Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

August 2007
Issue No. 6

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.

In This Issue…

FRAUD/ABUSE

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Alphabetical Listing...

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 8 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

Mailing Addresses	
Claims, Redetermination Requests and Correspondence Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727	**Benefit Protection** Noridian Administrative Services Benefit Protection – DME PO Box 6736 Fargo ND 58108-6736
Electronic Funds Transfer Forms Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728	**Electronic Data Interchange** CIGNA Government Services Attn: DMERC EDI PO Box 690 Nashville TN 37202
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737 Fax: 888-523-8449	**Program Safeguard Contractor** Medical Review IntegriGuard, LLC 2121 N 117 Avenue Suite 200 Omaha NE 68164 Fax: 402-498-2306

Reconsiderations and Administrative Law Judge Requests	
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 for 2007

Labor Day	September 3, 2007
Columbus Day*	October 8, 2007
Veterans Day*	November 12 (Observed)
Thanksgiving	November 22 and 23
Christmas Day	December 24 and 25

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 but the Contact Center will be closed and will not be receiving incoming calls. On those days, Contact Center staff will be attending internal training, but you may receive calls from our staff about claims processing or education.

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 Online Supplier Manual. The content is ordered with the most current changes appearing on top.

Chapter	Subheading	Supplier Manual Update	Change Date
Chapter 16	Modifiers	Added KL modifier effective July 1, 2007	6/25/07
Chapter 15	DME MACs	Updated Jurisdiction C contact information and states served	6/5/07
Chapter 16	Level II HCPCS Codes	Deleted J codes effective July 1, 2007	6/5/07
Chapter 16	Level II HCPCS Codes	Added Q codes effective July 1, 2007	6/5/07

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

Disclosure of Protected Health Information

In order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, NAS will authenticate your identity prior to disclosure of protected health information.

Be prepared to supply validating information when requesting protected health information in order to protect the privacy of Medicare beneficiaries as indicated below:

Supplier Contact Center: Supplier number and supplier name.

Interactive Voice Response System: Supplier number.

Written Inquiries: Supplier number and supplier name or supplier official letterhead.

Regardless of the type of inquiry, NAS will also authenticate the following elements before disclosing beneficiary information:

- Last name **(including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)**;
- First name or initial;
- Health Insurance Claim Number;
- Either date of birth (eligibility, next eligible date, CMN/DIF [pre-claim]) **or** date of service (claim status, CMN/DIF [post-claim])

For more information, refer to *MLN Matters* Article 5089 at: www.cms.hhs.gov/MLNMattersArticles/downloads/MM5089.pdf.

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (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."

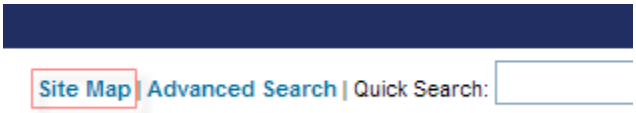
EDUCATIONAL

Website Changes-Site Map, Navigation, Coverage and Accessibility Help

Site Map

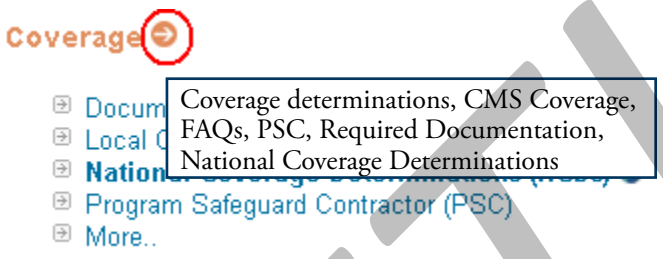
Improved navigation has been added to the NAS Medicare DME supplier website, www.noridianmedicare.com. Suppliers can now more easily locate the Site Map, view expanded category contents listing and receive "accessibility help" for site visitors with disabilities and/or diverse technology.

The SiteMap, or textual index of the website content, has been alphabetized within each related category for user convenience. This comprehensive listing is now available on every page in the top-right hand corner near the "Search" tool as well as within the Contact section of the site.



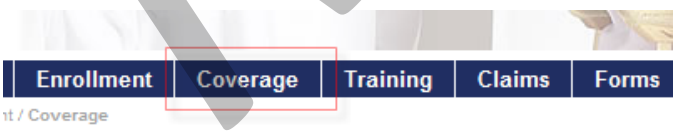
Improved Navigation

Using your mouse, hover over the arrow image next to a category title to see a listing of contents. Clicking the arrow will take you directly to that categories homepage.



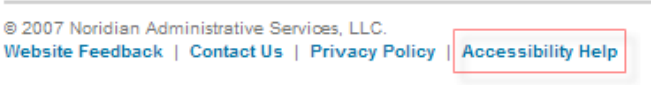
Coverage Section

The coverage page provides access to the Local Coverage Determinations (LCDs), Policy Articles, and National Coverage Determinations (NCDs) that are applied to DMEPOS claims processed by NAS. This page also contains information about the Program Safeguard Contractor and links to the LCD documentation requirements and the CMS DMEPOS coverage manuals. The coverage page can be accessed by selecting any of the "coverage" links from the NAS homepage, or by selecting "Coverage" from the main navigation bar near the top of each page.



Accessibility Help

Because our site visitors use a broad range of Web technologies (screen readers, dial-up connections, older browsers, web-enabled phones and Personal Digital Assistants), NAS has added "Accessibility Help" information within the footer of our site to assist our supplier community as they access and view our site. Information is provided on assistance with file formats and plug-ins, customizing the NAS site (i.e., how to make text larger, magnify your screen, change the font, font color and background color) and site navigation and keyboard shortcuts.



NAS appreciates the feedback our supplier community offers through the "Website Feedback" link on each web page, as well as through the online survey by ForeSee Results coordinated at the request of CMS.

Ask the Contractor Teleconference for Small Suppliers

NAS is pleased to announce our upcoming schedule of **small supplier** teleconferences for 2007. CMS has defined a small supplier as a supplier with ten or fewer full time equivalent employees. We will be continuing with our current format of brief opening remarks followed by the question and answer (Q&A) session.

If you have a question on your mind and are not sure who to ask - this teleconference is your opportunity to speak directly to your contractor. Knowledgeable NAS staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and then call you with the answer.

Following the teleconference the questions and answers (Q&A) from the teleconference will be posted to our web site. You can view the Q&A from the NAS home page by choosing Durable Medical Equipment > Training > Schedule of Events > Ask the Contractor Questions & Answers.

To participate in this ACT for **small suppliers**, dial 1-800-700-8174. For those suppliers who may need an international number (American Samoa, Guam or the Northern Mariana Islands) dial 1-651-291-0278.

After placing the call you will be asked to provide the following:

- Conference Name: DME Jurisdiction D Ask the Contractor Teleconference
- Your name
- Name of the organization you represent
- State from which you are calling

Note: The teleconference will start promptly at 3:00 pm CT and will last up to 90 minutes. NAS encourages participants to place the call 15 minutes prior to the start of the teleconference.

Upcoming teleconferences for **small suppliers** will be held at 3:00 pm CT on:

- August 22, 2007
- October 24, 2007
- December 19, 2007

NAS looks forward to your participation in these **small supplier** teleconferences.

Upcoming Ask the Contractor Teleconferences

NAS is pleased to announce our upcoming schedule of teleconferences for 2007. We will be continuing with our current format of brief opening remarks followed by the question and answer session.

If you have a question on your mind and are not sure who to ask - this teleconference is your opportunity to speak directly to your contractor. Knowledgeable NAS staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and then call you with the answer.

Following each teleconference the questions and answers (Q&A) for the teleconference will be posted to our web site. You can view the Q&A from the NAS home page by choosing Durable Medical Equipment > Training > Schedule of Events > Ask the Contractor Questions and Answers.

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After placing the call you will be asked to provide the following:

- Conference Name: DME Jurisdiction D Ask the Contractor Teleconference
- Your name
- Name of the organization you represent
- State from which you are calling

Note: Each teleconference will start promptly at 3:00 pm CT and will last up to 90 minutes. NAS encourages participants to place the call 15 minutes prior to the start of the teleconference.

The remaining teleconferences for 2007 will be held at 3:00 pm CT on:

- September 11, 2007
- December 11, 2007

NAS looks forward to your participation in these ask the contractor teleconferences.

Medicare Learning Network Web-Based Training Courses

Two web-based training courses offered by CMS on Fraud and Abuse and the CMS Form 1500 have recently been revised.

The Fraud and Abuse web-based training course provides information that will increase awareness of Medicare fraud and abuse including what constitutes Medicare fraud and abuse, providers' role in the effort to prevent fraud and abuse, possible penalties when fraud or abuse is committed and protective measures providers can implement to avoid fraud and abuse in several key areas of their organization.

The CMS Form 1500 (08-05) web-based training course provides information that will allow you to file claims accurately and reduce your chances of received "unprocessable claim" rejections. In this course, the CMS 1500 (08-05) is used to teach the learner about claim requirements for the paper form.

These courses are available with continuing education credits and can be accessed through the web-based training module link at www.cms.hhs.gov/MLNProducts.

News From the Medicare Learning Network

Want to know when the latest Medicare Learning Network (MLN) products are available? By subscribing to the ***MLN_EDUCATION_PRODUCTS-L listserv*** you will receive e-mail notifications of new and updated MLN products. To subscribe to the ***MLN_EDUCATION_PRODUCTS-L listserv*** or to any of the many other CMS listservs, go to the CMS Mailing Lists web page at http://www.cms.hhs.gov/apps/mailinglists/ and sign up today.

CMS Extending Bid Submission, Registration and Accreditation Deadlines for First Round of Medicare DMEPOS Competitive Bidding Program

Please note: All bids are now due by 9:00 p.m. prevailing Eastern Time on September 25, 2007. Suppliers that have already submitted their bids may revise and resubmit their bids until the new deadline. Suppliers that resubmit bids must submit a new certification statement.

- On May 15, 2007, CMS issued a request for bids for the first round of the Medicare DMEPOS competitive bidding program. The original due date was 9:00 p.m. prevailing Eastern Time on July 13, 2007. *All bids are now due by 9:00 p.m. prevailing Eastern Time on September 25, 2007.*
- Suppliers interested in bidding must first register and receive a User ID and Password before they can access the internet-based bid submission system. Registration opened on April 9, 2007. The original registration deadline was June 30, 2007. CMS has reopened registration. *The registration deadline is now August 27, 2007.*
- Suppliers must be accredited or be pending accreditation to submit a bid and will need to be accredited to be awarded a contract. The accreditation deadline for the first round of competitive bidding was originally August 31, 2007. *The accreditation deadline is now October 31, 2007.*

COMPETITIVE BIDDING CONT'D

- CMS is revising the contract periods. The original contract period for mail order diabetic supplies was April 1, 2008 – December 31, 2009. The contract period for all other first round product categories was April 1, 2008 – March 31, 2011. *The contract period for mail order diabetic supplies is now July 1, 2008 – March 31, 2010. The contract period for all other first round product categories is now July 1, 2008 – June 30, 2011.*
- CMS is providing a targeted period to address suppliers' remaining questions on the competitive bidding program. To help ensure that answers are available as soon as possible, please e-mail your questions to the Competitive Bidding Implementation Contractor (CBIC) no later than August 10, 2007. The e-mail address is cbic.admin@palmettogba.com.
- There are revised customer service hours at the Competitive Bidding Implementation Contractor (CBIC). Effective immediately, the CBIC help desk will be available to assist you from 9 a.m. until 9 p.m. EST, Monday through Friday. You may call the help desk at 877-577-5331.

