Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

March 2008
Issue No. 11

This Bulletin Shall Be Shared with All Health Care Practitioners and Managerial Members of Your Provider Staff. Bulletins Are Available at No Cost from Our Web Site, www.noridianmedicare.com.

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Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for all functions except Claim Status and Beneficiary Eligibility, which are available 6 am to 6 pm CT Monday – Friday
Supplier Contact Center	1-866-243-7272	8 am to 5:30 pm CT Monday – Friday
Beneficiary Customer Service	1-800-633-4227	24 hours a day/7 days a week
Telephone Reopenings	1-888-826-5708	8 am – 4 pm CT
Electronic Data Interchange Help Desk	1-866-224-3094	8 am – 5 pm CT

Web site: www.noridianmedicare.com

Fax	
Reopenings and Redeterminations	888-408-7405
Administrative Simplification Compliance Act (ASCA)	888-523-8449
Refunds to Medicare	888-529-3666
MSP Inquires and Refunds	888-535-5114
ADMC Requests/Documentation	877-662-8445
Medical Review Medical Documentation	866-465-0213
CERT Medical Documentation	877-436-4479

NAS Email Addresses	
NAS DME Customer Service	dme@noridian.com
Reopenings and Redeterminations	dmeredeterminations@noridian.com

Mailing Addresses	
Claims, Redetermination Requests, Correspondence and Mediccal Review Documentation Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727	**Advance Determination of Medicare Coverage Requests** Noridian Administrative Services Jurisdiction D DME Medical Review PO Box 6747 Fargo ND 58108-6747
Electronic Funds Transfer Forms Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728	**Electronic Data Interchange** Attn: Jurisdiction D EDI PO Box 690 Nashville TN 37202
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737	**Benefit Protection** Noridian Administrative Services Benefit Protection-DME PO Box 6736 Fargo ND 58108-6736

Reconsiderations - Qualified Independent Contractor	
Mailing Address RiverTrust Solutions, Inc. PO Box 180208 Chattanooga TN 37401-7208	**Courier Address** RiverTrust Solutions, Inc. 801 Pine Street Chattanooga TN 37402

Other DME MACs		
Jurisdiction A: NHIC, Corp	1-866-419-9458	www.medicarenhic.com
Jurisdiction B: National Government Services	1-877-299-7900	www.adminastar.com
Jurisdiction C: CIGNA Government Services	1-866-270-4909	www.cignagovernmentservices.com

Other Resources		
Statistical Analysis DMERC	1-877-735-1326	www.palmettogba.com/sadmerc
National Supplier Clearinghouse	1-866-238-9652	www.palmettogba.com/nsc
Centers for Medicare & Medicaid Services		www.cms.hhs.gov

FYI

Holiday Schedule

Noridian Administrative Services offices will be closed on the days listed below except for the federal holidays noted with a (*). These federal holidays are days that the NAS offices will be open and the Contact Center representatives will be available from 12:00 - 5:30 pm CT.

Holiday	Date
Good Friday	March 21, 2008
Memorial Day	May 26, 2008
Fourth of July Holiday	July 4, 2008
Labor Day	September 1, 2008
Columbus Day *	October 13, 2008
Veteran's Day *	November 11, 2008
Thanksgiving Day	November 27, 2008
Thanksgiving Holiday	November 28, 2008
Christmas Eve**	December 24, 2008
Christmas Day	December 25, 2008
** Partial day closure	

Sources for "Jurisdiction D Happenings" Articles

The purpose of "Jurisdiction D Happenings" is to educate Noridian Administrative Services' Durable Medical Equipment supplier community. The educational articles can be advice written by NAS staff or directives from the Centers for Medicare & Medicaid Services. Whenever NAS publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. NAS includes "Source" following CMS derived articles to allow for those interested in the original material to research it at CMS's web site, www.cms.hhs.gov/manuals. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled "MLN Matters", which will continue to be published in NAS bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

Summary of Supplier Manual Updates

The following table outlines updates to the DME MAC Jurisdiction D Supplier Manual. The content is ordered with the most current changes appearing on top.

Chapter	Subheading	Supplier Manual Update	Change Date
Chapter 13	Administrative Law Judge (ALJ)	Requests should now be mailed to the appropriate Office of Medicare Hearings and Appeals (OMHA)	2/14/08
Chapter 5	Oxygen Contents/ Units	Allow for portable oxygen contents with patient owned stationary system if owns or rents a portable system	1/24/08
Chapter 5	Oxygen Equipment and Contents Billing Chart	Changed to allow for portable oxygen contents with patient owned stationary systems if owns or rents a portable system	1/24/08
Chapter 16	Modifiers	Added EA, EB, EC effective January 1, 2008	1/23/08

The summary of updates is found on the Supplier Manual homepage, www.noridianmedicare.com/dme/news/manual/index.html.

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

"This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents."

Upcoming IVR Enhancements – Same/Similar Services

NAS is focused on providing more detailed information to suppliers on the Interactive Voice Response (IVR) system. We are currently working on enhancements to the IVR to provide more detailed information on same and/or similar services. The determination to add more detailed same and similar information to the IVR was based on analysis of the most common reasons for telephone inquires and redetermination requests.

These updates will be implemented in Spring 2008. Continue to watch the NAS web site for future updates.

DME MACs Issuing 1099s for 2007

DME MACs have been instructed by CMS to issue 1099s for Medicare payments generated in 2007. 1099s were to be issued by 1/31/08.

1099 forms were mailed to the same address on file with the National Supplier Clearinghouse as the Payee Address. The Payee Address is the same address where Medicare payments and remittance advices are currently mailed.

If the address information or Tax Identification number listed on the 1099 form is incorrect, suppliers should initiate updating this information with the National Supplier Clearinghouse by completing a CMS 855S form. If you have questions about this process or completing the form, call the NSC at 1-866-238-9652.

If you feel that the dollar amounts on the 1099 are incorrect, please contact our supplier contact center at 1-866-243-7272 for assistance.

Below is additional information on this 1099 requirement and reporting:

The reporting requirements of the Internal Revenue Code, Section 6041A states that any service-recipient engaged in a trade or business that pays in the course of such trade or business during any calendar year remuneration for such services in the aggregate of **$600 or more**, must file an information return.

CMS, HHS C.F.R 42 400.202 – Definitions specific to Medicare:

"***Services*** means medical care or services and items, such as medical diagnosis and treatment, drugs and biological, supplies, appliances, and equipment, medical social services, and use of hospital, CAN, or SNF facilities."

Internal Revenue Service – Special Rules:

Payments reportable to Corporations: Payments by Federal agencies to corporations are not exempt from the filing requirements. Internal Revenue Code, Section 6041A(d)(3) provides that payments made for services performed by a corporation are subject to information reporting requirements when the remuneration has been paid to the corporation by a Federal executive agency.

IRS Specific Instructions for Form 1099-MISC

States in part – File Form 1099-MISC, Miscellaneous Income, for each person to whom you have paid during the year:

At lease $600 in rents, services (including parts and materials), prizes and awards, other income payments, medical and health care payments.

Support Income Tax Reporting

MLN Matters Number: MM5816
Related Change Request (CR) #: 5816
Related CR Release Date: January 25, 2008
Related CR Transmittal #: R311OTN
Effective Date: January 1, 2007 (date of payment)
Implementation Date: January 30, 2008

Provider Types Affected
Suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs).

Provider Action Needed
This article is based on Change Request (CR) 5816, which notifies all DME MACs of the requirements to issue Internal Revenue Service (IRS) Form 1099-MISC to every supplier paid under contract and/or any other forms required for income tax and reporting purposes. Thus, your DME MAC will issue appropriate 1099 forms to you, when you receive $600 or more in Medicare payments in a calendar year, beginning with January 1, 2007.

Background
The reporting requirements of the Internal Revenue Code (Section 6041A) state that any service-recipient engaged in a trade or business that pays in the course of such trade or business during any calendar year remuneration for such services in the aggregate of $600 or more must file an information return with the Internal Revenue Service (IRS). Internal Revenue Code section 6041A(d)(3) provides that payments made for services performed by a corporation are subject to information reporting requirements when the remuneration has been paid to the corporation by a Federal executive agency. The $600 or more paid by a Federal executive agency to a corporation is subject to information reporting requirements per section 6041A(d)(3) of the Internal Revenue Code.

Further, the IRS has determined that payments to Durable Medical Equipment companies paid from Medicare trust fund monies are subject to Form 1099 MISC reporting requirements. IRS has also ruled that payments to persons providing health care services, including proprietary hospitals, physicians and dentists, often include charges for injections, drugs, dentures, and similar items. In such cases, the entire payment is subject to information reporting.

IRS instructions for completing form 1099-MISC states in part that Form 1099-MISC (Miscellaneous Income) should be filed for each person to whom one has paid during the year:

- At least $600 in rents, services (including parts and materials), prizes and awards, other income payments, medical and health care payments.

FYI CONT'D

For more information, visit http://www.irs.gov/pub/irs-pdf/f1099msc.pdf and http://www.irs.gov/pub/irs-pdf/i1099msc.pdf on the Internet.

Note that "services" as defined by Medicare means "medical care or services and items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital, Critical Access Hospital (CAH), or Skilled Nursing Facility (SNF)."

In summary, CR5816 instructs that DME MACs should:

- Issue to every supplier paid under contract a 1099 and/or any other forms required for income tax and reporting purpose;
- Comply with Form 1099 rules, regulations, procedures and instructions as published at http://www.irs.gov/; and
- Report all payments made to suppliers during the previous year.

Additional Information
The official instruction, CR 5816, issued to your DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R311OTN.pdf on the CMS web site.

EDUCATIONAL

New Access to Local Coverage Determinations

DME has improved access and navigation to the Local Coverage Determinations (LCDs) and Policy Articles on the CMS web site.

In accordance with CMS' requirements, these policies are maintained on the CMS web site in the Medicare Coverage Database (MCD). Based on supplier survey results and feedback, NAS has simplified navigation by offering a link directly to the specific LCD and Policy Article in the MCD.

A table has been created with the title, ID number and all HCPCS codes included in the policy. The ID number is a link directly to the LCD or Policy Article on the CMS web site.

Title	Policy	Policy Article	HCPCS
Ankle-Foot/Knee-Ankle-Foot Orthosis	L142	A19800	L1900, L1901, L1902, L1904, L1906, L1907, L1910, L1920, L1930, L1940, L1945, L1950, L1951, L1960, L1970, L1971, L1980, L1990, L2000, L2005, L2010, L2020, L2030, L2034, L2035, L2036, L2037, L2038, L2106, L2108, L2112, L2114, L2116, L2126, L2128, L2132, L2134, L2136, L2180, L2182, L2184, L2186, L2188, L2190, L2192, L2200, L2210, L2220, L2230, L2232, L2240, L2250, L2260, L2265, L2270, L2275, L2280, L2300, L2310, L2320, L2330, L2335, L2340, L2350, L2360, L2370, L2375, L2380, L2385, L2387, L2390, L2395, L2397, L2405, L2415, L2425, L2430, L2492, L2500, L2510, L2520, L2525, L2526, L2530, L2540, L2550, L2750, L2755, L2760, L2768, L2770, L2780, L2785, L2795, L2800, L2810, L2820, L2830, L2840, L2850, L2999, L4002, L4010, L4020, L4030, L4040, L4045, L4050, L4055, L4060, L4070, L4080, L4090, L4100, L4110, L4130, L4205, L4210, L4350, L4360, L4370, L4386, L4392, L4394, L4396, L4398
Automatic External Defibrillators	L13577	A23892	A9999, E0617, K0606, K0607, K0608, K0609

Note: The redirection from the NAS LCD page to the CMS MCD web site is almost immediate; however, the time it takes for the CMS MCD web site to display the result is not related to the functionality of the NAS web site.

This table is located on the Local Coverage Determinations page. To access this table:

- Select "Local Coverage Determinations" from the DME Quick Links menu at www.noridianmedicare.com; or
- Once in the NAS DME web site, under the Coverage tab, select "Local Coverage Determinations."

Reminder: Please take time to participate in the ForeSee Results survey to identify areas for improvement *as well as* areas that work well. NAS reviews all comments and results to enhance the DME web site for suppliers.

DME Online Learning Center

NAS DME is pleased to announce the Online Learning Center (OLC) for suppliers. The OLC is a self-pace learning environment that allows suppliers to take pre and post-assessments, complete lessons, view resources and participate in surveys. Suppliers can take advantage of this self-service technology 24 hours a day/7 days a week and can participate in a course as often as they would like.

The DME OLC provides two courses:

- Medicare and DME Fundamentals
    - Benefit & Payment Categories
    - Advance Beneficiary Notice
    - Certificate of Medical Necessity and DME MAC Information Forms
    - Appeals Process
- DME Coverage and Specialties – Under Construction

The Online Learning Center link is located on the Training page, along with step-by-step instructions on how to access the courses and topics. To access the OLC, visit www.noridianmedicare.com/learning or click on the OLC icon on the DME web site home page.

Additional DME OLC courses are under development. Suppliers will be notified of the availability of new courses via the "What's New" section of the NAS DME web site and through email list messages. We encourage you to take advantage of this new training tool. We look forward to hearing your suggestions for additional course topics and ways to improve the OLC.providers to access, update, and submit information over the Internet. CMS enterprise applications are those hosted and managed by CMS and do not include FI/Carrier/MAC Internet applications. Details of these provider applications will be announced as they become available.

