Social Security Act and centralized billers may not collect any payment upfront.

Comprehensive Error Rate Testing (CERT)

WPS CERT ERROR RATE UPDATE

~ August 2007 ~

Wisconsin Physicians Service (WPS) Medicare is strongly committed to the Centers for Medicare & Medicaid Services (CMS) goal of reducing the national CERT paid claims error rate. As one of the larger Medicare contractors, we recognize our responsibility to achieve further reductions in order to have an impact on the error rate at a national level.

In the past year, we have seen further improvement in our CERT error rate as a carrier. With the release of CMS' 2007 May (Mid-Year) Improper Medicare FFS Payments Report, our CERT paid claims error rate dropped to 3.7%. This remains below the carrier national average of 4.8%. The below table further illustrates our error rate reductions in the past year, compared to the national average of all other Medicare Contractors.

Type of Contractor	May-06	Nov-06	May-07
WPS	4.3%	4.2%	3.7%
Carrier	6.0%	5.0%	4.8%
DMERC	7.8%	7.5%	10.0%
FI	3.5%	2.3%	1.4%
QIOs	5.3%	4.9%	5.0%
All Medicare FFS Contractors	5.1%	4.4%	4.2%

Analysis of the types of errors that attributed to WPS' error rate showed that incorrect coding issues continue to have a large impact on our overall error rate. Incorrect coding errors are most commonly associated with Evaluation and Management (E/M) services, and are most frequently assessed because the level of service billed to Medicare was not documented in the medical records. Please see the below chart which summarizes the percent of total dollars improperly allowed by error category and contractor type, in comparison to WPS, for claims in the 2007 May (Mid-Year) FFS Report.

Type of Error	2007 May (Mid-Year) FFS Improper Payments Report					
	Total	Carrier	WPS	DMERC	FI	QIO
No Documentation Errors	0.6%	0.3%	0.4%	0.2%	0.0%	0.0%
Insufficient Documentation Errors	0.5%	0.3%	1.3%	0.0%	0.1%	0.0%
Medically Unnecessary Errors	1.5%	0.0%	0.0%	0.1%	0.0%	1.3%
Incorrect Coding Errors	1.5%	0.7%	1.9%	0.0%	0.2%	0.6%
Other Errors	0.2%	0.0%	0.1%	0.0%	0.0%	0.1%
Improper Payments	4.2%	1.4%	3.7%	0.4%	0.4%	2.0%

Although we continue to make improvements in our CERT error rate, we must strive for further reductions. In order to accomplish this goal, it is crucial that providers in our jurisdiction comply with CERT requests for medical records in a timely manner and submit documentation that supports the service(s) billed to Medicare, including the level of care and medical necessity.

For a complete copy of the 2007 May (Mid-Year) Improper Medicare FFS Payments Report referenced above, and past reports, please visit the CMS CERT Reports Website at <http://www.cms.hhs.gov/CERT/CR/list.asp#TopOfPage>.

For more information regarding the CERT program and other issues related to CERT review findings, please visit our Website at <http://www.wpsmedicare.com/provider/cert.shtml>. If you have questions related to the CERT process or a specific CERT sampled claim, you may email us at medicareadmin@wpsic.com. Be sure to include "CERT Question" in the subject line. Please also include your full name, telephone number, and Provider Identification Number (PIN) (if available) in the body of the e-mail. This will assure a prompt and accurate reply to your question.

When e-mailing WPS Medicare, please do not include sensitive information. If your question pertains to a specific claim, include the Internal Control Number, not your patient's Medicare Health Insurance Claim Number.

Coverage

INFORMATION ON WEBSITE

WPS publishes LMRPs, LCDs, NCPs, and NCDs, and retired LMRPs/LCDs for Medicare Part B on its Website: http://www.wpsmedicare.com/policies/pol_home.shtml. If you cannot gain access to the Internet from your office or home, you might try one of the many public libraries that offer Internet access. You may request a hard copy of a retired LMRP by writing to our Freedom of Information (FOI) Unit.

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



New Policies

Policy	Title	Policy Type	Published
GSURG-033	Cryosurgery (Cryoablation) and Radiofrequency Ablation for Treatment of Liver Tumors	LCD	August 2007
NEURO-004	Vagus Nerve Stimulation (VNS)	NCD	August 2007
RAD-018	Cranial Stereotactic Radiosurgery (SRS) and Cranial Stereotactic Radiotherapy (SRT)	LCD	September 2007
RAD-038	Selective Internal Radiation Therapy (SIRT) for Primary and Secondary Hepatic Malignancy (90Y-Microsphere Hepatic Brachytherapy)	LCD	September 2007

Policy Revisions

Policy	Title	Policy Type	Published
CV-007	Transesophageal Echocardiography	LCD	September 2007
CV-026	Transthoracic Echocardiography	LCD	September 2007
CV-039	Percutaneous Transluminal Angioplasty (PTA) (Carotid and Intracranial Stents)	NCD	August & September 2007
DENT-002	Dental Services	NCP	August 2007
DERM-008	Removal of Benign Skin Lesions	LCD	August 2007
DERM-009	Treatment of Actinic Keratosis DERM-009: Billing and Coding Guidelines	NCD	August 2007
GSURG-037	Application of Bioengineered Skin Substitutes and Skin Grafting	LCD	July 2007
HONC-002	Chemotherapy and Drug Administration	NCP	September 2007
HONC-010	Antineoplastics and their Adjuncts	LCD	September 2007
INJ-012	Immune Globulins	LCD	July & August 2007
INJ-025	Bisphosphonate Drug Therapy	LCD	July 2007
INJ-029	Rho (D) Immune Globulin	LCD	July 2007
INJ-038	Intravenous immune globulin for the treatment of autoimmune mucocutaneous blistering diseases	NCD	July 2007
MS-004	Bone Mineral Density (BMD) Studies	LCD	July & August 2007
NEURO-004	Vagus Nerve Stimulation (VNS)	LCD	August 2007
OPHTH-003	Optometrist Services	LCD	September 2007
PHYS-001	General Coverage for Physicians Services	NCP	July 2007
PHYS-031	Prolonged Evaluation and Management Services and Standby Services	NCP	September 2007
PHYS-040	Influenza, Pneumococcal and Hepatitis-B Vaccinations	NCP	August 2007
PHYS-041	Nutrition Training Benefits	NCD	July 2007
PHYS-078	Independent Diagnostic Testing Facilities (IDTF's)	LCD	August & September 2007
PHYSMED-009	Physical Medicine Rehabilitation Procedures and Modalities	LCD	September 2007
RAD-024	Magnetic Resonance Imaging	LCD	July 2007
RAD-026	Radiopharmaceutical Agents	LCD	August 2007
RAD-037	3D Interpretation and Reporting of Imaging Studies	LCD	August 2007



2008 ICD-9-CM COVERAGE - POLICY REVISIONS
~September 2007~

Effective for claims submitted with dates of service on or after 10/01/2007, WPS will cover the new 2008 ICD-9-CM codes for the policies and procedures listed below. We will post the listed changes to these affected policies to the Website after 10/01/2007.

