

Communiqué

Part B

Wisconsin Physicians Service Insurance Corporation

<http://www.wpsmedicare.com>

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Items of Importance**2012 PART B PARTICIPATION AND FEE INFORMATION**

The 2012 Medicare Participation information is now available on the WPS Medicare website. Visit the appropriate link below for your contract for more information:

J5 MAC: <http://www.wpsmedicare.com/j5macpartb/departments/enrollment/2012-participation-calendar.shtml>

Leg: http://www.wpsmedicare.com/part_b/departments/enrollment/2012-participation-calendar.shtml

WPS Medicare has also posted the 2012 fee schedule effective for dates of service January 1, 2012, and after. If you are interested in reviewing this fee schedule, please visit our 2012 Medicare Physician Fee Schedules page.

J5 MAC: http://www.wpsmedicare.com/j5macpartb/fees/physician_fee_schedule/2012-fee-schedule.shtml

Legacy: http://www.wpsmedicare.com/part_b/fees/physician_fee_schedule/2012-fee-schedule.shtml

THE 5010 DEADLINE IS APPROACHING, IS YOUR OFFICE PREPARED?

WPS Medicare is ready to be fully compliant with 5010 on January 1, 2012. We began external trading partner testing in January 2011, and production in April 2011. If you rely on a vendor or clearinghouse to maintain your billing system, ask them about their plans for transitioning to the new 5010 format.

All HIPAA-covered entities must be fully compliant with 5010 on January 1, 2012. If you fail to prepare, it will be your business and cash flow that will be affected.

Additional information and resources to help you prepare for 5010 are available on the WPS Electronic Data Interchange (EDI) website at <http://www.wpsic.com/edi/5010-Readiness.shtml> and on the following Centers for Medicare & Medicaid Services (CMS) website: http://www.cms.gov/Versions5010andD0/01_overview.asp

J5 MAC Providers Only (IA, KS, MO, NE)**ADDITIONAL FIELDS FOR ADDITIONAL DOCUMENTATION
REQUEST (ADR) LETTERS**

~Revised CMS MLN Article~

MLN Matters® Number: MM7254 Revised
Related CR Release Date: September 15, 2011

Related Change Request (CR) #: 7254
Effective Date: January 1, 2012, except April 1,
2012 for suppliers billing DME MACs
Implementation Date: January 3, 2012, except
April 2, 2012 for DME MACs

Related CR Transmittal #: R958OTN

Note: This article was revised on September 30, 2011, to clarify the description of the content in the ADR. All other information remains the same.

Provider Types Affected

This article is for physicians, providers, and suppliers who must respond to ADRs from Medicare Administrative Contractors (A/B MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

What You Need to Know

CR 7254, from which this article is taken, makes changes to the Medicare systems that allow A/B MACs and DME MACs to include, on Additional Documentation Request (ADR) letters, information about the Electronic Submission of Medical Documentation (esMD) pilot.

Background

CR7254, from which this article is taken, announces several changes to the Medicare systems that enable Medicare Review Contractors, participating in the esMD pilot, to include on ADR letters additional information necessary for Electronic Submission of Medical Documentation (esMD).

Specifically, these will allow MACs to include in each ADR:

- A statement about how providers can get more information about submitting medical documentation via the esMD mechanism
- A documentation case ID number that may facilitate tracking of submitted documents.

Additional Information

You can find the official instruction, CR7254, issued to your A/B MAC or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R958OTN.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

You can learn more about the esMD pilot by going to <http://www.cms.gov/ESMD/> on the CMS website. In addition, MLN Matters® article SE1110 provides more details on the esMD initiative. That article is at <http://www.cms.gov/MLNMattersArticles/downloads/SE1110.pdf> on the CMS website.

If you have any questions, please contact your A/B MAC or DME MAC at their toll-free number, which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

DISCONTINUATION OF HOSPICE LATE CHARGE CLAIMS ~CMS MLN Article~

MLN Matters® Number: MM7556
Related CR Release Date: October 27, 2011
Related CR Transmittal #: R2326CP

Related Change Request (CR) #: 7556
Effective Date: April 1, 2012
Implementation Date: April 2, 2012

Provider Types Affected

This article is for hospice providers submitting claims to Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know

Hospices may no longer submit late charge claims for services rendered on or after April 1, 2012. Hospices may adjust finalized claims to add late charges within the normal timely filing period as defined in the “Medicare Claims Processing Manual,” Chapter 1, Section 70. That manual chapter can be found at <http://www.cms.gov/manuals/downloads/clm104c01.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Historically, the late charge claim has been used to submit charges for services that were omitted from a previous claim submission. As payments for institutional claims moved to bundled payment systems, late charge billing has been discontinued for most claim types. Instead of late charge claim submissions, previous claims submissions must be adjusted to add additional services. Hospice providers are one of the few provider types that may still submit a late charge claim to Medicare. For hospices, the late charge claim, which is identified by bill type 815 or 825, has continued to be used only for submitting professional services that were omitted from a previous claim submission. These professional services could be processed as a late charge because they are paid a separate fee amount outside the hospice per diem payment amount. However, Medicare will discontinue the use of hospice late charge claims for dates of service on or after April 1, 2012. Instead, to report such charges, hospices must submit an adjustment (or replacement) claim on bill type 817 or 827, placing all services for a billing period on one claim.

Additional Information

The official instruction, CR7556, issued to your RHHI, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2326CP.pdf> on the CMS website.

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

Claim Submission**ADVANCED DIAGNOSTIC IMAGING ACCREDITATION
ENROLLMENT PROCEDURES**

~ Revised CMS MLN Article ~

MLN Matters® Number: MM7177 Revised
Related CR Release Date: August 3, 2011
Related CR Transmittal #: R380PI

Related Change Request (CR) #: 7177
Effective Date: July 1, 2011
Implementation Date: July 5, 2011

Note: This article was revised on November 17, 2011, to refer providers to MLN Matters® Article SE1122 at <http://www.cms.gov/MLN MattersArticles/downloads/SE1122.pdf> for important new information about these Accreditation Requirements. That information is that providers need not submit their ADI data on their 855 enrollment forms or via the PECOS enrollment system. CMS receives that data from the accrediting organizations. In the near future, CR7177 and this article will be further modified to reflect this information.

Provider Types Affected

Physicians, nonphysician practitioners, and Independent Diagnostic Testing Facilities (IDTF) submitting claims to Medicare contractors (carriers and A/B Medicare Administrative Contractors (MAC)) are affected by this article.

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

The Centers for Medicare & Medicaid Services (CMS) approved three national accreditation organizations (AOs) to provide accreditation services for suppliers of the TC of advanced diagnostic imaging procedures. The approved AOs are:

- The American College of Radiology,
- The Intersocietal Accreditation Commission, and
- The Joint Commission.

The accreditation will apply only to the suppliers of the images themselves, and not to the physician's interpretation of the image. The accreditation only applies to those who are paid under the Medicare Physician Fee Schedule.

CAUTION – What You Need to Know

If you are a provider submitting claims for the TC of advanced diagnostic imaging services for Medicare beneficiaries, you must be accredited by January 1, 2012, to be reimbursed for the claim if the service is performed on or after that date.

GO – What You Need to Do

You must be accredited by January 1, 2012, to be reimbursed for the claim if the service is performed on or after that date.

Background

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended the Social Security Act and required the Secretary, Department of Health and Human Services (DHHS) to designate organizations to accredit suppliers, including but not limited to physicians, non-physician practitioners and IDTFs, who furnish the TC of advanced diagnostic imaging services. MIPPA specifically defines advanced diagnostic imaging procedures as including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging, such as positron emission tomography (PET).

In order to furnish the TC of advanced diagnostic imaging services for Medicare beneficiaries, suppliers must be accredited by January 1, 2012.

Additional Information

You may also want to review MM7176

(<http://www.cms.gov/MLN MattersArticles/downloads/MM7176.pdf>) and SE1122 available at <http://www.cms.gov/MLN MattersArticles/downloads/SE1122.pdf> for further information about these Accreditation Requirements.

To obtain additional information about the accreditation process, please contact the AOs listed on the Medicare Provider-Supplier Enrollment page, Advanced Diagnostic Imaging Accreditation, available at

http://www.cms.gov/MedicareProviderSupEnroll/03_AdvancedDiagnosticImagingAccreditation.asp on the CMS website.

If you have questions, please contact your carrier or A/B MAC at their toll-free number which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

ANNUAL UPDATE OF HCPCS CODES USED FOR HOME HEALTH CONSOLIDATED BILLING ENFORCEMENT

~CMS MLN Article~

MLN Matters® Number: MM7599

Related CR Release Date: October 7, 2011

Related CR Transmittal #: R2317CP

Related Change Request (CR) #: 7599

Effective Date: January 1, 2012

Implementation Date: January 3, 2012

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare administrative contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries during an episode of home health care are affected.

Provider Action Needed

This article announces that Change Request (CR) 7599 is a recurring update notification that provides the annual HH consolidated billing update, effective January 1, 2012. Make sure your billing staff is aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (HCPCS) codes subject to the consolidated billing provision of the HH Prospective Payment System (HH PPS). With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a HH episode (i.e., under a HH plan of care administered by a home health agency). Medicare will only directly reimburse the primary HH agencies that have opened such episodes during the episode periods. Therapies performed by physicians, supplies incidental to physician services and supplies used in institutional settings are not subject to HH consolidated billing.

The HH consolidated billing code lists are updated annually, to reflect the annual changes to the HCPCS code set itself. Additional updates may occur as frequently as quarterly in order to reflect the creation of temporary HCPCS codes (e.g., 'K' codes) throughout the calendar year. The new coding identified in each update describes the same services that were used to determine the applicable HH PPS payment rates. No additional services will be added by these updates. New updates are required by changes to the coding system, not because the services subject to HH consolidated billing are being redefined.

Key Points

The HCPCS codes in the table below are being added to the HH consolidated billing supply code list.

Added HCPCS Code	Descriptor
A5056	Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each.
A5057	Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each.

Additional Information

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

The official instruction (CR7599) issued to your Medicare Carrier/FI/RHHI/MAC is available at <http://www.cms.gov/Transmittals/downloads/R2317CP.pdf> on the CMS website on the CMS website.

INSTRUCTIONS TO ACCEPT AND PROCESS ALL AMBULANCE TRANSPORTATION HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES

~Revised CMS MLN Article~

MLN Matters® Number: MM7489 Revised

Related CR Release Date: August 5, 2011

Related CR Transmittal #: R942OTN

Related Change Request (CR) #: CR 7489

Effective Date: January 1, 2012

Implementation Date: January 3, 2012

Note: This article was revised on October 13, 2011, to add a sentence to the “Go – What You Need to Do” section. All other information remains the same.

Provider Types Affected

This article is for ambulance providers and suppliers who bill Medicare Carriers, fiscal intermediaries (FIs), or Medicare Administrative Contractors (A/B MACs) for ambulance transportation services and transportation-related services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

Effective January 1, 2012, you will be able to submit “no-pay bills” to Medicare for statutorily excluded ambulance transportation services and transportation-related services, to obtain a Medicare denial to submit to a beneficiary’s secondary insurance for coordination of benefits purposes.

CAUTION – What You Need to Know

Change Request (CR) 7489, from which this article is taken, announces that, effective January 1, 2012, Medicare FIs, carriers, and A/B MACs will revise their claims processing systems to begin to allow for the adjudication of claims containing HCPCS codes that identify Medicare statutorily-excluded ambulance transportation services and transportation-related services. Medicare will then deny claims containing these codes as “non-covered,” which will allow you to submit the denied claim to a beneficiary’s secondary insurance for coordination of benefits purposes.

GO – What You Need to Do

You should ensure that your billing staffs are aware of this change and the need to include the “GY” modifier with the HCPCS code identifying the excluded ambulance transportation service and transportation-related services. In addition, if you are a facility-based ambulance provider billing a CMS-1450 claim form or the electronic equivalent (837I), you should be aware that you need to bill using the following non-covered revenue codes: 541, 542, 544, 547, 549, as applicable to the excluded ambulance transportation and transportation related-services that you are billing.

Background

Certain HCPCS codes identify various transportation services that are statutorily excluded from Medicare coverage and, therefore, not payable when billed to Medicare. In the Medicare Physician Fee Schedule Database (MPFSDB), a status indicator of “I” or “X” is associated with these codes. The “I” indicates that the HCPCS code is “Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these

services.” The “X” indicates a “statutory exclusion” of the code. (See the “Medicare Claims Processing Manual,” Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 30.2.2 (MPFSDB Status Indicators), available at <http://www.cms.gov/manuals/downloads/clm104c23.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.)

Because HCPCS codes are valid codes under the Health Insurance Portability and Accountability Act (HIPAA), claims for ambulance transportation and transportation-related services (HCPCS codes A0021 through A0424 and A0998) that are statutorily excluded or otherwise not payable by Medicare should be allowed into the Medicare claims processing system for adjudication and, since these services are statutorily excluded from, or otherwise not payable by, Medicare, then denied as such. Doing so affords providers and suppliers submitting the claims on behalf of Medicare beneficiaries the opportunity to submit “no-pay bills” to Medicare for statutorily excluded or otherwise not payable by Medicare services with the HCPCS code that accurately identifies the service that was furnished to the Medicare beneficiary. This, in turn, will allow providers/suppliers to obtain a Medicare denial to submit to a beneficiary’s secondary insurance for coordination of benefits purposes.

If you wish to bill for statutorily-excluded ambulance transportation services and transportation-related services to obtain a “Medicare denial,” you should bill for such services by attaching the “GY” modifier to the HCPCS code identifying the service, according to long-standing CMS policy. Additionally, if you are a facility-based ambulance provider submitting claims on the CMS Form-1450 or its electronic equivalent 837I, you should bill using the following non-covered revenue codes, depending on the statutorily-excluded ambulance transportation and/or transportation-related services that you are billing: 541, 542, 544, 547, 549.

When denying these claims for statutorily excluded services, your carrier, FI, or A/B MAC will use the following remittance advice language:

- Claim Adjustment Reason Code - 96 – “Non-covered charge(s);”
- Remittance Advice Remark Code - N425 – “Statutorily excluded service(s);” and
- Group Code - PR – “Patient Responsibility.”

Note: Make sure that you include the HCPCS code and, if necessary, the revenue code(s) that accurately identify the excluded ambulance transportation service and transportation-related services that the beneficiary was furnished.

Additional Information

You can find more information about instructions given to your carrier, FI, or A/B MAC to accept and process all ambulance transportation HCPCS Codes by going to CR7489, located at <http://www.cms.gov/Transmittals/downloads/R942OTN.pdf> on the CMS website.

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

**MAGNETIC RESONANCE IMAGING (MRI) IN MEDICARE
BENEFICIARIES WITH FOOD AND DRUG ADMINISTRATION
(FDA)-APPROVED IMPLANTED PERMANENT PACEMAKERS (PMS)
FOR USE IN THE MRI ENVIRONMENT**
~ Revised CMS MLN Article ~

MLN Matters® Number: MM7441 Revised
Related CR Release Date: September 22, 2011
Related CR Transmittal #: R2307CP and R135NCD

Related Change Request (CR) #: 7441
Effective Date: July 7, 2011
Implementation Date: September 26, 2011

Note: This article was revised on September 23, 2011, to reflect the release of an updated Change Request (CR) 7441. The transmittal number, CR release date, and link to accessing the transmittal have been changed. All other information is the same.

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (Fiscal Intermediaries (FI), Carriers, or A/B Medicare Administrative Contractors (A/B MAC)) for providing Magnetic Resonance Imaging (MRI) services to Medicare beneficiaries are affected.

What You Need to Know

This article, based on Change Request (CR) 7441, informs you that Medicare believes that the evidence is adequate to conclude that MRIs improve health outcomes for Medicare beneficiaries with implanted Pacemakers (PMs) when the PMs are used according to the Food and Drug Administration (FDA)-approved labeling for use in an MRI environment. Effective for services on or after July 7, 2011, Medicare will allow coverage of MRIs for beneficiaries with implanted PMs when the PMs are used according to the FDA-approved labeling for use in an MRI environment.

Effective for claims with dates of service on or after July 7, 2011, you should include the following information on MRI claims for beneficiaries with implanted PMs that are FDA-approved for use in an MRI environment:

- Appropriate MRI code;
- KX modifier; and
- ICD-9 code V45.01 (cardiac pacemaker).

Inclusion of the KX modifier on the claim line(s) means that the provider attests that documentation is on file verifying that FDA-approved labeling requirements are met. For such claims without the KX modifier, Medicare will deny MRI line items using the following remittance advice messages:

- Group Code of CO (contractual obligation); and
- Claim Adjustment Reason Code (CARC) 188 (This product/procedure is only covered when used according to FDA recommendations.).

As described previously in the MLN Matters® article MM7296 (<http://www.cms.gov/MLN MattersArticles/downloads/MM7296.pdf>), Medicare posted a separate decision on February 24, 2011, that allows coverage of MRIs for beneficiaries with implanted PMs or implantable cardioverter defibrillators (ICDs) for use in an MRI environment in a Medicare-approved clinical study. This policy is effective for claims with

dates of service on and after February 24, 2011. Providers should follow the instructions issued in the MM7296 article **and** the additional instructions referenced below.

The following information should be included on MRI claims for beneficiaries with implanted PMs or ICDs for use in an MRI environment in a Medicare-approved clinical study:

- Appropriate MRI code;
- Q0 modifier;
- ICD-9 code V70.7 - Examination of participant in clinical trial (institutional claims only);
- Condition code 30 (institutional claims only); and
- ICD-9 code V45.02 (automatic cardiac defibrillator) or CPT code V45.01 (cardiac pacemaker).

MRI claims for beneficiaries with implanted PMs or ICDs for use in an MRI environment in a Medicare-approved clinical study that do not include all the line items listed above will be denied using the following remittance messages:

- Group Code of CO;
- CARC B5 (Coverage/program guidelines were not met or were exceeded); and
- Remittance Advice Remarks Code (RARC) 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 www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD).

Providers are reminded that ICD-10 implementation occurs on October 1, 2013. At that time the ICD-9 codes mentioned above will be replaced by the appropriate ICD-10 codes, which are:

- ICD-10 - Z006 - Encounter for examination for normal comparison and control in clinical research program;
- ICD-10- Z950 - Presence of cardiac pacemaker; and
- ICD-10- Z95810 - Presence of automatic implantable cardiac defibrillator.

Medicare payment for these services is as follows:

- Professional claims (practitioners and suppliers) - based on the Medicare Physician Fee Schedule (MPFS).
- Inpatient (Type of Bill (TOB) 11x) - Prospective payment system (PPS), based on the diagnosis-related group.
- Hospital outpatient departments (TOB 13x) - Outpatient PPS, based on the ambulatory payment classification.
- Rural Health Clinics (RHCs)/Federally Qualified Health Centers (FQHCs) (TOB 71x/77x) - All-inclusive rate, professional component only, based on the visit furnished to the RHC/FQHC beneficiary to receive the MRI. The technical component is outside the scope of the RHC/FQHC benefit. Therefore the provider of the technical service bills their carrier or A/B MAC on the ANSI X12N 837P or hardcopy Form CMS-1500 and payment is made under the MPFS.
- Critical Access Hospitals (CAHs) (85x) - For CAHs that elected the optional method of payment for outpatient services, the payment for technical services would be the same as the CAHs that did not elect the optional method, which is reasonable cost. The FI or A/B MAC pays the professional component at 115% of the MPFS.

Medicare will not adjust claims automatically that were processed prior to implementation of CR7441. However, they will adjust such claims that you bring to the attention of your Medicare contractor.

Please be sure that your staffs are aware of these changes.

Additional Information

To view the article, MM7296, "Magnetic Resonance Imaging (MRI) in Medicare Beneficiaries with Implanted Permanent Pacemakers (PMs) or Implantable Cardioverter Defibrillators (ICDs)," visit <http://www.cms.gov/MLN MattersArticles/Downloads/MM7296.pdf> on the CMS website.

The official instruction, CR 7441, was issued to your FI, carrier, or A/B MAC regarding this change in two transmittals. The first modified the National Coverage Determinations Manual and is at <http://www.cms.gov/Transmittals/downloads/R135NCD.pdf> on the CMS website. The second updates the Medicare Claims Processing Manual and is at <http://www.cms.gov/Transmittals/downloads/R2307CP.pdf> on the CMS website.

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

MEDICARE FEE-FOR-SERVICE (FFS) CLAIMS PROCESSING GUIDANCE FOR IMPLEMENTING INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH EDITION (ICD-10) ~CMS MLN Article~

MLN Matters® Number: MM7492
Related CR Release Date: August 19, 2011
Related CR Transmittal #: R950OTN

Related Change Request (CR) #: 7492
Effective Date: October 1, 2013
Implementation Date: January 1, 2012

Provider Types Affected

This article is for all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (MACs), Regional Home Health Intermediaries (RHHs), and Durable Medical Equipment MACs (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

For dates of service on and after October 1, 2013, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the ICD-10 code sets in standard transactions adopted under HIPAA. The HIPAA standard health care claim transactions are among those for which ICD-10 codes must be used for dates of service on and after October 1, 2013. Make sure your billing and coding staffs are aware of these changes.

Key Points of CR7492**General Reporting of ICD-10**

As with ICD-9 codes today, providers and suppliers are still required to report all characters of a valid ICD-10 code on claims. ICD-10 diagnosis codes have different rules regarding specificity and providers/suppliers are required to submit the most specific diagnosis codes based upon the information that is available at the time. Please refer to <http://www.cms.gov/ICD10/> for more information on the format of ICD-10 codes. In addition, ICD-10 Procedure Codes (PCs) will only be utilized by inpatient hospital claims as is currently the case with ICD-9 procedure codes.

General Claims Submissions Information

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with FROM dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2013. Institutional claims containing ICD-9 codes for services on or after October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2013, will also be returned as unprocessable. You will be required to re-submit these claims with the appropriate ICD-10 code. A claim cannot contain both ICD-9 codes and ICD-10 codes. Medicare will RTP/return as unprocessable all claims that are billed with **both** ICD-9 and ICD-10 **diagnosis codes** on the same claim. For dates of service **prior to** October 1, 2013, submit claims with the appropriate ICD-9 diagnosis code. For dates of service on or after October 1, 2013, submit with the appropriate ICD-10 diagnosis code. Likewise, Medicare will also RTP/return as unprocessable all claims that are billed with **both** ICD-9 and ICD-10 **procedure codes** on the same claim. For claims with dates of service prior to October 1, 2013, submit with the appropriate ICD-9 procedure code. For claims with dates of service on or after October 1, 2013, submit with the appropriate ICD-10 procedure code. Remember that ICD-10 codes may only be used for services provided on or after October 1, 2013. Institutional claims containing ICD-10 codes for services prior to October 1, 2013, will be Returned to Provider (RTP). Likewise, professional and supplier claims containing ICD-10 codes for services prior to October 1, 2013, will be returned as unprocessable. Please submit these claims with the appropriate ICD-9 code.