For more information on the program, please visit http://www.dmecompetitivebid.com.

Pre-Bidding Activities for the Medicare DMEPOS Competitive Bidding Program

MLN Matters Number: SE0714 Revised

Note: This article was changed on July 9, 2007 to add a link to a related DMEPOS Competitive Bidding article SE0717 on page 3. All other information remains the same.

Provider Types Affected

All suppliers of durable medical equipment (DME) that wish to participate in the Medicare DMEPOS competitive bidding program.

Provider Action Needed

This Special Edition (SE) article, SE0714, outlines the pre-bidding activities that DME suppliers need to follow in order to participate in the Medicare DMEPOS Competitive Bidding Program.

Background

Providers and suppliers that furnish certain DMEPOS to Medicare beneficiaries under Medicare Part B will have an opportunity to participate in a competitive acquisition program (the "Medicare DMEPOS Competitive Bidding Program"). This program will improve the accuracy of Medicare's payments for certain DMEPOS, reduce beneficiary out-of-pocket expenses, and save the Medicare program money while ensuring beneficiary access to quality DMEPOS items and services.

To assist with the DMEPOS Competitive Bidding Program, CMS awarded a contract to Palmetto GBA to serve as the Competitive Bidding Implementation Contractor (CBIC) for program implementation and monitoring.

As the DMEPOS Competitive Bidding Program progresses, suppliers may want to view the final rule governing the program, which is available at http://www.cms.hhs.gov/quarterlyproviderupdates/downloads/cms1270f.pdf on the CMS Web site. In addition, you may want to visit http://www.cms.hhs.gov/competitiveacqfordmepos for more complete information on the program and the process whereby suppliers can bid and participate.

There are other *MLN Matters* articles on the program. These articles are discussed briefly in the "Additional Information" section of this article.

Basic Instructions

All suppliers submitting a bid must:

- Be in good standing and have an active National Supplier Clearinghouse number (NSC#);
- Meet any local or State licensure requirements, if any, for the item being bid;
- Be accredited or be pending accreditation. CMS cannot accept a bid from any supplier that is not accredited or that has not applied for accreditation. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. (For a listing of CMS-approved accrediting organizations, please visit http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf on the CMS Web site. *MLN Matters* article SE0713 provides additional information on accreditation and is located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/13.pdfSE07; and
- Complete initial registration in the internet application (Individuals Authorized Access CMS computer Services, IACS) to get a USER ID and password. Suppliers need to complete this initial registration process early to avoid delays in being able to submit bids. The initial registration process requires the **authorized official**, as identified in Section 15 of the CMS 855S, to complete the information required in the internet application. The authorized official's information must match the information on file at the National Supplier Clearinghouse. To complete this initial registration and obtain a USER ID and password, please go to https://applications.cms.hhs.gov.

All suppliers submitting a bid should:

- Review MLN Matters article SE0717, Initial Supplier Registration for Competitive Bidding Program is Now Open, which provides important information about the registration process. SE0717 can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/17.pdfSE07 on the CMS website;
- Review the information in the Bid Application Tool Kit to facilitate a better understanding of the bidding process and rules. This information is located on the CBIC Web site at http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersBid%20Application%20Tool%20Kit;

- View the educational webcast to learn more about the Medicare DMEPOS Competitive Bidding Program and detailed information on the bid application process. This information is located on the CBIC Web site at http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersEducational%20Tools; and
- CMS encourages you to register to receive updates on the Competitive Bidding Program. You may do so by going to http://www.cms.hhs.gov/apps/mailinglists/ on the Web.

Additional Information

The CMS complete listing of all DME resources is available at http://www.cms.hhs.gov/center/dme.asp on the CMS Web site. A background review of the rationale for this program is at http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DME_sum.pdf on the CMS Web site.

MLN Matters article SE0713, *Accreditation Information for Suppliers of Durable Medical Equipment, Orthotics, Prosthetics, and Supplies (DMEPOS)*, **relates to** this article and provides an overview of the Medicare Modernization Act legislation and how it impacts this competitive bidding program. It also outlines the quality standards for suppliers, describes the status of accreditation, and provides the web addresses of the ten accrediting organizations. SE0713 can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/13.pdfSE07 on the CMS website.

Another article, MM5574, provides more overview information regarding the DMEPOS Competitive Bidding Program and that article is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf on the CMS site.

Home Health Agencies Providing DME in Competitive Bidding Areas

MLN Matters Number: MM5551 Revised
Related Change Request (CR) #: 5551
Related CR Release Date: May 22, 2007
Related CR Transmittal #: R1246CP
Effective Date: April 1, 2008
Implementation Date: April 1, 2008

Note: This article was revised on May 22, 2007, to reflect changes made as CMS revised CR5551 on May 22. The effective date, implementation date, transmittal number, CR release date, and Web address for accessing CR5551 were changed. All other information remains the same.

Provider Types Affected

All HHAs billing Medicare contractors (Fiscal Intermediaries (FIs) or Regional Home Health Intermediaries (RHHIs)) for DME provided to Medicare beneficiaries.

Provider Action Needed

HHAs that furnish DME and are located in one of the competitive bidding areas for DME where the DME items are subject to the competitive bidding program, must be either awarded a contract to furnish the items in this area or use a DME supplier who does have a contract with Medicare for such DME items.

The competitive bidding items are identified by HCPCS codes and the competitive bidding areas are identified based on ZIP codes of the permanent residence of the beneficiary receiving the items. Further, the RHHIs will not process claims with affected HCPCS codes for competitive bid DME items. Such claims will be returned to the HHA for removal of the DME line items and appropriate submission of those items to DME Medicare Administrative Contractors (DME MACs).

HHAs should read the remainder of this article for important information regarding the new 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) 5551 provides general guidelines for processing HHA claims. Beginning in 2007, in a competitive bidding area, a supplier must be awarded a contract by the Centers for Medicare & Medicaid Services (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 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.

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.

Attached to CR5551 is a list of the HCPCS codes and zip codes applicable to the competitive bidding areas. (See *Additional Information* section of this article for the web address of CR 5551)

Additional Information

For information on registering to compete for a DME contract in the competitive bidding areas, see the MLN Matters article titled "Initial Supplier Registration for

COMPETITIVE BIDDING CONT'D

Competitive Biding Program is Now Open", which is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0717.pdf on the CMS website.

For complete details regarding this Change Request (CR) please see the official instruction (CR5551) issued to your Medicare RHHI, FI, or DME MAC. This instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1246CP.pdf on the CMS website.

NPI

Dissemination of Data from NPPES to Begin September 4, 2007

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

UPDATE!

The National Plan and Provider Enumeration System (NPPES) health care provider data that are disclosable under the Freedom of Information Act (FOIA) will be disclosed to the public by the Centers for Medicare & Medicaid Services (CMS). In accordance with the e-FOIA Amendments, CMS will be disclosing these data via the Internet. Data will be available in two forms:

1. A query-only database known as the NPI Registry.
2. A downloadable file.

CMS is extending the period of time in which enumerated health care providers can view their FOIA-disclosable NPPES data and make any edits they feel are necessary prior to our initial disclosure of the data.

We must build in time to resolve any errors or problems that may be encountered with edits that health care providers submit. Therefore, in order to ensure edits are reflected in the NPI Registry when it first becomes operational and in the first downloadable file, health care providers need to submit their edits no later than Monday, August 20, 2007. Health care providers who submit edits on paper need to ensure that they are mailed in time for receipt by the NPI Enumerator by that date.

CMS will be making FOIA-disclosable NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry will become operational on September 4 and the downloadable file will be ready approximately one week later.

Health care providers should refer to the document entitled, "Information on FOIA-Disclosable Data Elements in NPPES," dated June 20, 2007 (found on the CMS NPI web page at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf) for assistance in making their edits. Some of the key data elements that are FOIA-Disclosable are:

- NPI
- Entity Type Code (1-Individual or 2-Organization)
- Replacement NPI
- Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), OR the Legal Business Name for Organizations)
- Provider Other Name (First Name, Middle Name, Last Name, OR 'Doing Business As' Name, Former Legal Business Name, Other Name. for Organizations)
- Provider Business Mailing Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Provider Business Location Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Healthcare Provider Taxonomy Code(s)
- Other Provider Identifier(s)
- Other Provider Identifier Type Code
- Provider Enumeration Date
- Last Update Date
- NPI Deactivation Reason Code
- NPI Deactivation Date
- NPI Reactivation Date
- Provider Gender Code
- Provider License Number
- Provider License Number State Code
- Authorized Official Contact Information (First Name, Middle Name, Last Name, Title or Position, Telephone Number)

The delay in the dissemination of NPPES data does not alter the requirement that HIPAA covered entities must comply with the requirements of the NPI Final Rule no later than May 23, 2008. All NPI contingencies that may be in place must be lifted by that date.

Still Confused?

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 website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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

NPI CON'TD

Provider Education for Handling Issues Related to Deceased Providers

MLN Matters Number: MM5508 Revised
Related Change Request (CR) #: 5508
Related CR Release Date: March 30, 2007
Related CR Transmittal #: R1216CP
Effective Date: May 23, 2007
Implementation Date: April 30, 2007

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

Provider Types Affected

Those submitting claims on behalf of physicians and providers who died before obtaining a National Provider Identifier (NPI), where such submitted claims that were received by a Medicare contractor (carrier, Part A/B Medicare Administrative Contractors (A/B MAC), durable medical equipment (DMERC) and/or DME Medicare Administrative Contractors, (DME/MAC)) after May 23, 2007.

Background

This article and related Change Request (CR) 5508 addresses NPI issues related to deceased providers. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Secretary of the Department of Health and Human Services adopt standards providing for a standard unique health identifier for each health care provider for use in the healthcare system and to specify the purpose for which the identifiers may be used.

All entities covered under HIPAA must comply with the requirements of the NPI final rule no later than May 23, 2007. Among these requirements are the following:

- Any health care provider who is an entity covered under HIPAA must obtain an NPI.
- Health care providers meeting the definition of health care provider referenced in the NPI final rule but not covered entities are eligible to obtain NPIs as well.
- Health care providers covered under HIPAA must use NPIs to identify themselves and their subparts (if applicable) on all standard transactions adopted under HIPAA.

Because deceased providers may not have NPIs, this article discusses what representatives of those providers need to do in order to submit claims that need to be paid.

Key Points of CR5508

If an individual provider dies before obtaining an NPI, the following apply:

- If a provider dies before obtaining an NPI and claims for that provider are received by a Medicare contractor after May 23, 2007, and Medicare (the Medicare contractor, the **Medicare Online Survey and Certification Reporting System (OSCAR), of the National Supplier Clearinghouse (NSC)) has not been notified of the death, the claims will reject when received by Medicare due to the absence of the provider's NPI.**
- At that point, the claim submitter would be expected to contact the Medicare contractor to which the claims were submitted to discuss payment of the claims and report the provider's death. **Toll free number of the Medicare contractors are available at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.**
- The State in which a provider furnishes care will continue to be responsible for notification of Medicare of the death of a provider following existing procedures. Since some States send such notifications on a quarterly basis, CMS is implementing the following procedures to enable affected claims to be paid more promptly:
    - Because Medicare will reject an electronic claim received without an NPI after May 23, 2007, in cases where the provider died prior to obtaining an NPI, the provider's representative will need to submit the claim on paper.
    - A representative of the estate should then contact the claims processing contractor, who will notify the provider that they must submit the claims on paper and that they must annotate the claim to state that the provider is deceased in Item 19.