New! Schedule of Events for DME Suppliers

NAS DME now provides a Schedule of Events for suppliers. This calendar contains Ask the Contractor Teleconferences (quarterly and small supplier), web-based workshops, CMS teleconferences, events that NAS Education staff will be attending and Provider Outreach and Education Advisory Group meetings. Suppliers may choose the events they would like to view and the calendar is printable on one page per month.

The Schedule of Events also contains links to the various events. For example, the web-based workshop title on the calendar links directly to the Workshops page on the DME web site for easy registration. A time zone converter is available by clicking on the time above the workshop. The location of conferences links to a Google map for directions. The conference name links directly to the official web site of that specific event or state/national association.

The calendar provides three months of events and an "Updated date" is located in the upper right corner of the calendar to give suppliers notice of changes.

The Schedule of Events is located in the Training section of the NAS DME web site. A link is also provided on the DME home page under Training.

Top Ten Written Inquiries

The top ten written inquiries for October through December are listed below along with tips and reminders about submitting these requests to NAS.

1. **Reference Resources Referral/ Request**
   NAS has recently enhanced the Search function on our web site.

   First, suppliers may now separately search the fee schedules under the Advanced Search option located in the upper right corner of the DME web pages. Also, fee schedule results are excluded from the results when the *All of DME option is chosen.

   Suppliers may now also conduct searches on our web site using a wildcard feature. Wildcard searches allow a user to enter the first three or more characters of a word followed by the asterisk (*). The search results will include terms that begin with the entered characters.

   Also, the Site Map is available on every page near the Search tool. This index has been alphabetized for each category on our web site.

2. **Misrouted Written Correspondence**
   To ensure correspondence is sent to the appropriate address, view the Phone Numbers and Addresses on our web site under the Contact section before mailing

   Supplier enrollment information must be sent to the National Supplier Clearinghouse. EDI correspondence must be sent to Jurisdiction D EDI in Nashville, TN.

   Sending inquiries and information to an incorrect entity may cause a delay in processing.

3. **Other Issues**
   Suppliers are encouraged to visit the NAS DME web site frequently to stay abreast of Medicare changes. The latest news regarding policy changes, claim filing issues and other important information is found in the "What's New" section of the web site.

   Supplies should also subscribe to the NAS email list to receive emails with the latest news and information twice a week on Tuesdays and Fridays.

4. **1500 Form Item**
   NAS provides a CMS-1500 (08-05) claim form tutorial to assist in completing each Item of the claim. By hovering the mouse over a specific Item, a box will appear with the required information for that Item. Clicking on an Item in the tutorial provides complete claim form instructions.

   NAS also offered a CMS-1500 (08-05) Claim Form workshop in 2007 and the presentation is available in the Training section of our web site.

EDUCATIONAL CONT'D

5. **ATP Amount/ Check Information**
   Requests are being received at NAS for payment of claims (reopening or redetermination) that have already been paid. Ensure the claim has not been paid before sending a reopening or redetermination request by calling the IVR at 877-320-0390 for claim status.

6. **Stop Payment/ Check to be Reissued**
   NAS processes beneficiary check requests as well as supplier requests. Please note that the original check is needed before a stale-dated check may be reissued by NAS.

7. **Not on File**
   Some inquiries are received for information that is not in the system or a redetermination is requested for a claim that is not on file. If a remittance notice has not been received, call the IVR at 877-320-0390 for claim status. If a claim is not found on the IVR, resubmit the claim.

8. **Issue Not Identified/ Incomplete Information Provided**
   When sending inquiries to NAS, clearly state the question. This will ensure NAS has all of the information needed to answer the request. If information is submitted without a specific request, the Written Correspondence staff will reply with a letter indicating the inquiry was incomplete, causing a delay in receiving a response.

9. **Payment Explanation/ Calculation**
   Requests are received for more information on why claims are paid a certain way, such as downcoding. An excellent resource to refer to is the Local Coverage Determination (LCD). Many times the LCD provides guidance on downcoding specific HCPCS codes.

10. **Connectivity/ Installment/ Issues**
    For any issues regarding EDI, such as electronic remittance advices, technical assistance, and electronic claim submission, contact the Jurisdiction D Helpdesk at 866-224-3094 or visit their web site at www.cignagovernmentservices.com/edi/dmerc/index.html.help desk as shown in the "Additional Help "section at the end of this article.

"Guided Pathways to Medicare Resources for Medicare Fee-for-Service Health Care Professionals" Now Available

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of the latest **Medicare Learning Network** provider education product entitled, "**Guided Pathways to Medicare Resources for Medicare Fee-for-Service Health Care Professionals**."

Guided Pathways has been developed as an educational tool for fee-for-service (FFS) health care staff who are relatively unfamiliar with the Medicare Program, as well as for those professionals looking for easy access to the many resources on the CMS web site. Using a "road trip" motif, the pathways lead users through nine broad sections of information covering the Medicare Program, with links to further pertinent information. The pathways also provide links to other government resources pertaining to Medicare FFS items. *Guided Pathways* can be accessed at http://www.cms.hhs.gov/apps/training/guidedpathways/index.html on the CMS web site.

Located in the Provider Communications Group within CMS, the Medicare Learning Network (MLN) is the brand name for official CMS educational products designed to promote national consistency of information developed for Medicare FFS initiatives. Most importantly, it is available to help you! Each quarter the MLN will send updates on the latest products available – so be on the lookout!

For more information on the Medicare Learning Network, please visit www.cms.hhs.gov/MLNGenInfo on the CMS web site. Questions and requests for additional information can be sent to the MLN Mailbox at MLN@cms.hhs.gov.

NPI

Paper Claims Missing Valid NPI Will Not Be Processed Effective March 1, 2008

Effective March 1, 2008, CMS-1500 paper claims without a valid NPI in Item 33a will not be processed, per direction from CMS. Suppliers will receive an Education Status Letter with the following wording. This letter will also identify the patient name, HIC number and dates of service from the claims that could not be processed.

"Education Status # 522

Our Medicare office has received a claim(s) that we are unable to process for the following reason:

Medicare is unable to process the claim(s) because the NPI number in Item 33 is incorrect, missing, unreadable, or invalid. A valid NPI is ten numeric characters without any symbols or spaces as assigned by the National Plan and Provider Enumeration System (NPPES). If you do not have an NPI assigned to you, you will need to hold these claims until you have applied and received n NPI. You may resubmit the claims once you have an NPI assigned to you.

Please fill out a new "red drop out" CMS-1500 (08-05) claim form and resubmit."

Effective March 1, Medicare claims must include an NPI in the primary provider fields, i.e., the billing and pay-to provider fields. You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. Secondary provider fields, i.e., referring, ordering and supervising, may continue to include only your legacy number, if you choose.

Electronic claims missing an NPI in the primary provider fields will be rejected via the electronic frond-end edits. Suppliers will receive notice of these rejected claims via the Error Listing Report.

March 1 Milestone

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

Important Information for Medicare FFS Providers

Effective March 1, 2008, all 837P and CMS-1500 claims must have an NPI or NPI/legacy pair in the required primary provider fields. Failure to include an NPI will cause the claim to reject!

Background
One of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services (HHS) to establish unique national identifiers for providers. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. On March 1, 2008, Medicare claims submitted by physicians and other practitioners, laboratories, ambulance company suppliers, DMEPOS suppliers and others that bill Medicare are required to include the new National Provider Identifier (NPI).

Providers must use this information when they submit their claims to Medicare carriers, A/B Medicare Administrative Carriers (MACs), and DME MACs when they use certain electronic and paper Medicare claims (specifically the X12N 837P electronic claim and the CMS-1500 paper claims).

Hospitals, skilled nursing facilities, home health care agencies and other such institutional providers were required to begin using their NPI beginning on January 1, 2008.

The deadlines for submitting Medicare claims using the NPI are necessary to help the Centers for Medicare & Medicaid Services (CMS), the Medicare contractors and health care providers prepare for the final May 23, 2008, deadline for full NPI compliance. While the final NPI Rule required compliance on May 23, 2007, CMS stated in the NPI National Contingency Guidance that it will not take enforcement action against covered entities that deploy contingency plans through May 23, 2008, provided that conditions in the Guidance were met.

CMS is anticipating that some providers will experience some problems with claims submitted after March 1 – problems could arise in the following situations:

- The provider does not have an NPI
- The provider does not submit their NPI on their claim
- The provider has already received an NPI, but the NPI is not consistent with the provider's enrollment information received by the contractor.

Providers whose claims are rejected and returned to them should immediately contact their contractor before resubmitting that claim or submitting new claims for services provided to Medicare beneficiaries. Contact information for the Medicare contractors can be found at www.cms.hhs.gov/MLNGenInfo/ under "Downloads." The file is named, "Provider Call Center Toll-Free Numbers Directory."

Current Status
Physicians, non-physician practitioners, labs, ambulance company suppliers, DME suppliers, and others who traditionally bill carriers and DME MACs (2/22/08)

- 91.3% of Medicare carrier claims and 88.5% of DME MAC claims are being submitted with an NPI or NPI/legacy pair in the primary provider identifier fields (these numbers are consistent with institutional provider NPI use before the January 1 change).
- For claims submitted with an NPI, the current reject rate for carrier and DME MAC claims ranges from 1-12%, depending on the carrier. CMS has received very few complaints from providers.

Institutional Providers (January 1, 2008, deadline)

- In mid-January, the NPI submission rate jumped to 99% - compared to 90% in December.
- Currently, the submission rate is over 99.9%. Less than 0.1% of claims are being rejected for not having an NPI in the appropriate fields.

The March 1, 2008, Deadline
Expectations for March 1:

- A small portion of claims will continue to be submitted without an NPI. These claims will be rejected. Providers have had over two years to acquire and test their NPI.
- Some rejections may occur because a contractor has not completed processing a provider's enrollment application, submitted by the provider to fix inconsistencies between a provider's NPI and Medicare's provider enrollment files.

Medicare Risk Mitigation
CMS and the Medicare contractors are taking aggressive steps to ensure that providers will be paid for treating Medicare beneficiaries after March 1.

Medicare contractors are enhancing their toll-free phone lines by expanding the number of people available to answer calls. Throughout the month of February, CMS has intensified its planning efforts to assist contractors to prepare for the March 1 implementation date. In February 2008, CMS held a training sessions with contractor call centers and CMS regional office staff to ensure they are able to address provider inquiries on NPI issues.

Daily calls with the carriers, A/B MACs, and DME MACS are scheduled to monitor the status of successful and rejected claims, inquiries, enrollment backlog status, and other relevant information.

Each contractor has created a NPI Coordination Team to quickly identify and resolve claims processing issues related to the submission of the NPI or NPI-Legacy combination, expedite the processing of enrollment applications, and address other issues that may arise.

CMS has implemented temporary measures to allow the Medicare contractors time to address some of the backlog issues, but at some contractors, more work is needed.

Current Claims Process as of March 1
Currently, most Medicare providers (and their claims clearinghouse vendors) are submitting claims that include their new NPI. For those providers who don't have an NPI,

they are submitting claims using with their legacy provider numbers. When the claim is submitted, Medicare's computer systems will check to confirm that the claim includes an NPI. If there is no NPI, the claim will be rejected and the provider will receive an error message pointing to the lack of an NPI. If the provider has an NPI, the provider should make sure that the number is on the claim and resubmit the claim. If at that point the claim is again rejected, the provider should immediately contact the Medicare contractor to ensure that all provider records are correct before resubmitting the claim.

Contact information for the Medicare contractors can be found at http://www.cms.hhs.gov/MLNGenInfo/ under "Downloads." The file is named, "Provider Call Center Toll-Free Numbers Directory."

Medicare contractors expect to be able to handle all incoming calls, but some callers may experience extended hold times. CMS is urging providers to be patient – their issues will be addressed.

The Future – May 23, 2008
With May 23, 2008, less than three months away, CMS and the Medicare health care providers must make sure they are ready for full NPI implementation. Providers must be certain their NPI information and Medicare enrollment information is accurate and up-to-date before that date. Further, if providers' claims are being successfully processed with NPI/legacy pairs (and most are) now is the time for them to begin testing claims using only the NPI. Providers should start with small volumes of these NPI-only claims and gradually increase their submissions. Doing this testing now will allow time for any needed corrections prior to the May 23, 2008, deadline when claims must include the NPI only.

What to do if your 837P and CMS-1500 Claims are Rejected

- Check your record in the National Plan and Provider Enumeration System (NPPES)
    - Validate that the legacy identifier sent on the claim is reported in the provider/supplier's NPI Registry record. If the legacy identifier is not there, instruct the provider/supplier to add it.
- Validate that the Legal Business Name (if the provider/supplier is an organization) or the Legal Name (if the provider/supplier is an individual or a sole proprietorship) is correct.
- Validate that the correct Entity type was selected by the provider/supplier when applying for the NPI. Individuals obtain an NPI as Entity Type 1. Organizations obtain an NPI as Entity Type 2 NPI.
- Once your NPPES record is verified and/or updated, you should submit a small batch of claims 3-4 days later.

Note: If you enumerated through the EFI alternative, you should use the NPI Registry to check the content of the NPPES file. Make sure to have the Customer Service Representative at your Medicare contractor verify your TIN/EIN as the NPI Registry does not list this information.