Claims that Span the ICD-10 Implementation Date

The Centers for Medicare & Medicaid Services (CMS) has identified potential claims processing issues for institutional, professional, and supplier claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services that were rendered on September 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services that were rendered October 1, 2013, and later. In some cases, depending upon the policies associated with those services, there cannot be a break in service or time (i.e., anesthesia) although the new ICD-10 code set must be used effective October 1, 2013. The following tables provide further guidance to providers for claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

Table A – Institutional Providers

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (<i>incl. TERFHA hospitals, Prospective Payment System (PPS) hospitals, Long Term Care Hospitals (LTCHs), Critical Access Hospitals (CAHs)</i>)	If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
13X	Outpatient Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
14X	Non-patient Laboratory Services	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
23X	Skilled Nursing Facilities (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health – Request for Anticipated Payment (RAPs)*	* NOTE - RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	*See Note
34X	Home Health – (Outpatient)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
71X	Rural Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
76X	Community Mental Health Clinics	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
77X	Federally Qualified Health Clinics (effective 4/4/10)	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
81X	Hospice- Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
82X	Hospice – Non hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM
83X	Hospice – Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims - Require providers split the claim so all ICD-9 codes remain on one claim with Dates of Service (DOS) through 9/30/2013 and all ICD-10 codes placed on the other claim with DOS beginning 10/1/2013 and later.	FROM

Table B - Special Outpatient Claims Processing Circumstances

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three (3) days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

Table C – Professional Claims

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.	FROM

Table D –Supplier Claims

Supplier Type	Claims Processing Requirement	Use FROM or THROUGH/TO Date
DMEPOS	Billing for certain items or supplies (such as capped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).	FROM

Additional Information

The official instruction, CR7492 issued to your carrier, FI, RHHI, or MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R950OTN.pdf> on the CMS website.

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

NEW INFLUENZA VIRUS VACCINE CODE

~ Revised CMS MLN Article ~

MLN Matters® Number: MM7580 Revised
 Related CR Release Date: October 28, 2011
 Related CR Transmittal #: R2337CP

Related Change Request (CR) #: 7580
 Effective Date: May 9, 2011
 Implementation Date: April 2, 2012

Note: This article was revised on November 15, 2011, to correct the implementation date (above) to show April 2, 2012. All other information remains the same.

Provider Types Affected

Providers and physicians submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for influenza vaccines provided to Medicare beneficiaries are affected by this article.

What You Need to Know

Effective May 9, 2011, claims with influenza virus vaccine code 90654 (influenza virus vaccine, split virus, preservative-free, for intradermal use, for adults ages 18 – 64) will be payable by Medicare for claims with dates of service on or after May 9, 2011, if submitted on or after April 2, 2012. HCPCS code 90654 was added to the 2011 HCPCS file effective January 1, 2011. However, 90654 didn't become payable by Medicare until May 9, 2011.

Please make sure your billing staff is aware of these changes. Medicare contractors will not adjust claims submitted prior to May 9, unless you bring such claims to their attention.

Background

Change Request (CR) 7580 advises that payment for this code to institutional providers is as follows:

- Hospitals (Types of Bill (TOB) 12X and 13X, Skilled Nursing Facilities (SNFs) (TOBs 22X and 23X), Home Health Agencies (HHAs) (TOB 34X), hospital-based Renal Dialysis Facilities (RDFs) (TOB 72X) and Critical Access Hospitals (CAHs) (TOB 85X) are paid on reasonable cost;
- Indian Health Service (IHS) hospitals (TOB12X and 13X) and IHS CAHs (TOB 85X) are paid based on the lower of the actual charge or 95% of the Average Wholesale Price (AWP); and
- Comprehensive outpatient rehabilitation facilities and independent RDFs (TOB 72X) are paid based on the lower of the actual charge or 95% of the AWP.

Additional Information

The official instruction, CR7580, issued to your carrier, RHHI, FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2337CP.pdf> on the CMS website.

If you have any questions, please contact your carrier, RHHI, FI or A/B MAC at their toll-free number, which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

NEW WAIVED TESTS

~ Revised CMS MLN Article ~

MLN Matters® Number: MM7566
Related CR Release Date: October 21, 2011
Related CR Transmittal #: R2321CP

Related Change Request (CR) #: 7566
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

This article is for clinical diagnostic laboratories billing Medicare Carriers or Part A/B Medicare Administrative Contractors (MACs) for laboratory tests.

Provider Action Needed

STOP – Impact to You

If you do not have a valid, current, Clinical Laboratory Improvement Amendments of 1998 (CLIA) certificate and submit a claim to your Medicare Carrier or A/B MAC for a Current Procedural Terminology (CPT) code that is considered to be a laboratory test requiring a CLIA certificate, your Medicare payment may be impacted.

CAUTION – What You Need to Know

CLIA requires that for each test it performs, a laboratory facility must be appropriately certified. The CPT codes that the Centers for Medicare & Medicaid Services (CMS) considers to be laboratory tests under CLIA (and thus requiring certification) change

each year. Change Request (CR) 7566, from which this article is taken, informs carriers and MACs about the latest new CPT codes that are subject to CLIA edits.

GO – What You Need to Do

Make sure that your billing staffs are aware of these CLIA-related changes for 2012 and that you remain current with certification requirements.

Background

Listed below are the latest tests approved by the Food and Drug Administration (FDA) as waived tests under CLIA. The CPT codes in the following table must have the modifier QW to be recognized as a waived test. However, CPT codes 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651 do not require a QW modifier to be recognized as a waived test.

CPT Code	Effective Date	Description
81003QW	February 14, 2011	Germaine Laboratories Inc. AimStrip Urine Analyzer
G0434QW	April 22, 2011	UCP Biosciences, Inc. UCP Drug Screening Test Cups
G0434QW	April 22, 2011	Diagnostic Test Group Clarity Multiple Drug Screen Test Cups
81003QW	March 24, 2011	Mediwatch urinewatch Urine Analyzer
G0434QW	June 17, 2011	Insight Medical Drug of Abuse Urine Cassette Test
G0434QW	June 17, 2011	Insight Medical Drug of Abuse Urine Cup Test
G0434QW	June 17, 2011	Instant Technologies, Inc. iScreen Drug of Abuse Urine (Cassette) Test
G0434QW	June 17, 2011	Instant Technologies, Inc. iScreen Drug of Abuse Urine (Cup) Test
G0434QW	June 17, 2011	Jant Pharmacal Accutest Drug of Abuse Urine (Cassette) Test
G0434QW	June 17, 2011	Jant Pharmacal Accutest Drug of Abuse Urine (Cup) Test
G0434QW	June 17, 2011	Total Diagnostic Solutions Drug of Abuse Urine (Cassette) Test
G0434QW	June 17, 2011	Total Diagnostic Solutions Drug of Abuse Urine (Cup) Test
G0434QW	June 30, 2011	Diagnostic Test Group Clarity Simple Drug Screening Cups
G0434QW	June 30, 2011	Diagnostic Test Group Clarity Multi-Drug Test Cards
81003QW	July 14, 2011	Stanbio Uri-Trak 120 Urine Analyzer
G0434QW	July 21, 2011	UCP Biosciences, Inc. U-Checker Drug Screening Test Cups

Additional Information

The official instruction, CR7566 issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2321CP.pdf> on the CMS website.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

OCTOBER QUARTERLY UPDATE TO 2011 ANNUAL UPDATE OF HCPCS CODES USED FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB) ENFORCEMENT

~Revised CMS MLN Article~

MLN Matters® Number: MM7444 Revised
Related CR Release Date: September 13, 2011
Related CR Transmittal #: R2300CP

Related Change Request (CR) #: CR 7444
Effective Date: January 1, 2011
Implementation Date: October 3, 2011

Note: This article was revised to reflect the revised CR7444 issued on September 23, 2011. The article was revised to add HCPCS codes J9033 and G0121 to the bullet points on page 2. Also, the CR transmittal number, release date, and the web address for accessing the CR were revised. All other information is the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7444 which provides the October quarterly update to the 2011 Healthcare Common Procedure Coding System (HCPCS) codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) enforcement. CR7444 instructs the Medicare system maintainers to add HCPCS code J0894 (Injection, decitabine, 1 mg) to the File 1 Coding List for SNF CB and to Major III.A Chemotherapy services list in the FI/A/B MAC file for dates of service on or after January 1, 2011.

Background

The Social Security Act (Section 1888; see http://www.ssa.gov/OP_Home/ssact/title18/1888.htm on the Internet) codifies the Skilled Nursing Facility Prospective Payment System (SNF PPS) and consolidated billing (CB), and the Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the CB provision of the SNF PPS. No additional services are added by these routine updates. New updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

Services excluded from the SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. **Services not appearing on the exclusion lists** submitted on claims to Medicare contractors, including Durable Medical Equipment (DME) MACs, will not be paid by Medicare to any providers other than a SNF.

For non-therapy services, SNF CB applies only when the services are 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. In order to assure proper payment in all settings, Medicare must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

CR7444 instructs Medicare systems maintainers to:

- Add Healthcare Common Procedure Coding System (HCPCS) code J0894 to the File 1 Coding List for SNF Consolidated Billing for dates of service on or after January 1, 2011;
- Add HCPCS Code J9033 to the File 1 Coding list for SNF Consolidated Billing for dates of service on or after October 1, 2011;
- Add HCPCS code J0894 to Major Category III. A Chemotherapy services list in the FI/A/B MAC file effective January 1, 2011;
- Add HCPCS code J9033 to Major Category III. A Chemotherapy services list in the FI/A/B MAC file effective for dates of service on or after October 1, 2011; and
- Add HCPCS code G0121 to Major Category IV services effective January 1, 2011.

Note that Medicare contractors will reprocess claims affected by CR7444 when brought to their attention.

Additional Information

The official instruction, CR7444, issued to your carriers, FIs, or A/B MACs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2300CP.pdf> on the CMS website.

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

PHARMACY BILLING FOR DRUGS PROVIDED "INCIDENT TO" A PHYSICIAN SERVICE ~Revised CMS MLN Article~

MLN Matters® Number: MM7397 Revised
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R2312CP

Related Change Request (CR) #: 7397
Effective Date: January 1, 2012
Implementation Date: January 1, 2012

Note: This article was revised on September 26, 2011, to reflect the revised CR7397 issued on September 23. The effective and implementation dates were changed. Also, the CR release date, transmittal number, and the web address for accessing CR7397 were revised. All other information remains the same.

Provider Types Affected

Pharmacies that submit claims for drugs to Medicare contractors (Fiscal Intermediaries (FIs), Carriers, Regional Home Health Intermediaries (RHHIs), A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment MACs) are affected.

What You Should Know

This article is based on Change Request (CR) 7397, which clarifies policy with respect to restrictions on pharmacy billing for drugs provided “incident to” a physician service. The CR also clarifies policy for the local determination of payment limits for drugs that are not nationally determined.

This article notes that CR 7397 rescinds and fully replaces CR 7109. Please be sure your staffs are aware of this update.

Background***Pharmacies Billing Drugs***

Pharmacies may bill Medicare Part B for certain classes of drugs, including immunosuppressive drugs, oral anti-emetic drugs, oral anti-cancer drugs, and drugs self-administered through any piece of durable medical equipment.

Claims for these drugs are generally submitted to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The carrier or A/B MAC will reject these claims as they need to be sent to the DME MAC.

In the rare situation where a pharmacy dispenses a drug that will be administered through implanted DME and a physician’s service will not be utilized to fill the pump with the drug, the claim is submitted to the A/B MAC or carrier.

The DME MAC, A/B MAC, or carrier will make payment to the pharmacy for these drugs, when deemed to be covered and reasonable and necessary. All bills submitted to the DME MAC, A/B MAC, or carrier must be submitted on an assigned basis by the pharmacy.

When Drugs May Not be Billed by Pharmacies to Medicare Part B

Pharmacies, suppliers, and providers may not bill Medicare Part B for drugs dispensed directly to a beneficiary for administration “incident to” a physician service, such as refilling an implanted drug pump. These claims will be denied.

Pharmacies may not bill Medicare Part B for drugs furnished to a physician for administration to a Medicare beneficiary. When these drugs are administered in the physician’s office to a beneficiary, the only way these drugs can be billed to Medicare is if the physician purchases the drugs from the pharmacy. In this case, the drugs are being administered “incident to” a physician’s service and pharmacies may not bill Medicare Part B under the “incident to” provision.

Payment Limits

The payment limits for drugs and biologicals that are not included in the average sales price (ASP) Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing, except under the Outpatient Prospective Payment System (OPPS) where the payment allowance limit is 95 percent of the published average wholesale price (AWP). In determining the payment limit based on WAC, the payment limit is 106 percent of the lesser of the lowest-priced brand or median generic WAC.

Medicare contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but will adjust claims brought to their attention.

Additional Information

The official instruction, CR 7397 issued to your Medicare contractor regarding this issue may be viewed at <http://www.cms.gov/Transmittals/downloads/R2312CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

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

The following manual sections regarding billing drugs and biological and “incident to” services may be helpful:

- “Medicare Claims Processing Manual,” chapter 17, sections 20.1.3 and 50.B, available at <http://www.cms.gov/manuals/downloads/clm104c17.pdf> and
- “Medicare Benefit Policy Manual,” chapter 15, sections 50.3 and 60.1, available at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf> on the CMS website.

QUARTERLY UPDATE TO CORRECT CODING INITIATIVE (CCI) EDITS, VERSION 18.0, EFFECTIVE JANUARY 1, 2012 ~CMS MLN Article~

MLN Matters® Number: MM7616
Related CR Release Date: October 21, 2011
Related CR Transmittal #: R2322CP

Related Change Request (CR) #: CR 7616
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

This article is for physicians submitting claims to Medicare Carriers and/or A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7616 which provides a reminder for physicians to take note of the quarterly updates to Correct Coding Initiative (CCI) edits. The last quarterly release of the edit module was issued in October, 2011.

Background

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

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 by

- Review of current coding practice.

The latest package of CCI edits, Version 18.0, is effective January 1, 2012, and includes all previous versions and updates from January 1, 1996, to the present. It will be organized in two tables:

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

Additional information about the CCI, including the current CCI and Mutually Exclusive Code (MEC) edits, is available at <http://www.cms.gov/NationalCorrectCodInitEd> on the CMS website.

Additional Information

The CCI and MEC file formats are defined in the “Medicare Claims Processing Manual,” (Chapter 23, Section 20.9) which is available at <http://www.cms.gov/manuals/downloads/clm104c23.pdf> on the CMS website.

The official instruction, CR 7616, issued to your carrier or and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2322CP.pdf> on the CMS website.

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

Coverage – General**AUTOLOGOUS CELLULAR IMMUNOTHERAPY TREATMENT OF
METASTATIC PROSTATE CANCER****~ Revised CMS MLN Article ~**

MLN Matters® Number: MM7431 Revised
Related CR Release Date: November 2, 2011
Related CR Transmittal #: R2339CP and R136NCD

Related Change Request (CR) #: CR 7431
Effective Date: June 30, 2011
Implementation Date: August 8, 2011

Note: This article was revised on November 7, 2011, to reflect a revised CR7431 issued on November 2, 2011. The article has been revised to show that a separate payment for the cost of administration is allowed. In addition, the transmittal numbers, release date, and the web address for accessing CR7431 have been revised. All other information is the same.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or A/B Medicare Administrative Contractors (A/B MACs)) for metastatic prostate cancer treatment services provided to Medicare beneficiaries are affected.

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

This article is based on Change Request (CR) 7431 regarding the use of autologous cellular immunotherapy treatment for metastatic prostate cancer.

Caution – What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) finds that the evidence is adequate to conclude that the use of autologous cellular immunotherapy treatment - Sipuleucel-T; PROVENGE® improves health outcomes for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer. It is therefore reasonable and necessary to use for this on-label indication under the Social Security Act (1862(a)(1)(A)) effective for services performed on or after June 30, 2011.

GO – What You Need to Do

Make sure billing staff is aware of this article.

Background

In 2010 the Food and Drug Administration (FDA) approved Sipuleucel-T (APC8015) for patients with castration-resistant, metastatic prostate cancer. The posited mechanism of action, immunotherapy, is different from that of anti-cancer chemotherapy such as Docetaxel. This is the first immunotherapy for prostate cancer to receive FDA approval.

The goal of immunotherapy is to stimulate the body's natural defenses (such as the white blood cells called dendritic cells, T-lymphocytes and mononuclear cells) in a specific manner so that they attack and destroy, or at least prevent the proliferation of, cancer cells.

Specificity is attained by intentionally exposing a patient's white blood cells to a particular protein (called an antigen) associated with the prostate cancer. This exposure "trains" the white blood cells to target and attack the prostate cancer cells. Clinically, this is expected to result in a decrease in the size and/or number of cancer sites, an increase in the time to cancer progression, and/or an increase in survival of the patient.

Change Request (CR) 7431 instructs that, effective for services performed on or after June 30, 2011, CMS concludes that the evidence is adequate to support the use of autologous cellular immunotherapy treatment - Sipuleucel-T; PROVENGE® for Medicare beneficiaries with asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer.

Medicare contractors will continue to process claims for PROVENGE® with dates of service on June 30, 2011, as they do currently when providers submit Not Otherwise Classified Healthcare Common Procedure Coding System (HCPCS) code(s) J3590, J3490, or C9273. **HCPCS code C9273 will be deleted on June 30, 2011.**

The new HCPCS code Q2043 will:

- Replace C9273 (Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion);
- Be implemented in the July 2011 Update of Quarterly HCPCS Drug/Biological Code Changes (CR 7303 (Transmittal R2227CP); see <http://www.cms.gov/transmittals/downloads/R2227CP.pdf> on the CMS website); and
- Have an effective date of **July 1, 2011.**

The Ambulatory Surgical Center (ASC) Payment System will be updated to reflect these coding changes, and these changes will be announced in the ASC Quarterly Update CR for July 2011.

Coverage for PROVENGE®, Q2043, for asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer is limited to one (1) treatment regimen in a patient's lifetime, consisting of three (3) doses with each dose administered approximately two (2) weeks apart for a total treatment period not to exceed 30 weeks from the first administration.

The language given in the long descriptor of Provenge® that states "all other preparatory procedures" refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, subsequently sending the immune cells to the manufacturing facility, and then transporting the immune cells back to the site of service to be administered to the patient, as well as the infusion of the immune cells to the patient. Q2043 is all-inclusive and represents all routine costs, except for the cost of administration. Please note that the cost of administration can now be billed separately.

Note: For a local coverage determination by an individual MAC to cover PROVENGE® "off-label" for the treatment of prostate cancer, the International Classification of Diseases, Ninth Revision (ICD-9) diagnosis code must be either 233.4 (carcinoma in situ of prostate) or 185 (malignant neoplasm of prostate). ICD-9 diagnosis code 233.4 may not be used for "on-label" coverage claims.

Coding and Billing Information**ICD-9 Diagnosis Coding**

For claims with dates of service on and after July 1, 2011, for PROVENGE®, the on-label indication of asymptomatic or minimally symptomatic metastatic, castrate-resistant (hormone refractory) prostate cancer, must be billed using ICD-9 code 185 (malignant neoplasm of prostate) and at least one of the following ICD-9 codes:

ICD-9 code	Description
196.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
196.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
196.5	Secondary and unspecified malignant neoplasm of lymph nodes of inguinal region and lower limb
196.6	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
196.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple sites
196.9	Secondary and unspecified malignant neoplasm of lymph node site unspecified - The spread of cancer to and establishment in the lymph nodes.
197.0	Secondary malignant neoplasm of lung – Cancer that has spread from the original (primary) tumor to the lung. The spread of cancer to the lung. This may be from a primary lung cancer, or from a cancer at a distant site.
197.7	Malignant neoplasm of liver secondary - Cancer that has spread from the original (primary) tumor to the liver. A malignant neoplasm that has spread to the liver from another (primary) anatomic site. Such malignant neoplasms may be carcinomas (e.g., breast, colon), lymphomas, melanomas, or sarcomas.
198.0	Secondary malignant neoplasm of kidney - The spread of the cancer to the kidney. This may be from a primary kidney cancer involving the opposite kidney, or from a cancer at a distant site.
198.1	Secondary malignant neoplasm of other urinary organs
198.5	Secondary malignant neoplasm of bone and bone marrow – Cancer that has spread from the original (primary) tumor to the bone. The spread of a malignant neoplasm from a primary site to the skeletal system. The majority of metastatic neoplasms to the bone are carcinomas.
198.7	Secondary malignant neoplasm of adrenal gland
198.82	Secondary malignant neoplasm of genital organs

Coding for Off-Label PROVENGE® Services

At the discretion of the local Medicare Administrative Contractors, claims with dates of service on and after July 1, 2011, for PROVENGE® paid off-label for the treatment of prostate cancer must be billed using either ICD-9 code 233.4 (carcinoma in situ of prostate) or 185 (malignant neoplasm of prostate) in addition to HCPCS Q2043. Effective with the implementation date for ICD-10 codes, off-label PROVENGE®

services must be billed with either ICD-10 code D075 (carcinoma in situ of prostate) or C61 (malignant neoplasm of prostate) in addition to HCPCS Q2043.

ICD-10 Diagnosis Coding

The appropriate ICD-10 code(s) that are listed below are for future implementation.