Policy Name/Number	Policy Procedure Code	2008 ICD-9-CM Changes
CV-006 Cardiac Catheterization and Coronary Angiography	93501, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529	414.2, 415.12, 423.3
CV-007 Transesophageal Echocardiography (TEE)	93312-93317	414.2, 415.12.
CV-026 Transthoracic Echocardiography (TTE)	93303, 93304, 93307, 93308, 93320, 93321, 93325	359.21-359.24, 359.29, 414.2, 415.12, 423.3, 440.4, 999.31, 999.34 Delete: 359.2, 999.3
CV-033 Noninvasive Vascular Testing	93922-93931 93965-93971, G0365	440.4; 449 415.12
CV-034 Intraoperative Transesophageal Echocardiography	93312-93317	414.2, 415.12
HONC-010 Antineoplastics and their Adjuncts	J0640, J9000, J9015, J9020, J9040, J9045, J9050, J9060, J9062, J9065, J9070, J9080, J9090-J9097, J9100, J9110, J9120, J9130, J9140, J9150, J9165, J9178, J9181, J9182, J9185, J9190, J9200, J9201, J9208, J9209, J9213, J9214, J9215, J9230, J9250, J9260, J9270, J9280, J9290, J9291, J9293, J9310, J9320, J9340, J9360, J9370, J9375, J9380 J9999 (Teniposide)	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78
	J9160	202.70-202.78
	J9041	200.40-200.48 replaces non- specific code range 202.80-202.88 for Mantle cell lymphoma
GU-020 Diagnostic PAP Tests	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175	233.30-233.39 Delete: 233.3
INJ-012 Immune Globulins	J1566, Q4087, Q4088, Q4091, Q4092	284.81 Delete: 284.8
INJ-019 Human Granulocyte/Macrophage Colony Stimulating Factors	J1440, J1441, J2820	284.89 Delete: 284.8
NEUR0-005 Nerve Conduction Studies and Electromyography	All Code Listed	359.21-359.29

Policy Name/Number	Policy Procedure Code	2008 ICD-9-CM Changes
PATH-016 Flow Cytometry	88184, 88185, 88187, 88188, 88189	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78
PATH-027 Cytogenetic Studies	88237, 88239, 88262, 88271, 88272, 88273, 88274, 88275, 88283	233.30-233.39 Delete: 233.3
PATH-031 Syphilis Tests	86592, 86593, 86781	331.5
PSYCH-014 Psychiatry and Psychology Services	90802, 90810-90815, 90823, 90824, 90826-90829, 90857 90804-90809, 90816-90819, 90821, 90822, 90846, 90847, 90849, 90853, 90862, 90865, 90870, M0064	315.34 315.34
PSYCH-015 Health and Behavior Assessment/ Intervention	96150-96154	315.34
RAD-004 Chest X-Ray	71010, 71015, 71020-71023, 71030, 71034, 71035	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 255.41, 255.42, 414.2, 423.3, 449, 488, 787.20-787.24, 787.29, 789.51, 789.59, 999.31, 999.39, V12.53 Delete: 787.2, 789.5, 999.3 Coding Article Non-Covered: V68.01 Coding Article Non-Covered Delete: V68.0
RAD-014 Radiation Oncology Including Modulated Radiation Therapy (IMRT)	77301, 77418, 0073T	200.30-200.78; 202.70-202.78
RAD-023 MRA	71555 73725	415.12 440.4
RAD-024 Magnetic Resonance Imaging (MRI)	70336, 70540, 70542, 70543, 70551-70553	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 331.5, 359.21-359.24, 359.29, 388.45, 389.05, 389.06, 389.13, 389.17, 389.20-389.22, 787.20- 787.24, 787.29, 999.31, 999.39 Delete: 359.2, 389.2, 787.2, 999.3
	71550-71552	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 423.3

Policy Name/Number	Policy Procedure Code	2008 ICD-9-CM Changes
	72195-72197, 74181-74183	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 233.30-233.32, 233.39, 255.41, 255.42, 449, 569.43, 789.51, 789.59 Delete: 233.3, 255.4, 789.5
	73218-73223	359.21-359.24, 359.29 Delete: 359.2
	73718-73723	359.21-359.24, 359.29 Delete: 359.2
RAD-032 Vertebroplasty (Percutaneous) and Kyphoplasty	22520-22525, 72291, 72292,	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78,
RAD-033 Computerized Tomography (CAT Scans)	70450-70489	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 331.5, 359.21-359.24, 359.29, 388.45, 389.05, 389.06, 389.13, 389.17, 389.20-389.22, 787.20-787.24, 787.29, 999.31, 999.39 Delete: 359.2, 389.2, 787.2, 999.3
	71250-71270	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 415.12, 423.3
	72191-72194, 74150-74175, 75635	200.30-200.38, 200.40-200.48, 200.50-200.58, 200.60-200.68, 200.70-200.78, 202.70-202.78, 233.30-233.32, 233.39, 255.41, 255.42, 449, 569.43, 789.51, 789.59 Delete: 233.3, 255.4, 789.5
	73200-73206	359.21-359.24, 359.29 Delete: 359.2
	73700-73706	359.21-359.24, 359.29 Delete: 359.2
PHYSMED-009 Physical Medicine and Rehabilitation	97022, 97036, 97110, 97112, 97113, 97116, 97535	359.21, 359.22, 359.29 Delete: 359.2
DENT-002 Dental Services	Any	200.31, 200.41, 200.51, 200.61, 200.71, 202.71 Non-Covered Services 525.71, 525.72, 525.73, 525.79

BONE MASS MEASUREMENTS (BMMS)

~CMS MLN Matters – July 2007~

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

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

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5521.pdf>

This article was revised June 4, 2007 to clarify the Medicare Summary Notices on page 3. Essentially, MSN 16.10 will be issued with a denied claim as well as either MSN 36.1 or MSN 36.2, depending on if an ABN was issued. All other information remains the same.

CLARIFICATION OF MANUAL INSTRUCTION REGARDING SCOPE OF PORTABLE X-RAY BENEFIT

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5536
 Related CR Release Date: May 25, 2007
 Related CR Transmittal #: R71BP

Related Change Request (CR) #: 5536
 Effective Date: N/A
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5536.pdf>

Provider Action Needed

STOP – Impact to You

Currently, the Medicare Benefit Policy Manual, Publication 100-02, chapter 15, section 80.4.3, relating to the scope of portable x-ray benefit is **not completely consistent with regulations at 42 CFR 410.32(c)(3)(i)**. The manual section states that "skeletal films involving arms and legs" are covered services under the portable x-ray benefit.

