WPS Medicare HEALTH INSURANCE — A CMS Medicare Contractor

Medicare Part B - Current Updates
July 2013

Disclaimer

Every reasonable effort has been made to ensure the accuracy of this information. However, the provider has the ultimate responsibility for correct submission of claims. WPS Medicare bears no liability for the results or consequences of the misuse of this information. The official Medicare Program provisions are contained in the relevant laws, regulations and rulings.

Comprehensive Error Rate Testing (CERT) Program

CMS uses the CERT program to measure and improve the quality and accuracy of Medicare claims submission, processing and payment.

WPS Medicare uses the error rate information to ensure education will address and prevent the most common billing errors and claim denials.

CMS Comprehensive Error Rate Testing (CERT) Program web page
http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/index.html

WPS Medicare Comprehensive Error Rate Testing (CERT) Program web page
Illinois, Minnesota, and Wisconsin
http://www.wpsmedicare.com/part_b/departments/cert/

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/cert/

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/cert/

ICD-10 Compliance Date

The compliance deadline for ICD-10 is **October 1, 2014**. Providers and payers need to communicate regularly. Continue to check CMS website for updated materials.

CMS International Classification of Diseases – 10th Revision (ICD-10) web page
http://www.cms.gov/Medicare/Coding/ICD10/index.html

Revalidation of Medicare Provider Enrollment Information

Section 6401(a) of the Affordable Care Act established the requirement for providers and suppliers to revalidate their Medicare enrollment information under new enrollment screening criteria.

This requirement applies to providers and suppliers enrolled in Medicare prior to March 25, 2011. Providers and suppliers who submitted their Medicare enrollment on or after March 25, 2011 are not impacted.

Medicare Contractors will send out revalidation notices to the providers and suppliers by March 2015. Providers and suppliers **must wait to submit revalidation** until after they are asked to do so by their Medicare Contractors.

Get easy access to the revalidation process by scanning the Quick Response (QR) code with your smartphone or visit: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//SE1126.pdf

Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

Submit your Medicare Enrollment Application Using Internet-based PECOS
Do you need to enroll in the Medicare program? Change or add a practice location? Or revalidate? PECOS is the fastest, easiest way to enroll in the Medicare program or update your Medicare enrollment record.

Get easy access to Internet-based PECOS by scanning the Quick Response (QR) code with your smartphone or visit: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html

Internet-based PECOS Education Available

CMS has available an informative 14 page CMS publication (ICN 903767), entitled ***"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Provider and Supplier Organizations"*** to help you use internet-based PECOS. You can download it here: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_PECOS_ProviderSup_FactSheet_ICN903767.pdf

CMS has available an informative 12 page CMS publication (ICN 903764), entitled ***"The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners"*** to help you use internet-based PECOS. You can download it here: http://www.cms.gov/outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedEnroll_Pecos_PhysNonPhys_FactSheet_ICN903764.pdf

eNews

WPS Medicare sends out a weekly eNews Listserv on Monday with the most current and vital information Medicare providers need to know. The weekly e-News contains policy updates, all current Medicare information, and changes as they happen. A second eNews is sent out on Wednesday containing educational opportunities. To sign up, visit the WPS Medicare website and click on "e-News" in the upper right corner. We encourage all individuals at provider's office to subscribe, as there are no restrictions on how many individuals can subscribe.

Get easy access to the sign-up website by scanning the Quick Response (QR) code above with your smartphone or visit: http://corp-ws.wpsic.com/apps/commercial/unauth/medicareListservUserWelcomeLoadAction.do

Electronic Funds Transfer (EFT)

Are you still receiving paper checks? EFT sends your Medicare payments directly to your financial institution, allows faster access to funds, deposits your payments electronically on the next business day and eliminates the risk of Medicare paper checks being lost or stolen.

To set up, please download the authorization agreement for EFT at: http://www.cms.gov/Medicare/CMS-Forms/CMS-forms/downloads//CMS588.pdf

For EFT assistance you may also call: (866) 734-1522.