- If these claims are still rejecting, call your Medicare Contractor.
    - Have a copy of the NPPES record in hand. A copy of the NPPES record can be obtained online at https://nppes.cms.hhs.gov. The Employer Identification Number or Social Security Number will not be shown on this print out.
    - Have the claim reject number and message
    - Be prepared to give the following information:
        1. Legal Business Name of the Organization
        2. Contractor Tracking Number (if known)
        3. Approximate date (month/year) when the 855 enrollment application was submitted
        4. Provider/Supplier Tax Identification Number or Social Security Number (SSN)
        5. National Provider Identifier (NPI)
        6. Medicare legacy Identifier
        7. Practice location on claim (i.e. where is the practice located (e.g. 100 Main St. New Orleans, LA)
        8. Contact Information where Provider/Supplier can be reached if further discussion is needed

TEST NPI-only NOW

If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI by submitting one or two claims today with just the NPI (i.e., no Medicare legacy number). If the Medicare NPI Crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims rejects, go into your NPPES record and validate that the information you are sending on the claim is the same information in NPPES. If it is different, make the updates in NPPES and resend a small batch of claims 3-4 days later. If your claims are still rejecting, you may need to update your Medicare enrollment information to correct this problem. Call your Medicare carrier, FI, or A/B MAC enrollment staff or the National Supplier Clearinghouse for advice right away. Have a copy of your NPPES record available. The enrollment telephone numbers are likely to be quite busy, so don't wait.

Transcript from February 6th Roundtable now Available
The transcript from the February 6th NPI Roundtable on the FFS Medicare Implementation is now available at http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp on the CMS NPI web page.

Need More Information?

Still not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS web site. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

NPPES Information for Organization Providers and Importance of Complete Medicare Enrollment Applications

Important National Plan and Provider Enumeration System (NPPES) Information for Organization Providers
When organization health care providers apply for NPIs, it is important that they enter their correct legal business name and Employer Identification Number (EIN). NPPES will be establishing a verification process with the Internal Revenue Service (IRS) to verify the legal business name and the associated EIN submitted on the NPPES applications and updates. Providers will be notified as CMS develops and implements this process. In the meantime, CMS encourages providers to be proactive and verify that this information is correct in order to avoid any potential issues in the future.

Important Information for Medicare Providers

Importance of "Complete" Medicare Provider/Supplier Enrollment Applications
Correcting your 855 enrollment form can be critical to assuring your claims are processed. We are urging providers to avoid delays in 855 processing that are caused by missing or incomplete information.

CMS has instructed its Medicare Fee-For-Service (FFS) contractors to process complete Medicare provider/supplier enrollment applications that contain all supporting documentation, including the electronic funds transfer authorization agreement (CMS-588) and licensing information, within prescribed processing timeframes. Incomplete or incorrect application information will result in an extension of these processing times for as long as it takes to obtain the correct information from the provider. This wastes precious time, especially for those seeking to rectify NPI/legacy conflicts and poses unnecessary work for both the contractor and the provider.

For an enrollment application to be considered complete:

1. All applicable sections of the CMS-855 and fields, including check boxes, within a section must be filled-out at the time of filing,
2. The application must contain an original signature (blue ink is preferred) and date of signature (blue ink is preferred), and
3. The application must be accompanied by all supporting documentation listed in section 17 of the enrollment application.

Make Sure you Understand the Key Dates: New MLN Matters Article Now Available
The latest NPI-related MLN Matters Article is now available and illustrates information, in chart form, regarding the difference between the March 1st and May 23rd FFS Medicare NPI implementation dates. Visit http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0802.pdf to view this article.

Upcoming Critical Dates for Medicare's Fee-for-Service Implementation of NPI

MLN Matters Number: SE0802

Provider Types Affected
This article is primarily for physicians and providers who submit Medicare claims using the Medicare Fee-for-Service (FFS) 837P and the CMS-1500 form.

Provider Action Needed
This special edition article, SE0802, is being provided by the Centers for Medicare & Medicaid Services (CMS) in order to clear up some confusion that providers are experiencing regarding the March 1, 2008 implementation of the NPI on professional claims, and the May 23, 2008 requirement for **ONLY** the NPI on all Health Insurance Portability & Accountability Act (HIPAA) electronic transactions and their paper versions.

The following charts illustrate expected claim results for different identifiers, or combinations of identifiers, submitted in the primary provider fields on the Medicare FFS 837P and CMS-1500. Note that when the chart indicates that claims will be paid, this would only be if no other errors (non-NPI) exist.

Prior to March 1, 2008 – 837P and 1500 Claims, Primary Provider Fields

Legacy Medicare Identifier	NPI	Result
X		Claim will be paid
X	X	Claim will be paid as long as there is an NPI/legacy match on the NPI Crosswalk*
	X	Claim will be paid as long as there is an NPI/legacy match on the NPI Crosswalk*

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As of March 1, 2008 – 837P and 1500 Claims, Primary Provider Fields

Legacy Medicare Identifier	NPI	Result
X		Claim will be rejected
X	X	Claim will be paid as long as there is an NPI/ legacy match on the NPI Crosswalk*
	X	Claim will be paid as long as there is an NPI/ legacy match on the NPI Crosswalk*

May 23, 2008 and Beyond – All Providers, All Transactions**, Both Primary and Secondary Provider Fields

Legacy Medicare Identifier	NPI	Result
X		Claim/transaction will reject
X	X	Claim/transaction will reject
	X	Claim/transaction will be paid/processed as long as there is an NPI/ legacy match on the NPI Crosswalk*

*Claims will reject when there is not a match on the Medicare NPI Crosswalk. You must correct any data which may be preventing an NPI/legacy match on the NPI crosswalk. The correction might require that you file a CMS-855 Medicare

Provider Enrollment form with your Medicare carrier, A/B MAC, or DME MAC a process which can take a number of months to accomplish.

**HIPAA electronic transactions (837I, 837P, 837COB, NCPDP, 276/277, 270/271, and 835), paper claims and SPR remittance advice.

TEST NPI-Only NOW
If you have been submitting claims with both an NPI and a Medicare legacy number and those claims have been paid, you need to test your ability to get paid using only your NPI (i.e., no Medicare legacy number) by submitting one or two claims today for each NPI you've been assigned. If the Medicare NPI Crosswalk cannot match your NPI to your Medicare legacy number, the claim with an NPI-only will reject. You can and should do this test now! If the claim is processed and you are paid, continue to increase the volume of claims sent with only your NPI. If the claims reject, validate that the National Plan and Provider Enumeration System (NPPES) has the correct Medicare Legacy number. If your NPPES information is correct, contact your Medicare carrier or A/B MAC enrollment staff for advice right away.

Additional Information
As of January 1, 2008, FFS Medicare required an NPI in the primary provider fields on the 837I and UB-04 claim types. Providers billing with these claim forms must continue to include an NPI in the primary provider field until May 23rd at which time an NPI-only is required in all fields.

For more information on correcting NPPES errors and how to use the NPI on Medicare claims, visit http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf on the CMS web site.

If you do not have an NPI, you need to obtain one as soon as possible. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203.

A table of Medicare's key dates relative to the NPI is available at the CMS NPI page http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp on the CMS web site. More information and education on the NPI can be found through the CMS NPI page http://www.cms.hhs.gov/NationalProvIdentStand on the CMS web site.

Medicare Fee for Service Legacy Provider IDs Prohibited on Form CMS-1500 Claims after NPI Required Date

MLN Matters Number: MM5858
Related Change Request (CR) #: 5858
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R1432CP
Effective Date: Claims received on or after May 23, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers submitting CMS-1500 and CMS-1450 (UB-04) claims to Medicare carriers, Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries

Provider Action Needed
Effective May 23, 2008, if you report a Provider Legacy Identifier on Medicare CMS-1500 or CMS-1450 (UB-04) claims, your contractors will return them as unprocessable.

CR 5858, from which this article is taken, announces that Provider Legacy Identifiers are not to be reported on Medicare CMS-1500 or Form CMS-1450 claims received on or after May 23, 2008 (the date at which the NPI is required to be reported on claims). After that date, claims containing Legacy Identifiers will be returned as unprocessable.

Make sure that your billing staffs are aware that effective May 23, 2008, only NPIs are to be reported on Medicare CMS-1500 and CMS-1450 claims.

Background
The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and other health care provider who conducts HIPAA standard

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electronic transactions. In accordance with this act, CMS began issuing NPIs on May 23, 2005.

Further, on April 2, 2007, the Department of Health and Human Services (DHHS) provided covered entities guidance regarding contingency planning for NPI implementation. In this guidance, as long as a health plan was compliant, meaning they could accept and send NPIs on electronic transactions, they could establish contingency plans to facilitate the compliance of their trading partners.

As a compliant health plan, on April 20, 2007 Medicare fee for service (FFS) established a contingency plan that followed this guidance. Since then, CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only;
- Medicare legacy only (PINs, UPINs, or National Supplier Clearinghouse number); and
- NPI and legacy combination.

CR 5858, from which this article is taken, announces that beginning on May 23, 2008, CMS requires the NPI to be submitted on the Form CMS-1500 and CMS-1450 paper claims; and legacy numbers will NOT be permitted on claims received on or after that date. Effective that date, Form CMS-1500 and CMS-1450 claims containing legacy identifiers will be returned as unprocessable, without appeal rights.

When returning these claims, your contractors will use an appropriate message and Remittance Advice Remark code, such as:

> **N257** *Missing/incomplete/invalid billing provider primary identifier.*

Note that contractors will not return claims in certain situations where an NPI is not required (e.g., foreign claims, deceased provider claims, and other situations as allowed by CMS in the future). Such claims will be processed with established procedures for such claims.

Additional Information
You can find more information about the prohibition of Medicare fee for service legacy provider IDs on Form CMS-1500 and CMS-1450 claims after the NPI required date by going to CR 5858, located at http://www.cms.hhs.gov/Transmittals/downloads/R1432CP.pdf on the CMS web site. You will find updated *Medicare Claims Processing Manual* (100-04), Chapter 26 (Completing and Processing Form CMS-1500 Data Set), Section 10.4 (Items 14-33 - Provider of Service or Supplier Information) as an attachment to that CR.

Additional Information on Reporting NPI for Ordering/ Referring and Attending/ Operating/ Other/ Service facility for Medicare Claims

MLN Matters Number: MM5890
Related Change Request (CR) #: 5890
Related CR Release Date: January 18, 2008
Related CR Transmittal #: R235PI
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Physicians, providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for services or items furnished to Medicare beneficiaries.

Provider Action Needed
Effective with claims received on or after May 23, 2008, Medicare will not pay for referred or ordered services or items; unless the fields for the name and NPI of the ordering, referring and attending, operating, other, or service facility providers are completed on the claims.

CR 5890, from which this article is taken, provides that it is the claim/bill submitter's responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers NPIs for claims. Further, it requires that the provider or supplier who is furnishing the services or items, after unsuccessfully attempting to obtain the NPI from these providers; report their own name and NPI in the ordering/ referring/ attending/ operating/ other/ service facility provider/ purchased service provider fields of the claims.

Make sure that your billing staffs are aware of this requirement to place the "furnishing" provider or supplier's name and NPI in the appropriate fields and to use your name and NPI if those of the ordering/referring and attending/ operating/other/service facility provider/purchased service providers are not obtainable.

Background
The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The National Provider Identifier (NPI) final rule (45 CFR Part 162, CMS-045-F), published on January 23, 2004, established the NPI as this standard; and mandates that all entities covered under HIPAA (including health care providers) comply with the requirements of this NPI final rule.

Medicare previously required a unique physician identification number (UPIN) be reported on claims for any ordering, referring/attending, operating, other, and service facility providers (i.e., or for any provider that is not a billing, pay-to, or rendering provider). Further, in accordance with the NPI final rule; effective May 23, 2008, when reported on a claim, the identifier for such a provider must be an NPI, regardless of whether the provider is a covered entity, or participates in the Medicare program. **Therefore, Medicare will not pay for referred or ordered services, or items, unless the name and NPI number of the ordering, referring and attending, operating, other, or service facility provider are on the claim.**

Note: Physicians (MD and DO) and the following non physician practitioners: 1) nurse practitioners (NP); 2)

clinical nurse specialist (CNS); 3) physician assistants (PA); 4) and certified nurse midwives (CNM) are the only types of providers eligible to refer/order services or items for beneficiaries.

You should be aware that it is the claim/bill submitter's responsibility to obtain the ordering, referring and attending, operating, other, service facility providers, or purchased service providers' NPIs on the claim. If these providers do not directly furnish their NPIs to the billing provider at the time of the order, the billing provider must contact them to obtain their NPIs prior to delivery of the services or items.

If, after several unsuccessful attempts to obtain the NPI from the ordering, referring, attending, operating, other, service facility provider, or purchased service provider; CR 5890, from which this article is taken, requires that (effective May 23, 2008) the provider or supplier who is furnishing the services or items report their own name and NPI in the claim's ordering/referring/attending/operating/other/service facility provider/purchased service provider fields.

Additional Information
You can find more information about reporting an NPI for ordering, referring and attending, operating, other, service facility providers for Medicare Claims by going to CR 5890, located at http://www.cms.hhs.gov/Transmittals/downloads/R235PI.pdf on the Centers for Medicare & Medicaid Services (CMS) web site.