CAUTION – What You Need to Know

In order to make certain the manual conforms to the regulations, the Centers for Medicare & Medicaid Services (CMS) is revising the **manual to state that the benefit includes "skeletal films involving extremities"**. Although, the language differences are slight, the use of "**extremities**" in the regulation instead of "arms and legs" **delineates coverage beyond 'arms and legs' to the hands, feet, toes, fingers, wrist and ankle**. Language is also being added to **include the coverage of diagnostic mammograms, when certain requirements are met**.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes. Also, be aware that Medicare contractors will adjust claims previously processed incorrectly, if you bring those claims to their attention.

DRUGS AND INCIDENT TO PROVISIONS

~July 2007~

Medicare has a National Coverage Provision (NCP) to discuss "Incident To" Provisions. The NCP is PHYS-004, Incident to a Physician's Professional Service in the Office or Clinic. The NCP has instructions guiding Physician billing when someone other than the Physician or Non-Physician Practitioner (the person with the Medicare provider number) performs services for the patient. The policy goes into a lot of detail on when the Physician or Non-Physician Practitioner can and cannot bill services to Medicare.

One of the requirements is that the Physician or Non-Physician Practitioner must provide direct supervision. Direct supervision means the Physician or Non-Physician Practitioner must be in the office suite. Medicare cannot allow services when the Physician or Non-Physician practitioner is out of the office. We recently received a question concerning whether the "Incident to" NCP applies to drugs and biologicals (J procedure codes) given in the office when the Physician or Non-Physician Practitioner is not present.

According to NCP PHYS-004 and the Internet Only Manual (IOM), 100-02, Benefit Policy Manual, Chapter 15, Section 50 and 50.3 drug and biologicals must meet the "Incident to" provisions. The Physician or Non-Physician Practitioner must provide direct supervision and must be in the office suite. If the Physician or Non-Physician Practitioner is not in the office suite, the office cannot bill the drug or biological to Medicare.

You can reference PHYS-004 at the following Website:
<http://www.wpsmedicare.com/policies/wisconsin/phys004.pdf>

You can reference the IOM, Benefit Policy, Chapter 15 at the following Website:
<http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf>

**INSTRUCTIONS FOR IMPLEMENTING THE CENTERS FOR MEDICARE & MEDICAID (CMS)
 RULING CMS 1536-R; ASTIGMATISM-CORRECTING INTRAOCULAR LENS (A-C IOLS)
 ~CMS MLN Matters – September 2007~**

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

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

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

Note: This article was revised on July 18, 2007, to correct a typo in the sentence at the end of paragraph 1 on page 3 and to provide new Web addresses for accessing the Notices of Exclusion from Medicare Benefits. All other information remains the same.

**PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY (PTA)
 ~CMS MLN Matters – August 2007~**

MLN Matters Number: MM5660
 Related CR Release Date: June 29, 2007
 Related CR Transmittal #: R71NCD

Related Change Request (CR) #: 5660
 Effective Date: April 30, 2007
 Implementation Date: July 30, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5660.pdf>

Editor's Note: CV-039, "Percutaneous Transluminal Angioplasty (PTA) (Carotid and Intracranial Stents)" has been updated to reflect the information below. Please view the revised policy at <http://www.wpsmedicare.com/policies/wisconsin/cv039.pdf>

Provider Action Needed

STOP – Impact to You

On August 02, 2006, a request to reconsider the national coverage determination (NCD) for PTA and stenting of the carotid arteries initiated a national coverage analysis. Change request (CR) 5660 communicates the findings resulting from that analysis.

CAUTION – What You Need to Know

Effective for dates of service performed on and after April 30, 2007, be aware of

- Clarifications regarding the use of PTA and stenting of the carotid arteries for patients at high risk for carotid endarterectomy (CEA) and
- **Note the process that facilities must follow for certification and recertification** that is specified in section 20.7 of Publication 100-03, the *Medicare National Coverage Determinations Manual*.

GO – What You Need to Do

If you are a provider of PTA and stenting of the carotid arteries services be aware that CMS has reviewed the evidence and determined that **coverage for this NCD is unchanged** and that **facilities should follow the certification/recertification guidelines in CR5660**. See the *Background and Additional Information* sections of this Medicare Modernization Act (MMA) update.

**RETIRED LCD/NCDS
 ~September 2007~**

The following LCD and NCD policy documents will be retired effective 10/01/2007.

- GU-019 - Non-Implantable Pelvic Floor Electrical Stimulator
- OPTH-021 - Visual Rehabilitation Program
- PHYSMED-011 - Neuromuscular Electrical Stimulators (NMES)

Selected information and/or CMS manual references from these policies have been incorporated into the PHYSMED-009 PM&R policy. The national coverage criteria and Medicare regulations for these services remain

in place. Reference and note the following Medicare Internet Only Manual section for these services at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage>

Non-Implantable Pelvic Floor Electrical Stimulator, CMS Pub.100-03 Part 4 §230.8
Neuromuscular Electrical Stimulators (NMES), CMS Pub.100-03 Part 3 §160.12

VAGUS NERVE STIMULATION (VNS) FOR RESISTANT DEPRESSION

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5612

Related CR Release Date: June 22, 2007

Related CR Transmittal #: R1271CP and R70NCD

Related Change Request (CR) #: 5612

Effective Date: May 4, 2007

Implementation Date: July 23, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5612.pdf>

CR 5612, from which this article is taken, announces that CMS is issuing a national (non) coverage determination (NCD) stating that vagus nerve stimulation (VNS) is not reasonable and necessary for the treatment of resistant depression. Therefore, effective May 4, 2007, CMS will deny VNS claims when resistant depression is the indication for the procedure.

Electronic Data Interchange (EDI)

ELECTRONIC FUNDS TRANSFER STANDARDIZATIONS AND REVISIONS TO THE MEDICARE CLAIMS PROCESSING MANUAL (CHAPTER 24)

~CMS MLN Matters – September 2007~

MLN Matters Number: MM5586

Related CR Release Date: July 9, 2007

Related CR Transmittal #: R1284CP

Related Change Request (CR) #: 5586

Effective Date: July 1, 2007

Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5586.pdf>

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5586 which revises the *Medicare Claims Processing Manual*, Chapter 24 (General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims).

CAUTION – What You Need to Know

Effective July 1, 2007, your Medicare contractor will conduct Administrative Simplification Compliance Act (ASCA) reviews annually of at least 20% of providers submitting CMS 1500 paper claims who were not already reviewed in the past 2 years and found to have fewer than 10 FTEs employed by the practice. In addition, contractors will insure that the addenda record is sent with the Medicare claim payment when an ACH format is used to transmit an EFT payment to a financial institution but the remittance advice is separately transmitted to a provider. This will assist with reconciliation of the payment and the information that explains the payment. The EFT format will be the National Automated Clearinghouse Association (NACHA) format CCP - Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) as mentioned in the X12N 835 version 004010A1 implementation guide.