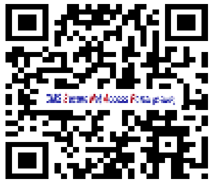
Sign up for Medicare Learning Network

The Medicare Learning Network® (MLN) is the brand name for official Centers for Medicare & Medicaid Services' national provider educational products. These products are designed to share up-to-date educational information and accompany the release of new or revised Medicare program policies. These educational tools are available through various mechanisms such as National Educational Articles, Brochures, Fact Sheets, Web-Based Training Courses, Videos and Podcasts.

For more details, please visit:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html

CMS Secure Net Access Portal (C-SNAP)

For C-SNAP Technical Support assistance, please reference the C-SNAP On Demand trainings listed below. The training may provide you with the answer to your question. Also, review our new feature "Help Center".



Illinois, Minnesota, and Wisconsin
http://www.wpsmedicare.com/part_b/training/on_demand/csnap-od.shtml

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/training/on_demand/csnap-od.shtml

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/training/on_demand/csnap-od.shtml

If you have questions that cannot be resolved after reviewing the C-SNAP On Demand Training, please contact Medicare Customer Service at:
http://www.wpsmedicare.com/contact.shtml

Get easy Access to C-SNAP by scanning the Quick Response (QR) code above with your smartphone or visiting: http://medicareinfo.com

Customer Satisfaction Survey

WPS Medicare strives to continue to improve our website to meet our providers' needs. We use the ForeSee Customer Satisfaction Survey as a primary means to gather your feedback and input and gauge your satisfaction with our website. Please take time to complete the Website Satisfaction Survey that pops up when visiting the WPS Medicare website.

Medicare Quarterly Provider Compliance Newsletter

The Medicare Learning Network® (MLN) Products Provider Compliance page contains educational products that inform Medicare Fee-For-Service (FFS) providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program. Since 1996, the Centers for Medicare & Medicaid Services (CMS) have implemented several initiatives to prevent improper payments before a claim is processed and to identify and recoup improper payments after the claim is processed. The overall goal of CMS' claim review programs is to reduce payment error by identifying and addressing billing errors concerning coverage and coding made by providers.

To learn more, visit the CMS Provider Compliance page:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html

Place of Service (POS) Coding Instructions - Revised and Clarified

CMS SE1104 revised and clarified POS coding instructions. Instructions are provided regarding the assignment of POS for all services paid under the Medicare Physician Fee Schedule and for certain services provided by independent labs. To learn more visit:

Internet Only Manual (IOM) Publication 100-04, Medicare Claims Process Manual, Chapter 26, Sections 10.5 and 10.6
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf

CR7631
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads//R2679CP.pdf

MLN Matters Article (MM7631):
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

Annual Process for Determining Eligibility for the Medicare Health Shortage Area (HPSA) Physician Bonus Payment

HPSA designations are determined and updated by the Health Resources and Services Administration (HRSA). The individual states provide information to HRSA. For instance if an area no longer qualifies for the same type of designation, or now qualifies for a different type of designation, HRSA will officially withdraw a designation or replace it with a new designation. Each year these types of changes will take place in the approved list of areas.

Please verify HPSA status of an area on the HRSA website:
http://hpsafind.hrsa.gov/HPSASearch.aspx

Medicare Remit Easy Print (MREP)

Are you still receiving paper Remit Notices? MREP enables providers and suppliers to view and print 835 files, saves time and money, generates several useful reports, makes remittances easy to navigate and view**.**

Get easy Access to MREP by scanning the Quick Response (QR) code above with your smartphone or visiting the WPS Medicare website below.

Illinois, Minnesota, and Wisconsin
http://www.wpsmedicare.com/part_b/departments/edi_/mrep.shtml
For assistance, please contact the EDI department at (877) 567-7261

Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/departments/edi_/mrep.shtml
For assistance, please contact the EDI department at (866) 503-9670

Indiana and Michigan
http://www.wpsmedicare.com/j8macpartb/departments/edi_/mrep.shtml
For assistance, please contact the EDI department at (866) 503-9670

CMS Fraud Prevention Training Modules for Providers

To help assist CMS in their efforts to prevent fraud and abuse, CMS created two fraud prevention training modules. Each module provides key information to health care practitioners and professionals on how they can be part of CMS' efforts to fight fraud and abuse.