Additional Information

You may view the official instruction (CR5508) issued to your Medicare carrier, DME/MAC, DMERC and/or A/B MAC by going to http://www.cms.hhs.gov/Transmittals/downloads/R1216CP.pdf on the CMS website.

CLAIM FORM

Deadline for Use of CMS 1500 (12-90) Claim Form

Per Change Request 5616, Medicare contractors cannot accept CMS-1500 Claim Form version (12-90) after July 1, 2007. The only acceptable claim form will be the CMS-1500 Claim Form version (08-05). The last day NAS will accept CMS-1500 Claim Forms version (12-90) is June 29, 2007. **All claims submitted to NAS on the CMS-1500 Claim Form version (12-90) and received after June 29, 2007 will not be processed. Therefore, NAS is recommending that you cease mailing this form June 25, 2007.**

For more information on how to correctly submit a CMS-1500 (08-05) claim form, refer to the CMS-1500

CLAIM FORM CONT'D

Claim Form (08-05) interactive tutorial located on the Noridian Administrative Services (NAS) website at: www.noridianmedicare.com. To access the tutorial, select the "Claims" tab from the drop down box beneath DME on the NAS homepage. The tutorial is listed beneath the "Claims Filing Information" subtitle in the left hand column.

To use the tutorial, place the cursor over any item on the form and the instructions for completing the item will appear. You may also select any item with the cursor for more detailed instructions.

MODIFIERS

Proper Use of GY, GA and GZ Modifiers

Noncovered Items - GY Modifier

The GY modifier was established to describe situations in which an item with a specific HCPCS code is non-covered.

GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit

It is important to distinguish situations in which an item is denied because it is statutorily excluded or does not meet the definition of any Medicare benefit from those situations in which an item is denied because it is not reasonable and necessary. Some examples of statutorily excluded items or situation include, but are not limited to:

- Hearing aids
- Eyeglasses or contact lenses, except those provided following cataract removal or other cause of aphakia
- Durable medical equipment and related accessories and supplies provided to patients in nursing facilities
- Dental items
- Personal comfort items
- Orthopedic shoes or shoe inserts, other than those covered under the therapeutic shoes for persons with diabetes benefit or those that are attached to a covered leg brace

Some examples of items or situations that do not meet the definition of a Medicare benefit include, but are not limited to:

- Parenteral or enteral nutrients that are used to treat a temporary (rather than permanent) condition
- Enteral nutrients that are administered orally
- Infusion drugs that are not administered through a durable infusion pump
- Surgical dressings that are used to cleanse a wound, clean intact skin, or provide protection to intact skin
- Immunosuppressive drugs used for conditions other than following organ transplants
- Durable items that are not primarily designed to serve a medical purpose, e.g., exercise equipment

Use of the GY modifier is usually limited to situations in which there is a specific HCPCS code to describe the item. If there is no specific HCPCS code to describe the item, then code A9270 (Noncovered item or service) is usually used. The GY modifier should generally not be used with a "miscellaneous" or "not otherwise classified" codes. e.g., E1399. The GY modifier is not needed with code A9270. Code A9270 must not be used in situations in which an item is expected to be denied as not reasonable and necessary.

An Advance Beneficiary Notice (ABN) is not required for items that are statutorily excluded from coverage or that do not meet the definition of any Medicare benefit category since the DME MAC does not make limitation of liability determinations for these types of denials.

Not Medically Necessary Items - GA/GZ Modifiers

The GZ modifier was established to describe certain situations in which an item or service is expected to be denied as not medically necessary and an ABN was not obtained or properly obtained. The GA modifier is used in other situations in which an item or service is expected to be denied as not medically necessary and an Advance Beneficiary Notices has been properly executed.

GZ - Item or service expected to be denied as not reasonable and necessary (Used when an Advance Beneficiary Notice **is not** on file)

GA - Waiver of liability statement on file (Used when an item or service is expected to be denied as not reasonable and necessary and an Advance Beneficiary Notice **is** on file)

It is important to distinguish situations in which an item is denied because it is not reasonable and necessary from those situations in which an item is denied because it is statutorily excluded or does not meet the definition of any Medicare benefit. Some examples of items or situations that are medically necessity denial include, but are not limited to:

- Items which are not ordered by a physician or qualified nurse practitioner, clinical nurse specialist, or physician assistant
- Items which do not meet medical necessity coverage criteria or frequency guidelines specified in national coverage or local coverage determination (LCD)
- Items which are the same as or similar to covered items that the beneficiary is already using
- Items whose safety and effectiveness in the home setting has not been established
- Experimental or investigational items

A GZ or GA modifier can be used on either a specific or a miscellaneous HCPCS code.

It would never be correct to place any combination of GY, GZ or GA modifiers on the same claim line. If these modifiers are used on the same claim line, it will be rejected or denied for invalid coding.

The *Winter 2005 DMERC Dialogue*, references when the GY and GA modifiers should be used when billing for infusion therapy services. This is a common question

asked by suppliers so please reference this article for additional information on this topic.

Important Note: The DME MAC and DME PSC monitor the utilization and proper usage of modifiers. Suppliers may ensure that modifiers are only used when appropriate and that all required supporting documentation is available upon request. This is especially true for usage of the GY modifier.

KL Modifier-Diabetic Supplies Delivered via Mail

Effective for claims with dates of service on or after July 1, 2007, the KL modifier should be used on claims for all diabetic supplies that are delivered via mail.

This applies to the HCPCS codes A4233, A4234, A4235, A4236, A4253, A4256, A4258 and A4259. The KL modifier should be used with diabetic supplies that are ordered remotely (i.e., by phone, email, Internet or mail) and delivered to the beneficiary's residence by common carriers (e.g., U.S. postal service, Federal Express, United Parcel Service) and not with items obtained by beneficiaries from local supplier storefronts.

See MLN Matters 5641 for complete CMS instruction.

Modifiers for DME Services

Several DME categories and frequently used modifiers are listed below. Chapter 16 of the Jurisdiction D DME Supplier Manual provides HCPCS codes with descriptions and the payment categories.

Inexpensive or Routinely Purchased DME

- Inexpensive DME-This category is defined as equipment whose purchase price does not exceed $150.
- Routinely Purchased-This category consists of equipment that is purchased at least 75% of the time.

Payment for this type of equipment is for rental or lump sum purchase. The total payment may not exceed the actual charge or the fee for a purchase.

Common modifiers used in this category are:

- **RR** Rental
- **NU** Purchase of new equipment
- **UE** Purchase of used equipment

Items Requiring Frequent and Substantial Servicing

Equipment in this category is paid on a rental basis only. Payment is based on the monthly fee schedule amount until the medical necessity ends. No payment is made for the purchase of equipment, maintenance and servicing or for replacement of items.

Use the **RR** (Rental) modifier for items in this category.

Capped Rental Items

Items in this category are provided on a rental basis; therefore, RR is one of the modifiers appropriate with these items.

There is an exception to the rental basis. For electric wheelchairs, suppliers must give beneficiaries the option of purchasing at the time the supplier first furnishes the item. The modifiers used with these items are:

- **BR** Beneficiary has elected to rent
- **BP** Beneficiary has elected to purchase

Modifiers used for capped rental items are:

- **KH** First rental month
- **KI** Second and third rental months
- **KJ** Fourth to thirteenth rental months

For capped rental items provided prior to January 1, 2006, suppliers must give beneficiaries the option to purchase their rental equipment during the tenth continuous rental month. Beneficiaries have one month from the date the supplier makes the offer to accept the option. If the beneficiary declines, rental payments continue until the 15th month. If the beneficiary accepts the purchase option, rental will continue until 13 continuous rental months have been paid. On the first day after 13 continuous months have been paid, the supplier must transfer the title of the equipment to the beneficiary.

Modifiers used for capped rental items prior to January 1, 2006 are:

- **BR** Beneficiary has elected to rent
- **BP** Beneficiary has elected to purchase
- **BU** Beneficiary has not informed supplier of decision after 30 days

Beginning January 1, 2006, payment for capped rental items may not exceed a period of continuous use longer than 13 months. After 13 months of rental have been paid, the supplier must transfer the title of the equipment to the beneficiary.

The BR, BP and BU modifiers are not required on most capped rental items where the first rental period began on/after January 1, 2006. They are still required, however, on PEN pumps and electric wheelchairs regardless of the date of the first rental period.

Oxygen and Oxygen Equipment

For stationary and portable oxygen equipment furnished on or after January 1, 2006, a 36-month cap applies on monthly payments. A listing of the applicable HCPCS codes is available in Chapter 5 of the Supplier Manual.

For stationary and portable oxygen equipment and oxygen contents furnished prior to January 1, 2006, payments were made for the duration of use of the equipment when medically necessary.

Contractors began the 36-month count on January 1, 2006, for beneficiaries that were receiving oxygen therapy prior to January 1, 2006. Months prior to January 1, 2006, are not included in the 36-month count.

MODIFIERS CONT'D

On the first day after the 36th month anniversary for which payment has been made, the supplier must transfer the title for the stationary and/or portable oxygen equipment to the beneficiary. On that same day, the title for the equipment is transferred to the patient and monthly payments can begin to be made for oxygen contents used with patient owned gaseous and liquid oxygen equipment.

Modifiers appropriate for oxygen and oxygen equipment are:

- **RR** Rental
- **QE** Use if the prescribed amount of oxygen is less than 1 LPM
- **QF** Use if the prescribed amount of oxygen exceeds 4 LPM and portable oxygen is prescribed
- **QG** Use if the prescribed amount of oxygen is greater than 4 LPM
- **QH** Use if an oxygen conserving device is being used with an oxygen delivery system

Maintenance and Servicing

MS Maintenance and servicing.

Maintenance and servicing is covered for capped rental items prior to January 1, 2006. Payment will no longer be made for maintenance and servicing on capped rental items in which the first rental month occurs on or after January 1, 2006.

Maintenance and servicing payments will be made for oxygen equipment every six months, starting six months after the beneficiary owns the equipment. The payment will be paid in 15 minute intervals and shall not exceed 30 minutes.

Additional information regarding maintenance and servicing for items on or after January 1, 2006, is found in MLN Matters 5461, available in the What's New section of our website.

Replacement and Repair

The **RP** modifier indicates replacement and repair.

Equipment the beneficiary owns may be replaced in cases of loss or irreparable damage without a physician's order. Claims involving replacement equipment necessitated because of wear or a change in the patient's condition must be supported by a current physician's order.

Repairs to equipment the beneficiary owns are covered when necessary to make the item serviceable. If the expense for repair exceeds the estimated expense of purchasing or renting another item for the remaining period of medical need, no payment can be made for the amount of the excess. Repairs of rented equipment are not covered.

Prosthetics and Orthotics

Many of the HCPCS codes in this category require the use of a K modifier. Reference the Lower Limb Prostheses policy for a listing of codes.

- **K0** Lower limb extremity prosthesis functional Level 0 - Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility
- **K1** Lower extremity prosthesis functional Level 1 - Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator
- **K2** Lower extremity prosthesis functional Level 2 - Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator
- **K3** Lower extremity prosthesis functional Level 3 - Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion
- **K4** Lower extremity prosthesis functional Level 4 - Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete

Osteogenesis Stimulators

E0747, E0748 and E0760 are Class III Devices that must be submitted with a KF modifier. The **KF** modifier indicates a FDA Class III Device.

Surgical Dressings

Modifiers **A1** through **A9** are used with surgical dressings to indicate the number of wounds. If modifier A9 (dressing for nine or more wounds) is used, information must be submitted in Item 19 on a paper claim, or the electronic equivalent, indicating the number of wounds.