Note: Medicare contractors will not approve any requests to change payment method from EFT to check.

HEALTHCARE PROVIDER TAXONOMY CODE (HPTC) UPDATE

~September 2007~

Change Requests (CR) 5436 and 5673 advise your carrier to use the most cost effective means to obtain the Healthcare Provider Taxonomy Code (HPTC) lists for April and October 2007 and update their HPTC tables as necessary.

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each

require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

Valid HPTCs are those codes approved by the National Uniform Claim Committee (NUCC) for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. The HPTC set is maintained by the National Uniform Claim Committee (NUCC) for standardized classification of health care providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1. Although the NUCC generally posts their updates on the Washington Publishing Company (WPC) Web page 3 months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update. Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs.

The HPTC list is available from the Washington Publishing Company (WPC) at <http://www.wpc-edi.com/codes/taxonomy> in two forms. The first form is a free Adobe PDF download. The second form, available for purchase, is an electronic representation of the code set that facilitates automatic loading of the codes.

NATIONAL PROVIDER IDENTIFIER (NPI) REQUIRED TO ENROLL IN ELECTRONIC DATA INTERCHANGE (EDI), AND UPDATE OF TELECOMMUNICATION AND TRANSMISSION PROTOCOLS FOR EDI

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5637 Revised
Related CR Release Date: July 6, 2007
Related CR Transmittal #: R1283CP

Related Change Request (CR) #: 5637
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5637.pdf>

Provider Action Needed

STOP – Impact to You

If not already enrolled for use of electronic billing & other electronic data interchange (EDI) transactions, you will not be able to enroll to begin use if you have not yet obtained a National Provider Identifier (NPI).

CAUTION – What You Need to Know

CR 5637, from which this article is taken, announces that providers must obtain an NPI, as a condition for initial enrollment, for the use of EDI. Your Medicare contractor will not issue you an EDI access number and password until you obtain an NPI.

GO – What You Need to Do

If you have not already obtained your NPI, you should apply now. You can apply on line by going to <https://nppes.cms.hhs.gov/>.

NPI: CLAIMS WILL BEGIN TO REJECT

~September 2007~

BEGINNING 8/27/07, ELECTRONIC CLAIMS WILL BE REJECTED IF NPI PREPASS EDIT OCCURS.

BELOW ARE THE DATES WHICH NPI EDITS WILL BE TURNED TO DELETE. ALL CLAIMS RECEIVING THESE EDITS ON OR AFTER THE FOLLOWING DATES WILL BE DELETED. THAT MEANS THAT IT WILL NOT BE SUBMITTED TO THE PROCESSING SYSTEM. IF DELETED, THE CLAIMS MUST BE CORRECTED AND RESUBMITTED FOR PROCESSING.

EDIT	WI/MN	IL/MI
M340	9/17/07	9/24/07
M379	9/17/07	9/24/07
M341	9/17/07	9/24/07
M380	9/17/07	9/24/07
M343	8/27/07	9/4/07
M381	8/27/07	9/4/07
M347	8/27/07	9/4/07
M382	8/27/07	9/4/07

What should you do if you fail a prepass edit? Read your report. Make sure that the provider/NPI combination is valid. Go to NPPES; add your legacy. Failing M379, 381, or M382? Make sure you are sending the correct qualifier with your Social Security Number or EIN.

Watch for the following Medicare Part B Prepass report NPI error messages:

- Billing Provider level (2010AA)– M340 & M379
- Pay To Provider level (2010AB) – M341 & M380
- Rendering Provider level (2310B) – M343 & M381
- Rendering Provider level (2420A) – M347 & M382

Edits M340, M341, M343, and M347 occur when the NPI submitted with legacy number does not match the crosswalk; that is the NPI legacy is not on the crosswalk or is invalid. Edits M379, M380, M381, and M382 will fail if you are sending NPI only and the NPI is not on the crosswalk or you are sending an EIN/SSN with the incorrect qualifier.

If you need additional information, you may also contact the WPS EDI Hotline for IL, MI, and WI 877-567-7261, or for MN 952-885-2811, 952-885-2881, or 952-885-2882.

NPI: LIFTING THE NATIONAL PROVIDER IDENTIFIER (NPI) CROSSWALK BYPASS LOGIC
~September 2007~

Since October 2, 2006, providers have been encouraged to submit both the NPI and Medicare legacy identifier (PIN) on their claims. During this timeframe providers were **not** penalized for invalid NPI/legacy ID combinations.

Effective **August 27, 2007 for Minnesota and Wisconsin and September 4, 2007 for Illinois and Michigan**, WPS Part B, will begin editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. Where a match cannot be located on the crosswalk, claims will be rejected or returned to the provider.

When the claim is returned, a provider should first verify that the correct NPI was submitted. If correct, you will need to verify that your legacy identifier (PIN or NSC) number corresponds with the information on file with the National Plan and Provider Enumeration System (NPPES). NPPES data may be checked on line at <https://nppes.cms.hhs.gov>

If your NPPES information is correct and you have included and matched ALL Medicare legacy identifiers with a corresponding NPI in NPPES, but you are experiencing provider identifier problems with your claims that contain an NPI, you may need to submit a Medicare enrollment application (i.e., the CMS-855). Please contact your contractor if you need more information.

More information and education on the NPI may be found at the CMS NPI page, <http://www.cms.hhs.gov/NationalProvidentStand> on the CMS Website. Also, providers can apply for an NPI online at <https://nppes.cms.hhs.gov>

Additional NPI information may be found at:
<http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf>

NPI: WPS ANNOUNCES SCHEDULE FOR TURNING ON NPI PREPASS EDITS: WHY NPI PREPASS EDITS OCCUR AND HOW TO CORRECT

~September 2007~

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

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

When a provider is not on crosswalk, an EDI prepass edit message will appear. Once the provider has been loaded to crosswalk, message should disappear. If message continues, you should verify the information you are sending is correct. If correct, access NPES and correct any errors if any found. Make sure all Medicare legacy numbers are loaded correctly (e.g. Michigan provider number containing leading zero(s), not the letter O; Wisconsin providers include all leading zeros). Updates to NPES typically update the crosswalk in 8-10 business days.

BELOW ARE THE DATES WHICH NPI EDITS WILL BE TURNED TO DELETE. ALL CLAIMS RECEIVING THESE EDITS ON OR AFTER THE FOLLOWING DATES WILL BE DELETED. THAT MEANS THAT IT WILL NOT BE SUBMITTED TO THE PROCESSING SYSTEM. IF DELETED, THE CLAIMS MUST BE CORRECTED AND RESUBMITTED FOR PROCESSING.