ICD-10	Description
C61	Malignant neoplasm of prostate (for on-label or off-label indications)
D075	Carcinoma in situ of prostate (for off-label indications only)
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
C77.2	Secondary and unspecified malignant neoplasm of intra-abdominal lymph nodes
C77.4	Secondary and unspecified malignant neoplasm of inguinal and lower limb lymph nodes
C77.5	Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
C77.8	Secondary and unspecified malignant neoplasm of lymph nodes of multiple regions
C77.9	Secondary and unspecified malignant neoplasm of lymph node, unspecified
C78.00	Secondary malignant neoplasm of unspecified lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C78.7	Secondary malignant neoplasm of liver
C79.00	Secondary malignant neoplasm of unspecified kidney and renal pelvis
C79.01	Secondary malignant neoplasm of right kidney and renal pelvis
C79.02	Secondary malignant neoplasm of left kidney and renal pelvis
C79.10	Secondary malignant neoplasm of unspecified urinary organs
C79.11	Secondary malignant neoplasm of bladder
C79.19	Secondary malignant neoplasm of other urinary organs
C79.51	Secondary malignant neoplasm of bone
C79.52	Secondary malignant neoplasm of bone marrow
C79.70	Secondary malignant neoplasm of unspecified adrenal gland
C79.71	Secondary malignant neoplasm of right adrenal gland
C79.72	Secondary malignant neoplasm of left adrenal gland
C79.82	Secondary malignant neoplasm of genital organs

Types of Bill (TOB) and Revenue Codes

The applicable TOBs for PROVENGE® are: 12X, 13X, 22X, 23X, 71X, 77X, and 85X.

On institutional claims, TOBs 12X, 13X, 22X, 23X, and 85X, use revenue code 0636 - drugs requiring detailed coding.

Payment Methods

Payment for PROVENGE® is as follows:

- TOBs 12X, 13X, 22X and 23X - based on the Average Sales Price (ASP) + 6%,
- TOB 85X – based on reasonable cost,

- TOBs 71X and 77X – based on all-inclusive rate (drugs/supplies are not reimbursed separately).
- For Medicare Part B practitioner claims, payment for PROVENGE® is based on ASP + 6%.

Note: Medicare Contractors will not pay separately for routine costs associated with PROVENGE®. HCPCS Q2043 is all-inclusive and represents all routine costs associated with its administration.

Remittance Advice Remark Codes (RARCs), Claim Adjustment Reason Codes (CARCs), and Group Codes

Medicare will use the following messages when denying claims for the on-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 185 and at least one diagnosis code from the ICD-9 table shown above:

- RARC 167 - This (these) diagnosis (es) are not covered. Note: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Group Code - Contractual Obligation (CO)

Medicare will use the following messages when denying line items on claims for the off-label indication for PROVENGE®, HCPCS Q2043, submitted without ICD-9-CM diagnosis code 233.4 or 185:

- RARC 167 - This (these) diagnosis (es) are not covered. Note: Refer to the 835 Healthcare Policy Identification segment (loop 2110 Service Payment Information REF), if present.
- Group Code – CO.

When denying claims for PROVENGE®, HCPCS Q2043® that exceed three (3) payments in a patient's lifetime, contractors shall use the following messages:

- RARC N362 - The number of Days or Units of Service exceeds our acceptable maximum.
- CARC 149 - Lifetime benefit maximum has been reached for this service/benefit category.
- Group Code - CO.

When denying claims for PROVENGE®, HCPCS Q2043® that are provided more than 30 weeks from the date of the 1st PROVENGE® administration, contractors shall use the following messages:

- CARC B5 – Coverage/program guidelines were not met or were exceeded.
- Group Code – CO.

Additional Information

The official instruction, CR 7431, was issued to carriers, FIs, and A/B MACs via two transmittals. The first modifies the National Coverage Determinations manual and it is at <http://www.cms.gov/Transmittals/downloads/R136NCD.pdf> on the CMS website. The second updates the Medicare Claims Processing Manual and it is at <http://www.cms.gov/Transmittals/downloads/R2339CP.pdf> on the CMS website.

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

CHANGES TO THE LABORATORY NATIONAL COVERAGE DETERMINATION (NCD) EDIT SOFTWARE FOR JANUARY 2012 ~CMS MLN Article~

MLN Matters® Number: MM7621

Related CR Release Date: November 4, 2011

Related Change Request (CR) #: 7621

Effective Date: January 1, 2012, except one item
(note below, which has an effective date of
October 1, 2011)

Related CR Transmittal #: R2344CP

Implementation Date: January 3, 2012

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7621, which announces the changes that will be included in the January 2012 release of Medicare's edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in October 2011. Please ensure that your billing staffs are aware of these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective July 1, 2003. In accordance with the "Medicare Claims Processing Manual," Chapter 16, Section 120.2, available at <http://www.cms.gov/manuals/downloads/clm104c16.pdf> on the Centers for Medicare & Medicaid Services (CMS) website, the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the ICD-9-CM codes.

CR 7621 Changes to the NCD Code Lists

CR 7621 announces changes to the laboratory edit module for changes in laboratory NCD code lists for January 2012. The changes to the NCD code lists are described below and are effective for dates of service on and after January 1, 2012.

Deleted ICD-9-CM Codes

- Delete ICD-9-CM codes 425.11 and 425.18 from the list of ICD-9-CM codes that are covered by Medicare for the **Alpha-fetoprotein (190.25) NCD**.

Added ICD-9-CM Codes (Effective October 1, 2011)

- Add ICD-9-CM codes 786.50 and 786.51 to the list of ICD-9-CM codes that are covered by Medicare for the Prothrombin Time (PT)(190.17) NCD.

ICD-10-CM Codes

- CR7621 also contains two ICD-10 codes that contractors will track to ensure that these edits are properly updated during the ICD-10 implementation (see table below).

ICD-9-CM Code	ICD-10-CM Code
786.50	R07.9
786.51	R07.2

Note: Contractors will not search their files to either retract payment for claims already paid or to retroactively pay claims, but they will adjust claims brought to their attention.

Additional Information

The official instruction, CR 7621 issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2344CP.pdf> on the CMS website.

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

**CHANGES TO THE LABORATORY NATIONAL COVERAGE
DETERMINATION (NCD) EDIT SOFTWARE FOR OCTOBER 2011**
~ Revised CMS MLN Article ~

MLN Matters® Number: MM7507 Revised
Related CR Release Date: September 2, 2011
Related CR Transmittal #: R2298CP

Related Change Request (CR) #: 7507
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Note: This article was revised on September 6, 2011, to reflect a revised CR7507. The CR was revised to add some codes and delete some codes from the various NCDs. In addition, the CR release date, transmittal number, and the web address for accessing the CR have been revised.

Provider Types Affected

This article is for physicians, providers, and suppliers submitting claims to Medicare Carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for clinical diagnostic laboratory services provided for Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 7507, which announces the changes that will be included in the October 2011 release of Medicare's edit module for clinical diagnostic laboratory National Coverage Determinations (NCDs). The last quarterly release of the edit module was issued in April 2011. Be sure billing staff know about these changes.

Background

The NCDs for clinical diagnostic laboratory services were developed by the laboratory negotiated rulemaking committee and published in a final rule on November 23, 2001. Nationally uniform software was developed and incorporated in Medicare's systems so that laboratory claims subject to one of the 23 NCDs were processed uniformly throughout the nation effective July 1, 2003. In accordance with the "Medicare Claims Processing Manual," Chapter 16, Section 120.2, available at <http://www.cms.gov/manuals/downloads/clm104c16.pdf> on the Centers for Medicare & Medicaid Services (CMS) website, the laboratory edit module is updated quarterly (as necessary) to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process.

CR7507 announces changes to the laboratory edit module for changes in laboratory NCD code lists for October 2011. These changes become effective for services furnished on or after October 1, 2011. The changes that are effective for dates of service on and after October 1, 2011 are as follows:

- For Codes That Are Denied By Medicare For All 23 Lab NCDs:
 - Delete ICD-9-CM code V19.1 from the list of ICD-9-CM codes that are denied by Medicare for all 23 Lab NCDs.
 - Add ICD-9-CM codes V19.11 and V19.19 to the list of ICD-9-CM codes that are denied by Medicare for all 23 Lab NCDs.
- For codes that are Covered by Medicare for the HIV Testing:
 - Add ICD-9-CM codes 512.81, 512.82, and 512.83 to the list of codes covered by Medicare for HIV Testing (Diagnosis) (190.14) NCD.
 - Delete ICD-9-CM code 512.8 from that same list.
- For Codes That Do Not Support Medical Necessity For The Blood Counts
 - Add ICD-9-CM codes 726.13, V40.31, V40.39, and V54.82 to the list of ICD-9-CM codes that Do Not Support Medical Necessity for the Blood Counts (190.15) NCD.
 - Delete ICD-9-CM codes 718.60 and V40.3 from that list.
- For Partial Thromboplastin Time
 - Delete ICD-9-CM codes 286.5, 444.0, and 596.8 from the list of ICD-9-CM codes that are covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
 - Add ICD-9-CM codes 286.52, 286.53, 286.59, 444.01, 444.09, 596.81, 596.82, 596.83, and 596.89 to the list of ICD-9-CM codes that are covered by Medicare for the Partial Thromboplastin Time (PTT) (190.16) NCD.
- For Prothrombin Time
 - Delete ICD-9-CM codes 286.5, 425.1, 444.0, 596.8, and 997.4 from the list of ICD-9-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.
 - Add ICD-9-CM codes 286.52, 286.53, 286.59, 414.4, 415.13, 425.11, 425.18, 444.01, 444.09, 573.5, 596.81, 596.82, 596.83, 596.89, 997.41, 997.49, and V12.55 to the list of ICD-9-CM codes that are covered by Medicare for the Prothrombin Time (PT) (190.17) NCD.

- For Serum Iron Studies
 - Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, and 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD.
 - Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 282.40, 282.43, 282.44, 282.45, 282.46, 282.47, 286.52, 286.53, 286.59, and 573.5 to the list of ICD-9-CM codes that are covered by Medicare for the Serum Iron Studies (190.18) NCD.
- For Blood Glucose Testing
 - Add ICD-9-CM codes 414.4, V23.42 and V23.87 to the list of ICD-9-CM codes that are covered by Medicare for the Blood Glucose Testing (190.20) NCD.
- For Glycated Hemoglobin/Glycated Protein
 - Delete ICD-9-CM code V12.2 from the list of ICD-9-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
 - Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the Glycated Hemoglobin/Glycated Protein (190.21) NCD.
- For Thyroid Testing:
 - Delete ICD-9-CM code V12.2 from the list of covered ICD-9-CM codes for the Thyroid Testing (190.22) NCD.
 - Add ICD-9-CM codes V12.21 and V12.29 to the list of ICD-9-CM codes that are covered by Medicare for the Thyroid Testing (190.22) NCD.
- For Lipids Testing
 - Delete ICD-9-CM code 444.0 from the list of ICD-9-CM codes that are covered by Medicare for the Lipids Testing (190.23) NCD.
 - Add ICD-9-CM codes 414.4, 444.01, 444.09, and 573.5 to the list of ICD-9-CM codes that are covered by Medicare for the Lipids Testing (190.23) NCD.
- For Digoxin Therapeutic Drug Assay:
 - Add ICD-9-CM codes 414.4, 425.11, 425.18, 444.01, 44.09, and 573.5 to the list of codes covered by Medicare for the Digoxin Therapeutic Drug Assay (190.24) NCD.
- For Alpha-fetoprotein:
 - Delete ICD-9-CM codes 425.1 and 793.1 from the list of codes covered by Medicare for the Alpha-fetoprotein (190.25) NCD.
 - Add ICD-9-CM codes 414.4, 425.11, 425.18, 444.01, 444.09, 573.5, 793.11, and 793.19 to the same list of covered codes.
- For Human Chorionic Gonadotropin
 - Delete ICD-9-CM code 631 from the list of ICD-9-CM codes that are covered by Medicare for the Human Chorionic Gonadotropin (190.27) NCD.
 - Add ICD-9-CM codes 631.0 and 631.8 to the list of ICD-9-CM codes that are covered by Medicare for the Human Chorionic Gonadotropin (190.27) NCD.

- For Gamma Glutamyl Transferase:
 - Delete ICD-9-CM codes 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, and 173.9 from the list of covered ICD-9-CM codes for the Gamma Glutamyl Transferase (190.32) NCD.
 - Add ICD-9-CM codes 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, and 573.5 to the list of ICD-9-CM codes that are covered by Medicare for the Gamma Glutamyl Transferase (190.32) NCD.
- Add ICD-9-CM code 573.5 to the list of codes covered by Medicare for the Hepatitis Panel/Acute Hepatitis Panel (190.33) NCD.
- For Fecal Occult Blood Test
 - Delete ICD-9-CM code 286.5 from the list of ICD-9-CM codes that are covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.
 - Add ICD-9-CM codes 286.52, 286.53, and 286.59 to the list of ICD-9-CM codes that are covered by Medicare for the Fecal Occult Blood Test (190.34) NCD.

Additional Information

The official instruction, CR7507 issued to your carrier, FI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2298CP.pdf> on the CMS website.

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

MEDICARE BENEFICIARIES AND HOSPICE BENEFITS

Medicare beneficiaries who have a terminal illness with a life expectancy of six months or less and who are entitled to Hospital Insurance (Part A) have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. The hospice provisions only cover care provided by a Medicare-certified hospice. The coverage is available for two 90-day periods and an unlimited number of 60-day periods during the hospice patient's lifetime. The coverage of the hospice benefit is discussed in the Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Chapter 11.

When the patient elects hospice care, the beneficiary waives all rights to Medicare Part B payments for services related to the treatment and management of the terminal illness during any period the beneficiary's hospice benefit is in force, except for the professional services of an "attending physician." Payment for all services related to the patient's terminal illness is made through the hospice under Medicare Part A benefits. Services not related to the patient's terminal illness are made under normal Medicare payment guidelines.

For more information concerning the reimbursement of an attending physician please see our article "Attending Physician for Patients who Elect Hospice Coverage."

J5 MAC: http://www.wpsmedicare.com/j5macpartb/resources/provider_types/hospice-attending-phys.shtml

Legacy: http://www.wpsmedicare.com/part_b/resources/provider_types/hospice-attending-phys.shtml

For more information concerning modifiers GV and GW, please see our "Hospice Modifiers Fact Sheet."

J5 MAC: <http://www.wpsmedicare.com/j5macpartb/resources/modifiers/hospicemodifier.shtml>

Legacy: http://www.wpsmedicare.com/part_b/resources/modifiers/hospicemodifier.shtml

OVERVIEW OF MEDICARE POLICY REGARDING CHIROPRACTIC SERVICES

~ Revised CMS MLN Article ~

MLN Matters® Number: SE1101 Revised

Related CR Release Date: N/A

Related CR Transmittal #: N/A

Related Change Request (CR) #: N/A

Effective Date: N/A

Implementation Date: N/A

Note: This article was revised on September 9, 2011, to clarify some of the language. No changes in policy are conveyed by these clarifications.

Provider Types Affected

Chiropractors and other practitioners billing Medicare for chiropractic services are affected by this Special Edition article. No new policies are contained in this article.

Provider Action Needed

STOP – Impact to You

This Special Edition article highlights Medicare policy regarding coverage of chiropractic services for Medicare beneficiaries.

CAUTION – What You Need to Know

Please review this article and go to the links listed in the information section below for further details.

GO – What You Need to Do

Please review your clinical documentation and billing practices. Ensure that your office staffs are aware of the correct use of codes and modifiers and Medicare coverage policy regarding chiropractic services.

Background

Numerous audits of chiropractic service claims have found a significant portion of the claims to have been paid inappropriately. Correct claim payment depends largely on providers complying with Medicare requirements for coverage, coding, and documentation of services. The goal of this article is to translate published Medicare coverage and payment requirements for chiropractic services into a few practical tips for better Medicare compliance to effectively lower the frequency of improper payments (and corresponding error rates).

The most common errors noted by Medicare auditors of chiropractic service claims are briefly described below.

- Technical errors such as missing signatures, date of service on the claim not found in the record, etc. In other words, specific documentation that is required as a condition of payment is often missing from the beneficiary’s medical record.
- Documentation that does not substantiate that all procedure(s) reported were performed. For example,
 - No documentation or insufficient documentation that **all** spinal levels of manipulation reported had been performed;
 - No documentation that each manipulation reported related to a relevant symptomatic spinal level.
- Insufficient or absent documentation that all procedures or services were medically reasonable and necessary. In other words, the submitted documentation was not sufficient for Medicare auditors to determine whether the services furnished were medically necessary. Examples of insufficient or absent documentation for purposes of determining medical necessity are as follows:
 - Required elements of the history and examination were absent.
 - Treatment plan absent or insufficient.
- Treatment furnished was “maintenance therapy. As discussed later in this article, Medicare pays only for medically necessary chiropractic services, which are limited to active/corrective manual manipulations of the spine to correct subluxations. **When further improvement cannot reasonably be expected from continuing care, the services are considered maintenance therapy, which is not medically necessary and therefore not a covered service under the Medicare program.**
- Non-Covered devices or techniques applied in performing manipulation. (See the key points section of this article.)

Previous Study by the Office of Inspector General (OIG) on Chiropractic Care

A recent study by the Office of Inspector General (OIG) entitled “*Inappropriate Medicare Payments for Chiropractic Services*” found inappropriate Medicare payments for chiropractic services.

The OIG study found that:

- Claims lack initial visit dates for treatment episodes, hindering the identification of maintenance therapy; and
- There is lack of compliance with the manual documentation requirements. For example, treatment plans, an important element in determining whether the chiropractic treatment was active/corrective in achieving specified goals, were either missing or lacked treatment goals, objective measures, or the recommended level of care.

The Key Points section below reviews Medicare policy for coverage of chiropractic services, with an emphasis on the billing and documentation requirements.

Key Points

Medicare Coverage of Chiropractic Services

Coverage of chiropractic services is specifically limited to treatment by means of manual manipulation (i.e., by use of the hands) of the spine to correct a subluxation. Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or

physiological function of the spine, are altered, although contact between joint surfaces remains intact.

Manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. No additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor's order is covered. If you order, take, or interpret an x-ray, or any other diagnostic test, the x-ray or other diagnostic test can be used for documentation, but Medicare coverage and payment are not available for those services. This does not affect the coverage of x-rays or other diagnostic tests furnished by other practitioners under the program.

Subluxation May Be Demonstrated by X-Ray or Physician's Examination

X-rays

As of January 1, 2000, an x-ray is not required by Medicare to demonstrate the subluxation. However, an x-ray may be used for this purpose if you so choose. The x-ray must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted if the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI are acceptable evidence if a subluxation of the spine is demonstrated.

Physical examination

To demonstrate a subluxation based on physical examination, two of the following four criteria (one of which must be asymmetry/misalignment or range of motion abnormality) are required:

1. Pain/tenderness evaluated in terms of location, quality, and intensity;
2. Asymmetry/misalignment identified on a sectional or segmental level;
3. Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility); and
4. Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle, and ligament.

Documentation Requirements Must Be Placed in the Patient's File

Initial Visit

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. **The history includes the following:**
 - a. Symptoms causing patient to seek treatment;
 - b. Family history if relevant;
 - c. Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);
 - d. Mechanism of trauma;
 - e. Quality and character of symptoms/problem;

- f. Onset, duration, intensity, frequency, location, and radiation of symptoms;
 - g. Aggravating or relieving factors; and
 - h. Prior interventions, treatments, medications, secondary complaints.
- 2. Description of the present illness, including:**
- a. Mechanism of trauma;
 - b. Quality and character of symptoms/problem;
 - c. Onset, duration, intensity, frequency, location, and radiation of symptoms;
 - d. Aggravating or relieving factors;
 - e. Prior interventions, treatments, medications, secondary complaints; and
 - f. Symptoms causing patient to seek treatment.

These symptoms must bear a direct relationship to the level of subluxation. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is “pain” is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. Evaluation of musculoskeletal/nervous system through physical examination

4. Diagnosis

The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine.

5. Treatment Plan should include the following:

- a. Recommended level of care (duration and frequency of visits);
- b. Specific treatment goals; and
- c. Objective measures to evaluate treatment effectiveness.

6. Date of the initial treatment.

7. The patient’s medical record.

- Validate all of the information on the face of the claim, including the patient’s reported diagnosis(s), physician work (CPT code), and modifiers.
- Verify that all Medicare benefit and medical necessity requirements were met.

Subsequent Visits

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History

- a. Review of chief complaint;
- b. Changes since last visit; and
- c. Systems review if relevant.

2. Physical examination

- a. Examination of area of spine involved in diagnosis;
- b. Assessment of change in patient condition since last visit;
- c. Evaluation of treatment effectiveness.

3. Documentation of treatment given on day of visit.

Necessity for Treatment

Acute and Chronic Subluxation

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical examination, as described above.

Most spinal joint problems fall into the following categories:

- Acute subluxation--A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical examination as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.
- Chronic subluxation--A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

You must place the AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary.

Maintenance Therapy

Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

The AT modifier **must not** be placed on the claim when maintenance therapy has been provided. **Claims without the AT modifier will be considered as maintenance therapy and denied.**

You should consider providing the **Advance Beneficiary Notice of Noncoverage (ABN)** to the beneficiary. Chiropractors who give beneficiaries an ABN will place the **modifier GA** (or in rare instances **modifier GZ**) on the claim. The decision to deliver an ABN must be based on a genuine reason to expect that Medicare will not pay for

a particular service on a specific occasion for that beneficiary due to lack of medical necessity for that service. The beneficiary can then make a reasonable and informed decision about receiving and paying for the service. If the beneficiary decides to receive the service, you must submit a claim to Medicare even though you expect that Medicare will deny the claim and that the beneficiary will pay.

"Since March 3, 2008 CMS has issued one form with the official title "Advance Beneficiary Notice of NonCoverage (ABN)" (form CMS-R-131). A properly executed ABN must use this form for each date an ABN is issued and all the required fields on the form must be completed including a mandatory field for cost estimates of the items/services at issue and a valid specific reason why the chiropractor believes Medicare payment for CMT will be denied on this date for this beneficiary. ABNs should not be issued routinely citing the same reason for each occurrence. One ABN cannot be used with added lines for future dates of services. For additional instructions on the proper completion of the ABN, see http://www.cms.gov/BNI/01_overview.asp#TopOfPage on the CMS website.

Key Billing Requirements

In addition to other billing requirements explained in Medicare's Manuals, it is important that you include the following information on the claim:

- The primary diagnosis of subluxation;
- The initial visit or the date of exacerbation of the existing condition;
- The appropriate Current Procedural Terminology (CPT) code that best describes the service:
 - o **98940:** Chiropractic Manipulative Treatment (CMT); spinal, one or two regions;
 - o **98941:** Spinal, three to four regions;
 - o **98942:** Spinal, five regions.

NOTE: 98943: CMT, extraspinal, one or more regions, is not covered by Medicare.

- The appropriate modifier that describes the services:
 - o **AT modifier*** used on a claim when providing active/corrective treatment to treat acute or chronic subluxation;
 - o **GA modifier** used to indicate that you expect Medicare to deny a service (e.g., maintenance services) as not reasonable and necessary and that you have on file an Advance Beneficiary Notice (ABN) signed by the beneficiary; or
 - o **GZ modifier** used to indicate that you expect that Medicare will deny an item or service as not reasonable and necessary and that you have **not** had an ABN signed by the beneficiary, as appropriate.