Modifiers **AU** (item furnished in conjunction with a urological, ostomy or tracheostomy supply), **AV** (item furnished in conjunction with a prosthetic or orthotic device) and **AW** (item furnished in conjunction with a surgical dressing) are used when billing codes for tape, A4450 and A4452.

KO, KP, KQ Modifiers

KO Single drug unit dose formulation.

KP First drug of a multiple drug unit dose formulation.

KQ Second or subsequent drug of a multiple drug unit dose formulation.

When there is a single drug in a unit dose container, the KO modifier is added to the unit form code. When two or more drugs are combined and dispensed to the patient in the same unit dose container (except for code J7620, Albuterol, up to 2.5 mg and Ipratropium Bromide, up to 0.5 mg, non-compounded inhalation solution), each of the drugs is billed using its unit dose form code. The KP modifier is added to only one of the unit dose form codes and the KQ modifier is added to the other unit dose code(s). See the Nebulizer policy article for additional information.

MODIFIERS CONT'D

Right and Left Modifiers

The **RT** and **LT** modifiers are used in reference to many different policies. Consult these policies for the proper use of the RT and LT modifiers:

- Ankle-Foot/Knee-Ankle-Foot Orthosis
- External Breast Prosthesis
- Eye Prosthesis
- Facial Prosthesis
- Lower Limb Prosthesis
- Orthopedic Footwear
- Refractive Lenses
- Surgical Dressings
- Therapeutic Shoes for Persons with Diabetes
- Wheelchair Option/Accessories

KX Modifier-Documentation on File

Many policies require the **KX** modifier be added to the code to indicate specific required documentation is on file. Currently, the following policies address KX modifier usage:

- Automatic External Defibrillators
- Cervical Traction Devices
- Commodes
- Continuous Positive Airway Pressure System
- Epoetin
- External Infusion Pumps
- Glucose Monitors
- High Frequency Chest Wall Oscillation Devices
- Home Dialysis Supplies and Equipment
- Hospital Beds and Accessories
- Manual Wheelchair Base
- Nebulizers
- Negative Pressure Wound Therapy Pumps
- Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
- Orthopedic Footwear
- Power Mobility Devices
- Pressure Reducing Support Surfaces
- Refractive Lenses
- Respiratory Assist Devices
- Speech Generating Devices
- Therapeutic Shoes for Persons with Diabetes
- Transcutaneous Electrical Nerve Stimulators
- Urological Supplies
- Walkers
- Wheelchair Options/Accessories
- Wheelchair Seating

EY Modifier-No Doctor's Order on File

The **EY** modifier indicates a supplier does not have a doctor's order for an item or service. A supplier must have an order from the treating physician before dispensing any DMEPOS item to a beneficiary.

GA, GZ, GY Modifiers-ABN/Not Reasonable and Necessary/Statutorily Excluded

The **GA** modifier is submitted on claims when the supplier has an Advance Beneficiary Notice on file.

An ABN is a written notice a supplier gives to a Medicare beneficiary before items or services are furnished when the supplier believes that Medicare will not pay because there is a lack of medical necessity.

Keep in mind that not all items submitted with the GA modifier are denied as patient responsibility. Items must be denied based on medical necessity in order to receive a patient responsibility denial.

Additional information on ABNs is found in Chapter 6 of the Supplier Manual.

The **GZ** modifier is used to indicate suppliers expect Medicare will deny an item or service as not reasonable and necessary and they do not have an ABN on file.

The **GY** modifier is submitted when suppliers indicate an item or service is statutorily non-covered or is not a Medicare benefit.

Examples of items to use the GY modifier with are infusion drugs that are not administered through a durable infusion pump, personal comfort items and enteral nutrients administered orally. Also, many of the LCDs provide instructions on when to use the GY modifier.

GK, GL Modifiers-Upgrades

GK Reasonable and necessary item ordered when a piece of equipment has been upgraded.

When billing for upgrades, suppliers must use two lines on the same claim. Line one contains the HCPCS code for the upgraded item the supplier actually provided to the beneficiary with the dollar amount of the upgraded item. If an ABN was obtained, the GA must be billed. If an ABN was not obtained, use the GZ modifier. Line two is billed with the HCPCS code for the reasonable and necessary item with modifier GK and for the full amount of that item.

Suppliers must also list the upgrade features in Item 19 of the CMS-1500 form or the electronic equivalent.

GL Item is a medically unnecessary upgrade provided instead of a standard item at no charge to the beneficiary and an ABN does not apply.

If a supplier furnishes an upgraded DMEPOS item but charges Medicare and the beneficiary for the non-upgraded item, the supplier must bill for the non-upgraded item rather than the item the supplier actually furnished. The claim is billed with the HCPCS code for the non-upgraded item with the charge of that item and modifier GL.

MODIFIERS CONT'D

Item 19 of the CMS-1500 form, or the electronic equivalent, must contain the make and model of the item actually furnished and describe why it is an upgrade.

KB and 99 Modifiers-More than Four Modifiers

KB Beneficiary requested upgrade for ABN, more than four modifiers identified on claim.

99 Modifier overflow.

The KB modifier only applies to beneficiary upgraded claims for DMEPOS where the supplier obtained an ABN and there are more than four modifiers on the claim line. The 99 modifier is used in any other situation when a claim line has more than four modifiers.

When a supplier uses more than four modifiers, the KB or 99 must be added as the fourth modifier to the HCPCS code. On paper claims, the remainder of the modifiers must be listed in Item 19 with an indicator as to which line they apply to. On electronic claims, the remainder should be entered in the NTE segment, the 2400 loop.

These are not all inclusive lists. For additional information on modifiers, see the Supplier Manual in the News and Publications section of our website. A complete listing of modifiers is available in Chapter 16, Coding. Also, remember to verify modifier usage in the policies. To locate the LCDs from our website, see the Accessing Local Coverage Determinations article from the What's New section for instructions.

BILLING

Reporting Beneficiary Paid Amounts

When completing Item 29 on the CMS-1500 (08-05) paper claim form (or the electronic equivalent), it is important to *only* enter an amount when the beneficiary has paid for the covered services.

The electronic equivalent of Item 29 is the 2300 CLM loop, AMT segment. In Express Plus, the patient paid field is on the Claim Level screen.

If any dollar amount is reported in Item 29 (or the electronic equivalent), part or all of the payment will go directly to the beneficiary, even if you are a participating provider or the claim was submitted as assigned. Reason code 100 will be reported on the remittance advice when this situation occurs. Reason code 100 reads as follows:

Payment made to patient/insured/responsible party.

Do not include the amount paid by the primary insurance, co-insurance, deductible, account balance or payments on previous claims when reporting the beneficiary paid amount.

Changes to Mandatory Medigap Claim-Based Crossover Process

CMS' Coordination of Benefits Contractor (COBC) will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on the incoming claim, effective October 1, 2007. During June through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the COBC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit Medigap identifier (ID). Providers may reference a weekly updated listing of the newly assigned COBA Medigap claim-based IDs on CMS' Coordination of Benefits website at http://www.cms.hhs.gov/COBAgreement/.

Once the COBC has assigned a new COBA Medigap claim-based ID to a Medigap insurer, participating providers that wish to trigger crossovers to Medigap insurers will be required to include that new identifier, as found on the CMS COB website, on their incoming Medicare claims. Failure to do so will result in their claims not being successfully crossed over to the Medigap insurer. If the older contractor-assigned number is included on the claim, Medicare will include the standard MA19 message—'Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer.'—on the provider's electronic remittance advice (ERA) or other production remittance advice for the associated claim(s). Participating providers that are permitted under Administrative Simplification Compliance Act (ASCA) to bill Medicare on paper should include the newly assigned 5-digit COBA Medigap claim-based ID within block 9-D of the CMS-1500 claim form. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) left-justified in field NM109 of the NM1 segment within the 2330B loop and followed by spaces. **(See important note that follows regarding the submission of claims to Durable Medical Equipment Medicare Administrative Contractors [DMACs].)** Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier left-justified within field 301-C1 of the T04 segment of their incoming NCPDP claims and followed by spaces.

IMPORTANT: For all of the claim submission situations discussed above, suppliers (including retail pharmacies) that bill DMACs must include an accompanying 4-byte "Z001" identifier with the newly assigned COBA Medigap claim-based crossover ID (for example, 55000Z001) when seeking to trigger Medigap claim-based crossovers during the interim transitional period, which runs from June through September 30, 2007. Providers should notify their clearinghouses and billing vendors of the impending changes to the existing Medigap claim-based crossover process as soon as possible. The Medigap transitional announcement is posted on the NAS DME MAC website at www.noridianmedicare.com/dme/

Revision to Medicare Publication 100-09, Chapter 3 – Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates

MLN Matters Number: MM5597
Related Change Request (CR) #: 5597
Related CR Release Date: June 29, 2007
Related CR Transmittal #: R19COM
Effective Date: May 23, 2007
Implementation Date: July 30, 2007

Provider Types Affected

All physicians, suppliers, and providers who submit written inquiries to, or contact the toll-free lines at, their Medicare contractors [fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative Contractors (DME/MACs), and/or regional home health intermediaries (RHHIs).]

Provider Action Needed

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

The remainder of this article provides information on the highlights of changes announced in CR5597.

Background

CR5597 modifies *Medicare Contractor Beneficiary and Provider Communications Manual*, Publication 100-09. These changes are summarized as follows:

Overlapping Claims—New Rules

- Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.
- When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/ legacy number or NPI, beneficiary name, Health Insurance Claim Number (HICN), and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.
- Contractors shall release overlapping claim information whether a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.
- For specific information regarding the resolution of claims rejected by Medicare's Common Working File (CWF) system, refer to the *Medicare Claims Processing Manual*, *Chapter 27, §50* at http://www.cms.hhs.gov/manuals/downloads/clm104c27.pdf on the CMS website.

Information Available on the IVR

- **USE THE IVR whenever possible**. Providers should be aware that if a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information is available on the IVR, the CSR/correspondent will probably encourage you to use the self-service options that are available.
- If at any time during a telephone inquiry, you request information that can be found on the IVR the CSR will most likely refer you back to the IVR.

Information Available on the Remittance Advice (RA)

- **USE THE RA whenever possible.** If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.
- To make your job easier you may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available at: http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS website.
- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* which is available at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS website.
- Also available is a website that serves as a resource allowing providers to check the definitions of *Claim Adjustment Reason Codes and Remittance Advice Remark Codes*. This information is available at http://www.wpc-edi.com/products/codelists/alertservice on the Washington Publishing Company website.

- There is a web-based training course, *Understanding the Remittance Advice for Professional Providers*, which is available at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1 on the CMS website. The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

Authentication of Beneficiary Elements—additions to current rules.

CR5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR5597 is available at http://www.cms.hhs.gov/Transmittals/downloads/R19COM.pdf on the CMS website.

Additional Key Points of CR5597

- Medicare's CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the Report of Contact made during a telephone response to a written inquiry, Medicare contractors will send you a letter detailing the discussion. This letter may be sent to you by e-mail or fax, if you request, unless the details include specific beneficiary or claim related information.
- When your Medicare contractor schedules a training event for which there is a charge for attendance and you register and pay, but are unable to attend, you may be entitled to a refund of some or all of your payment. But, to receive such a refund, **you must notify the contractor before the event**.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5597) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R19COM.pdf on the CMS website.

Quarterly Update to Medically Unlikely Edits, Version 1.2, Effective July 1, 2007

MLN Matters Number: MM5603 Revised
Related Change Request (CR) #: 5603
Related CR Release Date: June 12, 2007
Related CR Transmittal #: R1265CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

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

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare contractors (Fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative contractors (DME/MACs), durable medical equipment regional carriers (DMERCs), and/or regional home health intermediaries (RHHIs)).