The first module presents CMS' provider-focused fraud awareness and prevention initiatives that informs providers about how they can reduce the risk of fraud and abuse for their practices and patients. This module is located at: *http://www.medscape.org/viewarticle/764496*

The second module describes recent and on-going strategies that CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. The goal of this module is to increase awareness amongst providers about the strategies CMS has undertaken to detect and to prevent fraud and abuse in the Medicare and Medicaid programs. This module is located: *http://www.medscape.org/viewarticle/764791*

A total of 1.25 hours of continuing medical education (CME) credit can be earned for any Medscape user registered as a doctor or health care professional. Medscape accounts are free, and users do not have to be health care professionals to register for them. Registration is on the landing page of www.medscape.com.

Instructions for how to access these modules are as follows:

Step 1: Access the website: www.medscape.org. Medscape accounts are free of charge.

Step 2: Registration is on the upper right hand corner of the home page of www.medscape.org next to the log in field.

Step 3: To access the modules, first enter your membership log in information.

Step 4: To view the "Reducing Medicare and Medicaid Fraud and Abuse: Protecting Practices and Patients" module, use this link: http://www.medscape.org/viewarticle/764496

Step 5: To view the "How CMS Is Fighting Fraud: Major Program Integrity Initiatives" module, use this link: http://www.medscape.org/viewarticle/764791

For assistance, please contact the EDI department at (866) 503-9670

Medicare Incentive Programs

Incentive payments are available to eligible professionals who meet the eligibility and reporting requirements for each program. Eligible professionals may choose to participate in three payment incentive programs.

1. **Physician Quality Reporting System** – Medicare eligible professionals who satisfactory report data on quality measures for covered professional services furnished to Medicare beneficiaries.

   Find more information on the Physician Quality Reporting System program on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

2. **Electronic Prescribing (eRX)** – Medicare Eligible Professionals (EPs) who are successful electronic prescribers. An incentive program separate from and in addition to the Physician Quality Reporting System program.

Find more information on the eRX Incentive Program on the CMS website:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/Educational_Resources.html

Negative Payment Adjustment
The Medicare Improvements for Patients and Providers Act of 2008 requires CMS to apply a negative payment adjustment to any Eligible Professional (EP) who is not a successful e-prescriber under the eRx Incentive Program.

Effective January 1, 2012, EPs who are not successful electronic prescribers are subject to a negative payment adjustment. An EP receiving the negative payment adjustment would be paid 1% less than the Medicare Physicians Fee Schedule (MPFS) amount for that service. In 2013, the negative payment adjustment increases to 1.5% and in 2014 the negative payment adjustment is 2%.

CMS Quick Reference Guide for the 2012 eRx Payment Adjustment:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/downloads/QRGuide_understanding_2012eRxPayAdj_F01-09-2012_508.pdf

Posting the Limiting Charge after applying the e-Prescribing (eRx) Negative Adjustment.
The hard copy disclosure report will explain the eRx reduced limiting charge by providing the following message: *"Limiting charge reduced based on status as an unsuccessful e-prescriber per the Electronic Prescribing (eRx) incentive Program."*

MLN Matters Article (MM7877): Posting the limiting Charge after applying the e-Prescribing (eRx) Negative Adjustment:
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/mm7877.pdf

3. **Electronic Health Records (EHR)** – Medicare eligible professionals, hospitals, and critical access hospitals for the "meaningful use" of certified EHR technology. Medicare eligible professionals may not earn incentives under the eRX and Electronic Health Records incentive programs at the same time.

Find more information on the EHR Incentive Program on the CMS website:
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Quality and Resource Use Reports (QRUR)

QRUR reports provide confidential information about the quality of care providers furnish, the resources they use to care for their Medicare-fee-for-service patients and provide comparative information so physicians can see their quality of care compared to physicians / practices in similar specialties.

The Program Year 2011 (PY2011) QRURs were available from late December 2012 - April 2013 to physicians practicing within a group of 25 or more eligible professionals within the nine

states of California, Iowa, Illinois, Kansas, Michigan, Minnesota, Missouri, Nebraska and Wisconsin. The 2011 reports are no longer available.