NOTE: You must use the Acute Treatment modifier "AT" to identify services that are active/corrective treatment of acute or chronic subluxation and must document services in accordance with the Centers for Medicare & Medicaid Services' (CMS) "Medicare Benefit Policy Manual," Chapter 15, Section 240, when submitting claims.

Beneficiary Responsibility

For Medicare covered services, the beneficiary pays the Part B deductible and then 20 percent of the Medicare-approved amount. The beneficiary also pays all costs for any services or tests you order. If you provide an ABN, you must submit a claim to Medicare,

even though you expect the beneficiary to pay and you expect Medicare to deny the claim.

Additional Information

Providers improving their compliance with Medicare documentation requirements should lower the likelihood of continued audit identified shortcomings. In this regard, consider the following suggestions:

- **Signatures**
CMS published national provider "signature" requirements in April 2010. For details, please refer to the "Medicare Program Integrity Manual," Chapter 3; Section 3.3.2.4 (<http://www.cms.gov/manuals/downloads/pim83c03.pdf>).
- **Documenting Procedures**
Document procedures as soon as possible after performing them and include the code on which the service is based on that documentation. A helpful technique for assuring good documentation is to periodically self-audit claims against records to determine if the codes chosen are supported by the records. Auditing and correcting non-conforming office practices help minimize claim errors occurring with the clerical task of preparing and submitting the claim. It is helpful for practitioners who use devices to assist manipulations to clearly document the device's name, and, if necessary, send with records to auditors a device description or other information describing how the device meets CMS requirements for assistive devices.
- **Medical Necessity**
Thorough documentation of clinically relevant and CMS required documentation elements serve to create a clear portrait of the patient's baseline condition, treatments provided, and a treatment timeline in terms of the patient's symptomatic functional response. The patient's condition (symptoms, physical signs, and function) must be described with objective, measurable terms along with pertinent subjective information. Documentation must provide a clear description of the mechanism of injury and how it negatively impacts baseline function. A clear plan of treatment that includes treatment goals (expected duration and frequency) and the clinical milestones to be used as measures of progress is also necessary. Demonstrate progress in objective, rather than conclusory, terms. You should document modifications in the treatment plan, when needed, because of failure to satisfactorily progress in the clinically reasonable and predicted timeframe. Adequately demonstrate that treatments provide more than short term symptom control unaccompanied by durable functional improvement.

Documentation of the initial evaluation and periodic reevaluations at reasonable intervals is essential. Evaluation/reevaluation elements above need not be documented at each treatment. However, they must be documented often enough to show measurable progress or failure to progress. And, above all, they must be included with the documentation of any procedures sent to Medicare auditors.

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

CMS Manual References

The “Medicare Benefit Policy Manual,” Chapter 15, Section 30.5 – Chiropractor’s Services and Section 240 – Chiropractic Services, can be found at <http://www.cms.gov/manuals/Downloads/bp102c15.pdf> on the CMS website.

The “Medicare Claims Processing Manual,” Chapter 12, Section 220 – Chiropractic Services, can be found at <http://www.cms.gov/manuals/downloads/clm104c12.pdf> on the CMS website.

Other References

Office of Inspector General, May 2009, “Inappropriate Medicare Payments for Chiropractic Services,” can be found at <http://oig.hhs.gov/oei/reports/oei-07-07-00390.pdf> on the Internet.

The Medicare Learning Network® (MLN) educational product titled, “Advance Beneficiary Notice of Noncoverage (ABN),” can be found at http://www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf on the CMS website.

The MLN educational product titled, “Addressing Misinformation Regarding Chiropractic Services and Medicare,” can be found at http://www.cms.gov/MLNProducts/downloads/Chiropractors_fact_sheet.pdf on the CMS website.

MLN Matters® Article #MM3449, “Revised Requirements for Chiropractic Billing of Active/Corrective Treatment and Maintenance Therapy, Full Replacement of CR3063,” can be found at <http://www.cms.gov/MLNMattersArticles/downloads/MM3449.pdf> on the CMS website.

SELF-ADMINISTERED DRUG (SAD) EXCLUSION LIST

The Self-Administered Drug (SAD) Exclusion List has been updated in the Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database (MCD) as of October 1, 2011, at <http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>. The list is also available on our website. To view the entire list, please visit the appropriate web page for your contract:

J5 MAC: http://www.wpsmedicare.com/j5macpartb/policy/usad_listing/

Legacy: http://www.wpsmedicare.com/part_b/policy/usad_listing/

J3490 Icatibant (Firazyr™) has been added to our SAD list.

Coverage – Policies

INFORMATION ON WEBSITE

WPS Medicare publishes Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs), as well as retired LCDs for Medicare Part B, on its website:

J5 MAC (IA, KS, MO, NE): <http://www.wpsmedicare.com/j5macpartb/policy/>

Legacy (IL, MI, MN, WI): http://www.wpsmedicare.com/part_b/policy/

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

WPS Medicare Part B
Attn: Freedom of Information Act (FOIA)
P.O. Box 8810
Marion, IL 62959-0900
Fax Number (618) 998-5287



NEW POLICIES

The following are new policies. Be sure to note the effective date of the new policy, as the policy will not appear as an active policy until the effective date. Prior to the effective date, the policy can be found by selecting the link "Display Future Effective Documents" within the CMS Medicare Coverage Database (MCD):

<http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>

Visit our website at the appropriate link below for more information:

J5 MAC: <http://www.wpsmedicare.com/j5macpartb/policy/updates/new/>

Legacy: http://www.wpsmedicare.com/part_b/policy/updates/new/

October 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Drugs and Biologics (Non-chemotherapy)	L32013	INJ-041	11/15/2011

November 2011

There are no new policies for November 2011.

December 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Dialysis Shunt Maintenance	TBD	CV-027	01/16/2012

RETIRED POLICIES

The following are retired policies. Be sure to note the effective date of the retired policy, as the policy will not appear as retired until the effective date.

Visit our website at the appropriate link below for more information:

J5 MAC: <http://www.wpsmedicare.com/j5macpartb/policy/updates/retired/>

Legacy: http://www.wpsmedicare.com/part_b/policy/updates/retired/

October 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg	Chemotherapy and Drug Administration	NA	HONC-002	11/14/2011
MAC	Infliximab (Remicade)	L26658	INJ-540	11/14/2011
	This LCD is being retired. See our new LCD L32013, "Drugs and Biologics (Non-chemotherapy)."			
Leg	Injection List	NA	INJ-List	
	This document is being retired. See our new LCD L32013, "Drugs and Biologics (Non-chemotherapy)."			

November 2011

There are no retired policies for November 2011.

December 2011

There are no retired policies for December 2011.

REVISED POLICIES

The following are revised policies. Be sure to note the effective date of the revised policy, as the policy will not appear as an active policy until the effective date. Prior to the effective date, the policy can be found by selecting the link "Display Future Effective Documents" within the CMS Medicare Coverage Database (MCD):

<http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>

Visit our website at the appropriate link below for more information:

J5 MAC: <http://www.wpsmedicare.com/j5macpartb/policy/updates/revised/>

Legacy: http://www.wpsmedicare.com/part_b/policy/updates/revised/

October 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	2012 ICD-9-CM Coverage	Various	Various	10/01/2011
	The following ICD-9-CM revisions for 2012 were omitted or incorrectly listed. These corrections are effective for claims submitted with dates of service on or after 10/01/2011. WPS will cover the new 2012 ICD-9-CM codes for the policies and procedures listed below.			
	Policy Name/Number	Policy Procedure Code	2012 ICD-9-CM Changes/Additions/Deletions	

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	L30487 Cytogenetic Studies Path 027	88230, 88235, 88262, 88267, 88269, 88283, 88289		Added 630-631.8, codes 747.31, 747.32 and 747.39 added to range
		88230, 88237, 88239, 88262, 88271, 88272, 88273, 88274, 88275, 88283		Added 173.00-173.99; 284.01-284.09; 284.19, 284.2 - 284.9
	L30320 Brachytherapy RAD-036			Added codes 173.00-173.99 included in range(140.0-195.8)
	L30161 Flow Cytometry PATH-016	88184-88189		Added 284.19, code 996.88 added to range
	L28723 Magnetic Resonance Imaging RAD-024	70336, 70540-70543, 70551-70553		Add 173.00-173.39, 331.6, and 348.82. 310.81 incorrectly listed as 310.8. Add 310.81
		72195-72197, 74181-74183		Add 596.83
		73218-73223		Add 726.13
		73718-73723		Add 173.70, 173.71, 173.72 and 173.79
	L28565 Transthoracic Echocardiography (TTE) CV-026	93303, 93304, 93306, 93307, 93308, 93320, 93321, 93325, 93350, 93351		444.01 incorrectly listed as 444.00. Add 444.01 999.41 incorrectly listed as 99.41. Add 999.41
	L30151 Thrombopoietic Growth factor - Oprelvekin INJ-034	J2355		173.00-173.99 (Included in code range 140.0-204.92)
	L28586 Noninvasive Vascular Testing (N.I.V.T.) CV-033	93922-93931; 93978-93979		Added 444.01, 444.09
		93965-93971		Added 786.30,786.39 (2010)
	L30713 Mohs Micrographic Surgery DERM-004	17311, 17312, 17313, 17314, and 17315		Add 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99
	L28531 Outpatient Rehabilitation Therapy Services billed to Medicare Part B	97001, 97002, 97003, 97004, 97010, 97012, 97016, 97018, 97022, 97024,97026, 97028, 97032, 97034, 97035, 97036, 97039, 97110, 97112,		Added: 358.30, 358.31, 358.39, 808.44, 808.54, V54.82,

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	PHYSMED-009	97113, 97116, 97124, 97139, 97140, 97150, 97530, 97532, 97533, 97535, 97537, 97542, 97542, 97750, 97755, 97760, 97761, 97762 and G0283 All 97xxx codes except 97033, 97597, 97598, 97605, 97060 and all Gxxxx codes except G0281 and G0329 Only 97033		Add 726.13, 808.44, 808.54, V54.82 Add 726.13
	L31346 Nerve Conduction Studies and Electromyography NEURO-005	51785, 92265, 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870 95872, 95873, 95874, 95900, 95903, 95904, , 95905, 95933, 95934, 95936, 95937, 95999, G0255		Add ICD-9 code 358.30, 358.31, 358.39
	L30322 Routine Foot Care FT-001	11055, 11056, 11057, 11719, 11720, 11721, G0127		ICD-9 code V12.55 not covered, changed range of coverage to V12.50-V12.54
	L30316 Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) RAD-014	77261-77470 (except 77432) 77301, 77418, 0073T		Added 173.00-173.02, 173.09, 173.10-173.12, 173.19, 173.20-173.22, 173.29, 173.30- 173.32, 173.39, 173.40-173.42, 173.49, 173.50-173.52, 173.59, 173.60-173.62, 173.69, 173.70-173.72, 173.79, 173.80- 173.82, 173.89, 173.90-173.92, and 173.99 (Included in code ranges 140.0-198.89 and 140.0-239.9)
	Pet Scans	78608, 78811, 78812, 78813, 78814, 78815, 78816 78608		Initial Treatment 173.00 - 173.99, 793.11, 793.19 294.20-294.21, 331.6
Leg/ MAC	Acute Inpatient Services versus Observation (Outpatient) Services	DL32222	HOSP-001	10/01/2011
	Draft LCD name changed to "Acute Inpatient Services versus Observation (Outpatient) Services." Formerly known as "Acute Inpatient Services." Newly released draft version contains some formatting changes and clarifications.			
Leg/ MAC	Billing and Coding Guidelines for Magnetic Resonance Imaging (RAD-024)	L28723	RAD-024	10/01/2011
	This revision is to the Billing and Coding Guidelines for Magnetic Resonance Imaging (RAD-024): Removed from Denial Summary section, statement number 1 (one), which said; "For patients with cardiac pacemakers;"			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	<p>Addition of section entitled "Magnetic Resonance Imaging (MRI) in Medicare Beneficiaries with FDA-Approved Implanted Permanent Pacemakers (PMs) for use in an MRI Environment."</p> <p><i>Effective for claims with dates of service on or after July 7, 2011, CMS believes that the evidence is adequate to conclude that magnetic resonance imaging (MRI) improves health outcomes for Medicare beneficiaries with implanted permanent pacemakers (PMs) when the PMs are used according to the FDA-approved labeling for use in an MRI environment. Other contraindications that may be present in any given beneficiary would continue to apply in patients with PMs. These other contraindications are listed in section 220.2.C.1 of the National Coverage Determinations (NCD) manual and referenced in CR 7296.</i></p> <p><i>Effective February 24, 2011</i> <i>Medicare will allow for coverage of MRI for beneficiaries with implanted PMs or cardioverter defibrillators (ICDs) for use in an MRI environment in a Medicare-approved clinical study as described in section 220.C.1 of the NCD manual.</i></p> <p><i>Effective July 7, 2011</i> <i>Medicare will allow for coverage of MRI for beneficiaries with implanted pacemakers (PMs) when the PMs are used according to the Food and Drug Administration (FDA)-approved labeling for use in an MRI environment as described in section 220.2.C.1 of the NCD Manual</i></p> <p><i>Payment Requirements</i> <i>For claims with dates of service on and after February 24, 2011, the following diagnosis code and modifier shall be reported on MRI claims for beneficiaries with implanted PMs, that are outside FDA-approved labeling for use in an MRI environment (in a Medicare-approved clinical study):</i> <i>Appropriate MRI code</i> <i>Q0 modifier</i> <i>ICD-9 code V70.7- Examination of participant in clinical trial (for institutional claims)</i> <i>Condition code 30 (for institutional claims)</i></p> <p><i>ICD-9 code V45.02 (automatic implantable cardiac defibrillator) or ICD-9 code V45.01 (cardiac pacemaker),</i> <i>NOTE: Effective for claims with dates of service on and after October 1, 2013, providers report the following ICD-10 codes instead of the ICD-9 codes referenced above:</i> <i>Z006 - Encounter for examination for normal comparison and control in clinical research program</i> <i>Z95810 - Presence of automatic (implantable) cardiac defibrillator</i> <i>Z950 - Presence of cardiac pacemaker</i></p> <p><i>For claims with dates of services on and after July 7, 2011, the following codes shall be reported on MRI claims for beneficiaries with implanted PMs that have FDA-approved labeling for use in an MRI environment:</i> <i>Appropriate MRI code</i></p>			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	<p>ICD-9 code V45.01 (cardiac pacemaker) KX modifier</p> <p><i>NOTE: Effective for claims with dates of service on and after October 1, 2013, providers report ICD-10 code Z950 instead of the ICD-9 code referenced above for patients with a cardiac pacemaker.</i></p> <p><i>Added reasons number 7 and 8 to section entitled "Reasons for Denial."</i></p> <p><i>7. Effective for claims with dates of service on and after February 24, 2011, contractors shall deny line items that do not include all of the following line items:</i></p> <p><i>An appropriate MRI code</i> <i>ICD-9 code V45.02 (automatic implantable cardiac defibrillator) or ICD-9 code V45.01 (cardiac pacemaker)</i> <i>Modifier Q0</i> <i>ICD-9 code V70.7 - Examination of participant in clinical trial (for institutional claims only),</i> <i>and</i> <i>Condition code 30 - (for institutional claims only</i></p> <p><i>8. *Effective for claims with dates of service on and after July 7, 2011, contractors shall deny MRI line items on professional claims when billed with ICD-9 diagnosis code V45.01 if modifier KX is not also present on the line or the conditions of requirement 7441-04.2.1 are not met.</i></p> <p>CR 7296 effective for DOS 02/24/2011: CR 7441 effective for DOS 07/07/2011.</p>			
Leg/ MAC	Bone Mass Measurement	L31620	MS-004	10/01/2011
	<p>Deleted ICD-9-CM code V58.69 and replaced all references to it with the new 2012 ICD-9-CM code V58.68, which is specific for long-term (current) use of bisphosphonates. Added the second sentence to statement number three (3) found in the Utilization Guidelines. Sentence number three (3) now states: It is normally not medically necessary to have both peripheral and axial BMM tests performed. In the rare instance of an indeterminate confirmatory diagnosis, upon appeal documentation submitted will be evaluated for possible payment.</p>			
Leg/ MAC	Botulinum Toxin Type A & Type B	L28555	INJ-018	10/01/2011
	<p>Effective October 1, 2011, Botox for the treatment of Migraines may be billed with either CPT code 64612 or 64613, but not both on the same date of service. Added CPT code 64611 and ICD-9 codes 332.0 and 527.2.</p> <p>Billing and Coding Guidelines Revision: Effective 10/01/2011, allow on same DOS either CPT code 64612 or 64613 for migraine. Added section titled "Either 64612 or 64613." ICD-9 codes for CPT procedures 64612 and 64613 are 346.70, 346.71, 346.72, and 346.73. Removed CPT code 42699 and replaced with CPT code 64611. Added for CPT code 64611, ICD-9 codes 332.0 and 527.2.</p>			
Leg/ MAC	Chemotherapy Drugs and their Adjuncts	L28576	HONC-010	10/01/2011
	<p>Indications and Limitations of Coverage and/or Medical Necessity C. The following drugs are covered for the following indications: 35. Paclitaxel (Taxol) 30mg (J9265)</p>			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	Kidney 189.0 D. Not otherwise Classified Agents (NOC) (J3590, J9999, C9399) 1. Brentuximab vedotin (ADCETRIS™) (J9999/C9399) FDA approved 08/19/2011 <ul style="list-style-type: none"> The treatment of patients with Hodgkin lymphoma after failure of autologous stem cell transplant (ASCT) or after failure of at least two prior multi-agent chemotherapy regimens in patients who are not ASCT candidates (201.00-201.98) The treatment of patients with systemic anaplastic large cell lymphoma after failure of at least one prior multi-agent chemotherapy regimen (200.60-200.68) 			
Leg	Dialysis Shunt Maintenance	L20049	CV-027	10/01/2011
	Billing and Coding Guidelines: Correction of typographical error found in sentence number four (4) in the section entitled Coding Guidelines. CPT code 35475 incorrectly listed as 35477.			

November 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Drugs and Biologics (Non-chemotherapy)	L32013	INJ-041	11/15/2011
	Typo corrected in code range for J2562 Plerixafor (Mozobil™), 1mg. The correct code range is 202.40-202.48. ICD-9 codes 204.00-204.48 were removed.			
Leg/ MAC	Human Granulocyte/Macrophage Colony Stimulating Factors	L30306	INJ-019	11/01/2011
	D. Indications for Sargramostim (Leukine™) (J2820) 13. For the adjunct treatment of malignant melanoma (172.0-172.9) following surgery for stage III or IV melanoma for those at high risk for recurrence.			
Leg/ MAC	Magnetic Resonance Imaging	L28723	RAD-024	10/01/2011
	ICD-9-CM 2012 update; Include for MRI's for CHEST, THORAX (71550-71552) ICD-9 998.0 truncated to 998.00, 998.01, 998.02, and 998.09. MRI's for ABDOMEN AND PELVIS (72195-72197, 74181-74183) ICD-9 codes 998.11-998.7 inadvertently omitted from ICD-9-CM list October 2011 revision. Effective 10/01/2011.			
MAC	Optometrist Services	L32001	OPHTH-503	01/01/2010
	CPT codes 15820, 15821, 15822, and 15823 incorrectly listed in Table II. Moved to Table III, THERAPEUTIC/EXPANDED LICENSURE requiring a -55 modifier. Effective 01/01/2010.			
Leg/ MAC	Outpatient Rehabilitation Therapy Services Billed to Medicare Part B	L28531	PHYSMED-009	10/01/2011
	ICD-9 range 487.0-491.9 deleted and replaced with ICD-9 ranges 487.0-488.19 and 490-491.9; ICD-9 range 508.0-508.9 deleted and replaced with ICD-9 ranges 508.0-508.1 and 508.8-508.9; ICD-9 range 512.0-512.8 deleted and replaced with ICD-9 codes 512.0, 512.1 and 512.8; ICD-9 range 516.0-516.9 deleted and replaced with ICD-9 codes 516.0, 516.1, 516.2, 516.3, 516.8, 516.9, 517.1-517.8, 518.0-518.5, 518.6-518.89. Added ICD-9 codes 358.00-358.9			
Leg/ MAC	Radiopharmaceutical Agents	L31361	RAD-026	11/01/2011
	B. Iodine labeled radiopharmaceuticals:			

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
	1. I 123 e. Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries (DaTscan™-FDA approved 01/14/2011) (A4641 or C9406- ASC and Hospital Outpatient department-code effective 07/01/2011) 78607 Brain Imaging, tomographic (SPECT)			
Leg/ MAC	Routine Foot Care 11/01/2011: Removed ICD-9 codes V12.50 - V12.59 (typo, inappropriate cardiac diagnosis).	L30322	FT-001	11/01/2011
Leg/ MAC	Surgical Treatment of Obstructive Sleep Apnea (OSA) Added "investigational and experimental" to the statement below to explain why we do not cover CPT 41530. 4. Submucosal ablation of the tongue base, radiofrequency, one or more sites, per session. (41530) Will be denied as investigational and experimental.	L30731	ENT-012	11/01/2011

December 2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Cardiovascular Stress Testing ICD-9 Codes that Support Medical Necessity *425.0-425.9 Cardiomyopathy This is a correction to the previous policy update.	L28563	CV-004	Retroactive 02/16/2009
Leg/ MAC	Chemotherapy Drugs and their Adjuncts & Billing and Coding Guidelines Indications and Limitations of Coverage and/or Medical Necessity E. Monoclonal Antibodies that are useful in chemotherapeutic regimens: 1. Rituximab (Rituxan) 100 mg, (J9310) Dermatomyositis 710.3 Acquired hemophilia 286.52 Billing and Coding Guidelines: <i>Coverage for PROVENGE®, Q2043, for asymptomatic or minimally symptomatic metastatic castrate-resistant (hormone refractory) prostate cancer is limited to one (1) treatment regimen in a patient's lifetime, consisting of three (3) doses with each dose administered approximately two (2) weeks apart for a total treatment period not to exceed 30 weeks from the first administration.</i> <i>Contractors shall not pay separately for routine costs associated with PROVENGE®, HCPCS Q2043, except for the cost of administration. (Q2043 is all-inclusive and represents all routine costs except for its cost of administration)</i>	L28576	HONC-010	12/01/2011
Leg/ MAC	Computerized Tomography (CAT Scans) ICD-9-CM 2012 update; CHEST AND THORAX (71250-71270) ICD-9 code 998.0 truncated to 998.00, 998.01, 998.02 and 998.09. LOWER EXTREMITY (73700-73706) ICD-9 code 718.60 deleted, effective 10/01/2011.	L28544	RAD-033	10/01/2011

Leg/ MAC	Policy Title	CMS MCD Policy #	WPS Policy #	Effective Date
Leg/ MAC	Drugs and Biologics (Non-chemotherapy) J1300 Eculizumab, 10 mg (Soliris™) For the treatment of patients with atypical hemolytic uremic syndrome (aHUS) (283.11) to inhibit complement-mediated thrombotic microangiopathy. Effective 09/23/2011-FDA approval date	L32013	INJ-041	12/01/2011
Leg/ MAC	Magnetic Resonance Angiography Inadvertent omission from ICD-9 list for CPT code 71555, new ICD-9 code V12.55. Effective 10/01/2011	L31355	RAD-023	10/01/2011
Leg/ MAC	Magnetic Resonance Imaging Inadvertent omission of 726.13, new ICD-9 code for 2012 for CPT procedure UPPER EXTREMITY (73218-73223). ICD-9 code 718.60 invalid with 2012 revisions for CPT procedures LOWER EXTREMITY (73718-73723) effective 10/01/2011	L28723	RAD-024	10/01/2011
Leg/ MAC	Radiation Oncology Including Intensity Modulated Radiation Therapy (IMRT) Added ICD-9 code 527.7 and removed reference to Proton beam therapy.	L30316	RAD-014	12/01/2011

Electronic Data Interchange (EDI)
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9-DIGIT ZIP CODE REQUIREMENTS

The Centers for Medicare & Medicaid Services (CMS) requires contactors to determine the payment locality for services paid under the Medicare Physician Fee Schedule (MPFS) and anesthesia services by using the ZIP code on the claim that identifies where the service was performed.