Background

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

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

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

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

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

Additional Information

To see the official instruction (CR5603) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1265CP.pdf on the CMS website.

Additional CWF Editing for SNF Consolidated Billing

MLN Matters Number: MM5624 Revised
Related Change Request (CR) #: 5624
Related CR Release Date: July 13, 2007
Related CR Transmittal #: R1289CP
Effective Date: April 1, 2001
Implementation Date: January 7, 2008

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

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for services provided to Medicare beneficiaries in SNF stays.

What Providers Need to Know

Effective for dates of service on or after April 1, 2001, CR 5624, from which this article is taken, instructs Medicare carriers, A/B MACs, and DME MACs to bypass certain current SNF consolidated billing (CB) Part B and Part B/DMEMAC edits in order to enable the identification of periods when SNF CB edits should not be applied.

Background

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

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

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

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

Additional Information

You can find the official instruction, CR5624, issued to your carrier, A/B MAC, or DME MAC on the CMS website at http://www.cms.hhs.gov/Transmittals/downloads/R1289CP.pdf. As an attachment to CR5624, you will find updated Medicare Claims Processing Manual (100-04), Chapter 6 (SNF Inpatient Part A Billing), Sections 110.2.2 (A/B Crossover Edits), 110.2.4 (Edit for Ambulance Services), and 110.2.5 (Edit for Clinical Social Workers (CSWs)).

Update of Claim Adjustment Reason Codes and Remittance Advice Remark Codes and Enhancement of Medicare Remit Easy Print

MLN Matters Number: MM5634
Related Change Request (CR) #: 5634
Related CR Release Date: June 15, 2007
Effective Date: July 1, 2007
Related CR Transmittal #: R1267CP
Implementation Date: July 2, 2007

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed

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

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 instructs health plans to be able to conduct standard electronic transactions (submission of claims, claims inquiries, electronic remittance advice, etc.) adopted under HIPAA using valid standard codes. The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12 transactions are part of the Transactions and Code Sets Rule selected by HIPAA, and the ANSI X12 subcommittee 'N' covers standards in the insurance industry, including health insurance (hence these are X12N standards). The ANSI ASC X12N transaction number 835 (ANSI ASC X12N-835) is the ANSI standard electronic remittance advice

(ERA) transaction that provides payment information on a submitted claim.

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

As a reminder, Medicare policy states that:

- Claim Adjustment Reason Codes (CARCs) are required in the remittance advice and coordination of benefits transactions, and
- Remittance Advice Remark Codes (RARCs) are **required in the remittance advice for both paper and electronic formats**.

When the payment differs from the amount being billed, Payers communicate the reason for any adjustment using:

- **Group Codes** (which identify who is financially responsible for the amount that the payer is not reimbursing),
- **CARCs** (which provide an explanation why an amount is being adjusted), and
- **RARCs** (which provide a supplemental explanation about the adjustment) Any RARC that has the word "Alert" is an informational remark code that does not provide any supplemental explanation for a specific adjustment but provides general information related to adjudication.

The following table includes Group Codes currently being used by CMS:

Group Code	Definition
CO	Contractual Obligation (Provider is financially responsible)
PR	Patient responsibility (Provider can collect the amount from patient)
OA	Other Adjustment (Generally used to report bundling/unbundling situation, predetermination of benefits, and secondary payments)
CR	Correction (Used with reversal and correction)

The ANSI ASC X12N-835 Implementation Guide (version 004010A1) requires CARCs (if needed) but does not require use of RARCs. A HIPAA compliant version of the Implementation Guide for transaction 835 (Health Care Claim Payment & Remittance Advice) is available at: http://www.wpc-edi.com/HIPAA.

The code committee that maintains the CARC code set recently modified five CARCs (16, 17, 96, 125, and A1). These CARCs were selected for modification because they were very generic, and they were used most frequently. Of these 5 CARCs, the following 4 now require the use of at least one appropriate RARC, and they are **effective April 1, 2007**:

CARC	Definition
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
96	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

The remaining 1 CARC (which follows) also requires at least one RARC, but it is **effective June 1, 2007**.

CARC	Definition
A1	Claim denied charges

CMS instructed your Medicare contractor(s) to analyze their current use of RARCs with CARCs 16, 17, 96, and 125, and determine if any existing RARCs (that are not currently being used) may be appropriate to explain an adjustment. Your Medicare contractor(s) may start using any of the currently existing RARCs with CARCs 16, 17, 96, 125, and A1.

Note: The most current list of RARCs can be found at: http://www.wpc-edi.com/codes.

In addition, the committee that maintains reason codes approved the following CARC effective February 28, 2007:

CARC	Definition
204	This service/equipment/drug is not covered under the patient's current benefit plan

Your Medicare contractor(s) may use CARC 204 instead of CARC 96 and an appropriate remark code, e.g., N130.

RARC	Definition
N130	Consult plan benefit documents for information about restrictions for this service

RARC N130 will be used with CARC 96 as a default combination to be reported on all DME claims if:

- No code has been assigned by your Medicare contractor, and
- The service is not covered by Medicare.

Medicare Remit Easy Print (MREP) Enhancement

CMS developed Medicare Remit Easy Print (MREP) software that gives providers a tool to read and print an electronic remittance advice (RA) in a human readable format. Providers who use the MREP software have the ability to print paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that can be included with claims submissions to secondary/tertiary payers for Coordination of Benefits. Information regarding MREP and instructions on obtaining MREP are available through your Medicare contractor.

In a continuing effort to improve MREP, CMS established a process to receive suggestions to enhance the functionality and effectiveness of MREP from providers, contractors, and CMS staff. The next updated version of MREP that incorporates improvements approved by CMS will be available in July 2007. Note that the timeline for the annual MREP enhancement update has changed from October to July.

Additional Information

The official instruction, CR5634, issued to your carrier, FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1267CP.pdf on the CMS web site.

Medicare Contractor Annual Update of ICD-9-CM

MLN Matters Number: MM5643
Related Change Request (CR) #: 5643
Related CR Release Date: June 15, 2007
Related CR Transmittal #: R1269CP
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Provider Types Affected

Physicians, suppliers, and providers billing Medicare contractors (carriers, Medicare administrative Contractors (A/B MACs), durable medical equipment administrative contractors (DMACs), and fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs))

What Providers Need to Know

CR 5643, from which this article is taken, reminds the Medicare contractors and providers that the annual ICD-9-CM update will be effective for dates of service on and after October 1, 2007 (for institutional providers, effective for discharges on or after October 1, 2007).

You can see the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) website at http://www.cdc.gov/nchs/icd9.htm in June of each year.

Background

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

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

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

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

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

Additional Information

You can find the official instruction, CR5643, issued to your Medicare contractor by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1269CP.pdf on the CMS website. As mentioned, you can find the new, revised, and discontinued ICD-9-CM diagnosis codes on the CMS website at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#TopOfPage, or at the National Center for Health Statistics (NCHS) Web site at http://www.cdc.gov/nchs/icd9.htm, in June of each year. The annual ICD-9-CM code changes are also included in a CD-ROM, which you can purchase for $25.00 from the Government Printing Office (GPO), stock number 017-022-01573-1.

To learn more about ICD-9-CM codes, you might want to read *Medicare Claims Processing Manual*, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service); or look at the information provided at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp#TopOfPage on the CMS website.

Notifying Affected Parties Regarding Changes to Mandatory Medigap ("Claim-Based") Crossover Process

MLN Matters Number: MM5662 Revised
Related Change Request (CR) #: 5662
Related CR Release Date: June 15, 2007
Related CR Transmittal #: R283OTN
Effective Date: June 15, 2007
Implementation Date: July 16, 2007

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

Provider Types Affected

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

What Providers Need to Know

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

Background

The Centers for Medicare & Medicaid Services (CMS) has decided that, effective October 1, 2007, all mandatory Medigap ("claim-based") crossovers will now be accomplished through its Coordination of Benefits Contractor (COBC). Further, CMS has decided that, in accordance with Public Law 104-191 and 45 *Code of Federal Regulations* (CFR) 160, it will **only** transmit claims to Medigap claim-based crossover recipients in the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional (version 4010A1) coordination of benefits (COB) claim format or in the National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 format. (**NOTE**: The systematic requirements relating to this transition were communicated via change request (CR) 5601, as reflected in *MLN Matters* article MM5601 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf on the CMS website.)

Starting with June 2007, CMS' COBC will gradually begin to assign new Medigap claim-based COBA identifiers (range 55000 to 59999) to Medigap insurers that have not voluntarily moved to the COBA eligibility file-based crossover process. CMS anticipates that the COBC will complete the execution of crossover agreements with Medigap claim-based insurers and assign new COBA Medigap claim-based identifiers to these entities by August 31, 2007. As the COBC assigns a new COBA Medigap claim-based ID to a Medigap claim-based crossover recipient, CMS will alert all Part B contractors, including MACs, and DMACs via e-mail of this action on a weekly basis. The CMS alert will include the following information: affected entity's name; the entity's multiple formerly contractor-assigned Other Carrier Name and Address (OCNA) or N-key identifiers; and its newly assigned COBA Medigap claim-based ID. Upon receipt of the CMS alert, the affected contractors shall manually add the newly assigned COBA Medigap claim-based ID to their existing insurer screens or tables to replace the formerly assigned OCNA or N-key identifier. Contractors shall also maintain a link to the COB website (http://www.cms.hhs.gov/COBAgreement) for purposes of receiving updates to the COBA Medigap claim-based ID listing.

The affected contractors shall post CMS' Medigap claim-based crossover transition announcement in its entirety on their websites that are accessed by the public and insurers. These contractors shall also mail the CMS announcement on a one-time basis to their electronic Medigap claim-based crossover recipients and shall also notify their paper claim recipients through information included with their next scheduled claim mailings.

Providers should note the following: Effective October 1, 2007, the COBC will assume responsibility for the Medigap claim-based crossover, which is driven by information that participating providers enter on the incoming claim. The primary change for providers resulting from this transition will be that they will need to include a new Medigap identifier, even in advance of October 1, 2007, on their incoming Medicare claims to trigger crossovers to Medigap insurers. During June through August 2007, CMS will assign each Medigap insurer that does not provide an eligibility file to the COBC to identify all of its covered policy or certificate holders for crossover purposes a new 5-digit COBA Medigap claim-based identifier (ID). Providers may reference a weekly updated listing of the newly assigned COBA Medigap claim-based IDs for Medicare billing purposes at the following website: http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap Claim-based COBA IDs for Billing Purpose.pdf. Once the COBC has assigned a new COBA Medigap claim-based ID to a Medigap insurer, participating providers that wish to trigger crossovers to Medigap insurers will be required to include that new identifier, as found on the CMS COB website, on their incoming Medicare claims. Failure to do so will result in their claims not being successfully crossed over to the Medigap insurer. If the older contractor-assigned number is included on the claim, Medicare will include the standard MA19 message—'Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. Please verify your information and submit your secondary claim directly to that insurer on the provider's electronic remittance advice (ERA) or other production remittance advice for the associated claim(s). Participating providers that are permitted under Administrative Simplification Compliance Act (ASCA) to bill Medicare on paper should include the newly assigned 5-digit COBA Medigap claim-based ID within block 9-D of the CMS-1500 claim form. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include

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the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) left-justified in field NM109 of the NM1 segment within the 2330B loop and followed by spaces. (**See important note that follows regarding the submission of claims to DMACs.**)

Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier left-justified within field 301-C1 of the T04 segment of their incoming NCPDP claims and followed by spaces. **IMPORTANT**: For all of the claim submission situations discussed above, suppliers (including retail pharmacies) that bill DMACs must include an accompanying 4-byte "Z001" identifier with the newly assigned COBA Medigap claim-based crossover ID (for example, 55000Z001) when seeking to trigger Medigap claim-based crossovers during the interim transitional period, which runs from June through September 30, 2007.