In mid-September 2013, CMS will make available the PY 2012 QRURs for groups nationally that consist of 25 or more eligible professionals. The implementation of the Value Based Modifier in 2015, will be based on a 2013 performance period and will impact medical practice groups rather than individual physicians. QRURs for individual physicians will not be produced in 2013.

Information regarding the QRUR, value-based modifier and the Physician Feedback Program can be found on the Physician Feedback Program page of the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html

Email questions about the physician feedback program to QRUR@cms.hhs.gov

CMS National Physician Payment Transparency Program: Open Payments Training Module for Providers

CMS has produced a training module called "Are You Ready for the National Physician Payment Transparency Program?" Accessible via Medscape (http://www.medscape.org/viewarticle/780900?src=cmsaca), and accredited by the Accreditation Council for Continuing Medical Education, physicians can receive a maximum of 1.00 AMA PRA Category 1 Credit by participating in the activity and receiving a minimum score of 70% on the post-test. Through the activity, participants will learn more about OPEN PAYMENTS, the steps involved in collecting and reporting physician data, key dates for implementation, and actions they can take to verify their information in advance of website publication.

The module features Dr. Peter Budetti, Deputy Administrator and Director of the Center for Program Integrity and Dr. Shantanu Agrawal, Medical Director of the Center for Program Integrity and Director of the Data Sharing and Partnership Group.

Medscape accounts are free and users do not have to be health care professionals to register. Registration is on the landing page of http://www.medscape.com

July 19, 2013 Coalition Responses

Enrollment

There is some concern regarding the number of days that a Medicare enrollment is taking to be processed. Could WPS please address the number of day and the guidelines required by CMS. The opinion of some of the physician offices is that it is taking 90-100 to process an application regardless of whether it is a Revalidation or a regular enrollment. It is further complicated when other payers will not enroll a physician (provider) without a Medicare PTAN number. How can physician resolve this timeliness issue?

WPS Medicare Response: The CMS Medicare Program Integrity Manual, Publication 100-08, Chapter 10, includes Medicare Provider/Supplier Enrollment instructions, including timeliness standards for paper applications. The timeframes differentiate depending on the type of application and whether or not contractor development is needed during the enrollment process. Transmittals for these Chapter 10 Internet-Only Manual (IOM) references are available at http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf.

WPS Medicare is taking several steps to make the enrollment process more efficient. Provider Outreach & Education (POE) and Provider Enrollment (PE) staff will host a July 31, 2013 teleconference to address the reasons why we return or develop on 47% of applications. We requested and received feedback from Provider Outreach & Education Advisory Group (POE AG) members to assist us in the development of this educational event. For additional information or to register, refer to http://www.wpsmedicare.com/j8macpartb/training/training_programs/teleconference/provider-enrollment.shtml.

The most efficient way to submit revalidation information is by using the Internet-based Provider Enrollment, Chain and Ownership System (PECOS). To revalidate via the Internet-based PECOS, go to https://pecos.cms.hhs.gov/pecos/login.do on the CMS website. (Users can also choose a link to register for a user account, access several Enrollment Tutorials, and obtain Provider and Supplier Resources on this web page.) Internet-based PECOS allows users to review information currently on file, update and submit revalidation via the Internet. Once submitted, the applicant must immediately print, sign, date, and mail the certification statement along with all required supporting documentation to WPS Medicare.

CMS 1500

At the May 17, 2013 coalition meeting the question was asked regarding the new 1500 form. It appears the revision has been approved. The following is the information from CMS.

Revised CMS 1500 Paper Claim Form: Version 02/12

The National Uniform Claim Committee (NUCC), an industry organization in which CMS participates, maintains the CMS 1500 claim form and periodically revises it according to industry needs. The NUCC recently revised this form (version 02/12). The NUCC changed the form to adequately accommodate and

implement ICD-10-CM diagnosis codes, although the form does include other changes as well. More information is available on the NUCC website.

On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised CMS 1500 claim form, version 02/12, OMB control number, 0938-1197. The CMS 1500 claim form is the required format for submitting claims to Medicare on paper.

Features of the Revised Form

The revised form, among other changes, notably adds the following functionality:

Indicators for differentiating between ICD-9-CM and ICD-10-CM diagnosis codes.