The CMS ZIP Code file uses the convention of the United States Postal Service, which assigns these ZIP codes into counties. In some cases, services rendered in one county have a ZIP code assigned into a different county. This causes a payment issue when the counties have different payment localities with different payment amounts.

Medicare requires the submission of a 9-digit ZIP code for services paid under the Medicare Physician Fee Schedule and anesthesia services when the services are provided in those ZIP codes where there is a problem. For claims processed on or after January 1, 2011, on the 5010 version of the ANSI X12N 837 P electronic claim form, contractors shall return as unprocessable claims for services payable under the MPFS and anesthesia services when rendered in POS home (or any POS they consider home) if submitted without the service facility location.

To view the MLN article regarding this change for the 5010 format, visit the CMS website:
<http://www.cms.gov/MLN MattersArticles/downloads/MM6947.pdf>

5010 COMMON EDIT MODULE EDITING FOR NOC CODES

The 5010 electronic media claims (EMC) system reviews every claim for a number of edits to ensure that claim data is valid. The 5010 professional claim transaction (837P) requires that when a non-specific or Not Otherwise Classified (NOC) procedure code is used (in the 2400/SV101-2), then a description is required in the 2400/SV101-7. The 5010 TR3 instructs: "Use SV101-7 to describe non-specific procedure codes." While the 4010 837 professional claim submission allows for use of the NTE segment to include a description; however, 5010 specifically warns "Do not use this NTE Segment to describe a non-specific procedure code." The SV101-7 allows for 80 bytes (aka characters, including spaces) of information.

Below is a current list of the procedure codes which require the SV101-7. Please note that this list is subject to change.

A0999	G8641	J9999	S9976	00830	20999	41899	59899	81099	87449
A4641	G8689	K0108	S9977	00834	21089	42299	60659	82205	87450
A4913	G9012	K0812	T1505	00836	21299	42699	60699	82486	87797
A5507	G9055	K0898	T1999	00840	21499	42999	64722	82487	87798
A6261	G9062	L0999	T2025	00860	21899	43289	64999	82488	87799
A6262	G9067	L1499	T2028	00880	22899	43499	66999	82489	87899
A6512	G9070	L2999	T2029	00910	22999	43659	67299	82491	87999
A6549	G9083	L3649	T2032	00920	23929	43999	67399	82541	88099

A9152	G9089	L3999	T2033	00940	24999	44238	67599	82542	88199
A9153	G9095	L5999	T5999	0101T	25999	44799	67999	82543	88299
A9279	G9099	L7499	V2199	01210	26989	44899	68399	82544	88399
A9280	G9104	L8039	V5090	01230	27299	44979	68899	82657	88749
A9579	G9108	L8048	V5274	01270	27599	45499	69399	82658	89240
A9698	G9112	L8499	V5298	01400	27899	45999	69799	82664	89398
A9699	G9117	L8699	00120	01430	28899	46999	69949	83520	90399
A9999	G9130	Q0181	00140	01440	29799	47379	69979	83788	90749
B9998	G9131	Q2039	00160	01470	29999	47399	76496	83789	90899
B9999	G9138	Q4050	00170	01480	30999	47579	76497	83883	90999
C2698	G9139	Q4082	0019T	01500	31299	47999	76498	83986	91299
C2699	H0046	Q4096	00190	01520	31588	48999	76499	84311	92499
C9399	H0047	Q4100	00210	01630	31599	49329	76999	84591	92700
E0446	J0833	Q5009	00300	01650	31899	49659	77299	84999	93799
E0625	J1566	S2409	00320	01680	32999	49999	77399	85397	94799
E0676	J1599	S4015	00350	01710	33999	50549	77499	85999	95199
E0769	J3301	S5130	00400	01740	36299	50949	77799	86317	95999
E0770	J3490	S5131	00450	01770	36592	51999	78099	86329	96379
E1229	J3590	S5181	00470	01780	37501	53899	78199	86356	96549
E1239	J7192	S5199	00520	01830	37799	54699	78299	86486	96999
E1699	J7199	S5497	00540	01840	38129	55559	78399	86609	97039
E2399	J7599	S8189	00600	01850	38589	55899	78499	86671	97139
E2599	J7699	S8301	00620	01924	38999	58578	78599	86682	97760
G0235	J7799	S9379	00630	01930	39499	58579	78699	86753	97799
G8594	J8498	S9445	00700	01999	39599	58679	78799	86790	99199
G8599	J8499	S9446	00750	15999	40799	58999	78999	86849	99429
G8632	J8597	S9542	00790	17999	40899	59897	79999	86999	99499
G8635	J8999	S9810	00800	19499	41599	59898	80299	87299	99600
G8638									

Please visit our 5010 readiness site at <http://www.wpsic.com/edi/5010-Readiness.shtml>.

If you need additional information, you may also contact the WPS EDI Hotline.

J5 MAC: (866) 503-9670

Legacy: (877) 567-7261

5010A1-COMPLIANT PC-ACE PRO32 BILLING SOFTWARE UPGRADE AVAILABLE ONLINE

The implementation date for the 5010A1 format is January 1, 2012. If you are not transmitting your claims in this format after that date, your files will fail. As a current PC-Ace user, you are automatically set up to send production with this new format.

It is recommended that you begin transmitting in production in the 5010A1 format before the January 1, 2012 date.

If you are currently using the PC-Ace Pro32 billing software, you can download the latest upgrade online. Upgrade version 2.32 of the PC-Ace Pro32 billing software is available to download online. **With your upgrade to this version, your program will automatically be updated to the new 5010A1 format for you.**

Please be sure to create a backup file in the PC-Ace billing program you are currently using before you download this upgrade.

You can download the upgrade from <http://www.wpsic.com/edi/pcacepro32.shtml>.

Now available online is:

- The upgrade to the latest version of PC-Ace
- Instructions related to the upgrade
- Instructions for the 999 and 277CA transactions
- Users Guides/Manuals

It is important that each user updates their software program in a timely manner. Upgrades to the PC-Ace program are available quarterly. As software upgrades are received, please download/install the upgrades to update your program.

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

EDI Hotline:

J5 MAC: (866) 503-9670

Legacy: (877) 567-7261

5010A1-COMPLIANT PC-ACE PRO32 CLAIM ENTRY SOFTWARE

PC-Ace Pro32 is a 5010A1 compliant, "stand alone" software package that creates a patient database and allows your office to electronically submit most Medicare Part B J5 MAC and Legacy claims electronically.

The WPS Bulletin Board System must be accessed by a dial-up modem. It cannot be accessed by a DSL/cable internet connection.

If you are interested in obtaining the PC-Ace Pro 32 software, it is available for download on the WPS Electronic Data Interchange (EDI) website. If you are a new submitter you will also need to complete an EDI Enrollment form and PC-Ace request form in addition to downloading the Full Install of PC-Ace Pro 32 and the PC-Ace Professional User Guide. Existing PC-Ace users please download the upgrade version instead of the Full Install.

You can get the PC-Ace request form and EDI Enrollment form from the following website address:

<http://www.wpsic.com/edi/pcacepro32.shtml>

If you have questions about this or any other Medicare electronic billing issue, please contact EDI.

EDI Hotline:

J5 MAC: (866) 503-9670

Legacy: (877) 567-7261

5010A1 PRODUCTION VERIFICATION

This is a reminder to providers who are transmitting in the 5010A1 format for Medicare Part B claims. Be sure to verify the acceptance of the electronic file (999 Transaction) and the status of the individual claim(s) (277CA Transaction). Providers should also monitor their Remittance Advice to insure these claims are finalizing properly. If you have questions about this or any other Medicare electronic billing issue, please contact EDI.

J5 MAC: (866) 503-9670

Legacy: (877) 567-7261

ATTENTION PRINT LINK USERS

With the upcoming implementation of the HIPAA 5010 format, Print Link will no longer be an option for WPS Medicare submitters. The implementation date for HIPAA 5010 compliance is January 2012. You may use the PC-Ace Pro32 billing program as a claim entry program or you may need to research other vendors, billing services, or clearinghouses. To obtain a list of Medicare approved vendors, billing services, and clearinghouses, go to the following website: http://www.wpsic.com/edi/pdf/medicare_connection.pdf

If you have questions about this or any other Medicare electronic billing issue, please contact EDI at the appropriate number for your Medicare contract:

J5 MAC: (866) 503-9670

Legacy: (877) 567-7261

CALLING THE EDI HOTLINE

When you call the Electronic Data Interchange (EDI) Hotline, we need certain information to help you get your questions answered correctly and quickly. While we receive a large number of files daily, we do have ways to help find your specific file quickly, with your help. Here is a list of information that you can have ready when you call in to help us find your file quickly:

- Billing NPI
- Report Date or Submission Date
- ISA Control Number from the ISA 13 (you may get this from your clearinghouse or billing service)
- Error that you are questioning
- Patient's Medicare Number
- Date of Service

Please remember that we may not need all of this information to find your files, but the more information you have, the easier and more quickly we will be able to find the file you have a question on.

If you have questions about this or any other Medicare electronic billing issue, please contact EDI.

J5 MAC: (866) 503-9670

Legacy: (877) 567-7261

CLAIM ADJUSTMENT REASON CODES (CARC) AND REMITTANCE ADVICE REMARK CODES (RARC)

The claims adjustment reason codes and remittance advice remark codes are updated quarterly and are available on the Washington Publishing Company (WPC) website at <http://www.wpc-edi.com/codes>. Visit the WPC website to obtain the latest descriptions for the remittance advice reason and remark codes found on the Medicare Electronic Remittance Advice (ERA).

Medicare Remit Easy Print (MREP) Users

The claims adjustment reason codes and remittance advice remark codes can be downloaded from the CMS website at http://www.cms.gov/accesstodataapplication/02_medicarereмитеasyprint.asp. See page 65 of the "Medicare Remit Easy Print User Guide" for instructions. After viewing the instructions, select the link "Medicare Remit Easy Print - Version 3.1" from the CMS MREP page and follow the instructions from the Medicare Remit Easy Print User Guide.

CLAIM ADJUSTMENT REASON CODE (CARC), REMITTANCE ADVICE REMARK CODE (RARC), AND MEDICARE REMIT EASY PRINT (MREP) AND PC PRINT UPDATE

~CMS MLN Article~

MLN Matters® Number: MM7514

Related CR Release Date: September 15, 2011

Related CR Transmittal #: R2304CP

Related Change Request (CR) #: 7514

Effective Date: October 1, 2011

Implementation Date: October 3, 2011

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries are affected.

Provider Action Needed

Change Request (CR) 7514, from which this article is taken, announces the latest update of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) that are effective on October 1, 2011, for Medicare. It also instructs certain Medicare contractors to update Medicare Remit Easy Print (MREP) and PC Print software. Be sure your billing staffs are aware of these changes.

Background

The reason and remark code sets must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some Coordination-of-Benefits (COB) transactions. A national code maintenance committee maintains the Healthcare Claim Adjustment Reason Codes (CARCs). The CARC list is updated three times a year in early March, July, and November. The Centers for Medicare & Medicaid Services (CMS) maintains the Remittance Advice Remark Code (RARC) list, which is used

by all payers. The RARC list is also updated three times a year in early March, July, and November.

Both code lists are posted on the Washington Publishing Company (WPC) website, available at <http://www.wpc-edi.com/Codes> on the Internet.

The lists at the end of this article summarize the latest changes to these code lists, as announced in CR7514.

Additional Information

If you use the MREP and/or PC Print software, be sure to obtain an updated copy once it is available.

The official instruction, CR7514, issued to your FI, RHHI, carrier, A/B MAC, and DME MAC regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2304CP.pdf> on the CMS website.

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

CR 7514 Changes

New Codes – CARC

Code	Current Narrative	Effective Date
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	6/5/2011

Modified Codes – CARC

None

Deactivated Codes – CARC

None

New Codes – RARC

Code	Current Narrative	Medicare Initiated
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless corrected, this will not be paid in the future.	Yes
N545	Payment reduced based on status as an unsuccessful eprescriber per the Electronic Prescribing (eRx) Incentive Program.	Yes
N546	Payment represents a previous reduction based on the Electronic Prescribing (eRx) Incentive Program.	Yes

Modified Codes – RARC

None

Deactivated Codes – RARC
None

CLAIM STATUS CATEGORY AND CLAIM STATUS CODES UPDATE

~CMS MLN Article~

MLN Matters® Number: MM7585
Related CR Release Date: September 30, 2011
Related CR Transmittal #: R2314CP

Related Change Request (CR) #: 7585
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

This article is for all physicians, providers, and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), Medicare Carriers, and Durable Medical Equipment (DME) MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

This article, based on Change Request (CR) 7585, explains that the Claim Status and Claim Status Category Codes for use by Medicare contractors with the Health Care Claim Status Request and Response ASC X12N 276/277 and the Health Care Claim Acknowledgement ASC X12N 277 are updated three times per year at the Committee meeting. These meetings are held in the January/February time frame, again in June and finally in late September or early October, in conjunction with the Accredited Standards Committee (ASC) X12 meetings.

The Committee has decided to allow the industry 6 months for implementation of newly added or changed codes. Medicare contractors will begin using the current codes posted at <http://www.wpc-edi.com/codes> on the Internet, on or about November 1, 2011. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All providers are reminded to ensure that their billing staffs are aware of the updated codes and the timeframe for implementations.

Background

The Health Insurance Portability and Accountability Act (HIPAA) requires all health care benefit payers to use only Claim Status Category Codes and Claim Status Codes approved by the national Code Maintenance Committee in the X12 276/277 Health Care Claim Status Request and Response format adopted as the standard for national use (004010X093A1). These codes explain the status of submitted claims. Proprietary codes may not be used in the X12 276/277 to report claim status.

Additional Information

The official instruction, CR7585, issued to your Medicare contractors (FI, RHHI, A/B MAC, DME MAC, and carrier) regarding this change, may be viewed at <http://www.cms.gov/Transmittals/downloads/R2314CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

CP-2243, CR 7456, CLAIM STATUS CATEGORY AND CLAIM STATUS CODES UPDATE (RESCINDED)

~CMS Transmittal~

Transmittal 2243, dated June 17, 2011, is being rescinded. This Change Request is rescinded due to the timing of the code set update. A new change request is forthcoming.

EDI PAPERWORK AND SIGNATURES

Signatures are required on WPS EDI paperwork and forms. The only signatures we will accept are from those that can bind the provider to a contract. Examples would be the provider's Office Manager, CEO, COO, or Owner. If a provider has a Power of Attorney that has the consent to sign forms, you will need to include that Power of Attorney with each request. Also, we will not accept initials, printed names, or stamped signatures. WPS always strives to keep your information and your patient's information safe and this is one way to help us keep that promise.

If you have questions about this or any other Medicare electronic billing issue, please contact EDI at the appropriate number below.

J5 MAC: (866) 503-9670

Legacy: (877) 567-7261

HEALTHCARE PROVIDER TAXONOMY CODES (HPTC)

The National Uniform Claim Committee (NUCC) for standardized classification of health care providers maintains the Healthcare Provider Taxonomy Codes (HPTC). The NUCC updates the code set twice a year with changes effective April 1 and October 1. The HPTC list is available on the Washington Publishing Company (WPC) website at <http://www.wpc-edi.com/reference/>.

**POPULATING REF SEGMENT - OTHER CLAIM RELATED
ADJUSTMENT - FOR HEALTHCARE CLAIM PAYMENT/ADVICE OR
TRANSACTION 835 VERSION 5010A1**

~CMS MLN Article~

MLN Matters® Number: MM7484 Revised
Related CR Release Date: September 2, 2011
Related CR Transmittal #: R959OTN

Related Change Request (CR) #: CR 7484
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Note: This article was revised on September 6, 2011, due to changes in CR7484. The CR was revised to add qualifier "F1" in Loop 2100 NM1 – Service Provider Name under special situations where the NPI is not available - enabling Medicare to report the Federal Taxpayer's Identification Number instead of NPI if NPI is not available for the Rendering Provider and the Rendering provider is different from the Payee. The CR release date, transmittal number, and the web address for accessing the CR were also revised. All other information remains the same.

Provider Types Affected

This article is for physicians, other providers, and suppliers who bill Medicare Carriers, Fiscal Intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), Regional Home Health Intermediaries (RHHIs), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Part B services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare and Medicaid Services (CMS) has decided that populating the Healthcare Claim Payment/Advice or Transaction 835 version 5010A1 REF segment (Other Claim Related Adjustment) at Loop 2100 (for Part B) would provide useful information to providers and suppliers, and starting in January 2012, this segment will be populated for the Part B remittance advice.

CAUTION – What You Need to Know

CR7484, from which this article is taken, instructs Medicare systems, effective January 1, 2012, to populate the REF segment (Other Claim Related Adjustment) at Loop 2100 with qualifiers designated in the updated Flat File attached to CR7484. Note that CR also updates the 835 flat file by adding:

- PLB Code 90;
- Qualifier "PQ" to be used in Loop 1000B REF – Payee Additional Information under some special situations where the National Provider Identifier (NPI) is not available; and
- Qualifier "F1" to be used in Loop 2100 NM1 – service payable under some special situations where NPI is not available.

GO – What You Need to Do

You should make sure that your billing staffs are aware of this change.

Background

Currently the Healthcare Claim Payment/Advice or Transaction 835 REF segment (Other Claim Related Adjustment) at Loop 2100 is not being populated for the Part B remittance advice, and the 835 Flat File identifies this with a note: "N/U by Part B."

CMS has decided that using this segment would provide useful information to providers and suppliers. Therefore, CR7484, from which this article is taken, instructs the VIPS Medicare System (VMS) and the Multi Carrier System (MCS) to populate this segment, effective January 1, 2012, under specific situations (e.g., for cost avoid claims) using one of the qualifiers included in the updated Flat File that is an attachment to CR7484.

Specifically, VMS and MCS will use one of the following Reference Identification Qualifiers in REF01 as appropriate:

- 28: Employee Identification Number
- 6P: Group Number
(When they use this 6P qualifier, they will also populate NM1 – Corrected Priority Payer Name segment at Loop 2100 and REF02 with the Other Insured Group Number for the payer identified in NM1, and use Claim Status Code 2 in CLP02 in CLP – Claim Payment Information segment at Loop 2100);
- EA: Medical Record Identification Number
- F8: Original Reference

NOTE: Medicare will update Medicare Remit Easy Print (MREP) software to include this additional REF segment in the MREP Remittance Advice for version 5010A1.

Additional Information

You can find the official instruction, CR7484, issued to your FI, carrier, A/B MAC, RHHI, or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R959OTN.pdf> on the CMS website. You will find the updated 835 T 5010A1 flat file containing the qualifiers as an attachment to that CR.

Additionally, you can learn more about CMS's implementation activities to convert from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010A1 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0, by going to http://www.cms.gov/MFFS5010D0/01_Overview.asp#TopOfPage on the CMS website.

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

PROCESSING EDI ENROLLMENT AND WPS AUTHORIZATION FOR ELECTRONIC REMIT ADVICE (ERA) FORMS

Due to guidelines from the Centers for Medicare & Medicaid Services (CMS) included in the Health Insurance Portability and Accountability Act, effective November 1, 2011, WPS Medicare will no longer process any Electronic Data Interchange (EDI) Enrollment form unless the

Submitter ID you wish to be set up with is sending 5010 production. In addition, we will no longer process any ERA form unless the Submitter ID you wish to be set up with is currently receiving 5010 ERA files.

If you have questions about this or any other Medicare electronic billing issue, please contact EDI at the number appropriate for your Medicare contract.

J5 MAC: (866) 503-9670

Legacy: (877) 567-7261

REPORTING OF RECOUPMENT FOR OVERPAYMENT ON THE REMITTANCE ADVICE (RA) WITH PATIENT CONTROL NUMBER

~Revised CMS MLN Article~

MLN Matters® Number: MM7499 Revised
Related CR Release Date: August 5, 2011
Related CR Transmittal #: R993OTN

Related Change Request (CR) #: CR 7499
Effective Date: January 1, 2012
Implementation Date: January 3, 2012 for
professional claims billed to carriers or B MACs;
April 2, 2012 for institutional claims billed to
Fiscal intermediaries or A MACs; October 9,
2012 for supplier claims submitted to DME MACs

Note: This article was revised on November 7, 2011, to reflect changes made to CR7499. In this article, the implementation dates (see above), the CR release date, transmittal number, and the web address for accessing CR7499 were revised. All other information is the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7499 which instructs Medicare's claims processing systems maintainers to replace the Health Insurance Claim (HIC) number being sent on the ASC X12 Transaction 835) with the Patient Control Number received on the original claim, whenever the electronic remittance advice (ERA) is reporting the recovery of an overpayment.