EDIT	WI/MN	IL/MI
M340	9/17/07	9/24/07
M379	9/17/07	9/24/07
M341	9/17/07	9/24/07
M380	9/17/07	9/24/07
M343	8/27/07	9/4/07
M381	8/27/07	9/4/07
M347	8/27/07	9/4/07
M382	8/27/07	9/4/07

Recommendations for providers: Begin dual strategy immediately! Pay close attention to your prepass reports. Send NPI only on a small percentage of claims (recommended 25 claims). Track claims with NPI throughout the claim process (e.g. compare to your remittance). If results are as you expected, increase your volume of NPI only claims.

Medicare Part B Prepass report NPI error messages Important NPI error messages to watch for:

- Billing Provider level (2010AA) – M340 & M379
- Pay To Provider level (2010AB) – M341 & M380
- Rendering Provider level (2310B) – M343 & M381
- Rendering Provider level (2420A) – M347 & M382

Edits M340, M341, M343, and M347 occur when the NPI submitted with legacy number does not match the crosswalk; that is the NPI legacy is not on the crosswalk or is invalid. Edits M379, M380, M381, and M382 will fail if you are sending NPI only and the NPI is not on the crosswalk or you are sending an EIN/SSN with the incorrect qualifier.

What should you do? Verify that the provider number NPI combination is valid. Validate that legacy numbers are entered in NPES. If legacy numbers are added and you continue to receive the informational errors on your report contact your carrier. Updates to NPES typically update the crosswalk in 8-10 business days. If the error persists, contact EDI department. A new 855 may be required or the carrier may need to contact crosswalk team to have problem corrected manually. <https://npes.cms.hhs.gov/NPES/Welcome.do>

All NPI prepass edits will be turned on by September 24, 2007. It is important that you act now. If you fail to take action, your claims may reject which will impact your claim processing.

A complete list of current 4010A1 pre-pass edits is available in the WPS Bulletin Board in the EDI file library in the HIPAA directory (file name: 4010_401.doc) or on the WPS Website:

http://www.wpsic.com/edi/pdf/hipaa_mcs837.pdf

If you need additional information you may also contact the WPS EDI Hotline for IL, MI, and WI 877-567-7261, or for MN 952-885-2811, 952-885-2881, or 952-885-2882.

General Information

ADDITIONAL COMMON WORKING FILE (CWF) EDITING FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB)

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5624 Revised
Related CR Release Date: July 13, 2007
Related CR Transmittal #: R1289CP

Related Change Request (CR) #: 5624
Effective Date: April 1, 2001
Implementation Date: January 7, 2008

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5624.pdf>

Note: This article was revised on July 17, 2007, to reflect a correction made to CR5624. The implementation date was changed to January 7, 2008. All other information remains the same.

CR 5624 instructs Medicare carriers, A/B MACs, and DME MACs (effective April 1, 2001) to bypass SNF CB Part B and Part B/DMEMAC edits when certain inpatient claims are present on Medicare's history.

These revisions will allow Medicare SNF CB editing to take into account periods of SNF stays that are non-covered by Medicare Part A when services should be payable outside of CB by the Medicare Part B contractor.

Note: CR 5624 does not change the policy for SNF CB. It adjusts Medicare's claims systems to be in line with current policy.

Medicare contractors (carrier, A/B MAC, or DME MAC) will re-open and re-process inappropriately denied claims for dates of service on or after April 1, 2001 through January 1, 2008 when you bring such claims to their attention. You should contact your Medicare contractor to have claims re-processed that you feel were erroneously subject to these consolidated billing edits, and denied. The change will be implemented on January 7, 2008 and claims will be processed correctly as of that date.

APPEALS TRANSITION - BIPA SECTION 521 APPEALS

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5460
Related CR Release Date: June 29, 2007
Related CR Transmittal #: R1274CP

Related Change Request (CR) #: 5460
Effective Date: July 1, 2007
Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5460.pdf>

The Medicare claims appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) and the Medicare Prescription Drug Improvement and Modernization Act (MMA). The Social Security Act (Section 1869(c)), as amended by BIPA and MMA, requires changes to the Code of Federal Regulations (CFR; Title 42) regarding:

- Appointment of representatives,
- Fraud and abuse,
- Guidelines for writing appeals correspondence, and
- The disclosure of information.

Therefore, the Centers for Medicare & Medicaid Services (CMS) is revising provisions in Chapter 29 of the *Medicare Claims Processing Manual* that address these changes.

The purpose of CR5460 is to notify Medicare contractors about their need to comply with these revised *Medicare Claims Processing Manual* provisions, which are included as an attachment to CR5460.

Some of the key changes to the manual direct Medicare contractors to:

- Follow the procedures that define who may be a representative and how a representative is appointed (via the CMS-1696 Appointment of Representative (AOR) form);
 - Do not accept an appointment if the contractor has evidence that the appointment should not be honored;
 - Send notice only to the representative when the contractor takes action or issues a redetermination [if there is an appointed representative];
 - Provide assistance in completing the CMS-1696 form, as needed; and
 - Do not release beneficiary-specific information to a representative before the beneficiary or appellant and the prospective representative have completed and signed the CMS-1696 or other conforming written instrument.

Please note that the **AOR** applies to all services, claims and appeals submitted on behalf of the beneficiary for the duration of the AOR.

- Follow the procedures that describe the process a beneficiary must use to assign their appeal rights to a provider (via the CMS-20031) Transfer of Appeal Rights form):
 - For each new appeal request, a form needs to be submitted, this form is valid for all levels of the appeal process including judicial review, even in the event of the death of the beneficiary;
 - If a provider furnishes the service, he/she would be a party to the initial determinations, only providers or suppliers who are not a party may accept assignment of appeal rights from a beneficiary. That is assignment of appeal rights applies only to providers and suppliers who are never a party to an appeal because they do not participate in Medicare and have not taken the claim on assignment; and
 - The provider or supplier who accepts the appeal rights to collect payment from the beneficiary for the item or service that is the subject of the appeal. The provider or supplier may collect any applicable deductible or coinsurance. The provider or supplier agrees to this waiver by completing and signing Section II of the Transfer of Appeal Rights form.
- Provide redetermination letters that are understandable to beneficiaries.

Please note that an **Assignment of Appeal Rights** is valid for the duration of an appeal unless it is revoked by the beneficiary.