Expansion of the number of possible diagnosis codes to 12.

Qualifiers to identify the following provider roles (on item 17):

Ordering

Referring

Supervising

Instructions for Completing the Revised Form

CMS is updating the Medicare Claims Processing Internet Only Manual (IOM, Pub. 100-04) Chapter 26 to instruct contractors and providers regarding how to complete the revised form. CMS will post this information on the CMS website when it is available.

Tentative Timeline for Implementing the Revised Form for Medicare Claims

Medicare anticipates implementing the revised CMS 1500 claim form (version 02/12) as follows:

January 6, 2014: Medicare begins receiving and processing paper claims submitted on the revised CMS 1500 claim form (version 02/12).

January 6 through March 31, 2014: Dual use period during which Medicare continues to receive and process paper claims submitted on the old CMS 1500 claim form (version 08/05).

April 1, 2014: Medicare receives and processes paper claims submitted only on the revised CMS 1500 claim form (version 02/12).

These dates are tentative and subject to change. CMS will provide more information as it is available.

Note: The Administrative Simplification Compliance Act (ASCA) requires that Medicare claims be sent electronically unless certain exceptions are met. Some Medicare providers qualify for these exceptions and send their claims to Medicare on paper. For more information about ASCA exceptions, please contact the Medicare contractor who processes your claims. Claims sent electronically must abide by the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The current standard adopted under HIPAA for electronically submitting professional health care claims is the 5010 version of the ASC X12 837 Professional Health Care Claim standard and its implementation specification, Technical Report 3 (TR3). More information about the ASC X12 and TR3 is available on the ASC X12 website.

(Note: Per Jeri, this is informational and no response is requested from WPS Medicare.)

Transitional Care Management (TCM)

The following questions are being asked regarding TCM.

Can the TCM face-to-face be done in POS 12 by a nurse practitioner (NP)?

WPS Medicare Response: Yes, a nurse practitioner (NP) may perform the TCM face-to-face service in POS 12 (Home).

If the NP does the face-to-face, is the NP required to file the TCM claim, and not the physician, since there is no incident to in the POS 12?

WPS Medicare Response: Yes, if the NP performs the face-to-face, the NP must file the TCM claim. Reimbursement for the NP services is based on 85% of the Physician Fee Schedule.

If there is an additional Evaluation and Management (E/M) during the TCM time frame (entire 30 days), should the physician append the 25 modifier to the E/M?

WPS Medicare Response: E/M services that follow the first face-to-face visit may be reported separately during the 30 day period, with the exception of those services that cannot be reported according to CPT guidance and Medicare HCPCS codes G0181 and G0182. There is no CMS indication that a 25 modifier is necessary when billing an E/M service in this situation.

How is the TCM billing to be handled if the patient is readmitted on the 30th day of service? Can the TCM be billed?

WPS Medicare Response: If the patient is readmitted on the 30th day of TCM services after all elements of the TCM services are performed and documented, but before the readmission occurs on the 30th day, the TCM service can be billed to Medicare. Report the service on the 30th day.

According to CMS, if the patient is readmitted in the 30-day period, TCM services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for TCM services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge. CPT guidance for TCM services states that only one individual may report TCM services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within 30 days.

For the 7 or 14 day TCM visit when does the count begin? Is the day of discharge day one (1)?

WPS Medicare Response: The day of the discharge is day 1. The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The reported date of service should be the 30th day.

ISMA is seeing multiple claims denials due to the fact the service is being billed on the wrong day. A reminder of how to bill the codes and when to bill them is being requested. Emphasis on the date of the face-to-face.

WPS Medicare Response: The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The day of discharge is day 1. The reported date of service should be the 30th day. If the Common Working File (CWF) shows no indication for the discharge date, a TCM claim may deny. We recommend that providers develop a relationship with the hospital in order to monitor the discharge date of the patient.

Medicare will only pay the first eligible claim submitted during the 30 day period that commences with the day of discharge. Other practitioners may continue to report other reasonable and necessary services, including other E/M services, to beneficiaries during those 30 days.

This information is contained in *Frequently Asked Questions about Billing Medicare for Transitional Care Management Services,* published by CMS on March 25, 2013. It is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf.