NPI Enforcement, Key Dates, Sole Proprietor and Testing Information

Industry-Wide Enforcement of the NPI Compliance Date
The compliance date for the NPI for all HIPAA covered entities except small health plans was May 23, 2007. (Small health plans have until May 23, 2008 to comply.) In guidance provided on April 2, 2007, CMS announced that, through May 23, 2008, it would not impose penalties on covered entities that deploy contingency plans to facilitate the compliance of their trading partners. On May 24, 2008, CMS will lift its enforcement-leniency policy. Complaints will be investigated as they are today, but penalties will be a legitimate resolution if the entity does not demonstrate compliance or corrective action. CMS will continue to employ a complaint-driven approach to enforcement. For example, if a complaint is received alleging a failure to comply with the NPI requirements, CMS will contact the entity to secure evidence of compliance and the contingency plan that had been in place. If violations are identified, enforcement actions will take place.

This notice does not prohibit covered entities from lifting contingency plans prior to May 24, 2008.

In sum, no later than May 24, 2008, all covered entities are expected to be using the NPI in a compliant manner, and all contingency plans should be lifted.

NPPES and the NPI Enumerator: Misconceptions & Facts
In conversations and correspondence with health care providers, health plans, and others within the health care industry, it is very clear that there are misconceptions concerning the National Plan and Provider Enumeration System (NPPES) and the NPI Enumerator. Below we have listed some common misconceptions and the facts that correct those misconceptions.

Misconception	Fact
NPPES sends data directly to the Medicare provider enrollment system.	NPPES does not send data to the Medicare provider enrollment system or to the provider enrollment system of any health plan. As explained in the NPI Final Rule, applying for enrollment in a health plan is a completely separate process from the process of applying for an NPI.
NPPES sends data directly to the Medicare claims system.	NPPES does not send data to the Medicare claims system or to the claims system of any health plan. Medicare extracts certain NPPES data and uses those data in its Medicare NPI Crosswalk. That Crosswalk is used in processing Medicare Part A and Part B claims. Other health plans are also free to use NPPES data to help process their claims.
NPPES is part of the Medicare provider enrollment system.	Obtaining an NPI is required in order for a health care provider to enroll in Medicare; however, the NPPES does not function as a part of the Medicare provider enrollment system. Medicare requires a health care provider to have an NPI and to furnish that NPI on the Medicare provider enrollment application form (CMS-855). In addition, once a health care provider submits a CMS-855 to Medicare, Medicare compares the NPI and certain other information on the CMS-855 to certain information in that health care provider's record in NPPES. If the information being compared does not match, the health care provider must correct whichever information (NPPES or CMS-855) is incorrect in order for the enrollment process to continue.

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Obtaining an NPI guarantees payment to the health care provider by a health plan.	As explained in the NPI Final Rule, obtaining an NPI does not guarantee payment to the health care provider by Medicare or by any other health plan. NPI assignment simply establishes the uniqueness of an enumerated health care provider amongst all other enumerated health care providers. Most health plans will not pay a health care provider that is not enrolled in that health plan.
NPPES verifies licenses and credentials that are reported by health care providers when applying for NPIs.	NPPES does not verify licenses or credentials. NPPES verifies only two things: (1) It verifies a health care provider's Social Security Number if the health care provider is an individual who furnished his/her SSN when applying for the NPI; and (2) Using special software, it verifies that the health care provider's business mailing and practice location addresses are legitimate Postal Service addresses, but not that the health care provider is actually associated with or located at either of those addresses. Licensure and credentials must be verified by health plans as part of their enrollment processes. It is possible, under certain circumstances, that the NPI Enumerator may contact health care providers who have submitted applications, updates, or deactivations to verify information that was furnished in order to properly process those actions. Health care providers are reminded that the information they send to NPPES must be true, correct, and complete, in accordance with the Certification Statement of the NPI Application/ Update Form (paper form and web-based form).
NPPES is a Medicare system.	NPPES is not a Medicare system; it belongs to no health plan. It is maintained by CMS for the health care industry in general, in accordance with the NPI Final Rule and as part of CMS' delegated HIPAA authority. Health care providers who apply for NPIs are not required to furnish any information about their enrollment in any health plan. In an optional field, health care providers may report legacy identifiers that health plans have assigned to them in the past. This field, "Other Provider Identification Numbers," can capture the legacy identifiers and the issuers of those identifiers (i.e., the names of the health plans that assigned them). The information in this field is used by health plans to help them locate their enrolled providers in NPPES in order to know of their NPI assignments. For this reason, Medicare providers are urged to report their Medicare legacy identifiers in this field.
The NPI Enumerator can update the Medicare claims and enrollment systems.	The NPI Enumerator cannot view, update, or interact with the Medicare claims or the Medicare enrollment systems, nor can it do so with any health plan's claims or enrollment systems.
The NPI Enumerator can view and update/change the Medicare NPI Crosswalk.	The NPI Enumerator cannot view or update/change the Medicare NPI Crosswalk. The NPI Enumerator can assist providers with certain aspects of updating their NPPES records, and some of that information in those NPPES records could be used by Medicare in the Medicare NPI Crosswalk.
The NPI Enumerator serves Medicare providers and supports Medicare operations, not other providers or health plans.	The NPI Enumerator operates under contract to CMS in accordance with the NPI Final Rule and as part of CMS' delegated HIPAA authority. The NPI Enumerator serves the entire health care provider community for NPI purposes, not just Medicare providers. The functions of the NPI Enumerator are not specific to any health plan.

NPI CONT'D

CMS has posted information that lists the specific duties and responsibilities of the NPI Enumerator in a recent MLN Matters article located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0751.pdf on the CMS web site. An article that further clarifies the functions of NPPES and the NPI Enumerator is in development; this article will be announced once available.

Important Information for Medicare Providers

Medicare's Key Dates
There are two key dates remaining for 2008 in Medicare's NPI implementation plan. There is also some confusion as to the difference between the implementation steps for March 1st and May 23rd. The chart below indicates the implementation steps for each date; as well a new column to help further clarify the difference between these two dates.

Date	Implementation Steps	Key Point
March 1, 2008	–Medicare FFS 837P and CMS-1500 claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to, and rendering provider fields). –You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary provider fields. –Failure to submit an NPI in the primary provider fields will result in your claim being rejected or returned as unprocessable. –Until further notice, you may continue to include legacy identifiers only for the secondary provider fields.	**Claims with only legacy identifiers in the primary provider fields will be rejected.**
May 23, 2008	–In keeping with the Contingency Guidance issued on April 2, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims and SPR remittance advice. (Note that this date is one day earlier than that mandated by the National Enforcement Policy) –This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction. –CMS will also stop sending legacy identifiers on COB crossover claims at this time.	**If the claim contains a legacy identifier in any field, it will be rejected.**

Only 4 Months Until May 23rd - Test NPI-only claims NOW
While Medicare is receiving well over 90% of claims containing an NPI in primary provider fields, there is a very small percent of claims submitted with NPI- only. **Until you submit claims with an NPI-only, you will not have a preview of what your experience will be on May 23rd.** The time for correcting problems, should there be any, is getting short. CMS urges that ALL Medicare providers test NOW so that problems can be resolved prior to May 23rd. For example, if there is a problem that requires a change in your Medicare enrollment information, you will need to act immediately.

How to test - After Medicare providers have submitted claims containing both NPIs and legacy identifiers and those claims have been paid, Medicare urges these providers to send a small batch of claims now with **only the NPI** in the primary provider fields. If the results are positive, begin increasing the number of claims in the batch.

(Reminder: For institutional claims, the primary provider fields are the Billing and Pay-to Provider fields. For professional claims, the primary provider fields are the Billing, Pay-to, and Rendering Provider fields. If the Pay-to Provider is the same as the Billing Provider, the Pay-to Provider does not need to be identified.)

Remember, if you test and your claims are processed successfully, you can approach the May 23rd date with confidence. If you do not, you may face unanticipated cash flow problems.

Medicare DMEPOS Suppliers: If Your Claims Are Rejecting!
Medicare DMEPOS suppliers may be experiencing claims rejections if they did not obtain their NPIs properly, if they are not properly enrolled in Medicare, or both. For example, if a DMEPOS supplier who is a sole proprietorship enrolled with the National Supplier Clearinghouse (NSC) as an organization and furnished an Employer Identification Number (EIN) instead of a Social Security Number (SSN), but obtained a National Provider Identifier (NPI) as an Entity type 1 - Individual, the Medicare NPI Crosswalk will be unable to link that DMEPOS supplier's Medicare legacy identifier (the NSC number) to its NPI. This is because the NSC number and the NPI identify different entity types--one identifies an organization and the other an individual. When a linkage between a Medicare legacy identifier and an NPI used in a claim does not exist in the Medicare NPI Crosswalk, the claim will reject. DMEPOS suppliers should contact the DME MAC if they do not understand the error message they received.

If the rejection was due to the inability of the Medicare NPI Crosswalk to link the NPI to the NSC number, the DMEPOS supplier should check the NPPES record to ensure the appropriate Entity type (1 = Individual; or 2 = Organization) is reflected

NPI CONT'D

in that record. Individuals (including sole proprietorships) obtain NPIs as Entity type 1. Organizations obtain NPIs as Entity type 2. If the NPPES record shows the appropriate Entity type, the DMEPOS supplier should contact the NSC to ensure the enrollment record is correct. If the NPPES record does not show the appropriate Entity type, the DMEPOS supplier needs to take action to ensure the appropriate Entity type is selected. If assistance is necessary, the NPI Enumerator (1-800-465-3203) can explain to the DMEPOS supplier how this is done.

Once the NPPES record is correct, the DMEPOS supplier needs to ensure that it is properly enrolled in Medicare. The NSC, once contacted, will ask appropriate questions to determine if the DMEPOS supplier is, in fact, a sole proprietorship, and if so, properly reflected as such in the enrollment record. The NSC will assist the DMEPOS suppliers in correcting their enrollment records.

DMEPOS suppliers who are sole proprietorships should be aware of the following:

- A DMEPOS supplier who is a sole proprietorship obtains an Entity type 1 (Individual) NPI.
- When enrolling in Medicare (form CMS-855S) with the NSC, a DMEPOS supplier who is a sole proprietorship furnishes his/her SSN as the Taxpayer Identification Number (TIN).
- The Legal Name of the sole proprietorship business is the sole proprietor's name.
- It is possible for the sole proprietorship to have a "doing business as" (dba) name. The dba name can be reported on the CMS-855S and in the NPI application (in the "Other Name" field). A dba name, however, is not a Legal Name.
- It is possible that the sole proprietorship requested and received an Employer Identification Number (EIN) from the IRS if the sole proprietorship has employees. This EIN will protect the sole proprietor's SSN from appearing in claims and on W-2s.
- Medicare will treat the EIN as the TIN for purposes of claims processing, but the SSN must still be reported on the CMS-855S.
- When Medicare reports tax information to the IRS for that EIN, the IRS will link that EIN to the sole proprietor's SSN.

Additional Information on Reporting a National Provider Identifier (NPI) for Ordering/Referring and Attending/Operating/Other/Service facility for Medicare Claims
Visit http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5890.pdf for a recently released MLN Matters Article on the topic of reporting NPIs for order/referring and attending/operating/other/service facility for Medicare claims.

CMS to Host National NPI Roundtable on 2/6/2008
CMS will host a national NPI Roundtable on Wednesday, February 6 from 2:30 – 4 p.m. ET. This call will focus on the status of the Medicare implementation and a related question and answer session. Registration details are available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/listservwording2-6-08npicall.pdf on the CMS web site.

WEDI to Host NPI Audiocast
The Workgroup for Electronic Data Interchange (WEDI) will host an audiocast to discuss NPI implementation from an industry-wide standpoint. The audiocast will be held on February 21, 2008. Visit http://www.wedi.org/npioi/index.shtml for registration details. Please note there is a charge to participate in WEDI events.

Need More Information?
Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found through the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS web site. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

Medicare's Implementation of NPI: The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities

MLN Matters Number: SE0555

This article was rescinded on August 9, 2007, due to a number of factors affecting NPI implementation, especially the contingency plan announced in *MLN Matters* article MM5595. For the latest NPI information, you can view all NPI related *MLN Matters* articles by going to http://www.cms.hhs.gov/NationalProvIdentStand/downloads/MMarticles_npi.pdf on the Centers for Medicare & Medicaid Services web site.

ACCREDITATION

DMEPOS Accreditation Quality Standards

The 2006 DMEPOS Accreditation Quality Standards have undergone minor revisions and are posted for a 30-day comment period. Only comments on the revised sections will be considered. See DMEPOS Accreditation Standards for Public Comment – February 2008 for the revisions.

Comments must be received at the address provided below no later than 5 p.m. ET on Tuesday March 18, 2008. Due to staff and resource limitations, CMS cannot accept comments by facsimile or by hand or courier.

1. **Electronically**: Send comments to DMEPOSAccreditation@cms.hhs.gov. Any attachments should be compatible with Microsoft Word.

2. **Regular, Express or Overnight Mail**: Please allow sufficient time for mailed comments to be received before the close of the comment period. Send one original and two copies of your comments to:

   Centers for Medicare & Medicaid Services
   Attention: DMEPOS Accreditation Standards
   Mailstop C3-06-16
   7500 Security Blvd
   Baltimore, MD 21244

For more information on accreditation, refer to the DMEPOS Supplier Accreditation section under Enrollment at www.noridianmedicare.com.