Providers should notify their clearinghouses and billing vendors of the impending changes to the existing Medigap claim-based crossover process as soon as possible.

Additional Information

You can find the official instruction, CR5662, issued to your carrier, MAC, or DMAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R283OTN.pdf on the CMS website.

FRAUD/ABUSE

HHS Fights Durable Medical Equipment Fraud

Demonstration Project Targets Fraudulent Business Practices in South Florida and Southern California

HHS Secretary Mike Leavitt today announced a two-year effort designed to further protect Medicare beneficiaries from fraudulent suppliers of durable medical equipment, prosthetics and orthotics supplies (DMEPOS). The initiative is focused on preventing deceptive companies from operating in South Florida and Southern California.

The new initiative will have immediate effect in two regions of the country where there is a high concentration of suppliers, South Florida and Southern California. Based on the results of the project, it could be expanded nationwide.

Miami and Los Angeles have been identified as high-risk areas when it comes to fraudulent billing by DMEPOS suppliers. HHS, working with the Department of Justice (DOJ), formed a Medicare Fraud Strike Force to combat fraud through the use of real-time analysis of Medicare billing data. In just three months, 56 individuals have been charged in the Southern District of Florida with fraudulently billing Medicare for more than $258 million. The strike force is made up of federal, state and local investigators.

For your convenience, copies of the HHS Press Release and Fact Sheet on this topic are listed below. These documents will also be posted on the HHS Website at http://www.hhs.gov/news.

HHS Press Release

Fact Sheet

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 (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.

Suppliers who fail to submit medical documentation will receive claim adjustment denials from Noridian Administrative Services as the services for which there is no documentation are interpreted as services not rendered.

Signature Required on Redetermination Requests

Effective July 1, 2007, redetermination requests submitted without the signature of the requesting party will be processed as an incomplete request and dismissed.

The following information is required when submitting a redetermination request:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number of the beneficiary
- Specific service(s) and/or item(s) for which the redetermination is being requested, i.e., HCPCS
- Correct dates of service, including all from and through dates from the remittance advice
- Name and signature of the party, or representative of the party, requesting the redetermination

To ensure all required information is included on your redetermination request, NAS encourages suppliers to use the DME Inquiry/Redetermination request form.

Appeals Transition-BIPA Section 521 Appeals

MLN Matters Number: MM5460
Related Change Request (CR) #: 5460
Related CR Release Date: June 29, 2007
Related CR Transmittal #: R1274CP
Effective Date: July 1, 2007
Implementation Date: October 1, 2007

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.

Provider Action Needed

This article is based on Change Request (CR) 5460, which notifies Medicare contractors about their need to comply with changes to provisions in Chapter 29 of the *Medicare Claims Processing Manual* (Publication 100-04) that address the appointment of representatives, fraud and abuse, guidelines for writing appeals correspondence, and the disclosure of information.

Background

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

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

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

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

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

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

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

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

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agrees to this waiver by completing and signing Section II of the Transfer of Appeal Rights form.

- Provide redetermination letters that are understandable to beneficiaries.

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

Additional Information

The official instruction, CR5460, issued to your Medicare contractor regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1274CP.pdf on the CMS website. The revised portions of the *Medicare Claims Processing Manual* are attached to that CR.

EDI

Express Plus Version 4.3.6 Available for Download!

The full install and/or upgrade to Version 4.3.6 can be downloaded free of charge at

http://www.cignagovernmentservices.com/medicare_dynamic/expressplus/overview.asp.

Suppliers may also request a copy of this latest version on CD with a $5 shipping and handling fee.

Those offices that are new to electronic claim filing that are interested in using Express Plus must complete the EDI Enrollment Form and Jurisdiction D EDI Customer Profile. These forms are available at http://www.cignagovernmentservices.com/edi/dmerc/forms.html.

If you have any questions regarding the Express Plus software, please contact the EDI Helpdesk at 1-866-224-3094.

New Feature on Jurisdiction D EDI Website

Suppliers can now request to have Acknowledgement Reports (997s), Electronic Remittance Notices (ERNs) and Electronic Receipt Listings (ERLs) reposted to your mailboxes through a new feature available on the Jurisdiction D EDI website. These reports are initially kept in your mailbox for seven days. However, copies are kept and are available to be reposted. Please note, any reports over 30 days cannot be reposted. You can access this new feature using the following link: www.cignagovernmentservices.com/medicare_dynamic/edi/DMEMAC/form2.asp.

Simply complete all fields and submit your request. After submitting the request, you will receive two emails. The first email will be sent to acknowledge that EDI received your request and the second email will be sent once the request has been processed. Most requests should be completed within one business day.

If you have any additional questions, please contact the EDI Helpdesk at 866-224-3094.

Changes for Stratus Mailbox File Naming Conventions

The file naming conventions for the Stratus Bulletin Board System (BBS) will be changing. These changes will be implemented periodically over the next few months.

The date in the file name will now be the date the file was originally created. Previously, the date in the file name was the date the file was loaded into the mailbox (regardless of the creation date of the file).

The file number prefixes and their corresponding file types are:

A: 997 Functional Acknowledgements

E: 837 (Claim) Electronic Receipt Listings (ERLs)

F: 277 (Claim Status Response) files

X: 835 Electronic Remittance Notice (ERN) files

The file numbering sequence will be a sequential number for all files except the 997 Functional Acknowledgements. The file numbering sequence for the 997 Functional Acknowledgements will use the sweep time (Eastern Time Zone using a 24-hour clock) instead of using a sequential numbering system. Thus, the 997 files will show 8, 12, and 17 for their respective file sweeps.

All files will still end in ".7" until the file has been downloaded. Once the file is successfully downloaded it will end in ".cp".

Below is an example of a 997 Functional Acknowledgement created on June 2, 2007 from the 8am sweep and loaded into the mailbox on June 5, 2007.

A	The date the file was loaded into the mailbox.
B	The time the file was loaded into the mailbox.
C	The date the file was originally created.
D	The prefix that identifies the particular file type.
E	The file numbering sequence.

Any questions about the changes listed above, please contact the EDI department at 866-224-3094.

NPI Required to Enroll in EDI and Update of Telecommunication and Transmission Protocols for EDI

MLN Matters Number: MM5637 Revised
Related Change Request (CR) #: 5637
Related CR Release Date: July 6, 2007
Related CR Transmittal #: R1283CP
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

Note: This article was revised on July 17, 2007, to reflect a new Web address in the Additional Information section for NPI information. All other information remains the same.

EDI CONT'D

Provider Types Affected

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

Provider Action Needed

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

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

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

Background

Since May 2006, providers have been required to obtain a National Provider Identifier (NPI) prior to initial Medicare enrollment, or before updating their enrollment records, but were not required to have an NPI, as a condition for enrollment, in order to begin using electronic data interchange (EDI) transactions.

CR 5637, from which this article is taken, announces that (effective October 1, 2007) providers will need to obtain an NPI, as a condition for initial enrollment, for the use of EDI.

This is being implemented to further support efforts by the Centers for Medicare & Medicaid Services (CMS) to have all providers obtain NPIs as soon as possible. Moreover, as indicated in *MLN Matters* article MM5595 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf), Medicare is monitoring claims to determine the level of NPI reporting. This is being done to determine when it will be reasonable for Medicare to begin rejecting claims that lack an NPI for billing, pay-to or rendering providers.

CR 5637 also updates EDI connectivity information in the *Medicare Claims Processing Manual*, Section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), Sections 20 (EDI Enrollment) and 30.3 (Telecommunications and Transmission Protocols) because some of the information in the manual is obsolete due to technology changes.

In summary, these changes are:

- Medicare contractors will use V.90 56K modems for EDI transactions submitted via dial-in connections;
- Medicare contractors will offer data compression in a means that an EDI transaction sender/receiver requests, using the V.90 56 K modem, PK ZIP version 2.04x or higher, WinZIP or V.42 bis data compression;
- DME MACs will reject standard National Council for Prescription Drug Programs (NCPDP) transactions that do not use the standard NCPDP electronic envelope;
- Medicare contractors may, but are not required to, accommodate other types of data compression that an EDI submitter/receiver requests.

Additional Information

You can find more information about the requirement for an NPI in order to be able to use EDI transactions, by going to CR 5637, located at http://www.cms.hhs.gov/Transmittals/downloads/R1283CP.pdf on the CMS website. As an attachment to CR 5637, you will find updated *Medicare Claims Processing Manual*, Section 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims), Sections 20 (EDI Enrollment) and 30.3 (Telecommunications and Transmission Protocols). You can find more information about EDI on the CMS website at http://www.cms.hhs.gov/ElectronicBillingEDITrans/, and more information about the NPI at http://www.cms.hhs.gov/NationalProvIdentstand/ on the CMS website.

CODING

Albuterol and Levalbuterol – Coding Changes

Effective for claims with dates of service on or after July 1, 2007, the following codes will be invalid for claim submission:

J7611 Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 1 mg

J7612 Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 0.5 mg

J7613 Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 1 mg

J7614 Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 0.5 mg

The following new codes will be effective for claims with DOS on or after July 1, 2007:

Q4093 Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)

Q4094 Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)

Note that for both Albuterol and Levalbuterol, the unit of service for the new codes is the same as the unit of service for the old codes.

These changes will be incorporated in a future revision of the Nebulizers policy.

Electrical Joint Stimulation Devices – E0762 – Coding Guidelines

HCPCS code E0762 is used to bill Medicare for a transcutaneous electrical joint stimulation device system. The only products that may be billed using this code are those that have undergone Coding Verification Review by the SADMERC and that are listed in the DMECS Product Classification List on the SADMERC web site.

Currently, the only product that meets these requirements is the BioniCare Knee Device manufactured by BioniCare Medical Technologies. Suppliers may not submit claims using E0762 for any other item. For information on the correct coding of other items, contact the SADMERC.

Nebulizers – Brovana – Coverage Criteria and Billing Instructions

Arformoterol (Brovana) is a long-acting beta-adrenergic agonist (LABA) drug which has recently become available as an FDA-approved, non-compounded unit dose inhalation solution. It is covered for dates of service on or after the date of FDA approval, October 6, 2006.

Coverage Criteria

Arformoterol is covered when the following criteria are met:

1. It is medically necessary for the management of chronic obstructive pulmonary disease (ICD-9 diagnosis codes 491.0-492.8, 496).
2. The patient has a documented history of routine use of at least four doses per day of a short-acting beta-adrenergic agonist inhalation solution (e.g., albuterol, levalbuterol, metaproterenol).

If these criteria are not met, Arformoterol will be denied as not medically necessary.

Arformoterol is administered using a pneumatic compressor (E0570, E0571) and a small volume nebulizer (A7003, A7004, A7005).

A maximum of two vials of Arformoterol (15 micrograms each) will be covered per day.

Short-acting beta adrenergic agonists (SABAs) may be covered as rescue/supplemental medication in addition to Arformoterol. However, when Arformoterol is used, the maximum amount of SABA inhalation solutions that will be covered is an average of one dose per day (31 doses per month).