Multiple Procedure Payment Reduction (MPPR)

Some practices are still struggling with the MPPR. Could WPS provide a brief tutorial on how to locate and calculate the rate of payment?

(Note: Jeri verified that it is the MPPR for therapy services that practices are still struggling with.)

WPS Medicare Response: CMS published Change Request (CR) 7050 which announced that Medicare is applying a new Multiple Procedure Payment Reduction (MPPR) to the Practice Expense (PE) component of payment of select therapy services paid under the Medicare Physician Fee Schedule. Specifically, CMS is applying a MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnish in office settings and other non-institutional settings (services paid under section 1848 of the Act) and 75 percent payment for the PE for services furnished in institutional settings (service aid under section 1834). This CR, including an example, is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R826OTN.pdf

Subsequent to implementation of Section 633 of the American Taxpayer Relief Act of 2012, CMS published, MM8206, a revision, effective for claims with dates of service on or after April 1, 2013. This informs providers that Practice Expense RVU for always therapy services will be reduced to 50% on all

services for the same patient same date of Service. An example appears in the article, located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8206.pdf

Medical Director

Please provide information for the new J8 Medical Director I don't have anything on this.

WPS Medicare Response: Dr. Ella Noel, DO is our new J8 Contractor Medical Director (CMD). We published this announcement on our J8 Provider home page as a special message. The text appears below and is available at http://www.wpsmedicare.com/j8macpartb/archived-messages.shtml.

Dr. Ella Noel Is New J8 CMD

We are proud to introduce Dr. Ella Noel as our new J8 Contractor Medical Director. You may have already met her at the recent CAC meetings in Indiana and Michigan. Dr. Noel is a resident of Michigan and is deeply committed to assisting you in medical policy matters. Dr. Noel looks forward to working with the Indiana and Michigan provider community.

Durable Medical Equipment (DME) Face-to-Face Encounters

Please provide information on the new deadline for the required face-to-face encounters for DME.

WPS Medicare Response: Section 6407 of the Affordable Care Act establishes a face-to-face encounter requirement for certain items of DME. The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient and that it must occur within 6 months before the order is written for the DME.

Physicians are provided an additional payment, using code G0454, for signing/co-signing the face-to-face encounter of the PA/NP/CNS. The physician should not bill the G code when he/she conducts the face-to-face encounter. The G code may only be paid to the physician one time per beneficiary per encounter, regardless of the number of covered items documented in the face-to-face encounter.

Due to concerns that some providers and suppliers may need additional time to establish operational protocols necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act for certain items of DME, CMS will start actively enforcing and will expect full compliance with the DME face-to-face requirements beginning on October 1, 2013. In their initial Change Request (CR) 8304, the original effective date for DME Medicare Administrative Contractors (MACs) to implement requirements was July 1, 2013.

Although many DME suppliers and physicians are aware of and are able to comply with this policy CMS is concerned that some may need additional time to establish operational protocols necessary to comply with this new law. As such, CMS expects that during the next several months, suppliers and physicians who order certain DME items will continue to collaborate and establish internal processes to ensure compliance with the face-to-face requirement. CMS expects DME suppliers to have fully established

such internal processes and have appropriate documentation of required encounters by October 1, 2013. CMS will continue to address industry questions concerning the new requirements and will update information as needed.

For more information, providers may refer to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8304.pdf.

Drug Wastage

There has recently been some discussions on how to bill for drug wastage and whether; anything is billable to the patient.

Scenario:

The patient is scheduled to have a stress test. After the medication has been ordered and paid for the patient decides not to come to the appointment. They notify the physician the day of the appointment. Medicare is billed and the claim denied. After an appeal it is still denied. Is the physician allowed to bill the patient for any of the medication that was ordered and paid for by the physician?

WPS Medicare Response: For the situation described above, no claim should be submitted to Medicare. There is no billable service as no item or service was provided. Submission of a claim to Medicare, even for denial purposes, is inappropriate. If protocols for doing so are established in the physician's office, the physician may bill the patient for the medication.

Place of Service (POS)

There is still confusion on how to bill for POS when a patient is in a SNF. A tutorial or reminder of the appropriate way to bill place of service when patient is in a SNF and goes to the physician's office is being requested.