COMPETITIVE BIDDING

Update to the Implementation Date for Home Health Agencies Providing Durable Medical Equipment in Competitive Bidding Areas

MLN Matters Number: MM5868
Related Change Request (CR) #: 5868
Related CR Release Date: February 1, 2008
Related CR Transmittal #: R1431CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Provider Types Affected
All HHAs billing Medicare contractors Regional Home Health Intermediaries (RHHIs)) for DME provided to Medicare beneficiaries

Provider Action Needed
This Change Request (CR) 5868 is updating the previously released CR5551. The MLN Matters article related to CR5551 may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5551.pdf on the Centers for Medicare & Medicaid Services (CMS) web site.

The effective and implementation dates in CR5551 **were originally April of 2008 and CR5868 changes those dates to July of 2008**.

HHAs may want to review the remainder of this article for information regarding the competitive bidding program for DME under Medicare and take appropriate action based on the impact of this program on your DME billings.

Background
This article and related Change Request (CR) 5868 provides general guidelines for processing HHA claims. Beginning in 2008, in a competitive bidding area, a supplier must be awarded a contract by CMS in order to bill Medicare for competitively bid DME. Therefore, HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program must either:

- Be awarded a contract to furnish the items in this area; or
- Use a contract supplier in the community to furnish these items.

The competitive bidding items will be identified by Healthcare Common Procedure Coding System (HCPCS) codes and the competitive bidding areas will be identified based on zip codes where beneficiaries receiving these items maintain their permanent residence. The DME Medicare Administrative Contractors (DME MACs) will have edits in place indicating which entities are eligible to bill for competitive bid items and the appropriate competitive bid payment amount.

As of July 1, 2008, important points to remember are:

- All suppliers of competitively bid DME **must bill the DME MAC** for these items and will no longer be allowed to bill the RHHIs for competitive bid items.
- Claims submitted to the RHHI for HCPCS codes subject to a competitive bidding program will be returned to the provider to remove the affected DME line items and the providers will be advised to submit those charges to the DME MACs who will have jurisdiction over all claims for competitively bid items.
- Claims for DME furnished by HHAs that are not subject to competitive bidding would still be submitted to the RHHIs.

For your reference, the HCPCS codes subject to competitive bidding and a list of ZIP codes and Core Based Statistical Areas (CBSAs) applicable to the competitive bidding areas is available at http://www.dmecompetitivebid.com/cbic/cbic.nsf/(Pages)/Competitive+Bid+Areas on the Internet.

Additional Information
For complete details regarding CR5868 please see the official instruction (CR5868) issued to your Medicare A/B MAC, RHHI, or FI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1431CP.pdf on the CMS web site.

MEDICAL REVIEW

Items and Special Services Having Special DME Review Considerations

MLN Matters Number: MM5909
Related Change Request (CR) #: 5909
Related CR Release Date: February 22, 2008
Related CR Transmittal #: R242PI
Effective Date: March 1, 2008
Implementation Date: March 1, 2008

Provider Types Affected
Suppliers who submit claims to durable medical equipment Medicare Administrative Contractors (DME MACs) for DME items and services furnished to Medicare beneficiaries.

What Suppliers Need to Know
This article is informational for suppliers and is based on Change Request (CR) 5909 that alerts suppliers that the medical review (MR) function (Chapter 5 of the *Program Integrity Manual* (PIM) - Items and Services Having Special DME Review Considerations) that was the responsibility of the DME Program Safeguard Contractors (PSCs) is being transitioned to the DME MACs.

CR 5909 rescinds and replaces CR 5765 of the same title. This replacement also renames the DME PSCs to be Zone Program Integrity Contractors (ZPICS).

Additional Information
To see the official instruction (CR5909) issued to your Medicare DME MAC visit http://www.cms.hhs.gov/Transmittals/downloads/R242PI.pdf on the CMS web site.

Medical Review Transition to DME MACs

Effective March 1, 2008, medical review functions will be transitioned to the DME MAC jurisdictions. This transition is only for medical review functions. It does not include benefit integrity. Until March 1, DME Program Safeguard Contractors are responsible for medical review.

Currently, IntegriGuard, a subcontractor of SafeGuard Services, is performing these medical review functions for Jurisdiction D:

- Comprehensive Error Rate Testing (CERT)
- Advance Determination of Medicare Coverage (ADMC)
- Medical Review of edits and claims (not for benefit integrity)
- Local Coverage Determination development
- Probe reviews
- Prepay/Postpay reviews

Beginning March 1, 2008, all medical review education and policy/article revisions and updates will be provided by NAS DME. All updates will be posted to the NAS DME web site and sent in the email updates.

All current email subscribers to SafeGuard Services, who have **not** subscribed to NAS DME emails, must subscribe to the NAS DME email in order to continue receiving medical review updates. To subscribe, see Join NAS Medicare Email Lists.

NAS will provide updates to changes that will occur, including mailing addresses and fax numbers, in the near future. Do not make any changes until notice and instructions are provided.

Medical Review Transition Updates

Suppliers should take note of the following changes as a result of the March 1, 2008, medical review transition. Effective March 1, 2008, medical review activities (not in support of benefit integrity) will be transitioned from IntegriGuard, as the Program Safeguard Contractor for Jurisdiction D to NAS, the DME MAC.

Advance Determination of Medicare Coverage Requests

Effective February 25, 2008, all ADMC requests must be faxed or mailed to NAS. The last day that IntegriGuard will accept ADMC requests is February 22. Any pending ADMC requests will be transferred to NAS for completion.

ADMC requests can be faxed or mailed to NAS using the following information:

ADMC Fax #: 877-662-8445

Mailing Address:

Noridian Administrative Services LLC
Jurisdiction D DME Medical Review
PO Box 6747
Fargo ND 58108-6747

NAS has developed a new ADMC Request Form and ADMC Fax Cover Sheet for suppliers to use. These forms are also located on our web site in the Forms section. Please remember to send all requested ADMC documentation with your request to prevent requests being denied for lack of documentation.

Suppliers will receive a written confirmation of any ADMC requests received by NAS. NAS will process all ADMC requests within 30 days from receipt. If an ADMC request was sent to IntegriGuard and you have not received a decision by March 1, please note that all unfinished work will be transitioned from IntegriGuard to NAS. You will not need to resubmit any requests.

Medical Documentation Submission

Any medical documentation requested by NAS for either pre-pay or post-pay medical review purposes will be done via a letter. This letter will include instructions on where to fax or mail the requested documentation. Please discontinue use of any IntegriGuard mailing addresses, unless specifically asked for documentation from them in regards to medical review for benefit integrity purposes. All letters sent to suppliers will be on letterhead identifying the requestor.

Below is the information for sending **medical documentation not related to ADMC** requests.

Documentation Fax #: 866-465-0213

Mailing Address:

Noridian Administrative Services LLC
PO Box 6727
Fargo ND 58108-6727

Local Coverage Determinations

As of February 28, 2008, Jurisdiction D Local Coverage Determinations (LCDs) and policy articles on the CMS Medicare Coverage Database (MCD) will identify NAS (19003, DME MAC) as the contractor instead of Electronic Data Systems Corp.

LCDs and policy articles will contain a Revision History statement indicating this transition. LCDs and policy articles in Jurisdiction D will otherwise be exactly the same as they were before the transition, including the LCD and Article ID numbers, statuses and effective dates.

As of March 3, 2008, suppliers can locate the DME MAC Jurisdiction D Local Coverage Determinations at www.noridianmedicare.com/dme/coverage. This page provides an alphabetic listing of the policies, along with links to the LCD and related policy article and a listing of HCPCS addressed in each policy.

MEDICAL REVIEW CONT'D

Medical Director

The NAS DME Medical Director is Dr. Robert Szczys. He will be involved with the development and revision of LCDs, in coordination with the other DME MAC medical directors. Dr. Szczys has worked at NAS for 8 years, in the role of both Medicare Part A and Part B Medical Director.

Medical Review Questions

Effective March 3, 2008, suppliers with questions about coverage or DME LCDs should contact the Supplier Contact Center at 1-866-243-7272 for assistance. Questions of this nature can also be mailed to dme@noridian.com. Our customer service staff and written correspondence staff will consult with medical review staff to answer these questions.

FORMS

Interactive CMNs and DIFs

NAS provides all CMNs and DIFs in an interactive form. All of them may be completed online and printed so no handwriting is necessary.

Fields may be highlighted to show which ones are required to be completed by the supplier and to ensure the form is completed in its entirety. CMS instructions are also included with each form.

The interactive CMNs and DIFs are accessible in the Forms section of the NAS DME web site.

REIMBURSEMENT

E0461 Added to 2008 Fee Schedule

The E0461 (Volume control ventilator, without pressure support mode, may include pressure control mode, used with noninvasive interface (e.g., mask)) was inadvertently omitted from the 2008 fee schedule.

NAS has added this HCPCS to the fee schedules posted on our web site in the News and Publications section.

CERT

CERT Documentation

This article is to remind suppliers they must comply with requests from the CERT Documentation Contractor for medical records needed for the Comprehensive Error Rate Testing program. An analysis of the CERT related appeals workload indicates the reason for the appeal is due to "no submission of documentation" and "submitting incorrect documentation."

Suppliers are reminded the CERT program produces national, contractor-specific and service-specific paid claim error rates, as well as a supplier compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The supplier compliance error rate is a measure of the extent to which suppliers are submitting claims correctly.

The CDC sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CDC will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT Operations Center via fax, the preferred method, or mail at the number/address specified below. The secure fax number for submitting documentation to the CDC is (240) 568-6222.

Mail all requested documentation to:

CERT Documentation Office
Attn: CID #:xxxxxx
9090 Junction Drive, Suite 9
Annapolis Junction, MD 20701

The CID number is the CERT reference number contained in the documentation request letter.

Suppliers may call the CDC at (888) 779-7477 or (301) 957-2380 with questions regarding specific documentation to submit.

Suppliers must submit medical records to the CDC within 75 days from the receipt date of the initial letter or claims will be denied. The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims.

Also, Medicare patients have already given authorization to release necessary medical information in order to process claims. Therefore, Medicare suppliers do not need to obtain a patient's authorization to release medical information to the CDC.

APPEALS

Multiple Dates of Service on Reopenings and Redeterminations

When completing the DME Reopening and Inquiry/ Redetermination form, the dates of service must be specific. Use numeric dates and list each date that needs review separately.

Do not request 9/1/07 – present, for example. This should be listed as 9/1/07, 10/1/07, 11/1/07, and 12/1/07.

Notification of Fully Favorable Appeal Decisions

Written notification of fully favorable appeal decisions will no longer be sent by NAS. CMS has determined the supplier's Remittance Advice and the Medicare Summary Notice sent to beneficiaries provides adequate information regarding the claim reversal.

Change in Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals

MLN Matters Number: MM5897
Related Change Request (CR) #: 5897
Related CR Release Date: February 5, 2008
Related CR Transmittal #: R1437CP
Effective Date: January 1, 2008
Implementation Date: May 5, 2008

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

Impact on Providers
This article is based on Change Request (CR) 5987 which notifies Medicare contractors of an increase in the Amount in Controversy (AIC) required to sustain Administrative Law Judge (ALJ) and Federal District Court appeal rights beginning January 1, 2008. ***The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2008 is $110. The amount remaining in controversy requirement for requests made on or after January 1, 2008 is $120. For Federal District Court review, the amount remaining in controversy goes from $1,130 for requests prior to January 1, 2008 to $1,180 for requests on or after that date.***

Background
The Medicare claims appeal process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). In addition, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for annual reevaluation (beginning in 2005) of the dollar amount in controversy required for an Administrative Lay Judge (ALJ) hearing and Federal District Court review.

Change Request (CR) 5897 revises the *Medicare Claims Processing Manual* (Publication 100-4, Chapter 29, Section 330.1 and Section 345.1) to update the Amount In Controversy (AIC) required for an ALJ hearing or Federal District Court review. As of January 1, 2008, the amount remaining in controversy must be at least $120 for an ALJ hearing or at least $1,180 for a Federal District Court review requested on or after January 1, 2008.

Additional Information
The official instruction, CR5987, issued to your carrier, FI, RHHI, A/B MAC, and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1437CP.pdf on the Centers for Medicare & Medicaid Services (CMS) web site.

Common Electronic Data Interchange Web Site Available and Other Important CEDI Transition Information

The CEDI Web site, www.ngscedi.com is now available. This Web site will be the primary source of communication between CEDI and all DME MAC trading partners (electronic submitters) including billing services, clearinghouses and software vendors. Previously published material, the implementation schedule and many additional documents are currently accessible on our new Web site.

National Government Services, Inc. is also pleased to announce the availability of a CEDI Listserv. CEDI strongly encourages all DME MAC trading partners (electronic submitters), software vendors, billing services and clearinghouses to sign up for the CEDI Listserv through the new CEDI Web site at: www.ngscedi.com/listserv/subscribe.htm

Note: The CEDI Help Desk toll-free number is 866-311-9184. The Help Desk is available from 9 am – 9 pm Eastern Time. The Help Desk can also be contacted via e-mail at: NGS.CEDIHelpdesk@wellpoint.com. All emails will be responded to within two business days.