CHARGES FOR MISSED APPOINTMENTS

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5613
 Related CR Release Date: June 29, 2007
 Related CR Transmittal #: R1279CP

Related Change Request (CR) #: 5613
 Effective Date: October 1, 2007
 Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5613.pdf>

According to Chapter 12, section 30.3.13 of the *Medicare Claims Processing Manual*, which is attached to CR5613, CMS policy allows physicians, providers, and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments and the charges for Medicare and non-Medicare patient are the same. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

The other key points of CR5613 are:

- The provider may bill the Medicare beneficiary directly.
- Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians, or other suppliers.
- Claims for missed appointments sent to Medicare will be denied with the reason code 204 (This service/equipment/drug is not covered under the patient's current benefit plan.).

- In most instances, a hospital outpatient department can charge a beneficiary a missed appointment charge.
- In the event, however, that a hospital inpatient misses an appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the beneficiary a missed appointment fee.

IDENTIFICATION OF RECENT DENIALS

~ July 2007 ~

Beneficiary Name Mismatch

The Medicare Claims Processing system requires an exact match on the beneficiary first initial, last name, and Health Insurance Claim Number (HICN). Providers should submit claims for services using the exact name and HICN as it appears on the beneficiary Medicare card. Claims received with a beneficiary name or HICN mismatch will reject in the Medicare processing system as unprocessable. Providers cannot bill the patient for any rejected as unprocessable. Providers must correct claims and resubmit a new claim before Medicare can consider the service for payment.

If the beneficiary indicates the Medicare card is incorrect, you should advise the beneficiary to contact their local Social Security Office to report any inaccuracy and obtain a new Medicare card.

Individual and Group Provider Information do Not Match

All Physicians and other practitioners have individual provider and/or National Provider Identifier (NPI) numbers with Medicare. The individual provider numbers shows Medicare who performed the service. All claims submitted to Medicare must show the individual provider number.

Individual providers may practice independently, as a member of a group, or as members of multiple groups. The groups expecting Medicare payment must enroll and receive an identification number for the group.

When an individual practitioner joins an established group practice, the individual practitioner must share the information with Medicare through the Provider Enrollment process using the 855R enrollment form. Our Provider Enrollment department will then associate the individual practitioner number/NPI with the group provider number and claims will pay correctly.

When the individual provider number/NPI and the group provider number/NPI show the correct association, Medicare can make payment. If the individual provider number and the group provider number submitted to Medicare do not match, Medicare will deny the charges with MA112 – Missing/incomplete/invalid group practice information. Providers can correct the information and resubmit the claim.

IMPLEMENTATION OF THE CARRIER JURISDICTIONAL PRICING RULES FOR ALL PURCHASED DIAGNOSTIC SERVICE CLAIMS

~ CMS MLN Matters – July 2007 ~

MLN Matters Number: MM5543 Revised
 Related CR Release Date: May 25, 2007
 Related CR Transmittal #: R1250CP

Related Change Request (CR) #: 5543
 Effective Date: October 1, 2007
 Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5543.pdf>

Note: This article was revised on June 13, 2007, to delete an unnecessary note from page 2 regarding current processes and to add a bullet point (in italics) on page 3. All other information remains the same.

Through CR 3481, the Centers for Medicare and Medicaid Services (CMS), on April 1, 2005, implemented a Medicare Physician Fee Schedule (MPFS) national abstract file containing the Healthcare Common Procedural Coding System (HCPCS) codes, billable as a purchased diagnostic test/interpretation, for every locality throughout the country. With this file's implementation, CMS changed the carrier jurisdictional pricing rules for purchased diagnostic tests/interpretations to allow suppliers (including laboratories, physicians, and independent diagnostic testing facilities) to bill their local carrier/MAC for these services and receive the correct payment amount, regardless of the location where the service was performed. (See CR 3481, issued on October 29, 2004)

However, CMS delayed implementation of the CR3481's billing instructions for physicians, because of a previously noted potential problem with reporting the locality data in physician claims for such services performed outside of the local carrier's jurisdiction. Rather, through CR 3630, CMS implemented a temporary change in the carrier jurisdictional pricing rules for purchased diagnostic services to allow physicians providing out-of-jurisdiction diagnostic tests/interpretations to bill their local carrier for these services and receive the local rate. CR 5543, from which this article is taken, replaces the temporary physician billing instructions specified in CR 3630 with new billing procedures to allow all physicians and suppliers to receive the correct payment amount for all purchased diagnostic services (based on the ZIP code of the location where the service was rendered, in accordance with the carrier jurisdictional pricing rules), including those performed outside of the local carrier's jurisdiction, effective for claims with dates of service on or after October 1, 2007.

NOTIFYING AFFECTED PARTIES REGARDING CHANGES TO THE MANDATORY MEDIGAP ("CLAIM-BASED") CROSSOVER PROCESS

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5662 Revised
 Related CR Release Date: June 15, 2007
 Related CR Transmittal #: R283OTN

Related Change Request (CR) #: 5662
 Effective Date: June 15, 2007
 Implementation Date: July 16, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5662.pdf>

Note: This article was revised on June 26, 2007, to reflect a corrected Web address on page 3 as noted when CR5662 was re-issued on June 26. All other information remains the same.

CR 5662, from which this article is taken, outlines the processes that Part B carriers, Medicare Administrative Contractors (MACs) responsible for Part B claims processing, and Durable Medical Equipment Medicare Administrative Contractors (DMACs) shall follow in notifying affected parties that the mandatory Medigap (claim-based) crossover process is being transitioned to the Coordination of Benefits Contractor (COBC) effective October 1, 2007. Providers should notify their clearinghouses and billing vendors of the impending changes to the existing Medigap claim-based crossover process as soon as possible.

REVISION TO MEDICARE PUBLICATION 100-09, CHAPTER 3 – PROVIDER INQUIRIES AND CHAPTER 6 - PROVIDER CUSTOMER SERVICE PROGRAM UPDATES

~CMS MLN Matters – September 2007~

MLN Matters Number: MM5597 Revised
 Related CR Release Date: July 13, 2007
 Related CR Transmittal #: R20COM

Related Change Request (CR) #: 5597
 Effective Date: May 23, 2007
 Implementation Date: July 30, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5597.pdf>

Note: This article was revised on July 16, 2007, to reflect changes that CMS made to CR5597. The transmittal number, CR release date, and the Web address for accessing CR5597 were changed. All other information remains the same.

CR5597 contains a number of revisions to the *Medicare Contractor Beneficiary and Provider Communications Manual*, including changes for authenticating providers who make inquiries of Medicare contractors. Due to the Medicare fee-for-service contingency plan for the National Provider Identifier (NPI), the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare fee-for-service provider contact centers (PCCs), will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and written inquiry units. **While the authentication rules are part of CR5597, for complete details about these rules under the Medicare NPI contingency plan, see MLN Matters article SE0721**, which you will find at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf> on the CMS Website.