WPS Medicare Response: The following article appears on the Claims Submission web page on our website, available at http://www.wpsmedicare.com/j8macpartb/claims/submission/place-of-service-procedure-code.shtml.

Place of Service and Procedure Code

Change Request (CR) 7631A requires all providers to submit the Place of Service (POS) code reflecting the location of the patient at the time of service. This CR discusses the billing requirements and the exceptions. Providers are required to use the procedure code that corresponds to the POS code used. For example, the patient is seen in the office, but the appropriate POS is 21 since the patient is an inpatient at the time of service, the POS code is 21 and the procedure codes should be the inpatient procedure codes, not the office or other outpatient procedure codes. The same thing would hold true when the patient is in a Part A covered stay at a SNF; the provider would use the SNF procedure codes rather than the office or other outpatient procedure codes. Medicare will deny the service as unprocessable when the procedure code and the POS do not match.

Please clarify when a patient is a registered inpatient in a Skilled Nursing Facility (SNF) (regardless of whether a Part A stay or not) what CPT codes are expected and what POS is to be used?

WPS Medicare Response: The physician office needs to determine if the patient is in a covered Part A stay. If the patient is in a covered Part A SNF stay, the POS is 31 (SNF). If the patient is in a Part B stay, the POS can be 11 (office). The procedure code and POS must match or the claim line will reject as unprocessable. If this occurs, the provider will need to correct the claim and resubmit it.

Needle Guidance with Botox

Has the issue with needle guidance and Botox injections denying with 95874 been resolved. This denial is processing against Policy L31346 instead of L28555?

WPS Medicare Response: Our Medical Policy staff is aware of the recent denials, thanks to a member of the Provider Outreach & Education Advisory Group who raised this issue. We are correcting our internal processes. This should be completed by July 23, 2013, at which time providers may resubmit or request an appeal on any denials.

Telehealth

When a patient is in an Emergency Department (ED) and there are telehealth services performed for medical reasons, and the patient is then transferred by ambulance to another hospital ED, is it appropriate for both facilities to bill their individual charges? We are currently seeing denials for this.

WPS Medicare Response: Telehealth services can not be performed in an Emergency Department. CMS has published helpful information, entitled *Telehealth Services,* about calendar year (CY) 2013 Medicare telehealth services. It is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf.

Without identifiers for this claim specific scenario, such and Internal Control Numbers (ICNs), we cannot ascertain why denials occurred. If this is a provider specific issue, please contact Customer Service for immediate assistance. If this is a widespread issue affecting the greater provider community, please provide ICN examples so that we may research for resolution and any needed education.

Incident to

ISMA is requesting WPS to remind attendees the "incident to" policy with WPS and nurse practitioners' changing a physicians' treatment plan is no longer considered "incident to." Is there a date when the Fact Sheet will be on the WPS website?

WPS Medicare Response: This information is published and available on our website as a handout we will utilize in our July 23, 2013 *Incident to Services – Documentation and Correct Billing* teleconference. For additional details, or to register for this teleconference, please visit http://www.wpsmedicare.com/j8macpartb/training/training_programs/teleconference/incident-to-

services.shtml. The recording of the teleconference and the reference documents will later be available on our On Demand Training web page, located at http://www.wpsmedicare.com/j8macpartb/training/on_demand/.

Currently, there are several On Demand training topics available on our website, including 3-Day Payment Window, Ambulance, Appeals, Ask-the-Contractor Teleconference (ACT), Chiropractic, Coding and Billing, C-SNAP, Evaluation and Management (E/M), Foot Care, General Office Staff, High Dollar claim Review, Hospice, Injections, Internal Medicine, Mid-Level Providers, Modifiers, Place of Service, Preventive Care, Provider Enrollment, Radiology, Surgery, Therapy, and Wound Care.

Comprehensive Error Rate Testing (CERT) Program

The ISMA is requesting a discussion on the CERT recouping money when there is no evidence of an exam in the discharge summary for hospital discharge day management.

WPS Medicare Response: A discharge visit does not require an exam unless medically appropriate. The visit, however, does require a face-to-face visit with the patient. If there is no documentation to support a face-to-face visit, we will recoup the payment.