Important Transition Information

- CEDI will use the existing submitter IDs established by each DME MAC Jurisdiction for current trading partners (electronic submitters). Trading partners (electronic submitters) who have previously completed electronic registration or enrollment forms with a DME MAC do not need to re-enroll with CEDI.
- DME MAC trading partners (electronic submitters) with multiple submitter IDs now have the opportunity to consolidate their multiple submitter IDs into one. Trading partners (electronic submitters) who want to take advantage of this consolidation must contact CEDI using the CEDI Help Desk e-mail address: NGS.CEDIHelpdesk@wellpoint.com to initiate the consolidation of their multiple submitter IDs.
- The CEDI system is now available for testing. Software vendors must test with CEDI prior to moving their customers to the CEDI. Suppliers, billing services and clearinghouses who use internally developed software and communications (in-house programmers) must also test with CEDI. Vendors and "in-house programmers" should contact the CEDI Help Desk either by phone or e-mail to initiate the testing process. The CEDI Web site contains the following information for software vendors in support of this transition: Trading Partner Agreements for each transaction, the telecommunications user guide, and a CEDI user guide.
- Once a software vendor has passed testing with CEDI, the vendor can begin moving their existing trading partners (electronic submitters) to CEDI. Any new trading partners (electronic submitters) who sign up with that vendor can enroll exclusively with CEDI.

EDI CONT'D

- Suppliers new to EDI may sign up with a DME MAC for electronic transactions prior to transitioning to CEDI if their software vendor has not passed testing with CEDI.
- Suppliers new to EDI who are using a vendor who has passed CEDI testing will be required to enroll only with CEDI and not with a DME MAC.
- CEDI will maintain a list of software vendors who are approved for CEDI on the CEDI web site. This list will be updated daily.
- The Express Plus software will be modified to include new communication software. Additionally, the Express Plus manual will be updated. Once both the Express Plus software and manual are available on the CEDI Web site, a CEDI Listserv will be sent.
- Pro32 PC-ACE users may continue using this software to submit claims to CEDI. Pro32 PC-ACE users will not have to test but will have to update their communication software. No updates should be made until announced by CEDI. Stay tuned to our Web site and Listserv for these announcements.

At this time, DME Claim Status Inquiry (CSI) and Electronic Funds Transfer (EFT) support will continue to be handled by each DME MAC Jurisdiction.

National Government Services looks forward to servicing the DME MAC electronic submitter community as the CEDI contractor.

Healthcare Provider Taxonomy Codes Update for April 2008

This article provides notice to Medicare providers of modifications, additions and deletions to the Healthcare Provider Taxonomy Codes (HPTC) maintained by the National Uniform Claim Committee (NUCC) for standardized classification of healthcare providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1.

Pharmacists should take note of the following change:

1835P0018X Under the **Pharmacy Service Providers Type**, the **Pharmacist Classification**, the **Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist Specialization** was added:

Pharmacist Clinician/Clinical Pharmacy Specialist is a pharmacist with additional training and an expanded scope of practice that may include prescriptive authority, therapeutic management, and disease management.

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

Policy
The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC Web page three months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update.

CODING

New "K" Code for Replacement Interface Material

MLN Matters Number: MM5900
Related Change Request (CR) #: 5900
Related CR Release Date: February 7, 2008
Related CR Transmittal #: R1441CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for orthosis services for Medicare beneficiaries

What You Need to Know
CR 5900, from which this article is taken, announces that (effective April 1, 2008) a new "K" code (K0672 – Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each) will be established for replacement interface material. You should make sure that your billing staffs are aware of this new "K" code.

Additional Information
You can find more information about K0672 (new "K" code for interface material) by going to CR 5900, located at http://www.cms.hhs.gov/Transmittals/downloads/R1441CP.pdf on the Centers for Medicare & Medicaid Services (CMS) web site.

Clarification Regarding Coordination of Benefits Agreement Medigap Claim-based Crossover Process

MLN Matters Number: MM5837 Revised
Related Change Request (CR) #: 5837
Related CR Release Date: January 25, 2008
Related CR Transmittal #: R1420CP and R135FM
Effective Date: October 1, 2007
Implementation Date: February 1, 2008

Note: This article was revised on January 30, 2008, to show the correct implementation date (see above), which is February 1, 2008. All other information remains the same.

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for Medicare Part B services provided to Medicare beneficiaries.

Provider Action Needed
This article is based on Change Request (CR) 5837 which clarifies instructions regarding the Coordination of Benefits Agreement (COBA) Medigap claim-based crossover process.

CR 5837 provides formal confirmation of a recent Centers for Medicare & Medicaid Services (CMS) decision to **not require** Medicare Part B contractors (including Durable Medical Equipment Medicare Administrative Contractors (DME MACs) to update their internal insurer tables or files with each Medigap insurer's newly assigned Coordination of Benefits Agreement (COBA) Medigap claim-based ID, as was previously prescribed in CR 5662. In addition, CR 5837 conveys clarifying provider billing requirements in relation to Medigap claim-based crossovers.

Background
Effective October 1, 2007, the CMS transferred responsibility for the mandatory Medigap crossover process (also known as the "Medicare claim-based crossover process") to its Coordination of Benefits Contractor. With this change, Part B contractors, including A/B MACs and DME MACs:

- No longer maintain crossover relationships with Medigap insurers, and
- No longer bill such entities for crossover claims effective with the last claims file that they transmit to these entities no later than October 31, 2007.

In a directive issued on September 18, 2007, CMS communicated to Medicare Part B contractors (carriers, DME MACs, and A/B MACs) its decision that they are not required to update their internal insurer files or tables with the Coordination of Benefits Contractor (COBC)-assigned COBA Medigap claim-based identifiers (IDs). This is because, as discussed in Change Request (CR) 5601, the contractors' front-end system now simply verifies that a Medigap claim-based crossover identifier on an incoming claim is syntactically correct (5 digits, beginning with a "5"). CMS' Common Working File (CWF) system is now tasked with validation of the actual ID submitted on incoming claims.

The September 18, 2007, directive represented a departure from previous guidance communicated in CR5662 (see MLN Matters article, MM5662, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5662.pdf on the CMS web site), in which CMS provided for transitional updating of the contractors' internal insurer files/tables prior to October 1, 2007, once the COBC had:

- Assigned COBA Medigap claim-based IDs to the various Medigap insurers, and
- Deemed Medigap insurers "production-ready."

CMS also required Medicare contractors to post language on their provider web sites stipulating that:

- Providers are not to begin including the new COBA Medigap claim-based IDs on incoming Part B claims or claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) before October 1, 2007.

CR 5837 instructs Part B contractors (including A/B MACs and DME MACs) that they **are not required to update their internal insurer files/tables** following a Medigap insurer's readiness to move into production with the COBC. This requirement formerly applied to situations where CMS expected that contractors update their internal insurer files/tables prior to October 1, 2007, in accordance with CR 5662 (Transmittal 283). These Part B contractors may retain their older Other Carrier Name and Address (OCNA) or N-key identifiers within their internal insurer files/tables for purposes of avoiding system issues or for the printing of post-hoc beneficiary-requested Medicare Summary Notices (MSNs). However, in accordance with CR 5601, at http://www.cms.hhs.gov/transmittals/downloads/R1242CP.pdf on the CMS web site, contractors will have disabled the logic that they formerly used to tag claims for crossover to Medigap insurers effective prior to claims they received for processing on October 1, 2007.

Effective with CR 5837, all Part B contractors (including A/B MACs and DME MACs) will discontinue publication of their routine Medigap newsletters. These contractors may, however, at their discretion, publish one last edition of this newsletter if desired to include the provider education language that follows:

In accordance with the language modification to MSN message 35.3
—"A copy of this notice will not be forwarded to your Medigap insurer because the information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."—which contractors made as part of Transmittal 1242, CR 5601, all Part B contractors, including A/B MACs, and DME MACs shall make available a Spanish translation of the modified MSN message, which shall read as follows: "No se enviará copia de esta notificación a su asegurador de Medigap debido a que la información estaba incompleta o era inválida. Favor de someter una copia de esta notificación a su asegurador Medigap."

BILLING CONT'D

All Part B contractors (including A/B MACs, and DME MACs) are to inform their associated billing providers that are exempted from billing their claims electronically under the Administrative Simplification Compliance Act (ASCA) that they should only be entering the newly assigned 5-byte COBA Medigap claim-based ID (range 55000 to 59999) with item 9-D of the CMS-1500 claim form for purposes of triggering a crossing over of the claim to a Medigap insurer.

All Part B contractors (including A/B MACs, and DME MACs) are also to provide a link on their provider Web sites (preferably under "Hot Topics") to the recently published special edition MLN article (SE0743 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0743.pdf on the CMS web site) that clarifies for providers the differences between:

- Medigap crossover that is accomplished via the automatic, eligibility file-based crossover process, and
- The Medigap claim-based crossover process, which is triggered by information that they include on incoming claim.

Providers should note that the listing at

http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf on the CMS COB web site is:

- Complete and up-to-date, and
- The only source for the identifiers to be included on incoming claims for purposes of triggering crossovers to those Medigap insurers that do not participate fully in the automatic crossover process.

Additional Information
The official instruction, CR 5837, was issued in two transmittals issued to your Medicare carrier, DME MAC, or A/B MAC. Those transmittals may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1420CP.pdf and http://www.cms.hhs.gov/Transmittals/downloads/R135FM.pdf on the CMS web site. These transmittals make revisions to the *Medicare Claims Processing* and *Medicare Financial Management Manuals*, respectively.

New HCPCS Modifiers when Billing for Patient Care in Clinical Research Studies

MLN Matters Number: MM5805
Related Change Request (CR) #: 5805
Related CR Release Date: January 18, 2008
Related CR Transmittal #: R1418CP
Effective Date: January 1, 2008
Implementation Date: No later than April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries in clinical research studies.

What Providers Need to Know
This article is based on Change Request (CR) 5805. The Centers for Medicare & Medicaid Services (CMS) is discontinuing the QA (FDA Investigational Device Exemption), QR (Item or Service Provided in a Medicare Specified Study), and QV (Item or Service Provided as Routine Care in a Medicare Qualifying Clinical Trial) HCPCS modifiers as of December 31, 2007, and creating two new modifiers that will be used solely to differentiate between routine and investigational clinical services.

These new modifiers will be included in the 2008 Annual HCPCS Update and are effective for dates of service on and after January 1, 2008:

Q0 - Investigational clinical service provided in a clinical research study that is in an approved clinical research study. Q0 replaces QA and QR.

Q1 - Routine clinical service provided in a clinical research study that is in an approved clinical research study. Q1 replaces QV.

Use these two new modifiers as follows:
Investigational clinical services are defined as those items and services that are being investigated as an objective within the study. Investigational clinical services may include items or services that are approved, unapproved, or otherwise covered (or not covered) under Medicare.

Routine clinical services are defined as those items and services that are covered for Medicare beneficiaries outside of the clinical research study; are used for the direct patient management within the study; and, do not meet the definition of investigational clinical services. Routine clinical services may include items or services required solely for the provision of the investigational clinical services (e.g., administration of a chemotherapeutic agent), clinically appropriate monitoring, whether or not required by the investigational clinical service (e.g., blood tests to measure tumor markers), and items or services required for the prevention, diagnosis, or treatment of research related adverse events (e.g., blood levels of various parameters to measure kidney function).

Medicare contractors will not search their files to adjust affected claims processed prior to implementation of this change, but they will adjust such claims that you bring to their attention.

Note: If a Category A or B investigational device is used on the clinical trial, providers should continue to include the Investigational Device Exemption (IDE) in item 23 of the CMS-1500 claim form or the electronic equivalent. Also, your Medicare contractor will validate the IDE# number when it appears on the claim with the Q0 modifier and if the IDE# does not meet validation criteria, the claim will be returned as unprocessable.

Additional Information
You may see the official instruction (CR5805) issued to your Medicare A/B MAC, FI, DMERC, DME/MAC, RHHI or carrier by going to http://www.cms.hhs.gov/Transmittals/downloads/R1418CP.pdf on the CMS web site.

Use of 8-Digit Registry Number on Clinical Trail Claims

MLN Matters Number: MM5790
Related Change Request (CR) #: 5790
Related CR Release Date: January 18, 2008
Related CR Transmittal #: R310OTN
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (A/B MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries in clinical research studies.

Provider Action Needed
This article is based on Change Request (CR) 5790 that notifies providers and suppliers that Medicare claims forms will be modified to accommodate the 8-digit clinical trail number for claims that Medicare receives on or after April 1, 2008. Reporting this number is voluntary and claims submitted without the clinical trial number will be paid the same as claims containing a number. While reporting is voluntary, the number will assist the Centers for Medicare & Medicaid Services (CMS) in informing beneficiaries about the availability of clinical trials and to use claims information to inform coverage decisions. Be sure your billing staff is aware of this rule.

Background
The purpose of CR5790 is to instruct providers and suppliers on new, voluntary reporting for placing a clinical trial number on claims for items and services provided in clinical trials that are qualified for coverage as specified in the *Medicare National Coverage Determination Manual*, Publication 100-03, section 310.1. That publication is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS web site. The clinical trial number that the CMS is requesting to be voluntarily reported is the number assigned by the National Library of Medicine (NLM) Clinical Trials Data Bank when a new study is registered by a sponsor or investigator. Information regarding NLM clinical trials is available at http://clinicaltrials.gov/ on the Internet.