Program Safeguards**SANCTIONED AND REINSTATED PROVIDERS**

~July, August, September 2007~

The Medicare and Medicaid Patient and Program Protection Act provides the Department of Health and Human Services with the authority to exclude health care providers, individuals and businesses from receiving Medicare payment for services otherwise payable. This sanction practice represents the full range of administrative remedies and actions available to deal with questionable, improper or abusive practices of providers under the Medicare program. WPS will not issue payments for services performed, ordered or referred by these providers after the indicated changes. Current listings of sanctioned and reinstated providers are published in the monthly *Communiqué*. Complete lists are available at: <http://oig.hhs.gov/fraud/exclusions/listofexcluded.html>

Provider Education**PROVIDER EDUCATION EVENTS AVAILABLE!**

~July, August, September 2007~

Take advantage of a Medicare Education event in your area, on-line, or via telephone. Provider Outreach and Education are offering free educational events.

Sign up today by going to http://www.wpsmedicare.com/provider/proved_seminar.shtml and clicking on the course number for the seminar that you are interested in attending.

PROVIDER EDUCATION FOR HANDLING ISSUES RELATED TO DECEASED PROVIDERS

~CMS MLN Matters – August 2007~

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

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

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

This article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595, at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf> on the CMS Website. Also, on June 28, 2007, the article was revised to delete one sentence that should not have been in the article.

Reimbursement**CLIA WAIVED TESTS**

~July 2007~

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with a CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the Food and Drug Administration as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the attached list (i.e., CPT codes: 81002, 81025, 82270, 82272, G0394, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

CPT Code/Modifier	Effective Date	Description
80101QW	12/28/06	Wolfe Drug Testing RealityCheck Integrated Specimen Cup
80101QW	12/28/06	Drug Detection Devices Ltd. Multi-Drug Multi-Line Screeners Dip Drug Test With the Integrated Screeners AutoSplit KO Test Cup
82274QW, G0328QW	01/26/07	InSure Quik Fecal Immunochemical Test (F.I.T.)
82947QW, 82950QW, 82951QW, 82952QW, 83718QW and 84478QW	02/07/07	Polymer Technology Systems CardioChek PA Analyzer (PTS Panels Metabolic Chemistry Panel Test Strips)
86318QW	02/07/07	Inverness Medical Clearview H. pylori Test {whole blood}
80101QW	02/22/07	Innovacon Integrated E-Z Split Key Cup II {Professional Use}
80101QW	03/14/07	Redwood Toxicology Laboratory Reditest 6 Cassette substance abuse screening device {Professional Use}
85610QW	03/23/07	Roche Diagnostics CoaguChek XS

To view the complete list of CLIA Waived Tests, please go to
http://www.wpsmedicare.com/provider/pdfs/clia_tests.pdf

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) DESIGNATION CHANGES

~August and September 2007~

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

The Health Resources and Services Administration (HRSA), within the Department of Health & Human Services, is responsible for designating Health Professional Shortage Areas.

The address where the service is rendered, not the location of the physician's office or the patient's address, is the determining factor in HPSA incentives. Only physicians furnishing services in a geographic, primary care HPSA are eligible to receive bonus payments.

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

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

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

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

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5646 Revised
 Related CR Release Date: June 15, 2007
 Related CR Transmittal #: R1270CP

Related Change Request (CR) #: 5646
 Effective Date: July 1, 2007
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5646.pdf>

Note: This article was revised on June 25, 2007, to delete references in the title and elsewhere to a revised October 2006 ASP file. All other information is the same.

This article is based on Change Request (CR) 5646 which informs Medicare providers of the availability of the July 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 and April 2007 ASP files. Providers should make certain that your billing staffs are aware of these changes.

The CMS ASP webpage is located at <http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/> on the CMS Website. The revised files are applicable to claims based on dates of service as shown in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
July 2007	July 1, 2007 through September 30, 2007
January 2007	January 1, 2007 through March 31, 2007
April 2007	April 1, 2007 through June 30, 2007

NOTE: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim shall make these determinations.

JULY, 2007 QUARTERLY UPDATE TO THE HCPCS CODES FOR ALBUTEROL, LEVALBUTEROL, AND RECLAST®

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5645
 Related CR Release Date: June 1, 2007
 Related CR Transmittal #: R1260CP

Related Change Request (CR) #: 5645
 Effective Date: July 1, 2007
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5645.pdf>

CR 5645, from which this article is taken, implements the July, 2007 quarterly update to the HCPCS Codes for Albuterol, Levalbuterol, and Reclast®.

Also, please note the following:

- Currently, Reclast® 5 mg/100 ml bottle (NDC 0078-0435-61) is the only product that should be billed using code Q4095. If other products under the FDA's approval for Reclast® become available, code Q4095 would be used to bill for such products.
- HCPCS code J3487 (short description: Zoledronic acid; long description: Injection, zoledronic acid, 1 mg) is used to bill for products under the FDA's approval for Zometa® or such therapeutically equivalent products that may become available as identified in the FDA's Orange Book.
- Payment limits for the new Q codes will be included in the July 2007 quarterly Average Sales Price payment file, when those files are posted at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage.
- Payment information for the new Q codes under the Hospital Outpatient Prospective Payment System (OPPS) can be found in the July 2007 update of OPPS Addendum A and Addendum B when those addendums are added to the hospital outpatient Website at: <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage/>

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

~CMS MLN Matters – July 2007~

MLN Matters Number: MM5641 Revised
 Related CR Release Date: June 8, 2007

Related Change Request (CR) #: 5641
 Effective Date: January 1, 2007 for implementation of fee schedule amounts for codes in effect on January 1, 2007; July 1, 2007 for all other changes
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5641.pdf>

Note: This article was revised on June 19, 2007, to clarify that the modifier that should not be used with HCPCS codes E0691, E0692, E0693, and E0694 for dates of service on or after January 1, 2005, is the KF modifier. All other information remains the same.

Provider Action Needed

This article is based on Change Request (CR) 5641, which provides the July 2007 quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error or that may no longer be paid under the fee schedule. Be sure billing staff are aware of these changes.

Background

The quarterly updates process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual (Publication 100-04), Chapter 23, Section 60; <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf> on the CMS Website.

CR 5641 provides specific instructions regarding the July quarterly update for the 2007 DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in Title 42 of the Code of Federal Regulations (42 CFR 414.102).

MEDICARE PAYMENT FOR PREADMINISTRATION-RELATED SERVICES ASSOCIATED WITH IVIG ADMINISTRATION—PAYMENT EXTENDED THROUGH CY 2007
~CMS MLN Matters – August 2007~

MLN Matters Number: MM5428 Revised
Related CR Release Date: December 22, 2006
Related CR Transmittal #: R1140CP

Related Change Request (CR) #: 5428
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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

Note: This article was changed on July 9, 2007, to reference MM5635. MM5635 implemented HCPCS coding changes for Immune Globulin. **On and after July 1, 2007, HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg) will no longer be payable by Medicare.** To view the new HCPCS codes, please go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5635.pdf> on the CMS Website.