J8 providers can find CERT Identified Errors by Provider Specialty at http://www.wpsmedicare.com/j8macpartb/departments/cert/errors-by-specialty.shtml.

This informative information includes details on errors, how to correct the errors, and resources. In addition to these details on actual errors, J8 providers can find recent CERT Quarterly Error Finding Reports at http://www.wpsmedicare.com/j8macpartb/departments/cert/cert-error-analysis.shtml

New Items with WPS

Could WPS provide attendees with any new happening with WPS, such as the C-SNAP update?

WPS Medicare Updates – July, 2013 (Handout)

CMS Secure Net Access Portal (C-SNAP) – New "Help Center" now available! It includes Frequently Asked Questions, Helpful Tips, Training and Contact Information. You can browse these or enter a keyword to search the Help Center.

C-SNAP Password Guidelines are also available.

To view Help Center information, please visit https://www.medicareinfo.com/apps/cms/redirectN.do?Page=unauth/helpcenter.do

Reciprocal Billing Arrangements/Locum Tenens Arrangements

Publication 100-04, Chapter 1, available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf**

Payment Under Reciprocal Billing Arrangements – Claims Submitted to Carriers – found in section 30.2.10

Physician Payment Under Locum Tenens Arrangements – Claim Submitted to Carriers – found in section 30.2.11

July 19, 2013 Coalition Response Resources

Enrollment

Transmittals for CMS Publication 100-08, Chapter 10 Internet-Only Manual (IOM) references

http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c10.pdf.

WPS Medicare July 31, 2013 Provider Enrollment Teleconference

http://www.wpsmedicare.com/j8macpartb/training/training_programs/teleconference/provider-enrollment.shtml

CMS Internet-based Provider Enrollment, Chain and Ownership System (PECOS)

https://pecos.cms.hhs.gov/pecos/login.do

Transitional Care Management (TCM)

CMS Frequently Asked Questions about Billing Medicare for Transitional Care Management Services

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf

Multiple Procedure Payment Reduction (MPPR) – Therapy Services

CMS Change Request (CR) 7050

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R826OTN.pdf

CMS Medicare Learning Network Matters Article MM8206 – Multiple Procedures Payment Reduction (MPPR) for Selected Therapy Services

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8206.pdf

Medical Director

WPS Medicare Special Message – New J8 Contractor Medical Director (CMD)

http://www.wpsmedicare.com/j8macpartb/archived-messages.shtml

Durable Medical Equipment (DME) Face-to-Face Encounters

CMS Medicare Learning Network Matters Article MM8304 – Detailed Written Orders and Face-to-Face Encounters

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8304.pdf

Place of Service (POS)

WPS Medicare Article – Place of Service and Procedure Code

http://www.wpsmedicare.com/j8macpartb/claims/submission/place-of-service-procedure-code.shtml

Telehealth

CMS Fact Sheet- Telehealth Services

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf

Incident to

WPS Medicare Handout - July 23, 2013 *Incident to Services – Documentation and Correct Billing T*eleconference Announcement/Registration/Handout

http://www.wpsmedicare.com/j8macpartb/training/training_programs/teleconference/incident-to-services.shtml

WPS Medicare On Demand Training Web Page

http://www.wpsmedicare.com/j8macpartb/training/on_demand/

CERT

WPS Medicare CERT Identified Errors by Provider Specialty
http://www.wpsmedicare.com/j8macpartb/departments/cert/errors-by-specialty.shtml

WPS Mediare CERT Quarterly CERTError Finding Reports
http://www.wpsmedicare.com/j8macpartb/departments/cert/cert-error-analysis.shtml

CMS Secure Net Access Portal (C-SNAP)

New "Help Center"

https://www.medicareinfo.com/apps/cms/redirectN.do?Page=unauth/helpcenter.do

Reciprocal Billing Arrangements/Locum Tenens Arrangements

CMS Publication 100-04, Chapter 1

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

Payment Under Reciprocal Billing Arrangements – Claims Submitted to Carriers – found in section 30.2.10

Physician Payment Under Locum Tenens Arrangements – Claim Submitted to Carriers – found in section 30.2.11