Coding and Billing Guidelines

When submitting claims from Brovana, use code J7699 with a KO modifier. Enter "J7699-Brovana" in the narrative field of the electronic record. A KX modifier may be added to J7699KO only if (a) the drug being billed is Brovana and (b) the coverage criteria stated above have been met. There is no other drug that may be billed using the KX modifier with code J7699.

When billing for Brovana, 1 unit of service = 1 vial (15 micrograms).

Refer to the Nebulizers LCD and Policy Article for additional information on coverage, coding and billing of inhalation solutions. The recently released Nebulizers policy, which has an effective date of July 1, 2007, will be revised prior to that date incorporating this information.

Revised HCPCS Codes Relating to Immune Globulin

MLN Matters Number: MM5635 Revised
Related Change Request (CR) #: 5635
Related CR Release Date: June 1, 2007
Related CR Transmittal #: R1261CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

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

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (carriers; Fiscal Intermediaries (FI), including Regional Home Health intermediaries (RHHIs); Medicare Administrative Contractors (A/B MACs); and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for Immune Globulin.

What You Need to Know

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

- **HCPCS code J1567** (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg)) **will no longer be payable by Medicare**.
- **In its place, the following HCPCS codes are payable: Q4087 (Octagam Injection), Q4088 (Gammagard Liquid Injection), Q4091 (Flebogamma Injection), and Q4092 (Gamunex Injection);**
- **In addition, for services on or after July 1, 2007, two new codes are payable:**
  - **Q4089 (Rhophylac injection)**. Note that currently, Rhophylac® is the only product that should be billed using code Q4089. If other products under the Food and Drug Administration's (FDA) approval for Rhophylac® become available, code Q4089 would be used to bill for such products.
  - **Q4090 (HepaGam B injection)**. Note that currently, HepaGam BTM, when given intramuscularly, is the only product that should

be billed using code Q4090. If other products under the FDA's approval for HepaGam BTM IM become available, code Q4090 would be used to bill for such products. HepaGam BTM when given intravenously should be billed using an appropriate Not Otherwise Classified code in the absence of a specific HCPCS code.

- For institutional claims, revenue code 0636 should be used for billing codes Q4087, Q4088, Q4089, Q4090, Q4091, and Q4092.
- As described in CR 5428, Medicare contractors will pay for pre-administration-related services (G0332) associated with intravenous Immune Globulin administration when Q4087, Q4088, Q4091, or Q4092 is billed in lieu of J1567.

Background

CR 5635, from which this article is taken, implements HCPCS Coding Changes for Immune Globulin, Effective for services on or after July 1, 2007. See Table 1, below, for details.

Table 1

HCPCS Code Changes for Immune Globulin

Effective July 1, 2007

HCPCS Code	Short Description	Long Description
Status: Not Payable by Medicare on or after July 1, 2007		
J1567	Immune globulin, liquid	Injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg
Status: Payable for services on or after July 1, 2007		
Q4087	Octagam Injection	Injection, immune globulin (Octagam), intravenous, non-lyophilized (e.g. liquid), 500 mg
Q4088	Gammagard Liquid Injection	Injection, immune globulin (Gammagard Liquid), intravenous, non-lyophilized (e.g. liquid), 500 mg
Q4091	Flebogamma Injection	Injection, immune globulin (Flebogamma), intravenous, non-lyophilized(e.g. liquid), 500 mg
Q4092	Gamunex Injection	Injection, immune globulin (Gamunex), intravenous, non-lyophilized (e.g., liquid), 500 mg
Status: New/Payable for services on or after July 1, 2007		
Q4089*	Rhophylac injection	Injection, Rho(D) immune globulin (human), (Rhophylac), intramuscular or intravenous, 100 iu
Q4090^	HepaGam B injection	Injection, hepatitis B immune globulin (HepaGam B), intramuscular, 0.5 ml

*Currently, Rhophylac® is the only product that should be billed using code Q4089. If other products under the FDA approval for Rhophylac® become available, code Q4089 would be used to bill for such products.

^Currently, HepaGam BTM, when given intramuscularly, is the only product that should be billed using code Q4090. If other products under the FDA's approval for HepaGam BTM IM become available, code Q4090 would be used to bill for such products. HepaGam BTM when given intravenously should be billed using an appropriate Not Otherwise Classified code in the absence of a specific HCPCS code.

Additional Information

You can find the official instruction issued to your Medicare contractor about the revised HCPCS codes relating to Immune Globulin by going to CR5635, located at http://www.cms.hhs.gov/Transmittals/downloads/R1261CP.pdf on the CMS website.

Payment limits for the new Q codes will be included in the July 2007 quarterly Average Sales Price payment file, which will be posted at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage

In addition, more information regarding the Outpatient Prospective Payment System (OPPS) and the new Q codes in the July update of OPPS Addendum A and Addendum B on the hospital outpatient website at http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage.

You might also want to look at CR 5428 (Medicare Payment for Pre-administration-Related Services Associated with IVIG Administration—Payment Extended through CY 2007). The *MLN Matters* article (MM5428) associated with that CR is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5428.pdf on the CMS website.

July, 2007 Quarterly Update to HCPCS Codes for Albuterol, Levalbuterol, and Reclast®

MLN Matters Number: MM5645
Related Change Request (CR) #: 5645
Related CR Release Date: June 1, 2007
Related CR Transmittal #: R1260CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected

Physicians, providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI)(including Regional Home Health Intermediaries (RHHI)), Medicare Administrative Contractors (A/B MAC) and Durable Medical

CODING CONT'D

Equipment Medicare Administrative Contractors (DME MAC)) for providing Albuterol, Levalbuterol, Reclast®, and Zometa® to Medicare beneficiaries.

What Providers Need to Know

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

Effective for dates of service on or after July 1, 2007, the following HCPCS codes are no longer payable by Medicare: J7611, J7612, J7613, and J7614; and the following are payable by Medicare: Q4093, Q4094, and Q4095. Code J3487 continues in use for Zometa®.

Background

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

Effective July 1, 2007, the Health Care Procedure Code System (HCPCS) codes in **table 1** will no longer be payable for Medicare.

Table 1

HCPCS Codes Not Payable for Dates of Service on or after July 1, 2007

HCPCS Code	Short Description	Long Description
J7611	Albuterol non-comp con	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg
J7612	Levalbuterol non-comp con	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
J7613	Albuterol non-comp unit	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
J7614	Levalbuterol non-comp unit	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg

In place of the Table 1 codes, the HCPCS codes displayed in **Table 2** will be payable, effective July 1, 2007.

Table 2

HCPCS Codes Payable for Services on or After July 1, 2007

HCPCS Code	Short Description	Long Description
Q4093	Albuterol inh non-comp con	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)
Q4094	Albuterol inh non-comp u d	Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol)

In addition, a new code, Q4095 (in **Table 3**) will be effective July 1, 2007, for Reclast®.

Table 3

HCPCS Q4095 Payable for Services on or after July 1, 2007

HCPCS Code	Short Description	Long Description
Q4095	Reclast injection	Injection, zoledronic acid (Reclast), 1 mg

Also, please note the following:

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

CODING CONT'D

Additional Information

You can find the official instruction, CR 5645, issued to your carrier, FI (including RHHI), A/B MAC or DME MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1260CP.pdf on the CMS website

REIMBURSEMENT

July 2007 Fee Schedule Changes-Requesting Payment Adjustments

MLN Matters 5641, July Quarterly Update for 2007 DMEPOS Fee Schedule, affects allowances for several HCPCS codes.

HCPCS codes for which allowed amounts have changed are:

- **E2374** (Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only)
- **E0691** (Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area two square feet or less)
- **E0692** (Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, four foot panel)
- **E0693** (Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection, six foot panel)
- **E0694** (Ultraviolet multidirectional light therapy system in six foot cabinet, includes bulbs/lamps, timer and eye protection)

To request the additional allowance on E2374 for services on or after January 1, 2007, either **call Telephone Reopenings at 888-826-5708** (10 am-4 pm CT) or request a **reopening in writing**.

To request a written reopening, complete the DME Reopening Form. Mail the form and all appropriate documentation to:
Medicare DME
Attn: Reopenings
PO Box 6727
Fargo ND 58108-6727

It has been determined that ultraviolet light therapy systems are classified as class II devices instead of class III devices. Therefore, suppliers should not submit the KF modifier (FDA class III device) for HCPCS codes E0691, E0692, E0693 or E0694 with dates of service on or after January 1, 2005.

To remove modifier KF on HCPCS E0691 through E0694 for dates of service on or after January 1, 2007, complete the Refunds to Medicare Form and submit the refund to:
Medicare Refunds-DME
PO Box 6727
Fargo ND 58108-6727

Select this link for the complete *MLN Matters* 5641 information.

July Quarterly Update for 2007 DMEPOS Fee Schedule

MLN Matters Number: MM5641 Revised
Related Change Request (CR) #: 5641
Related CR Release Date: June 8, 2007
Related CR Transmittal #: R1263CP
Effective Date: January 1, 2007 for implementation of fee schedule amounts for codes in effect on January 1, 2007; July 1, 2007 for all other changes
Implementation Date: July 2, 2007

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

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Regional Carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

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

Background

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

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

Key Points
The following are key changes in the July 2007 quarterly update of the DMEPOS fee schedule including the Healthcare Common Procedure Coding System (HCPCS) codes:

- **HCPCS code E0762** (Transcutaneous electrical joint stimulation device system, includes all accessories) is:
  - **Added** to the fee schedule on **July 1, 2007**, **and**
  - **Effective** for claims submitted with dates of service on or after January 1, 2007.

REIMBURSEMENT CONT'D

- HCPCS codes added July 1, 2007 with dates of service on or after July 1, 2007 are:
    - **K0553** Combination Oral/Nasal Mask, Used With Continuous Positive Airway Pressure Device, Each
    - **K0554** Oral Cushion For Combination Oral/Nasal Mask, Replacement Only, Each
    - **K0555** Nasal Pillows For Combination Oral/Nasal Mask, Replacement Only, Pair
- Suppliers must use the **"KL" modifier** on claims for all diabetic supplies that are **delivered via mail** with dates of service on or after **July 1, 2007**, with the following codes: A4233, A4234, A4235, A4236, A4253, A4256, A4258 and A4259. The KL modifier must be used with diabetic supplies that are ordered remotely (i.e., by phone, email, internet, or mail) and delivered to the beneficiary's residence by common carriers (e.g., U.S. postal service, Federal Express, United Parcel Service) and not with items obtained by beneficiaries from local supplier storefronts.
- Fee schedule amounts for HCPCS code E2374 (Power Wheelchair Accessory, Hand or Chin Control Interface, Standard Remote Joystick (Not Including Controller), Proportional, Including all Related Electronics and Fixed Mounting Hardware, Replacement Only) are being revised to correct errors in the fee schedule calculation. Medicare contractors will adjust previously processed claims with dates of service on or after January 1, 2007, if resubmitted as adjustments.
- If suppliers re-submit previously processed claims for **code K0864 in Puerto Rico with dates of service from November 15, 2006 through March 31, 2007**, the DME MACs and DMERCs will adjust the claims f or payment.

Also, after consulting with the Food and Drug Administration, the Centers for Medicare & Medicaid Services (CMS) determined that **ultraviolet light therapy** systems are classified as **class II devices** and are not class III devices. Thus, suppliers **should not submit the class III "KF" modifier with claims for HCPCS codes E0691, E0692, E0693 and E0694 with dates of service on or after January 1, 2005**. CMS is removing HCPCS codes E0691, E0692, E0693, and E0694, billed with the KF modifier, from the fee schedule, effective July 1, 2007 and as of that date, Medicare contractors will reject claims for HCPCS codes E0691, E0692, E0693, and E0694, which contain the KF modifier and a date of service on or after January 1, 2005. Medicare contractors will adjust previously processed claims for E0691, E0692, E0693 and E0694 with dates of service on or after January 1, 2007, if suppliers resubmit the claims as adjustments.