Background

The Centers for Medicare & Medicaid Services (CMS) generates Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice that includes enough information to providers so that manual intervention is not needed on a regular basis. CMS changed reporting of recoupment for overpayment on the ERA as a response to provider request per CR6870 and CR7068. The MLN Matters article corresponding to CR6870 can be reviewed at <http://www.cms.gov/MLN MattersArticles/downloads/MM6870.pdf> and CR7068 can be reviewed at <http://www.cms.gov/transmittals/downloads/R812OTN.pdf> on the CMS website.

It has been brought to the attention of CMS that providing the Patient Control Number as received on the original claim rather than the Health Insurance Claim (HIC) number would:

- Enhance provider ability to automate payment posting, and
- Reduce the need for additional communication (via telephone calls, etc.) that would subsequently reduce the costs for providers as well as Medicare.

CR7499 instructs the shared systems to replace the HIC number being sent on the ERA with the Patient Control Number, received on the original claim. The ERA will continue to report the HIC number if the Patient Control Number is not available. This would appear in positions 20-39 of PLB 03-2. A demand letter is also sent to the provider when the Accounts Receivable (A/R) is created. This document contains a claim control number for tracking purposes that is also reported in positions 1-19 of PLB 03-2 on the ERA.

Note: Instructions in CR7499 apply to the 005010A1 version of ASC X12 Transaction 835 only and do not apply to the Standard Paper Remit or the 004010A1 version of ASC X12 Transaction 835.

Additional Information

The official instruction, CR7499, issued to your carrier, FI, A/B MAC, DME MAC, or RHHI regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R993OTN.pdf> on the CMS website.

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

General Information**ELIGIBLE PHYSICIANS AND NON-PHYSICIAN PRACTITIONERS
WHO NEED TO ENROLL IN THE MEDICARE PROGRAM FOR THE
SOLE PURPOSE OF ORDERING AND REFERRING ITEMS AND
SERVICES FOR MEDICARE BENEFICIARIES**

~Revised CMS MLN Article~

MLN Matters® Number: MM7097 Revised
Related CR Release Date: September 1, 2011
Related CR Transmittal #: R387PI

Related Change Request (CR) #: 7097
Effective Date: October 18, 2010
Implementation Date: October 18, 2010

Note: This article was revised on September 6, 2011 to reflect the revised CR7097 issued on September 1. The CR was revised to delete chiropractors from the list of providers who may order and/or refer. The CR release date, transmittal number, and the web address for accessing the CR were also revised. All other information remains the same.

Provider Types Affected

This article is for physicians and non-physician practitioners who are eligible to order and refer items and services for Medicare beneficiaries and who are enrolling in Medicare for the sole purpose of ordering or referring.

What You Need to Know

CR 7097, from which this article is taken, announces that physicians and non-physician practitioners will need to enroll in the Medicare program so they can order and refer items and services for Medicare beneficiaries.

The enrollment requirement is applicable to those physician and non-physician practitioners of a profession eligible to order and refer who are:

- Employed by the Department of Veterans Affairs (DVA), Public Health Service (PHS), Department of Defense (DOD) TRICARE, or by Medicare enrolled Federally Qualified Health Centers (FQHC), Rural Health Clinics, (RHC), or Critical Access Hospitals (CAH);
- Physicians in a fellowship; or
- Dentists, including oral surgeons.
- Other employed eligible physicians and non-physician practitioners

Background

On May 5, 2010, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register an Interim Final Rule with Comment (IFC) regulation titled, "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements." This IFC proposed requirements to implement several of the provisions of the Patient Protection and Affordable Care Act (Affordable Care Act, or ACA) (Pub. L. 111-148) designed to support the Administration's efforts to prevent and detect fraud, waste, and abuse in the Medicare and Medicaid programs, and to ensure quality care for beneficiaries.

Specifically, this regulation proposed requirements to implement section 6405 of the ACA, which (effective July 6, 2010) requires home health agencies and certain Part B suppliers to include, on a claim, the legal name and National Provider Identifier (NPI) of the physician or non-physician practitioner who ordered or referred the billed items or services for the beneficiary.

This action means that Medicare will reimburse claims from providers and suppliers who furnished, ordered, or referred items or services to Medicare beneficiaries **only** when the ordering/referring provider identified in those claims is of an eligible discipline as noted in the following list, and is also enrolled in the Medicare program (has an enrollment record in the Provider Enrollment, Chain and Ownership System (PECOS)) at the time of the service:

- Doctor of medicine or osteopathy;
- Doctor of dental medicine;
- Doctor of dental surgery;
- Doctor of podiatric medicine;
- Doctor of optometry;
- Physician assistant;
- Certified clinical nurse specialist;
- Nurse practitioner;
- Clinical psychologist;
- Certified nurse midwife; and
- Clinical social worker.

Further, while most physicians and non-physician practitioners enroll in the Medicare program to furnish covered services to Medicare beneficiaries, in implementing this section of the ACA, the Centers for Medicare & Medicaid Services (CMS) has become aware of certain physicians and non-physician practitioners who only order or refer items and services for Medicare beneficiaries—the services they furnish to Medicare beneficiaries are not reimbursable by the Medicare program. CR 7097 announces that such physicians and non-physician practitioners will need to enroll in the Medicare program in order to be able to continue to order or refer items or services for Medicare beneficiaries.

Specifically, if you order or refer items or services for Medicare beneficiaries and (1) you are employed by the Department of Veterans Affairs (DVA), the Public Health Service (PHS), the Department of Defense (DOD) TRICARE; or by a Medicare enrolled Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or Critical Access Hospital (CAH), (2) you are in a fellowship, or (3) you are a dentist or oral surgeon, you will need to enroll in Medicare using the modified enrollment process described below. (Any provider can enroll for the sole purpose of ordering or referring, regardless of who their employer is.)

Modified Enrollment Process for Physicians and Non-Physician Practitioners who are Enrolling Solely to Order and Refer

To enroll in Medicare for the sole purpose of ordering or referring items or services, you must do the following:

1. Complete the following sections paper of form CMS-855I (“Medicare Enrollment Application for Physicians and Non-Physician Practitioners”):
 - Section 1 – Basic Information (you would be a new enrollee);
 - Section 2 – Identifying Information (section 2A, 2B, 2D and if appropriate 2H and 2K);
 - Section 3 – Final Adverse Actions/Convictions;

- Section 13 – Contact Person; and
 - Section 15 - Certification Statement (must be signed and dated—blue ink recommended).
2. You **must** include a cover letter with this enrollment application stating that you are enrolling for the sole purpose of ordering and referring items or services for a Medicare beneficiary and cannot be reimbursed by the Medicare program for services that you may provide to Medicare beneficiaries.
 3. Mail the completed enrollment application and cover letter to your designated Medicare enrollment contractor, which you can find at http://www.cms.gov/MedicareProviderSupEnroll/downloads/contact_list.pdf on the CMS website.

Your designated Medicare enrollment contractor will verify that the information you provided on the application meets the Medicare requirements for your profession (supplier type) and, if approved, will enter the data into PECOS. This will place you on the Ordering Referring File that is available on the Medicare provider/supplier enrollment web site (<http://www.cms.gov/MedicareProviderSupEnroll>) and the information will be in the Medicare claims system so that claims for the items or services you ordered or referred can be paid. The designated Medicare contractor will send you a letter notifying you that you are enrolled in the Medicare program for the sole purpose of ordering and referring items or services for Medicare beneficiaries.

Notes:

- 1) *When enrolling, you do **not** have to complete the CMS 460, Medicare Participating Physician or Supplier Agreement or the CMS 588, Electronic Funds Transfer (EFT) Authorization Agreement, in with the CMS-855I application. Also, license information received from a physician or practitioner employed by DVA or DOD may be active in a state other than the DVA or DVA location.*
- 2) *Since the abbreviated application does not require you to complete section 4 and CMS is requiring a cover letter, the Medicare enrollment contractors will reject your application if section 4 is blank and a cover letter is not attached.*
- 3) *You are not permitted to be reimbursed by Medicare for services you may furnish to Medicare beneficiaries.*
- 4) *If, in the future, you wish to be reimbursed by Medicare for services performed, you must submit the full enrollment application via the paper application(s) (CMS-855) or Internet-based PECOS; the Medicare enrollment contractor will deactivate the current information.*

Additional Information

You can find more information about enrolling in Medicare for the sole purposes of ordering and referring by going to CR 7097, located at <http://www.cms.gov/Transmittals/downloads/R387PI.pdf> on the CMS website. You will find the updated "Medicare Program Integrity Manual," Chapter 15 (Medicare Provider/Supplier Enrollment), Section 16.1 (Ordering/Referring Providers Who Are Not Enrolled in Medicare) as an attachment to that CR.

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

IMPLEMENTATION OF PROVIDER ENROLLMENT PROVISIONS IN CMS-6028-FC

~Revised CMS MLN Article~

MLN Matters® Number: MM7350 Revised
Related CR Release Date: March 23, 2011
Related CR Transmittal #: R371PI

Related Change Request (CR) #: 7350
Effective Date: March 25, 2011
Implementation Date: March 25, 2011

Note: MM7350 was revised on October 31, 2011, to provide a new web address for making payment of the application fees. All other information remains the same.

Provider Types Affected

All providers and suppliers submitting enrollment applications to Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Medicare Carriers, A/B Medicare Administrative Contractors (A/B MACs), and the National Supplier Clearinghouse (NSC) are affected by this article.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS) published a final rule with comment period, entitled, “Medicare, Medicaid, and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers” (CMS-6028-FC). This rule was published in the February 2, 2011, edition of the “Federal Register.”

CAUTION – What You Need to Know

This rule finalized provisions related to the:

- Establishment of provider enrollment screening categories;
- Submission of application fees as part of the provider enrollment process;
- Suspensions of payment based on credible allegations of fraud; and
- Authority to impose a temporary moratorium on the enrollment of new Medicare providers and suppliers of a particular type (or the establishment of new practice locations of a particular type) in a geographic area.

GO – What You Need to Do

This article is based on Change Request (CR) 7350, which describes how Medicare contractors will implement the changes related to provider enrollment screening, application fees, and temporary moratoria. (Payment suspensions will be addressed via separate CMS guidance.). Please ensure that your staffs are aware of these new provisions.

Background

CR7350 describes how Medicare will implement certain provisions of the final rule CMS-6028-FC. These details are provided in new sections 19 through 19.4 of Chapter 15 in the “Medicare Program Integrity Manual.” Those manual sections are attached to CR7350 and are summarized as follows:

Screening Processes

Beginning on March 25, 2011, Medicare will place newly-enrolling and existing providers and suppliers in one of three levels of categorical screening: limited, moderate, or high. The risk levels denote the level of the contractor's screening of the provider or supplier when it initially enrolls in Medicare, adds a new practice location, or revalidates its enrollment information.

Chapter 15, Section 19.2.1 of the "Program Integrity Manual" (PIM) provides the complete list of these three screening categories, and the provider types assigned to each category, and a description of the screening processes applicable to the three categories (effective on and after March 25, 2011), and procedures to be used for each category. Once again, that new section of the PIM is attached to CR7350.

Although fingerprinting and criminal background checks are included in CMS-6028-FC as requirements for providers and suppliers in the "high" category of screening, these requirements will be implemented at a later date and providers and suppliers will be notified well in advance of their implementation.

Application Fees

With the exception of physicians, non-physician practitioners, physician group practices and non-physician group practices, providers and suppliers that are (1) initially enrolling in Medicare, (2) adding a practice location, or (3) revalidating their enrollment information, must submit with their application:

- An application fee in an amount prescribed by CMS, and/or
- A request for a hardship exception to the application fee.

This requirement applies to applications that your Medicare contractor receives on or after March 25, 2011. **Note that a physician, non-physician practitioner, physician group, or non-physician practitioner group that is enrolling as a DMEPOS supplier via the CMS-855S application must pay the required application fee.**

The application fee must be in the amount prescribed by CMS for the calendar year in which the application is submitted. The fee for March 25, 2011, through December 31, 2011, is \$505.00. Fee amounts for future years will be adjusted by the percentage change in the consumer price index (for all urban consumers) for the 12-month period ending on June 30 of the prior year. CMS will give Medicare contractors and the public advance notice of any change in the fee amount for the coming calendar year.

The application fee is non-refundable, except if it was submitted with one of the following:

- A hardship exception request that is subsequently approved;
- An application that was rejected prior to the Medicare Contractor's initiation of the screening process; or
- An application that is subsequently denied as a result of the imposition of a temporary moratorium as described in 42 CFR 424.570.

The provider or supplier must pay the application fee electronically by going to <https://pecos.cms.hhs.gov/pecos/feePaymentWelcome.do> and paying their fee via credit card, debit card, or check. Providers and suppliers are strongly encouraged to submit

with their application a copy of their receipt of payment. This may enable the contractor to more quickly verify that payment has been made.

Hardship Exception

A provider or supplier requesting a hardship exception from the application fee must include with its enrollment application a letter (and supporting documentation) that describes the hardship and why the hardship justifies an exception. If a paper CMS-855 application is submitted, the hardship exception letter **must** accompany the application. If the application is submitted via the Internet-based Provider Enrollment, Chain and Ownership System (PECOS), the hardship exception letter **must** accompany the certification statement. Hardship exception letters will not be considered if they were submitted separately from the application or certification statement, as applicable. If your Medicare contractor receives a hardship exception request separately from the application or certification statement, it will: (1) return it to you, and (2) notify you via letter, e-mail, or telephone, that it will not be considered.

Upon receipt of a hardship exception request with the application or certification statement, the contractor will send the request and all documentation accompanying the request to CMS. CMS will determine if the request should be approved. **During this review period, the contractor will not begin processing the provider's application.** CMS will communicate its decision to the institutional provider and the contractor via letter.

IMPORTANT: In addition, the contractor will not begin to process the provider's application until: (1) the fee has been paid, or (2) the hardship exception request has been approved. Once processing commences, the application will be processed in the order in which it was received.

Review of Hardship Exception Request

As already stated, the application fee for CY 2011 is \$505. This generally should not represent a significant burden for an adequately capitalized provider or supplier. **It is not enough for the provider to simply assert that the imposition of the application fee represents a financial hardship.** The provider must instead make a strong argument to support its request, including providing comprehensive documentation (which may include, without limitation, historical cost reports, recent financial reports such as balance sheets and income statements, cash flow statements, tax returns, etc.).

Other factors that **may** suggest that a hardship exception is appropriate include the following:

- (a) Considerable bad debt expenses,
- (b) Significant amount of charity care/financial assistance furnished to patients,
- (c) Presence of substantive partnerships (whereby clinical, financial integration are present) with those who furnish medical care to a disproportionately low-income population;
- (d) Whether an institutional provider receives considerable amounts of funding through disproportionate share hospital payments, or
- (e) Whether the provider is enrolling in a geographic area that is a Presidentially-declared disaster under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 5121-5206 (Stafford Act).

Note that if the provider fails to submit appropriate documentation to support its hardship exception request, the contractor is not required to contact the provider to request it. **Ultimately, it is the provider's responsibility to furnish the necessary supporting evidence at the time it submits its hardship exception request.**

Appeal of the Denial of Hardship Exception Decision

If the provider or supplier is dissatisfied with CMS's decision, it may file a written reconsideration request with CMS within 60 calendar days from receipt of the notice of initial determination. The request must be signed by the individual provider or supplier, a legal representative, or any authorized official within the entity. Failure to file a reconsideration request within this timeframe is deemed a waiver of all rights to further administrative review. To file a reconsideration request, providers and suppliers should follow the procedures outlined in Chapter 15, Section 19 of the "Program Integrity Manual" (PIM), which is attached to CR7350.

Temporary Moratoria

CMS may impose a moratorium on the enrollment of new Medicare providers and suppliers of a particular type or the establishment of new practice locations of a particular type in a particular geographic area.

The announcement of a moratorium will be made via the Federal Register. For initial and new location applications involving the affected provider and supplier type, the moratorium:

- Will not apply to applications for which an approval or a recommendation for approval has been made as of the effective date of the moratorium, even if the contractor has not yet formally granted Medicare billing privileges. Such applications can continue to be processed to completion.
- Will apply to applications that are pending as of the effective date of the moratorium and for which the contractor has not yet made a final approval/denial decision or recommendation for approval. The contractor will deny such applications and will return the application fee if it was submitted with the application.
- Will apply to initial applications that the contractor receives on or after the effective date of the moratorium, and for as long as the moratorium is in effect. The contractor will deny such applications and will return the application fee if it was submitted with the application.

If a particular moratorium is lifted, all applications pending with the contractor as of the effective date of the moratorium's cessation are no longer subject to the moratorium and may be processed. However, such applications will be processed in accordance with the "high" level of categorical screening. In addition, any initial application received from a provider or supplier: (a) that is of a provider or supplier type that was subject to a moratorium, and (b) within 6 months after the applicable moratorium was lifted, the contractor will process the application using the "high" level of categorical screening.

Additional Information

The official instruction, CR7350, issued to your FI, RHHI, carrier, and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/transmittals/downloads/R371PI.pdf> on the CMS website. Complete details regarding this issue, as defined in the PIM revisions, are attached to CR7350.

MLN Matters® article SE1126, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/SE1126.pdf>, has further details on the Affordable Care Act-required revalidation of provider enrollment information for all providers and suppliers who enrolled in the Medicare program prior to March 25, 2011.

For more information about the application fee payment process, refer to MLN Matters® article SE1130, which is available at <http://www.cms.gov/MLN MattersArticles/downloads/SE1130.pdf> on the CMS website.

A sample letter requesting providers to review, update, and certify their enrollment information is available at <http://www.cms.gov/MedicareProviderSupEnroll/Downloads/SampleRevalidationLetter.pdf> on the CMS website.

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

MEDICARE BENEFICIARIES IN STATE OR LOCAL CUSTODY

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

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

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

Exclusion from Coverage

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

items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody.

Claims Processing Procedures

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

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

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

Appeals

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

QUARTERLY PROVIDER UPDATE

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

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at <http://www.cms.gov/QuarterlyProviderUpdates/>.

We encourage you to bookmark this website and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update Listserv (electronic mailing list) at http://subscriptions.cms.hhs.gov/service/subscribe.html?code=USCMS_460.

Provider Education

TRAINING PROGRAMS

WPS Medicare offers three formats for live training, to allow maximum provider participation. These include:

- **Seminars**, which are presented in person by our experienced Provider Outreach and Education staff. These usually last one-half day or full day.
- **Teleconferences**, which offer topic driven education and/or open question and answer format. These typically run for 60-90 minutes.
- **Webinars** (web-based seminars), presented live over the Internet in an audiovisual format, allowing providers to view slide shows, listen to the presenter, and ask questions.

J5 MAC Providers

If you are a J5 MAC Part B provider in Iowa, Kansas, Missouri, or Nebraska, please be sure to visit the WPS Medicare Education Schedule at

http://www.wpsmedicare.com/j5macpartb/training/training_programs/ to learn more about the educational events we have scheduled for the upcoming months.

Legacy Providers

If you are a Legacy Part B provider in Illinois, Michigan, Minnesota, or Wisconsin, please be sure to visit the WPS Medicare Education Schedule at

http://www.wpsmedicare.com/part_b/training/training_programs/ to learn more about the educational events we have scheduled for the upcoming months.

Reimbursement**2012 ANNUAL UPDATE OF HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES FOR SKILLED NURSING FACILITY (SNF) CONSOLIDATED BILLING (CB) UPDATE
~CMS MLN Article~**

MLN Matters® Number: MM7552
Related CR Release Date: August 26, 2011
Related CR Transmittal #: R2286CP

Related Change Request (CR) #: CR 7552
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

Physicians, other providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries who are in a Part A covered Skilled Nursing Facility (SNF) stay.

What You Need to Know

This article is based on Change Request (CR) 7552 which provides the 2012 annual update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility Consolidated Billing (SNF CB) and how the updates affect edits in Medicare claims processing systems.

By the first week in December 2011:

- Physicians and other providers/suppliers who bill carriers, DME MACs, or A/B MACs are advised that new code files (entitled 2012 Carrier/A/B MAC Update) will be posted at <http://www.cms.gov/SNFConsolidatedBilling/> on the Centers for Medicare & Medicaid Services (CMS) website; and
- Providers who bill Fiscal Intermediaries or A/B MACs are advised that new Excel and PDF files (entitled 2011 FI/A/B MAC Update) will be posted to <http://www.cms.gov/SNFConsolidatedBilling/> on the CMS website.

It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI/A/B MAC update in order to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Background

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to HCPCS codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for Skilled Nursing Facility Consolidated Billing (SNF CB) contained in the "Medicare Claims Processing Manual" (Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs) which is available at <http://www.cms.gov/manuals/downloads/clm104c06.pdf> on the CMS website.

Please note that these edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Additional Information

You can find the official instruction, CR7552, issued to your carrier, FI, A/B MAC, or DME MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2286CP.pdf> on the CMS website.

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

AMBULANCE INFLATION FACTOR FOR CALENDAR YEAR (CY) 2012 ~CMS MLN Article~

MLN Matters® Number: MM7546
Related CR Release Date: September 23, 2011
Related CR Transmittal #: R2310CP

Related Change Request (CR) #: CR 7546
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

This article is for providers and suppliers of ambulance services who bill Medicare Carriers, Fiscal Intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs) for those services.

What You Need to Know

Change Request (CR) 7546, from which this article is taken, updates the Medicare Claims Processing Manual by providing the AIF for CY 2012 so that Medicare Carriers, FIs, and A/B MACs can accurately determine the payment amounts for ambulance services. The ambulance inflation factor (AIF) for CY 2012 is **2.4 percent**. You should ensure that your billing staffs are aware of this 2012 AIF.

Background

Section 1834(l) (3) (B) of the Social Security Act (the Act) provides the basis for updating the payment limits that carriers, FIs, and A/B MACs use to pay for the claims that you submit for ambulance services. Specifically, this section of the Act provides for a yearly payment update that is equal to the percentage increase in the urban consumer price index (CPI-U), for the 12-month period ending with June of the prior year.

On March 23, 2010, Section 3401 of the Affordable Care Act amended Section 1834(l)(3) of the Act to require that specific Prospective Payment System and Fee Schedule update factors be adjusted by changes in economy-wide productivity. The statute defines the productivity adjustment to be equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (MFP) (as projected by the Secretary for the 10-year period ending with the applicable fiscal year, cost reporting period, or other annual period). The MFP for CY 2012 is 1.2 percent and the CPI-U for 2012 is 3.6 percent. According to the Affordable Care Act, the CPI-U is reduced by the MFP, even if this reduction results in a negative AIF update. Therefore, the AIF for CY 2012 is 2.4 percent.