REVISION TO INTERNET ONLY MANUAL (IOM) PUB 100-04, CHAPTER 12, SECTION 90.4 BILLING AND PAYMENT IN A HEALTH PROFESSIONAL SHORTAGE AREA (HPSA)
~CMS MLN Matters – August 2007~

MLN Matters Number: MM5625
Related CR Release Date: June 29, 2007
Related CR Transmittal #: R1273CP

Related Change Request (CR) #: 5625
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5625.pdf>

CMS is simplifying the process of determining designations that are eligible to receive the Health Professional Shortage Area (HPSA) bonus payment; in order to ensure a more accurate method of 1) paying claims in areas that are designated for the HPSA bonus payment, and 2) reducing the risk of overpayments in area that are not designated as HPSA bonus payment areas.

To reflect these changes, Medicare Claims Processing manual (100-04) Chapter 12 (Physician/Practitioner Billing), Section 90.4 (Billing and Payment in a Health Professional Shortage Area (HPSA)) is being updated; and CR 5625, from which this article is taken, revises how Medicare contractors will disseminate information about HPSA bonus payment to the provider community.

Per these revisions, carriers will no longer maintain an updated Website of HPSA designations for physicians to use when filing HPSA bonus payment claims. The carriers, instead, will be required to provide two direct links for you to use when filing HPSA bonus payment claims. Those links are:

- To the CMS site, to verify automated HPSA bonus designation status, which you can access at <http://www.cms.hhs.gov/hpsapsaphysicianbonuses/>; and
- To the HRSA site, to verify HPSA bonus designation status, which you can access at <http://www.bhpr.hrsa.gov/shortage/>,

You should be aware that CMS will continue to automatically pay a bonus for those ZIP codes that are considered to fully fall in the county based on a determination of dominance made by the United States Postal Service (USPS) and for those ZIP codes that fully fall within a partial county HPSA (effective for services rendered on or after the date of designation by HRSA)

However, for those ZIP codes that do not fully fall within a full county HPSA or fully within a non full county HPSA, you must continue to enter the AQ modifier on the claim in order to receive the bonus.

UPDATE OF CLAIM ADJUSTMENT REASON CODES (CARCS) AND REMITTANCE ADVICE REMARK CODES (RARCS) AND ENHANCEMENT OF MEDICARE REMIT EASY PRINT (MREP)

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5634
 Related CR Release Date: June 15, 2007
 Related CR Transmittal #: R1267CP

Related Change Request (CR) #: 5634
 Effective Date: July 1, 2007
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5634.pdf>

This article is based on Change Request (CR) 5634 which instructs Medicare contractors that a Remittance Advice Remark Code (RARC) must be used with Claim Adjustment Reason Codes (CARCs) 16, 17, 96, 125, and A1. CR5634 also instructs that updated Medicare Remit Easy Print (MREP) software will be provided which incorporates enhancements approved by the Centers for Medicare & Medicaid Services (CMS) and the currently valid Claim Adjustment Reason and and Remittance Advice Remark Codes.

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

~CMS MLN Matters – August 2007~

MLN Matters Number: MM5614 Revised
 Related CR Release Date: May 29, 2007
 Related CR Transmittal #: R1258CP

Related Change Request (CR) #: 5614
 Effective Date: January 1, 2007
 Implementation Date: July 2, 2007

Read this entire article at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5614.pdf>

Note: This article was changed on July 9, 2007, to reference MM5635. MM5635 implemented HCPCS coding changes for Immune Globulin. **On and after July 1, 2007, HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg) will no longer be payable by Medicare.** There is a reference to J1567 on page 3 of this article. To view the new HCPCS codes for Immune Globulin, please go to <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5635.pdf> on the CMS Website.

Provider Action Needed

STOP – Impact to You

Payment files for the MPFS were issued based on the December 1, 2006 Medicare Physician Fee Schedule Final Rule. CR5614, amends those files and includes new/revised codes for the Physician Quality Reporting Initiative (PQRI)

CAUTION – What You Need to Know

Physicians and providers may want to pay particular attention to **Attachment 1** of CR5614 that identifies the changes included in the July Update to the 2007 MPFSDB—the **highlights of attachment 1 are:**

- Effective for dates of service on or after July 1, 2007 Category II modifier 8P will be recognized in addition to Category II modifiers 1P, 2P and 3P. (NOTE: Modifier 8P is intended to be used as a “reporting modifier” to allow the reporting of circumstances when an action described in a measure’s numerator is not performed and the reason is not otherwise specified.)
- Effective for dates of service on or after January 1, 2007, Medicare contractors will update their systems to reflect 11 base units for CPT code 00797.
- This CR 5614 lists the new Category II HCPCS codes that will be added to the MPFSDB with a status indicator of “M” for the PQRI.

GO – What You Need to Do

Make certain that your billing staffs are aware of these changes.

Background

Section 1848 (c)(4) of the Social Security Act provides for the establishment of the policies needed in order to implement relative values for physicians’ services. CR 5614 is the official document that announces these changes in the Medicare schedule. Rather than duplicate all the additions, deletions and changes in this article, the Centers for Medicare & Medicaid Services (CMS) directs you to **CR5614, which contains lengthy lists of these items.** CR5614 is available at <http://www.cms.hhs.gov/Transmittals/downloads/R1258CP.pdf> on the CMS Website.

QUARTERLY COMMUNIQUÉ SATISFACTION SURVEY

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

WPS MEDICARE QUARTERLY COMMUNIQUÉ SATISFACTION SURVEY

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

1. Do you have access to a computer with a CD-ROM Drive? Yes No
Comments: _____
2. Are you comfortable using a CD-ROM? Yes No
If no, would you be interested in learning more about using a CD-ROM? Yes No
Comments: _____
3. Would you be interested in receiving a CD-ROM each quarter that contains the monthly Communiqués in their entirety instead of the paper Quarterly summary Communiqué? Yes No
Comments: _____
4. Do you have access to the Internet? Yes No
If you are not connected to the Internet, what obstacles prevent you from accessing on-line resources?

5. Do you currently find the Communiqué to meet your needs? Yes No
Comments: _____
6. Would you like the Communiqué to include complete articles? Yes No
Comments: _____
7. What information do you look for within the Communiqué?
 Policy/Coverage Medlearn Matters Articles Claim Submission
Other: _____
8. Overall, how would you rate the paper copy of the Communiqué?
Excellent _____ Good _____ Fair _____ Poor _____ Very Poor _____
9. If we could improve one thing, what would you suggest? _____

You may send us your comments via:

E-Mail: MedicareAdmin@wpsic.com

FAX your survey to: (608) 301-2775

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

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