CMS will use this number to identify all items and services provided to beneficiaries during their participation in a clinical trial. Furthermore, this identifier will permit CMS to meet the recommendations of the 2000 Institute of Medicine report that led to the Executive Memorandum to increase participation of Medicare beneficiaries in clinical trials and the development and implementation of the CMS clinical trials policy.

Recommendations from The White House Executive Memorandum included:

- Tracking Medicare payments;
- Ensuring that the information gained from the research is used to inform coverage decisions;
- Making certain that the research focuses on issues of importance to the Medicare population; and,
- Enabling CMS to better inform Medicare beneficiaries about the clinical studies available for their participation.

Key Points

- Claims submitted without the clinical trial number will be paid the same as claims containing a number.
- Institutional clinical trial claims are identified through the presence of all of the following elements:
  - Value Code D4 and corresponding 8-digit clinical trial number (when present on the claim);
  - ICD-9 diagnosis code V70.7;
  - Condition Code 30; and
  - HCPCS modifier Q1: outpatient claims only. (See MM5805 related to CR5805 for more information regarding modifier Q1.)
- Practitioner/DME clinical trail claims are identified through the presence of all of the following elements:
  - ICD-9 diagnosis code V70.7;
  - HCPCS modifier Q1; and
  - 8-digit clinical trial number (when present on the claim).
- On institutional claims, the 8-digit numeric clinical trial number should be placed in the value amount of value code D4 on the paper claim UB-40 (Form Locators 39-41) or in Loop 2300, HI – Value Information segment, qualifier BE on the 837I.
- On professional claims, the clinical trial registry number should be preceded by the two alpha characters of "CT" and placed in Field 19 of the paper Form CMS-1500 or it should be entered WITHOUT the "CT" prefix in the electronic 837P in Loop 2300 REF02(REF01=P4).

Additional Information
You may see the official instruction (CR5790) issued to your Medicare A/B MAC, FI, DME/MAC, or carrier by going to http://www.cms.hhs.gov/Transmittals/downloads/R310OTN.pdf on the CMS web site. You may see the article related to the Q1 modifier, MM5805, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5805.pdf on the CMS web site.

Reporting of Hematocrit or Hemoglobin Levels on All Claims for Administration of Erythropoiesis Stimulating Agents, Implementation of New Modifiers for Non-ESRD ESA Indications, and Reporting of Hematocrit or Hemoglobin Levels on all Non-ESRD, Non-ESA Claims Requesting Payment for Anti-Anemia Drugs

MLN Matters Number: MM5699 Revised
Related Change Request (CR) #: 5699
Related CR Release Date: January 11, 2008
Related CR Transmittal #: R1412CP
Effective Date: January 1, 2008
Implementation Date: April 7, 2008

Note: This article was revised on February 15, 2008, to add clarifying information to bullet points 1 and 3 on pages 3 and 4, respectively. All other information remains the same.

Provider Types Affected
Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Competitive Acquisition Plan (CAP) Designated Carriers, and A/B Medicare administrative contractors (A/B MACs)) for providing ESAs and related anti-anemia administration services to Medicare beneficiaries.

Impact on Providers
Effective for services on or after January 1, 2008, you must report the most recent hemoglobin or hematocrit levels on any claim for a Medicare patient receiving: (1) ESA administrations, or (2) Part B anti-anemia drugs other than ESAs used in the treatment of cancer that are not self-administered. In addition, non-ESRD claims for the administration of ESAs must also contain one of three new Healthcare Common Procedure Coding System (HCPCS) modifiers effective January 1, 2008. Failure to report this information will result in your claim being returned as unprocessed. (**Note that renal dialysis facilities are already reporting this information on claim types 72X, so CR5699 applies to providers billing with other types of bills**.) See the rest of this article for reporting details.

Background
Medicare Part B provides payment for certain drugs used to treat anemia caused by the cancer itself or by various anti-cancer treatments, including chemotherapy, radiation, and surgical therapy. The treatment of anemia in cancer patients commonly includes the use of drugs, specifically ESAs such as recombinant erythropoietin and darbepoetin. Emerging data and recent research has raised the possibility that ESAs administered for a number of clinical indications may be associated with significant adverse effects, including a higher risk of mortality in some populations.

Most recently, section 110 of Division B of the Tax Relief and Health Care Act (TRHCA) of 2006 directs the Secretary to amend Section 1842 of the Social Security Act by adding at the end the following new subsection: *"Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual."*

In light of the health and safety factors and the TRHCA legislation, effective January 1, 2008, the Centers for Medicare & Medicaid Services (CMS) is implementing an expanded reporting requirement for all claims billing for administrations of an ESA. Hematocrit and /or hemoglobin readings are already required for ESRD claims for administrations of an ESA. Effective with the implementation of change request (CR) 5699, all other claims for ESA administrations will also require the reporting of the most recent hematocrit or hemoglobin reading, along with one of three new HCPCS modifiers effective January 1, 2008.

In addition, CR 5699 requires the reporting of the most recent hematocrit or hemoglobin readings on all claims for the administration of Part B anti-anemia drugs OTHER THAN ESAs used in the treatment of cancer that are not self-administered.

What you Need to Know
CR 5699, from which this article is taken, instructs all providers and suppliers that:

1. Effective January 1, 2008, all claims billing for the administration of an ESA with HCPCS codes J0881, J0882, J0885, J0886 and Q4081 must report the most recent hematocrit or hemoglobin reading available when the billed ESA dose was administered. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month. Claims submitted prior to the publication of change request 5699 that were not completed per the instructions in change request 5699 should be re-submitted.

    - For institutional claims, the hemoglobin reading is reported with a value code 48 and a hematocrit reading is reported with the value code 49. Such claims for ESAs not reporting a value code 48 or 49 will be returned to the provider.
    - Effective for services on or after January 1, 2008, for professional paper claims, test results are reported in item 19 of the Form CMS-1500 claim form. For professional electronic claims (837P) billed to carriers or A/B MACs, providers report the hemoglobin or hematocrit readings in Loop 2400 MEA segment. The specifics are MEA01=TR (for test results), MEA02=R1 (for hemoglobin) or R2 (for hematocrit), and MEA03=the test results. The test results should be entered as follows: TR= test results, R1z=hemoglobin

or R2=hematocrit (a 2-byte alpha-numeric element), and the most recent numeric test result (a 3-byte numeric element, decimal implied [xx.x]). Results exceeding 3-byte numeric elements (10.50) are reported as 10.5.

Examples: If the most recent hemoglobin test results are 10.50, providers should enter: TR/R1/10.5, or, if the most recent hematocrit results are 32.3, providers would enter: TR/R2/32.3.

- Effective for dates of service on and after January 1, 2008, contractors will return to provider paper and electronic professional claims, or return as unprocessable paper and electronic institutional claims for ESAs when the most recent hemoglobin or hematocrit test results are not reported.
- When Medicare returns a claim as unprocessable for ESAs with HCPCS codes J0881, J0882, J0885, J0886, or Q4081 for failure to report the most recent hemoglobin or hematocrit test results, it will include Claim Adjustment Reason Code 16 (Claim/service lacks information which is needed for adjudication.) and Remittance Advice Code MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with complete/correct information.)

2. Effective January 1, 2008, all non-ESRD ESA claims billing HCPCS J0881 and J0885 must begin reporting one (**and only one**) of the following three modifiers on the same line as the ESA HCPCS:
    - EA: ESA, anemia, chemo-induced;
    - EB: ESA, anemia, radio-induced; or
    - EC: ESA, anemia, non-chemo/radio
    - Non-ESRD ESA institutional claims that do not report one of the above three modifiers along with HCPCS J0881 or J0885 will be returned to the provider.
    - Non-ESRD ESA professional claims that are billed without one of the three required modifiers as line items along with HCPCS J0881 or J0885 will be returned as unprocessable with reason code 4 and remark code MA130. If more than one modifier is reported, the claim will be returned with reason code 125 and remark code N63.
3. Effective January 1, 2008, all non-ESRD, non-ESA claims billing for the administration of Part B ani-anemia drugs used in the treatment of cancer that are not self-administered must report the most recent hematocrit or hemoglobin reading. Facilities should bill at a frequency that allows for the reporting of the most recent hematocrit or hemoglobin reading prior to the start of the billing period that is applicable to the administrations billed on the claim. For new patients this would be the most recent reading prior to the onset of treatment. Note that a provider may have to submit more than one claim for the month if there were multiple readings that were applicable to the administrations given during the month.
    - Institutional claims that do not report the most recent hematocrit or hemoglobin reading will be returned to the provider.
    - Professional claims that do not report the most recent hematocrit or hemoglobin reading will be returned as unprocessable using Reason Code 16, and Remarks Codes MA130 and N395
    - Your Medicare contractor will not search for claims with dates of service on or after January 1, 2008, processed prior to implementation of this CR, but will adjust such claims when you bring them to the attention of your contractor.

Additional Information
For complete details regarding this CR please see the official instruction (CR5699) issued to your Medicare carrier, FI, DME MAC, CAP Designated Carrier, and A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1412CP.pdf on the CMS web site.

COVERAGE

Platform Crutch Non-Covered Effective April 1, 2008

Effective for dates of service April 1, 2008 and after, E0118, crutch substitute, lower leg platform, with or without wheels, each will be denied as non-covered as this is not deemed a "medical necessity." For dates of service on/after April 1, 2008, E0118 will be denied as supplier liable, unless a valid ABN is obtained and the GA modifier is reported on the claim.

Dates of service prior to April 1, 2008 for E0118 will be paid at the least costly alternative.

Medically Unlikely Edits – Revisited

To reduce the number of denied claims, NAS is analyzing the top reasons for claim denials. This article is in response to denials related to Medically Unlikely Edits (MUEs). In December 2007, MUE denials were identified as one of the top ten denial reasons submitted for redetermination.

The Centers for Medicare & Medicaid Services (CMS) developed MUEs to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a supplier would report under most circumstances for a single beneficiary on a single date of service. MUEs were developed based on Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code descriptors, CPT coding instructions, anatomic considerations, established CMS policies, nature of service/procedure, nature of analyze, nature of equipment and clinical judgment. All edits based on clinical judgment, as well as many others, were reviewed by workgroups of contractor medical directors.

MUEs were implemented January 1, 2007 and are utilized to adjudicate claims at Carriers, Fiscal Intermediaries and DME MACs. Not all HCPCS/CPT codes have an MUE and MUE updates are implemented on a quarterly basis.

DME MACs will deny the entire claim line when units of service are in excess of MUE criteria. DME suppliers receiving denials due to an MUE will receive reason code message N362: "Payment denied or reduced because the payer deems the information submitted does not support this level of service, this many services, this length of services, this dosage, or this day's supply."

If appealing a MUE denial, supporting documentation for the excess units of service should be submitted with the redetermination request. This includes the order for the services and an explanation of why this particular beneficiary needs the excess quantities, including medical documentation.

Additional information regarding MUEs, including Frequently Asked Questions, can be located on the CMS web site at www.cms.hhs.gov/NationalCorrectCodInitEd. Select "Medically Unlikely Edits" on the upper-left side of the page.

Erythropoiesis Stimulating Agents in Cancer and Related Neoplastic Conditions

MLN Matters Number: MM5818
Related Change Request (CR) #: 5818
Related CR Release Date: January 14, 2008
Related CR Transmittal #: R80NCD and R1413CP
Effective Date: July 30, 2007
Implementation Date: April 7, 2008

Provider Types Affected
Providers and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Regional Home Health Intermediaries (RHHI), Medicare Administrative Contractors (A/B MAC) and Durable Medical Equipment Medicare Administrative Contractors (DME MAC)) for administering or supplying Erythropoiesis Stimulating Agents (ESAs) for cancer and related neoplastic conditions to Medicare beneficiaries.

What You Need to Know
Following a National Coverage Analysis (NCA) to evaluate the uses ESAs in non-renal disease applications, the Centers for Medicare & Medicaid Services (CMS), on July 30, 2007, issued a Decision Memorandum (DM) that addressed ESA use in non-renal disease applications (specifically in cancer and other neoplastic conditions).

CR 5818 communicates the NCA findings and the coverage policy in the National Coverage Determination (NCD). Specifically, CMS determines that ESA treatment is reasonable and necessary for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia under specified conditions; and not reasonable and necessary for beneficiaries with certain other clinical conditions, as listed below.

The HCPCS codes specific to non-end-stage renal disease (ESRD) ESA use are J0881 and J0885. Claims processed with dates of service July 30, 2007, through December 31, 2007,do not have to include the ESA modifiers as the modifiers are not effective until January 1, 2008. However, providers are to begin using the modifiers as of January 1, 2008, even though full implementation of related system edits are not effective until April 7, 2008.

Make sure that your billing staffs are aware of this guidance regarding ESA use.

Background
Emerging safety concerns (thrombosis, cardiovascular events, tumor progression, and reduced survival) derived from clinical trials in several cancer and non-cancer populations prompted CMS to review its coverage of ESAs. In so doing, on March 14, 2007, CMS opened an NCA to evaluate the uses of ESAs in non-renal disease applications, and on July 30, 2007, issued a DM specifically narrowed to the use of ESAs in cancer and other neoplastic conditions.