Note: The Part B coinsurance and deductible requirements apply to payments under the ambulance fee schedule.

Additional Information

You can find the official instruction, CR7546, issued to your carrier, FI, or A/B MAC by visiting <http://www.cms.gov/Transmittals/downloads/R2310CP.pdf> on the CMS website. You will find the updated "Medicare Claims Processing Manual" Chapter 15 (Ambulance), Section 20.4 (Ambulance Inflation Factor (AIF)) as an attachment to that CR.

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

ANNUAL CLOTTING FACTOR FURNISHING FEE UPDATE 2012 ~CMS MLN Article~

MLN Matters® Number: MM7543
Related CR Release Date: August 19, 2011
Related CR Transmittal #: R2279CP

Related Change Request (CR) #: CR 7543
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

This article is for physicians and other providers billing Medicare Carriers, Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (MACs), or Regional Home Health Intermediaries (RHHIs) for services related to the administration of clotting factors to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 7543, from which this article is taken, announces that for Calendar Year 2012, the clotting factor furnishing fee of \$0.181 per unit is included in the published payment limit for clotting factors and will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the Average Sales Price (ASP) or Not Otherwise Classified (NOC) drug pricing files. Please be sure your billing staffs are aware of this fee update.

Background

Section 1842(o)(5)(C) of the Social Security Act (added by the Medicare Modernization Act Section 303(e)(1)) requires, beginning January 1, 2005, that a clotting factor furnishing fee be paid separately if you furnish clotting factor; unless the costs associated with furnishing the clotting factor are paid through another payment system.

The Centers for Medicare & Medicaid Services (CMS) includes the clotting factor furnishing fee in the published national payment limits for clotting factor billing codes. When the national payment limit for a clotting factor is not included on the Average Sales Price (ASP) Medicare Part B Drug Pricing File, or the Not Otherwise Classified (NOC) Pricing File; your carrier, FI, RHHI, or A/B MAC must make payment for the clotting factor as well as make payment for the furnishing fee.

The clotting factor furnishing fee is updated each Calendar Year based on the percentage increase in the Consumer Price Index (CPI) for medical care for the 12-month period ending with June of the previous year. The clotting factor furnishing fees applicable for dates of service in each Calendar Year (CY) are listed below:

Clotting Factor Furnishing Fee	
CY 2005	\$0.140 per unit
CY 2006	\$0.146 per unit
CY 2007	\$0.152 per unit
CY 2008	\$0.158 per unit
CY 2009	\$0.164 per unit
CY 2010	\$0.170 per unit
CY 2011	\$0.176 per unit
CY 2012	\$0.181 per unit

For dates of service January 1, 2012, through December 31, 2012, the clotting factor furnishing fee of \$0.181 per unit is included in the published payment limit for clotting factors and will be added to the payment for a clotting factor when no payment limit for the clotting factor is published either on the ASP or NOC drug pricing files.

Additional Information

You can find the official instruction, CR7543, issued to your carrier, FI, RHHI, or A/B MAC by visiting <http://www.cms.gov/transmittals/downloads/R2279CP.pdf> on the CMS website.

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

CLARIFICATION OF EVALUATION AND MANAGEMENT (E/M) PAYMENT POLICY ~CMS MLN Article~

MLN Matters® Number: MM7405

Related CR Release Date: August 26, 2011

Related CR Transmittal #: R147BP and R2282CP

Related Change Request (CR) #: 7405

Effective Date: January 1, 2011

Implementation Date: November 28, 2011

Provider Types Affected

Physicians, non-physician practitioners (NPP), and hospices billing Fiscal Intermediaries (FI), Regional Home Health Intermediaries (RHHI), carriers, and A/B Medicare Administrative Contractors (A/B MAC) for certain services to Medicare beneficiaries are affected by this article.

What You Need to Know

This article, based on Change Request (CR) 7405, alerts physicians, NPPs, and hospices that the Centers for Medicare & Medicaid Services (CMS) recognized the newly created Current Procedural Terminology (CPT) subsequent observation care codes (99224-99226).

The article also clarifies the use of Evaluation and Management (E/M) Codes by providers for services in various settings.

Medicare contractors will not search their files to adjust claims already processed, but will adjust claims brought to their attention. Be sure your billing staffs are aware of these changes.

Background

In the Calendar Year (CY) 2010 Physician Fee Schedule (PFS) final rule with comment period (CMS-1413-FC), CMS eliminated the payment of all CPT consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation Healthcare Common Procedure Coding System (HCPCS) G-codes.

In the CY 2011 PFS final rule with comment period (CMS-1503-FC), CMS recognized the newly created CPT subsequent observation care codes (99224-99226).

All references to billing CPT consultation codes in the “Medicare Benefit Policy Manual,” Chapter 15, and the “Medicare Claims Processing Manual,” 12, are revised, as a result of CR7405, to reflect the current policy on reporting E/M services that would otherwise be described by CPT consultation codes.

References to billing observation care codes in the “Medicare Claims Processing Manual,” Chapter 12, section 30.6, are also revised to account for the new subsequent observation care codes (99224-99226).

Key Points of CR 7405

Consultation Codes No Longer Recognized

Effective January 1, 2010, CPT consultation codes were no longer recognized for Medicare Part B payment. A previous article, MM6740, Revisions to Consultation Services Payment Policy, issued on December 14, 2009, informed you that you must code patient evaluation and management visits with E/M codes that represent where the visit occurred and that identify the complexity of the visit performed. (MM6740, Revisions to Consultation Services Payment Policy, is available at <http://www.cms.gov/MLN Matters Articles/downloads/MM6740.pdf> on the CMS website.)

- CMS instructed physicians (and qualified NPPs where permitted) billing under the Physician Fee Service (PFS) to use other applicable E/M codes to report the services that could be described by CPT consultation codes.
- CMS also provided that, in the inpatient hospital setting, physicians (and qualified NPPs where permitted) who perform an initial E/M service may bill the initial hospital care codes (99221 – 99223).

Reporting Initial Hospital Care Codes

CMS is aware of concerns pertaining to reporting initial hospital care codes for services that previously could have been reported with CPT consultation codes, for which the minimum key component work and/or medical necessity requirements for CPT codes 99221 through 99223 are not documented.

- Physicians may bill initial hospital care service codes (99221-99223), for services that were reported with CPT consultation codes (99241 – 99255) prior to January 1, 2010, when the furnished service and documentation meet the minimum key component work and/or medical necessity requirements. Physicians must meet all

- the requirements of the initial hospital care codes, including “a detailed or comprehensive history” and “a detailed or comprehensive examination” to report CPT code 99221, which are greater than the requirements for consultation codes 99251 and 99252.
- In situations where the minimum key component work and/or medical necessity requirements for initial hospital care services are not met, subsequent hospital care CPT codes (99231 and 99232) could potentially be reported for an E/M service that could be described by CPT consultation code 99251 or 99252.
 - Subsequent hospital care CPT codes 99231 and 99232, respectively, require “a problem focused interval history” and “an expanded problem focused interval history.” An E/M service that could be described by CPT consultation code 99251 or 99252 could potentially meet the component work and medical necessity requirements to report 99231 or 99232. Physicians may report a subsequent hospital care CPT code for services that were reported as CPT consultation codes (99241 – 99255) prior to January 1, 2010, where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.
 - Reporting CPT code 99499 (Unlisted evaluation and management service) should be limited to cases where there is no other specific E/M code payable by Medicare that describes that service. Reporting CPT code 99499 requires submission of medical records and contractor manual medical review of the service prior to payment. Contractors shall expect reporting under these circumstances to be unusual.

Medicare contractors have been advised to expect changes to physician billing practices accordingly. Contractors will not find fault with providers who report subsequent hospital care codes (99231 and 99232) in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

Billing Visits Provided in Skilled Nursing Facilities and Nursing Facilities

The general policy of billing the most appropriate visit code, following the elimination of payments for consultation codes, will also apply to billing initial visits provided in skilled nursing facilities (SNFs) and nursing facilities (NFs) by physicians and NPPs who are not providing the federally mandated initial visit. If a physician or NPP is furnishing that practitioner's first E/M service for a Medicare beneficiary in a SNF or NF during the patient's facility stay, even if that service is provided prior to the federally mandated visit, the practitioner may bill the most appropriate E/M code that reflects the services the practitioner furnished, whether that code be an initial nursing facility care code (CPT codes 99304-99306) or a subsequent nursing facility care code (CPT codes 99307-99310), when documentation and medical necessity do not meet the requirements for billing an initial nursing facility care code.

CPT Subsequent Observation Care Codes

In CY 2011 PFS final rule with comment period (CMS-1503-FC), CMS recognized the newly created CPT subsequent observation care codes (99224-99226).

- For the new subsequent observation care codes, the current policy for initial observation care also applies to subsequent observation care.

- Payment for a subsequent observation care code is for all the care rendered by the treating physician on the day(s) other than the initial or discharge date.
- All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.
- In the rare circumstance when a patient receives observation services for more than 2 calendar dates, the physician will bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes.

Additional Information

The official instruction, CR 7405, was issued to your FI, RHHI, carrier, and A/B MAC via two transmittals. The first updates the “Medicare Benefit Policy Manual” and is at <http://www.cms.gov/Transmittals/downloads/R147BP.pdf> on the CMS website. The second transmittal updates the “Medicare Claims Processing Manual” and is at <http://www.cms.gov/Transmittals/downloads/R2282CP.pdf> on the same site.

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

CLARIFICATION TO CHAPTER 26, SECTION 10.4 - ITEMS 14-33 - PROVIDER OF SERVICE OR SUPPLIER INFORMATION

~CMS MLN Article~

MLN Matters® Number: MM7538
Related CR Release Date: August 26, 2011
Related CR Transmittal #: R2284CP

Related Change Request (CR) #: 7538
Effective Date: September 26, 2011
Implementation Date: September 26, 2011

Provider Types Affected

This article is for physicians, providers, and suppliers billing Medicare contractors (Carriers and Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 7538 and clarifies the manual section specified in the article title to confirm that the changes implemented in CR6947 are applicable only to services payable under the Medicare Physician Fee Schedule and anesthesia services.

Specifically, CR7538 clarifies Chapter 26, Section 10.4 of the “Medicare Claims Processing Manual” to confirm that the changes implemented in CR6947 are applicable only to services payable under the Medicare Physician Fee Schedule and anesthesia services. Please make sure your billing staff is aware of these changes.

Additional Information

The official instruction, CR7538, issued to your carrier and/or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2284CP.pdf> on the CMS website.

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

CLINICAL LABORATORY FEE SCHEDULE - MEDICARE TRAVEL ALLOWANCE FEES FOR COLLECTION OF SPECIMENS ~ Revised CMS MLN Article ~

MLN Matters® Number: MM7526 Revised
Related CR Release Date: September 16, 2011
Related CR Transmittal #: R2306CP

Related Change Request (CR) #: 7526
Effective Date: July 1, 2011
Implementation Date: November 29, 2011

Note: This article was revised on September 19, 2011, to reflect a revised CR7526. The CR was revised to change the referenced per mile cost of \$1.005 to \$1.01 (actual total of \$1.005 rounded up to reflect systems capabilities). Also, the CR transmittal number, release date, and the web address for accessing the CR were changed. All other information remains the same.

Provider Types Affected

Clinical Laboratories submitting claims to Medicare contractors (Carriers, Fiscal Intermediaries (FIs), and/or A/B Medicare Administrative Contractors (A/B MACs)) for specimen collection services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on Change Request (CR) 7526, which revises the payment of travel allowances for specimen collection services when billed on a per mileage basis using Health Care Common Procedure Coding System (HCPCS) code P9603 and when billed on a flat rate basis, using HCPCS code P9604 for Calendar Year (CY) 2011.

The per mile travel allowance (P9603) for services on or after July 1, 2011, is \$1.01 per mile and the per flat-rate trip basis travel allowance (P9604) is \$10.05. Payment of the travel allowance is made only if a specimen collection fee is also payable. Your Medicare contractor has the option of establishing a higher per mile rate in excess of the minimum \$1.01 per mile (actual total of \$1.005 rounded up to reflect systems capabilities) if local conditions warrant it. Be sure your staffs are aware of these changes.

Background

CR7526 revises the CY 2011 payment of travel allowances when billed either on a:

- Per mileage basis using HCPCS code P9603, or
- Flat rate basis using HCPCS code P9604.

Note: Payment of the travel allowance is made only if a specimen collection fee is also payable.

The travel allowance is intended to cover the estimated travel costs of collecting a specimen, including the laboratory technician's salary and travel expenses.

Medicare contractors have the discretion to choose either the mileage basis or flat rate. In addition, your Medicare contractor can choose how to set each type of allowance. Also, many contractors established local policy to pay based on a flat rate basis only.

Under either method, when one trip is made for multiple specimen collections (e.g., at a nursing home), the travel payment component is prorated based on the number of specimens collected on that trip for both Medicare and non-Medicare patients. This is done either:

- At the time the claim is submitted by the laboratory, or
- When the flat rate is set by the Medicare contractor.

Per Mile Travel Allowance (P9603) – The per mile travel allowance is a minimum of \$1.01 per mile. This per mile travel allowance rate is used in situations where the average trip to the patients' homes is longer than 20 miles round trip, and is prorated in situations where specimens are drawn from non-Medicare patients in the same trip.

The allowance per mile rate was computed using the Federal mileage rate of \$0.555 per mile plus an additional \$0.45 per mile to cover the technician's time and travel costs for a total of \$1.01 per mile (actual total of \$1.005 rounded up to reflect systems capabilities). At no time will the laboratory be allowed to bill for more miles than are reasonable, or for miles that are not actually traveled by the laboratory technician.

Per Flat-Rate Trip Basis Travel Allowance (P9604) – The per flat-rate trip basis travel allowance is \$10.05.

The Internal Revenue Service (IRS) determines the standard mileage rate for businesses based on periodic studies of the fixed and variable costs of operating an automobile.

Additional Information

The official instruction, CR7526, issued to your FI, Carrier, and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2306CP.pdf> on the CMS website.

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

CY 2012 FEE SCHEDULE UPDATE FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS)

~CMS MLN Article~

MLN Matters® Number: MM7635
Related CR Release Date: November 4, 2011
Related CR Transmittal #: R2340CP

Related Change Request (CR) #: CR 7635
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider Action Needed

STOP – Impact to You

Updates and information in CR 7635 can impact reimbursement for your claims for DMEPOS items or services.

CAUTION – What You Need to Know

This article, based on Change Request (CR) 7635, advises you of the Calendar Year (CY) 2012 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule.

Key points about these changes are summarized in the Background section below. These changes are effective for DMEPOS provided on or after January 1, 2012.

GO – What You Need to Do

You should make that sure your billing staffs are aware of these changes.

Background and Key Points of CR 7635

Payment on a fee schedule basis is required for durable medical equipment, prosthetic devices, orthotics, prosthetics, and surgical dressings (DMEPOS) by Sections 1834(a), (h), and (i) of the Social Security Act (the Act); and for parenteral and enteral nutrition (PEN) by 42 CFR, Section 414.102.

In accordance with these statutes and regulations, the DMEPOS fee schedules are updated annually; and the process for this update is documented in the "Medicare Claims Processing Manual", Chapter 23 Fee Schedule Administration and Coding Requirements), Section 60 (Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule at <http://www.cms.gov/manuals/downloads/clm104c23.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

CR 7635, from which this article is taken, provides instructions regarding annual the DMEPOS fee schedule annual update for 2012.

Fee Schedule Files

The DMEPOS fee schedule file will be available on or after November 16, 2011, for State Medicaid Agencies, managed care organizations, and other interested parties at <http://www.cms.gov/DMEPOSFeeSched/> on the CMS website.

HCPCS Codes Added

The following new codes are effective as of January 1, 2012:

- A9272 which has no assigned payment category;
- A5056 and A5057 in the ostomy, tracheostomy, and urological supplies (OS) payment category;
- E0988 in the capped rental (CR) category;
- L5312, L6715, and L6880 in the prosthetics and orthotics category; and
- E2358, E2359, E2626, E2627, E2628, E2629, E2630, E2631, E2632, and E2633 in the inexpensive/routinely purchased (DME) payment category.

The fee schedule amounts for the above new codes will be established as part of the July 2012 DMEPOS Fee Schedule Update, when applicable. Also when applicable, DME MACs will establish local fee schedule amounts to pay claims for the new codes from January 1, 2012 through June 30, 2012. The new codes are not to be used for billing purposes until they are effective on January 1, 2012.

Please note that the HCPCS codes listed as new codes in this CR may not be final and are subject to change pending release of the CY 2012 HCPCS file.

For gap-filling purposes, the 2011 deflation factors by payment category are listed in the following table:

Factor	Category
0.485	Oxygen
0.488	Capped Rental
0.490	Prosthetics and Orthotics
0.621	Surgical Dressings
0.676	Parenteral and Enteral Nutrition

HCPCS Codes Deleted

The following codes are being deleted from the HCPCS effective January 1, 2012, and are therefore being removed from the DMEPOS fee schedule files:

- E0571
- L1500, L1510, L1520, L3964, L3965, L3966, L3968, L3969, L3970, L3972, L3974, L4380, L5311, L7266, L7272, L7274, and L7500.

Specific Coding and Pricing Issues

CMS has learned that the current language in the "Medicare Claims Processing Manual," Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 60.3(Gap-filling DMEPOS Fees), that describes the longstanding methodology for calculating gap-filled fee schedule amounts, can be misinterpreted.

For this reason, CR 7635 revises the first paragraph of this section by replacing the phrase "previous data base period" with "fee schedule data base year," and later in the same sentence replacing the phrase "database year" with "fee schedule database year."

These revisions closely approximate the original gap-fill instructions as they appeared in the "Medicare Carriers Manual," Part 3 (Claims Process), Section 5102 (Fee Schedules for Durable Medical Equipment and Orthotic/Prosthetic Devices). In addition, CR 7635 revises this section to include the addition of the 2011 deflation factors, as noted above.

CR 7635 also announces other coding and pricing changes, effective January 1, 2012:

1. New HCPCS codes: E2626, E2627, E26268, E 2629, E2630, E2631, E2632, and E2633 (for wheelchair accessories for shoulder elbow arm supports) are re-designated from codes L3964-L3974 and the fee schedule amounts will be directly assigned from the deleted codes to the new codes.
2. The fee schedule amounts for shoe modification HCPCS codes A5503 through A5507 are being adjusted to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the original fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2012, the base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2010 and the fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change.

KE Modifier Update

To ensure appropriate modifier processing when submitting claims for HCPCS code E0776 (IV Pole), suppliers should bill using the following modifiers depending upon the type of pump that the IV pole is used with:

- For use with infusion pumps – submit E0776RR, E0776NU, or E0776UE;
- For use with parenteral pumps – submit E0776RRBAKE, E0776NUBAKE, or E0776UEBAKE;
- For use with enteral pumps – submit E0776RRBA, E0776NUBA or E0776UEBA; or
- For use with enteral pumps by beneficiaries that permanently reside in Round I Rebid competitively bid areas - submit E0776RRBAKG, E0776NUBAKG or E0776UEBAKG.

Similarly, when submitting claims for a replacement HCPCS code E2373 (POWER WHEELCHAIR ACCESSORY, HAND OR CHIN CONTROL INTERFACE, COMPACT REMOTE JOYSTICK) suppliers should bill using the following modifiers depending upon the associated base wheelchair:

- For use with a power wheelchair HCPCS code that was bid in Round I of the DMEPOS Competitive Bidding Program – submit E2373KCRR, E2373KCNU or E2373KCUE;
- For use with a power wheelchair HCPCS code that was not bid in Round I of the DMEPOS Competitive Bidding Program – submit E2373KCRRKE, E2373KCNUKE or E2373KCUEKE; or
- For beneficiaries that permanently reside in Round I Rebid competitively bid areas when used with a power wheelchair HCPCS code that was bid in the Round I Rebid

of the DMEPOS Competitive Bidding Program – submit E2373KCRRKK, E2373KCNUKK, or E2373KCUEKK.

Note: The above billing instructions supersede the E0776 and E2373 KC billing instructions furnished in Transmittal 1630, CR6270, dated November 7, 2008.

Attachment B to CR 7635 contains a list of the HCPCS codes that were selected in 2008 for Round I of the DMEPOS Competitive Bidding Program. For beneficiaries who permanently reside in Round I Rebid competitive bid areas, a list of the Round 1 Rebid competitively bid items is available in the single payment amount charts located at <http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Single%20Payment%20Amounts> on the Competitive Bidding Implementation Contractor (CBIC) website.

CY 2012 Fee Schedule Update Factor

For CY 2012, the update factor of 2.4 percent is applied to the applicable CY 2011 DMEPOS fee schedule amounts.

In accordance with section 1834(a)(14) of the Act, the DMEPOS fee schedule amounts are to be updated for 2012 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2011, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP).

The MFP adjustment is 1.2 percent and the CPI-U percentage increase is 3.6 percent. Thus, the 3.6 percentage increase in the CPI-U is reduced by the 1.2 percentage increase in the MFP resulting in a net increase of 2.4 percent for the MFP-adjusted update factor.

2011 Update to Labor Payment Rates

2012 Fees for Healthcare Common Procedure Coding System (HCPCS) labor payment codes K0739, L4205, L7520 are increased by 3.6 percent effective for dates of service on or after January 1, 2012 through December 31, 2012, and those rates are as follows:

STATE	K0739	L4205	L7520	STATE	K0739	L4205	L7520
AK	\$26.47	\$30.16	\$35.48	NC	\$14.05	\$20.94	\$28.43
AL	14.05	20.94	28.43	ND	17.51	30.10	35.48
AR	14.05	20.94	28.43	NE	14.05	20.92	39.64
AZ	17.37	20.92	34.98	NH	15.08	20.92	28.43
CA	21.56	34.38	40.07	NJ	18.96	20.92	28.43
CO	14.05	20.94	28.43	NM	14.05	20.94	28.43
CT	23.47	21.41	28.43	NV	22.39	20.92	38.75
DC	14.05	20.92	28.43	NY	25.88	20.94	28.43
DE	25.88	20.92	28.43	OH	14.05	20.92	28.43
FL	14.05	20.94	28.43	OK	14.05	20.94	28.43
GA	14.05	20.94	28.43	OR	14.05	20.92	40.88
HI	17.37	30.16	35.48	PA	15.08	21.54	28.43
IA	14.05	20.92	34.03	PR	14.05	20.94	28.43

STATE	K0739	L4205	L7520	STATE	K0739	L4205	L7520
ID	14.05	20.92	28.43	RI	16.75	21.56	28.43
IL	14.05	20.92	28.43	SC	14.05	20.94	28.43
IN	14.05	20.92	28.43	SD	15.70	20.92	38.00
KS	14.05	20.92	35.48	TN	14.05	20.94	28.43
KY	14.05	26.81	36.35	TX	14.05	20.94	28.43
LA	14.05	20.94	28.43	UT	14.09	20.92	44.27
MA	23.47	20.92	28.43	VA	14.05	20.92	28.43
MD	14.05	20.92	28.43	VI	14.05	20.94	28.43
ME	23.47	20.92	28.43	VT	15.08	20.92	28.43
MI	14.05	20.92	28.43	WA	22.39	30.69	36.45
MN	14.05	20.92	28.43	WI	14.05	20.92	28.43
MO	14.05	20.92	28.43	WV	14.05	20.92	28.43
MS	14.05	20.94	28.43	WY	19.59	27.91	39.64
MT	14.05	20.92	35.48				

2012 National Monthly Payment Amounts for Stationary Oxygen Equipment

CR 7635 implements the 2012 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2012. As required by statute, the payment amount must be adjusted annually, as necessary, to ensure budget neutrality of the new payment class for oxygen generating portable equipment (OGPE).

The updated national 2012 monthly payment amount of \$176.06 for stationary oxygen equipment codes is included in the DMEPOS fee schedule.

Please note that when the stationary oxygen equipment fees are updated, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2012 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

CR 7635 also updates the 2012 payment amount for maintenance and servicing for certain oxygen equipment.

You can read more about payment for claims for maintenance and servicing of oxygen equipment in MLN Matters® Articles, MM6792 "Maintenance and Servicing Payments for Certain Oxygen Equipment," which you can find at <http://www.cms.gov/MLNMattersArticles/downloads/MM6792.pdf> and MM6990 "Clarification of the Date of Service for Maintenance and Servicing Payments for Certain Oxygen Equipment after July 1, 2010," which you can find at <http://www.cms.gov/MLNMattersArticles/downloads/MM6990.pdf> on the CMS website.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either

HCPSC code E1390, E1391, E0433 or K0738, billed with the “MS” modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR Section 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section 1834(a)(14) of the Act. Thus, the 2011 maintenance and servicing fee is adjusted by the 2.4 percent MFP-adjusted covered item update factor to yield a CY 2012 maintenance and servicing fee of \$67.51 for oxygen concentrators and transfilling equipment.

Additional Information

You can find the official instruction, CR 7635, issued to your carrier, DME MAC, FI, A/B MAC, or RHHI by visiting <http://www.cms.gov/Transmittals/downloads/R2340CP.pdf> on the CMS website. You will find the updated "Medicare Claims Processing Manual", Chapter 23 (Fee Schedule Administration and Coding Requirements, Section 60.3 (Gap-filling DMEPOS Fees) as an attachment to that CR.

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

FORMAT REVISIONS TO THE SPECIAL INCENTIVE REMITTANCE ADVICE USED TO REPORT QUARTERLY INCENTIVE PAYMENTS FOR HEALTH PROFESSIONAL SHORTAGE AREAS (HPSAS), THE PRIMARY CARE INCENTIVE PAYMENT PROGRAM (PCIP), AND THE HPSA SURGICAL INCENTIVE PAYMENT PROGRAM (HSIP)

~CMS MLN Article~

MLN Matters® Number: MM7561
Related CR Release Date: October 27, 2011
Related CR Transmittal #: R975OTN

Related Change Request (CR) #: CR 7561
Effective Date: April 1, 2012
Implementation Date: April 2, 2012

Provider Types Affected

This article is for physicians and non-physician practitioners submitting claims to Medicare carriers and Part A/B Medicare Administrative Contractors (A/B MACs) for primary care services; and for general surgeons submitting claims to Medicare carriers and A/B MACs for major surgical procedures furnished in Health Professional Shortage Areas (HPSAs).

What You Need to Know

A revision to the special remittance advice used to report quarterly incentive payments for Health Professional Shortage Areas (HPSAs), the Primary Care Incentive Payment Program (PCIP), and the HPSA Surgical Incentive Payment Program (HSIP) will allow you to know your total individual incentive payment amount for HPSA, PCIP, and/or HSIP (which ever applies).

Change Request (CR) 7561, from which this article is taken, announces that the special remittance advice currently used for quarterly HPSA, PCIP, and the HSIP incentive payments is being revised to include a summary page with a grand total incentive payment amount per performing National Provider Identifier (NPI), per incentive payment.

Background

Section 5501(a)(3) of the Affordable Care Act (the Act) provides payment of the Primary Care Incentive Payment Program (PCIP) as an additional payment amount for specified primary care services regardless of any other additional payment for services under Section 1833(m) of the Act; and Section 5501(b) revises Section 1833(m) of the Act to authorize the HPSA Surgical Incentive Payment Program (HSIP), an incentive payment program for major surgical services furnished by general surgeons in Health Professional Shortage Areas (HPSAs).

Note: An eligible primary care physician furnishing a primary care service in an HPSA may receive both a HPSA physician bonus payment and a PCIP payment; however, a general surgeon in an HPSA is only eligible to receive a HSIP payment.

In order to coordinate these payments, the Centers for Medicare & Medicaid Services (CMS) instructed Medicare carriers and A/B MACs to revise the Special Incentive Remittance to include the PCIP and HSIP programs in: 1) Change Request (CR) 7060 (Incentive Payment Program for Primary Care Services, Section 5501(a) of the Affordable Care Act), released on February 25, 2011; and 2) CR7063 (Section 5501(b) Incentive Payment Program for Major Surgical Procedures Furnished in Health Professional Shortage Areas under the Affordable Care Act), released August 27, 2010. These CRs also instructed the Medicare contractors, when appropriate, to pay the primary care incentive payment and the HPSA general surgery payment at the same time and in the same payment as the HPSA physician bonus.

Note: The MLN Matters® Articles related to these CRs are available at <http://www.cms.gov/MLN MattersArticles/downloads/MM7060.pdf> and <http://www.cms.gov/MLN MattersArticles/downloads/MM7063.pdf>, respectively.

The first PCIP and HSIP payments were made in April 2011; and at that time, many providers reported to CMS that the accompanying Special HPSA Remittance report was long (in some cases several hundred pages), and did not total the incentive payments by an individual practitioner's NPI. After a review of public comments, CMS is responding to the request to modify this report (now re-named the "Special Incentive Remittance") to provide detailed incentive billing and payment information.

CR7561 announces that CMS has revised the Special Incentive Remittance currently used for quarterly HPSA, PCIP, and HSIP incentive payments to include a summary page with a total incentive amount paid per performing NPI, per incentive program. At a minimum, it includes the following information **per performing NPI**:

- Performing NPI;
- Sum total HPSA amount paid for all claims on the remittance advice;
- Sum total number of HPSA claims on the remittance advice;
- Sum total PCIP amount paid for all claims on the remittance advice;
- Sum total number of PCIP claims on the remittance advice;

- Sum total HSIP amount paid for all claims on the remittance advice; and
- Sum total number of HSIP claims on the remittance advice.

Additional Information

You can find the official instruction, CR7561, issued to your carrier or A/B MAC by visiting <http://www.cms.gov/Transmittals/downloads/R975OTN.pdf> on the CMS website.

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

INFLUENZA VACCINE PAYMENT ALLOWANCES - ANNUAL UPDATE FOR 2011-2012 SEASON ~ Revised CMS MLN Article ~

MLN Matters® Number: MM7575 Revised
Related CR Release Date: November 9, 2011
Related CR Transmittal #: R2345CP

Related Change Request (CR) #: 7575
Effective Date: September 1, 2011
Implementation Date: No later than
January 27, 2012

Note: This article was revised on November 10, 2011, to reflect a revised CR7575. The implementation date has been clarified to read "no later than January 27, 2012." In addition, the CR release date, transmittal number, and the web address for accessing CR7575 have been revised. All other information remains the same.

Provider Types Affected

This article is for physicians and providers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for influenza vaccines provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 7575 in order to update payment allowances, effective September 1, 2011, for influenza vaccines when payment is based on 95 percent of the Average Wholesale Price (AWP). Be sure your billing staffs are aware of this update.

Background

CR7575 provides the payment allowances for the following seasonal influenza virus vaccines: Current Procedural Terminology (CPT) codes 90654, 90655, 90656, 90657, 90660, and 90662 and Healthcare Common Procedure Coding System (HCPCS) codes Q2035, Q2036, Q2037, Q2038, and Q2039 when payment is based on 95 percent of the AWP. The payment allowances for influenza vaccines are updated on an annual basis effective September 1 of each year.

Effective for dates of service on or after September 1, 2011, (except payment is based on reasonable cost where the vaccine is furnished in a hospital outpatient department, a Rural Health Clinic, or a Federally qualified health center), the Medicare Part B payment allowance for:

- CPT 90655 is \$15.705;
- CPT 90656 is \$12.375;
- CPT 90657 is \$6.653;
- HCPCS Q2035 (Afluria®) is \$11.543;
- HCPCS Q2036 (Flulaval®) is \$8.784
- HCPCS Q2037 (Fluvirin®) is \$13.652; and
- HCPCS Q2038 (Fluzone®) is \$13.306.

Note: The Medicare Part B payment allowance for HCPCS Q2039 (Flu Vaccine Adult - Not Otherwise Classified) will be determined by your local Medicare contractor.

Payment for CPT 90654 (Flu vaccine, Intradermal, Preservative free (Fluzone ID®)), for CPT 90660 (FluMist®, a nasal influenza vaccine), or CPT 90662 (Fluzone High-Dose®) may be made if your local Medicare contractor determines its use is medically reasonable and necessary for the beneficiary. Effective for dates of service on or after September 1, 2011, when payment is based on 95 percent of the AWP, the Medicare Part B payment allowance for CPT 90654 is \$18.383, for CPT 90660 is \$22.316, and for CPT 90662 is \$30.923.

CPT 90654 is a valid code effective January 1, 2011. However, the product was not FDA approved until May 9, 2011. Therefore, the code is non-payable for Medicare purposes from January 1, 2011 until May 8, 2011. For any claims containing dates of service May 9, 2011 through August 31, 2011, Medicare contractors shall price the vaccine. Effective for dates of service on and after September 1, 2011, CMS has established a price for CPT 90654.

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the Quarterly Average Sales Price (ASP) Drug Pricing Files.

Note: Medicare contractors will not automatically adjust claims processed prior to implementation of CR7575. However, they will adjust such claims that you bring to their attention.

Additional Information

The official instruction, CR7575 issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2345CP.pdf> on the CMS website.

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

JANUARY 2012 QUARTERLY AVERAGE SALES PRICE (ASP) MEDICARE PART B DRUG PRICING FILES AND REVISIONS TO PRIOR QUARTERLY PRICING FILES

~CMS MLN Article~

MLN Matters® Number: MM7624
Related CR Release Date: October 27, 2011
Related CR Transmittal #: R2331CP

Related Change Request (CR) #: CR 7624
Effective Date: January 1, 2012
Implementation Date: January 3, 2012

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 7624 which instructs your Medicare contractors to download and implement the January 2012 Average Sales Price (ASP) Medicare Part B drug pricing file for Medicare Part B drugs and, if released by the Centers for Medicare & Medicaid Services (CMS), also to download and implement the revised October 2011, July 2011, April 2011, and January 2011 files. Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after January 3, 2012, with dates of service January 1, 2012, through March 31, 2012.

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c); see <http://www.cms.gov/MMAUpdate/downloads/PL108-173summary.pdf> on the Centers for Medicare & Medicaid Services (CMS) website) revised the payment methodology for Part B covered drugs and biologicals that are not priced on a cost or prospective payment basis. The Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPSS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in the "Medicare Claims Processing Manual" (Chapter 4, Section 50; see <http://www.cms.gov/manuals/downloads/clm104c04.pdf> on the CMS website).

The following table shows how the quarterly payment files will be applied:

Files	Effective for Dates of Service
January 2012 ASP and ASP NOC	January 1, 2012, through March 31, 2012
October 2011 ASP and ASP NOC	October 1, 2011, through December 31, 2011
July 2011 ASP and ASP NOC	July 1, 2011, through September 30, 2011
April 2011 ASP and ASP NOC files	April 1, 2011, through June 30, 2011
January 2011 ASP and ASP NOC files	January 1, 2011, through March 31, 2011

Additional Information

The official instruction, CR7624, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2331CP.pdf> on the CMS website.

If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

OCTOBER 2011 UPDATE OF THE AMBULATORY SURGERY CENTER (ASC) PAYMENT SYSTEM

~ Revised CMS MLN Article ~

MLN Matters® Number: MM7547 Revised
Related CR Release Date: September 15, 2011
Related CR Transmittal #: R2305CP

Related Change Request (CR) #: 7547
Effective Date: October 1, 2011
Implementation Date: October 3, 2011

Note: This article was revised on September 19, 2011, to reflect a revised CR7547. The CR was revised to correct the title of Table 1 and related references. Also, the CR transmittal number, release date, and the web address for accessing the CR were changed. All other information remains the same.

Provider Types Affected

This article is for Ambulatory Surgery Centers (ASCs), who submit claims to Medicare Administrative Contractors (MACs) and carriers, for services provided to Medicare beneficiaries paid under the ASC payment system.

Provider Action Needed

This article is based on Change Request (CR) 7547 which describes changes to, and billing instructions for, payment policies implemented in the October 2011 ASC payment system update.

CR7547 provides information regarding three newly created Healthcare Common Procedure Coding System (HCPCS) codes that will be added to the ASC list of covered ancillary services effective October 1, 2011. No new HCPCS codes are being added to the ASC list of covered surgical procedures for October 1, 2011. Be sure your billing staff is aware of these changes.

Background

Medicare policy under the revised ASC payment system requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare Hospital Outpatient Prospective Payment System (OPPS). Those rates are updated on a quarterly basis.

Key Points of CR7547**New Category II CPT Codes Separately Payable under the ASC Payment System Effective October 1, 2011**

Two new Category II CPT Codes have been created for payable surgical procedures that are payable for dates of service on and after October 1, 2011. The new HCPCS codes, the long descriptors, the short descriptors, and payment indicators are identified in below in Table 1.

Table 1—Category Level II Codes Effective October 1, 2011

HCPCS Code	Long Descriptor	Short Descriptor	Payment Indicator (PI) Effective 10/1/2011
C1830	Powered bone marrow biopsy needle	Powered bone marrow bx needle	J7
C1840	Lens, intraocular (telescopic)	Telescopic intraocular lens	J7

One new drug and biological has been granted ASC payment status effective October 1, 2011. This item, along with the long and short descriptor, and payment indicator is identified in Table 2 below.

Table 2—New Drug and Biological Separately Payable under the ASC Payment System Effective October 1, 2011

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI
C9286	Injection, belatacept, 1 mg	Injection, belatacept	K2

NOTE: HCPCS code C9286 is a new code effective October 1, 2011.

Updated Payment Rate for HCPCS Code J9185 Effective July 1, 2011 through September 30, 2011

The payment rate for HCPCS code J9185 (Fludarabine phosphate inj) was incorrect in the July 2011 ASC Drug file. The corrected payment rate is listed in Table 3 below and has been included in the revised July 2011 ASC DRUG file effective for services furnished on July 1, 2011, through implementation of the October 2011 update. Suppliers who think they may have received an incorrect payment between July 1, 2011, and September 30, 2011, may request contractor adjustment of the previously processed claims.

Table 3 – Updated Payment Rates for HCPCS Code J9185 Effective July 1, 2011, through September 30, 2011

HCPCS Code	Short Descriptor	ASC Payment	ASC PI
J9185	Fludarabine phosphate inj	\$104.52	K2

Additional Information

If you have questions, please contact your Medicare MAC or FI at their toll-free number which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the Centers for Medicare & Medicaid Services (CMS) website.

The official instruction (CR7547) issued to your Medicare MAC and/or carrier is available at <http://www.cms.gov/Transmittals/downloads/R2305CP.pdf> on the CMS website. CMS also

reminds ASCs that HCPCS payment updates are posted quarterly at http://www.cms.gov/ASCPayment/11_Addenda_Updates.asp#TopOfPage on the CMS website.

OCTOBER UPDATE TO THE CALENDAR YEAR (CY) 2011 MEDICARE PHYSICIAN FEE SCHEDULE DATABASE (MPFSDB) ~CMS MLN Article~

MLN Matters® Number: MM7528
Related CR Release Date: August 19, 2011
Related CR Transmittal #: R2276CP

Related Change Request (CR) #: 7528
Effective Date: January 1, 2011
Implementation Date: October 3, 2011

Provider Types Affected

Physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (Carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS).

Provider Action Needed

This article is based on Change Request (CR) 7528 and instructs Medicare contractors to download and implement a new Medicare Physician Fee Schedule Database (MPFSDB) as of October 3, 2011. Affected providers should be aware that Medicare contractors will only adjust claims brought to their attention. Please make sure your billing staff is aware of these changes.

Background

Section 1848 (c) (4) of the Social Security Act authorizes the Secretary to establish ancillary policies necessary to implement relative values for physicians' services. In order to reflect appropriate payment policy in line with the CY 2011 MPFS Final Rule, the MPFSDB has been updated effective January 1, 2011, and new payment files have been created.

The original payment files were issued to Medicare contractors based upon the CY 2011 Medicare Physician Fee Schedule (MPFS) Final Rule, published in the Federal Register on November 29, 2010, as modified by the Final Rule Correction Notice, published in the Federal Register on January 11, 2011, and relevant statutory changes applicable January 1, 2011. CR7528 amends those payment files.

For the October 2011 update, there are no new or deleted Healthcare Common Procedure Coding System (HCPCS) codes. However, there are a number of HCPCS codes with MPFS payment indicator changes. Those changes are listed in the table attached to CR7528, which is available at <http://www.cms.gov/transmittals/downloads/R2276CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Medicare contractors will not search their files to adjust claims already processed prior to implementation of these changes. However, they will adjust any impacted claims that you bring to their attention.

Additional Information

The official instruction, CR7528 issued to your carrier, FI, or A/B MAC regarding this change may be viewed at <http://www.cms.gov/transmittals/downloads/R2276CP.pdf> on the CMS website. If you have any questions, please contact your carrier, FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

UPDATES TO THE INTERNET ONLY MANUAL PUBLICATION 100-04, CHAPTER 15 – AMBULANCE TO INCLUDE MEDICARE AND MEDICAID EXTENDERS ACT OF 2010 (MMEA) PROVISIONS

~Revised CMS MLN Article~

MLN Matters® Number: MM7558 Revised
Related CR Release Date: October 13, 2011
Related CR Transmittal #: R2318CP

Related Change Request (CR) #:7558
Effective Date: January 18, 2012
Implementation Date: January 18, 2012

Note: This article was revised on October 18, 2011, to reflect a revised Change Request (CR) 7558. The CR was revised to include additional portions of Section 20.1.4 (Pub. 100-04). The effective and implementation dates were also changed. The transmittal number, CR release date, and link to the transmittal were also changed. All other information remains unchanged.

Provider Types Affected

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

What You Need to Know

Change Request (CR) 7558 updates Chapter 15 of the Centers for Medicare & Medicaid Services (CMS) “Medicare Claims Processing Manual” to include the correct extension dates per the MMEA. CR7558 instructs contractors to ensure that they are in compliance with the instructions found in Chapter 15 of the “Medicare Claims Processing Manual.”

The MMEA of 2010 extends the increase in the ambulance fee schedule amounts for covered ground ambulance transports which originated in rural areas by 3 percent and for covered ground ambulance transports which originated in urban areas by 2 percent through December 31, 2011.

The MMEA of 2010 also extends the “super-rural” bonus an additional year, through December 31, 2011.

Background***Urban and Rural Ambulance Payment Extensions***

The Medicare Improvements for Patients and Providers Act of 2008 (MIPAA) provided for an increase in the ambulance fee schedule amounts for covered ground ambulance transports which originated in rural areas by three percent and for covered ground ambulance transports which originated in urban areas by two percent. These increases were only applicable for claims with dates of service July 1, 2008, through December 31,

2009. The Patient Protection and Affordable Care Act of 2010 reinstated these provisions to on or after January 1, 2010.

Subsequently, the MMEA again extended the payment add-ons an additional year through December 31, 2011.

“Super-Rural” Ambulance Payment Extension

In addition, Section 414 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) specified that, for services furnished during the period July 1, 2004, through December 31, 2009, the payment amount for the ground ambulance base rate was increased where the ambulance transport originated in a rural area included in those areas comprising the lowest 25th percentile of all rural populations arrayed by population density. For this purpose, rural areas included Goldsmith areas (a type of rural census tract). Approximately half of all rural areas (rural counties plus Goldsmith areas) were required to include 25 percent of the rural population arrayed in order of population density. The amount of this increase was based on the Secretary’s estimate of the ratio of the average cost per trip for the rural areas comprised of the lowest quartile of population arrayed by density compared to the average cost per trip for the rural areas comprised of the highest quartile of population arrayed by density.

CMS determined that the amount of this increase was equal to 22.6 percent. The Patient Protection and Affordable Care Act of 2010 reinstated this provision for claims with dates of service on or after January 1, 2010, and before January 1, 2011, using the percentage increase that was applicable under this provision for ambulance services during 2009.

Subsequently, the MMEA again extended the rural bonus an additional year, through December 31, 2011.

Additional Information

The official instruction, CR7558, issued to your A/B MAC, FI, or carrier regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2318CP.pdf> on the CMS website.

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

To review the CMS one-stop resource focused on the informational needs and interests of Medicare Fee-for-Service (FFS) ambulance suppliers, you may go to <http://www.cms.gov/AmbulanceFeeSchedule/> on the CMS website.

An Ambulance Fact Sheet is also available at http://cms.gov/mlnproducts/downloads/ambulancefeesched_508.pdf on the CMS website.

WPS MEDICARE PROVIDER SERVICES

For additional information on the content of this newsletter, changes in policy or procedures, how to obtain a hardcopy of a Local Coverage Determination (LCD), or if you experience difficulties obtaining a policy on our website, please contact a customer service representative at the telephone numbers/addresses listed below.

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