Reasonable and Necessary ESA Use
CMS has determined that ESA treatment for the anemia secondary to a regimen of myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia is reasonable and necessary only under the following specified conditions:

- The hemoglobin level immediately prior to the first administration is < 10 g/dL (or the hematocrit is < 30%) and the hemoglobin level prior to any maintenance administration is < 10g/dL (or the hematocrit is < 30%.);
- The starting dose for ESA treatment is up to either of the recommended Food and Drug Administration (FDA) approved label starting doses for cancer patients receiving chemotherapy, which includes the, 150 U/kg/3 times weekly or the 40,000 U weekly doses for epoetin alfa and the 2.25 mcg/kg/weekly or the 500 mcg once every three week dose for darbepoetin alpha;
- Maintenance of ESA therapy is the starting dose if the hemoglobin level remains below 10 g/dL (or hematocrit is < 30%) 4 weeks after initiation of therapy and the rise in hemoglobin is > 1g/dL (hematocrit > 3%);
- For patients whose hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline over 4 weeks of treatment and whose hemoglobin level remains < 10 g/dL after 4 weeks of treatment (or the hematocrit is < 30%), the recommended FDA label starting dose may be increased once by 25%. Continued use of the drug is not reasonable and necessary if the hemoglobin rises < 1 g/dl (hematocrit rise < 3%) compared to pretreatment baseline by 8 weeks of treatment;
- Continued administration of the drug is not reasonable and necessary if there is a rapid rise in hemoglobin > 1 g/dl (hematocrit > 3%) over any 2 week period of treatment unless the hemoglobin remains below or subsequently falls to < 10 g/dL (or the hematocrit is < 30%). Continuation and reinstitution of ESA therapy must include a dose reduction of 25% from the previously administered dose; and

COVERAGE CONT'D

- ESA treatment duration for each course of chemotherapy includes the 8 weeks following the final dose of myelosuppressive chemotherapy in a chemotherapy regimen.

Not Reasonable and Necessary ESA Use
Either because of a deleterious effect of ESAs on the underlying disease, or because the underlying disease increases the risk of adverse effects related to ESA use, CMS has also determined that ESA treatment is not reasonable and necessary for beneficiaries with the following clinical conditions:

- Any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), or bone marrow fibrosis;
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81);
- Anemia of cancer not related to cancer treatment;
- Any anemia associated only with radiotherapy;
- Prophylactic use to prevent chemotherapy-induced anemia;
- Prophylactic use to reduce tumor hypoxia;
- Erythropoietin-type resistance due to neutralizing antibodies; and
- Anemia due to cancer treatment if patients have uncontrolled hypertension.

Claims Processing
Effective for claims with dates of service on or after January 1, 2008, Medicare will deny non-ESRD ESA services for J0881 or J0885 when:

- Billed with modifier EC (ESA, anemia, non-chemo/radio) when a diagnosis on the claim is present for any anemia in cancer or cancer treatment patients due to folate deficiency (diagnosis code 281.2), B-12 deficiency (281.1 or 281.3), iron deficiency (280.0-280.9), hemolysis (282.0, 282.2, 282.9, 283.0, 283.2, 283.9, 283.10, 283.19), bleeding (280.0 or 285.1), anemia associated with the treatment of acute and chronic myelogenous leukemias (CML, AML) (205.00-205.21, 205.80-205.91), or erythroid cancers (207.00-207.81).
- Billed with modifier EC for any anemia in cancer or cancer treatment patients due to bone marrow fibrosis, anemia of cancer not related to cancer treatment, prophylactic use to prevent cancer-induced anemia, prophylactic use to reduce tumor hypoxia, erythropoietin-type resistance due to neutralizing antibodies, and anemia due to cancer treatment if patients have uncontrolled hypertension.
- Billed with modifier EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anticancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported.
- Billed with modifier EB (ESA, anemia, radio-induced).

Note: Denial of claims for non-ESRD ESAs for cancer and related neoplastic indications as outlined in NCD 110.21 are based on reasonable and necessary determinations. A provider may have the beneficiary sign an Advance Beneficiary Notice (ABN), making the beneficiary liable for services not covered by Medicare. When denying ESA claims, contractors will use Medicare Summary Notice 15.20, *The following policies [NCD 110.21] were used when we made this decision, and remittance reason code 50, These are non-covered services because this is not deemed a `medical necessity' by the payer*. However, standard systems shall assign liability for the denied charges to the provider unless documentation of the ABN is present on the claim. Denials are subject to appeal and standard systems shall allow for medical review override of denials. Contractors may reverse the denial if the review results in a determination of clinical necessity.

Medicare contractors have discretion to establish local coverage policies for those indications not included in NCD 110.21

Medicare Contractors shall not search files to retract payment for claims paid prior to April 7, 2008. However, contractors shall adjust claims brought to their attention.

Additional Information
This addition/revision of section 110.21 of Pub.100-03 is an NCD. NCDs are binding on all carriers, FIs, quality improvement organizations, qualified independent contractors, the Medicare Appeals Council, and administrative law judges (ALJs) (see 42 CFR section 405.1060(a)(4) (2005)). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an ALJ may not review an NCD. (See section 1869(f)(1)(A)(i) of the Social Security Act.)

The official instruction, CR5818, was issued to your contractor in two transmittals. The first is the NCD transmittal and that is available at http://www.cms.hhs.gov/Transmittals/downloads/R80NCD.pdf on the CMS web site. The second transmittal revises the *Medicare Claims Processing Manual* and it is at http://www.cms.hhs.gov/Transmittals/downloads/R1413CP.pdf on the same site.

Nebulizer Drug Non-Covered Denials-Claim Adjustment Update

Suppliers were notified via the NAS DME web site on 1/16/08 that some nebulizer claims and corresponding dispensing fees for inhalation drugs were recently denied in error and that the claims would be adjusted. **NAS will be adjusting these claims during the week of February 4 and we anticipate that many of these claims will be finalized and payment issued by the end of this week.** Some claims may suspend for other type of editing and will take additional time to finalize. We appreciate your patience as we complete these claim adjustments.

Below is the 1/16/08 posting which describes the claim denials:
Some suppliers billing for nebulizer drugs may have received denials that the drugs are not covered, in error. NAS notified suppliers of this through a web posting on NAS recently implemented system changes to ensure that the beneficiary had a nebulizer code on file or a comment stating that the patient owns the nebulizer, in order to pay for all nebulizer drugs. In implementing this system logic on December 20, 2007, we missed looking for one type of information in the claims processing system. This oversight was corrected on January 10 and NAS will be adjusting the claims that denied in error due to this oversight. We will be adjusting claims with dates of service 7/1/07-1/10/08.

Suppliers should be aware that if a second non-covered nebulizer drug denial is received in **mid-late January** that this is a valid denial. (Claims that have been adjusted will have an ICN that ends in 001, rather than 000). This means that there was no evidence in the patient's claim history or on the claim submitted that the beneficiary has a nebulizer to administer these drugs. In this situation, suppliers should submit a written reopening asking for the claim to be reprocessed, along with documentation showing that the patient was receiving the drugs via a nebulizer. If the patient owns their nebulizer and therefore a nebulizer code was not ever billed to Medicare or if another insurance company paid for the nebulizer in the past, please include documentation that explains the situation, along with the purchase date, make/model and serial # of the nebulizer.

Dispensing fees for inhalation drugs, HCPCS Q0513 and Q0514, will also be adjusted automatically by NAS, if denied because the corresponding drug was denied in error, due to the issue described above.

Resubmit J7609, J7615 and J7645 Claims Denied with DOS Prior to 7/1/07

NAS is notifying suppliers that codes J7609 (**Albuterol**, inhalation solution, compounded product, administered through DME, unit dose, 1 mg), J7615 (**Levalbuterol**, inhalation solution, compounded product, administered through DME, unit dose, 0.5 mg) and J7645 (**Ipratropium bromide**, inhalation solution, compounded product, administered through DME, unit dose form, per milligram) may have been denied in error for dates of service prior to 7/1/07. The denial message was CO-204 (this service/equipment/drug is not covered under the patient's current benefit plan). **Note**: These codes are only covered from 1/1/07-6/30/07.

When NAS identified the total universe of claims denied in error in late September, most suppliers had already resubmitted the denied claims, however we wanted to make all suppliers aware of this situation so any remaining denied claims can be resubmitted. Suppliers will also want to determine if the dispensing fee codes for these inhalation drugs, G0333, Q0513 and Q0514 also denied due to the corresponding drug being denied and resubmit any such claims.

We apologize for the delay in this communication and for the inconvenience caused by these erroneous denials.

Possible Duplicate Payments for Q4093 and Q4094

NAS inadvertently allowed the claims processing system to potentially pay twice for the drugs Q4093 and Q4094, once when submitted with the code alone and once with the code submitted along with the KO, KP or KQ modifiers. This occurred during the timeframe of 7/1/07-8/29/07.

Many suppliers have already refunded these duplicate payments, but we wanted to inform our supplier community of this situation so all suppliers can check their records for duplicate payments. The suppliers with the largest number of these claims submitted during this timeframe were mailed at letter notifying them of this situation on February 4, 2008.

Please review your records to determine if there were any duplicate payments for these drugs. If a refund is required, complete the Refunds to Medicare form, located at www.noridianmedicare.com/dme/forms/docs/ref_med_dme.pdf

For more information on billing codes Q4093 and Q4094, reference the article titled "Correct Billing for Q4093 and Q4094", posted on our DME web site, www.noridianmedicare.com, on 9/18/07.

We apologize for any duplicate payments you may have received and the work involved in refunding the duplicate payment.

Adjudicating Claims for Immunosuppressive Drugs When Medicare Did Not Pay for the Original Transplant

MLN Matters Number: MM5916
Related Change Request (CR) #: 5916
Related CR Release Date: February 15, 2008
Related CR Transmittal #: R1448CP
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Provider Types Affected
Suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for immunosuppressive drugs.

What You Need to Know
CR 5916, from which this article is taken, implements an automated process for adjudicating claims for immunosuppressive drugs when the beneficiary was enrolled in Medicare Part A at the time of their transplant, even though Medicare did not pay for the transplant.

Make sure that your billing staffs are aware that you must be able to document the date of the patient's transplant, and must include the "KX" Modifier on the claim to attest that you have documentation on file that proves that the beneficiary had the transplant for which the immunosuppressive drug was prescribed while the beneficiary was enrolled in Medicare Part A.

Background
Medicare covers a beneficiary's immunosuppressive drugs following an organ transplant, provided that the beneficiary receiving the drug was enrolled in Medicare Part A at the time of the organ transplant procedure. Moreover, Medicare will pay for medically necessary immunosuppressive drugs for such a beneficiary whether or not Medicare paid for the transplant itself.

Prior to April of 2006, the Durable Medical Equipment (DME) Regional Carriers (DMERCs) received information about the date of a beneficiary's transplant through a DMERC Information Form (DIF), which included a field in which the supplier could enter a transplant date. However, on February 17, 2006, the Centers for Medicare & Medicaid Services (CMS) issued Transmittal 867, Change Request (CR) 4241, which: 1) eliminated the DIF; and 2) implemented an edit at the Medicare's Common Working File (CWF) system to search the Medicare's Master Beneficiary Record (MBR) for a transplant upon receipt of a claim for an immunosuppressive drug. If the CWF system does not find evidence of a transplant in the MBR, the claim line for immunosuppressive drug is rejected.

Because CWF does not have a transplant record for a beneficiary if Medicare did not actually pay for the procedure, the DME Medicare Administrative Contractors (DME MACs) have been inappropriately denying claims even when such beneficiaries were enrolled in Medicare Part A at the time of their transplant.

To resolve this issue, CR 5916, from which this article is taken, implements an automated process for adjudicating claims for immunosuppressive drugs when the beneficiary was enrolled in Medicare Part A at the time of their transplant, but Medicare did not pay for the transplant.

Specifically, CR 5916 requires that:

- For claims filed on and after July 1, 2008, suppliers who furnish an immunosuppressive drug to a Medicare beneficiary (in association with a previous organ transplant): 1) Secure from the prescriber the date of the organ transplant, 2) Retain documentation of the transplant date in its files, and 3) Annotate the Medicare claim for the drug with the "KX" modifier to signify both that the supplier retains the documentation of the beneficiary's transplant date and that the transplant date precedes the Date of Service (DOS) for furnishing the drug.
- For claims received on and after July 1, 2008, DME MACs will accept claims for immunosuppressive drugs without a KX modifier but will deny such claims if the MBR shows that Medicare has made payment for an organ transplant on a date that precedes the date of service (DOS) of the immunosuppressive drug claim.

Suppliers should note that the use of the KX modifier, in the context of a claim submitted to Medicare in order to receive payment for an immunosuppressive drug, signifies that the supplier attests that it has on file documentation that the beneficiary has undergone an organ transplant on a particular date while enrolled in Medicare Part A and that the immunosuppressive drug has been prescribed associated with that transplant.

A supplier who has not determined (or does not have documentation on file to support a determination) that the beneficiary either did not receive an organ transplant, or was not enrolled in Medicare Part A as of the date of the transplant; may not: 1) Bill Medicare for furnishing an immunosuppressive drug, 2) bill or collect any amount from the beneficiary for such a drug, or 3) issue an Advance Beneficiary Notice (ABN) to the beneficiary.

Additional Information
The official instruction, CR 5916, issued to your DME MAC is available at http://www.cms.hhs.gov/Transmittals/downloads/R1448CP.pdf on the CMS web site. The revised *Medicare Claims Processing Manual*, Chapter 17 (Drugs and Biologicals), Section 80.3 (Billing for Immunosuppressive Drugs) is an attachment to that CR.