The HCPCS Quarterly Update public use file, containing the long and short descriptors for all new codes, is available for downloading at www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp.

COVERAGE

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5641) issued to your Medicare A/B MAC, FI, DMERC, DME MAC, RHHI or carrier. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1263CP.pdf on the CMS website.

LCD and Policy Article Revisions Summary for June 2007

Outlined below is a summary of the principal changes to the DME Local Coverage Determinations (LCDs) that have been revised for the June 2007 Publication. These policy revisions are effective for dates of service on or after July 1, 2007. Please review the ***entire*** LCD and/or each related Policy Article for ***complete*** information.

Automatic External Defibrillators

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added ICD-9 412 to HCPCS code E0617 and K0606-K0609.

Removed DMERC references.

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Added ICD-9 412 to HCPCS code E0617 and K0606-K0609.

For code E0617, corrected 426.02 to 426.82.

DOCUMENTATION REQUIREMENTS:

Removed DMERC references.

APPENDICES:

Added ICD-9 412 to definition of myocardial infarction.

Canes and Crutches

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Cold Therapy

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

PA

Revision Effective Date: 07/01/2007

CODING GUIDELINES:

Removed: DMERC references.

Epoetin

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

External Breast Prostheses

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Facial Prosthesis

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Revised billing requirements for codes L8048, V2629.

PA

Revision Effective Date: 07/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: DMERC references.

CODING GUIDELINES:

Removed: DMERC references.

High Frequency Chest Wall Oscillation Devices

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Removed additional documentation requirements.

SOURCES OF INFORMATION AND BASIS FOR DECISION:

Removed references

Infrared Heating Pad Systems

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

SOURCES OF INFORMATION:

Information in this section was removed.

Intrapulmonary Percussive Ventilation System

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Mechanical In-exsufflation Devices

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Oral Anticancer Drugs

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

PA

Revision Effective Date: 07/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: DMERC references.

CODING GUIDELINES:

Removed: DMERC references.

Orthopedic Footwear

LCD

Revision Effective Date: 07/01/2007

INDICATONS AND LIMITATIONS:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Patient Lifts

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Power Mobility Devices

LCD

Revision Effective Date: 07/01/2007

DOCUMENTATION REQUIREMENTS:

Removed: DMERC reference.

Pressure Reducing Support Surfaces - Group 2

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Walkers

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Revised: Requirements for billing E1047.

Revised: Requirements for billing E1399.

Wheelchair Seating

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: Duplicate paragraph.

** **Note: The information contained in this article is only a *summary* of revisions to LCDs and Policy Articles. For complete information on any topic, you must review the *entire* LCD and/or its related Policy Article.**

LCD and Policy Article Revisions Summary for July 2007

Outlined below is a summary of the principal changes to the DME Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised for July 2007 publication. Please review the entire LCD and each related Policy Article for complete information.

Ankle-Foot/Knee-Ankle-Foot Orthosis

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: References to DMERC.

DOCUMENTATION REQUIREMENTS:

Removed: References to DMERC.

Policy Article

Revision Effective Date: 07/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Changed title of previous Therapeutic Shoes for Diabetics LMRP, to the new LCD title – Therapeutic Shoes for Persons with Diabetes.

CODING GUIDELINES:

Changed title of previous Therapeutic Shoes for Diabetics LMRP, to the new LCD title – Therapeutic Shoes for Persons with Diabetes.

Removed: Reference to DMERC.

Continuous Positive Airway Pressure System (CPAP)

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

Revised: Usual maximum quantity parameter for A7037.

Added: Usual maximum quantity parameters for new HCPCS codes – K0553, K0554, and K0555.

HCPCS CODES AND MODIFIERS:

Added: K0553, K0554 and K0555

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Policy Article

Revision Effective Date: 07/01/2007

CODING GUIDELINES:

Added: Narrative definition for new HCPCS code K0553.

Eye Prostheses

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Hospital Beds and Accessories

LCD

Revision Effective Date: 07/01/2007

HCPCS CODES AND MODIFIERS:

Added: GA, GK, GL, and GZ modifiers

DOCUMENTATION REQUIREMENTS:

Clarified instructions for KX modifiers.

Added modifier requirements for upgrades.

Negative Pressure Wound Therapy Pumps

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY:

Moved documentation requirements for extra supplies to the Documentation Requirements section of the LCD.

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Revised documentation requirements for extra supplies.

Removed: DMERC references.

Oxygen and Oxygen Equipment

Policy Article - Effective January 2007 (June 2007 Publication)

Revision Effective Date: 01/01/2007 (June 2007 Publication)

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised statements concerning separate payment for portable contents.

Refractive Lenses

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Clarified: Replacement lenses are covered for patients without an implanted intraocular lens (IOL).

Moved: Statement about coverage for patients with surgery prior to Medicare entitlement to the Policy Article.

Removed: DMERC references.

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

Moved: Covered ICD-9 codes to the Policy Article.

DOCUMENTATION REQUIREMENTS:

Removed: Requirement for date of surgery to accompany the claim.

Removed: DMERC references.

APPENDICES:

Moved: Definition of aphakia and pseudophakia to Indications and Limitations of Coverage section.

Policy Article

Revision Effective Date: 07/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Definitions of aphakic and pseudophakia.

Moved: Statement about coverage for patients with surgery prior to Medicare entitlement from the LCD.

ICD-9 CODES THAT ARE COVERED:

Moved: Codes 379.31, 743.35 and V43.1 from the LCD.

Respiratory Assist Devices

LCD

Revision Effective Date 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added K0553-K0555 to usual quantities table.

Removed: DMERC references.

Revised maximum amount for A7037.

COVERAGE CON'TD

HCPCS CODES AND MODIFIERS:

Added codes K0553-K0555

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Policy Article

Revision Effective Date: 07/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed code list of payable accessories.

CODING GUIDELINES:

Removed paragraph describing use of CPAP codes for RAD.

Added definition for K0553.

Speech Generating Devices

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC reference.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Policy Article

Revision Effective Date: 07/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added statement concerning non-coverage of replacements or upgrades during reasonable useful lifetime.

CODING GUIDELINES:

Revised definitions of E2511 and E2599.

Tracheostomy Care Supplies

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Therapeutic Shoes for Persons with Diabetes

LCD

Revision Effective Date: 07/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Moved: Requirement for an order to the Policy Article.

Moved: Statement about covered of modifications to the Policy Article.

Removed: DMERC references.

DOCUMENTATION REQUIREMENTS:

Removed: DMERC references.

Policy Article

Revision Effective Date: 07/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Moved: Requirement for a physician order from the LCD and noted that absence of the order was a statutory coverage denial.

Moved: Statement about coverage of modifications from the LCD.

Clarified: Physician assistants, nurse practitioners, and clinical nurse specialists may not be the Certifying Physician but may be the Prescribing Physician.

CODING GUIDELINES:

Removed: DMERC reference.

Revised: Statement about billing for inserts based on the SADMERC Product Classification list.

Urological Supplies

Policy Article – Effective June 2007

Revision Effective Date: 06/01/2007

CODING GUIDELINES:

Removed guidelines for A4347, code deleted 12/31/2004.

Updated code narrative for A4349.

Removed A5119, code deleted 12/31/2005.

Removed A4325 from the bundling table.

** **Note: The information contained in this article is only a *summary* of revisions to the LCDs and Policy Articles. For complete information on any topic, you must review the *entire* LCD and/or Policy Article.**

July 2007 Quarterly ASP Medicare Part B Drug Pricing File

MLN Matters Number: MM5646 Revised
Related Change Request (CR) #: 5646
Related CR Release Date: June 15, 2007
Related CR Transmittal #: R1270CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

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

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Regional Carriers (DMERCs), 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.

Provider Action Needed

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

Background

The Medicare Modernization Act of 2003 (MMA; Section 303(c)) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Starting January 1, 2005, many of the drugs and biologicals not paid on a cost or prospective payment basis are paid based on the average sales price (ASP) methodology, and pricing for compounded drugs is performed by the local Medicare contractor. Additionally, beginning in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on the ASP methodology.

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. CMS also posts these files to its website at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.

As announced in late 2006, after carefully examining Section 1847A of the Social Security Act, as added by the Medicare Modernization Act of 2003, CMS has been working further to ensure that more accurate and, as appropriate, separate payment is made for single source drugs and biologicals under Section 1847A. As part of this effort, CMS reviewed how the terms "single source drug," "multiple source drug," and "biological product" are operationalized in the context of payment under section 1847A. For the purposes of identifying "single source drugs" and "biological products" subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. CMS will consider:

- The FDA approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003, the payment limit under Section 1847A for that biological product or single source drug will be based on the pricing information for products produced or distributed under the applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may also be operationalized through use of existing specific HCPCS codes or "not otherwise classified" HCPCS codes.

For 2007, a separate fee of $0.152 per International Unit (I.U.) of blood clotting factor furnished is payable when a separate payment for the blood clotting factor is made. The furnishing fee will be included in the payment amounts on the quarterly ASP pricing files.

ASP Methodology

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent (106%) of the ASP. Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

- ESRD drugs (when separately billed by freestanding and hospital-based ESRD facilities), and
- Specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS.

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.
- Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. **The payment allowance limits will not be updated in 2007**. Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the

published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded.

- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department and, then, is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, other than new drugs that are produced or distributed under a new drug application (or other application) approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. The payment limit is 100 percent of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.
- The payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after June 19, 2007, revised January 2007 and April 2007 ASP payment files and the July 2007 ASP file will be available for retrieval from the CMS ASP webpage. The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP webpage is located at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ on the CMS website. The revised files are applicable to claims based on dates of service as shown in the following table:

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

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); http://www.ssa.gov/OP_Home/ssact/title18/1842.htm may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for the physician (or other practitioner) to perform the service. Medicare contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if the medication administered is accepted as a safe and effective treatment of the patient's illness or injury; there is a medical reason that the medication cannot be taken orally; and the skills of the nurse are needed to infuse the medication safely and effectively. Payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology as described above. Note that pricing for compounded drugs is done by your local Medicare contractor.

Additional Information

The official instruction (CR5646) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI is available at http://www.cms.hhs.gov/Transmittals/downloads/R1270CP.pdf on the CMS web site.

Oxygen Contents – Payment Rules

Fee schedule allowances for oxygen contents have changed in 2007. In 2006, the fee schedule allowance for stationary oxygen contents (E0441 and E0442) included payment for portable oxygen contents. For claims with dates of service on or after January 1, 2007, if a patient owns both a stationary gaseous or liquid system and a portable gaseous or liquid system, bill two codes – one for the stationary contents (E0441, E0442) and one for the portable contents (E0443, E0444).

The following is a revision of the applicable section of the Oxygen Policy Article. It is effective for claims with dates of service on or after 01/01/2007. It will be incorporated in a future revision of the Policy Article.

OXYGEN CONTENTS:

Oxygen contents are included in the allowance for rented oxygen systems. Stationary oxygen contents (E0441, E0442) are separately payable only when the coverage criteria for home oxygen have been met and they are used with a patient owned stationary gaseous or liquid system respectively. Portable contents (E0443, E0444) are separately payable only when the coverage criteria for home oxygen have been met and:

1. The beneficiary owns a stationary system (concentrator, gaseous, or liquid) and rents or owns a portable system, or
2. The beneficiary has no stationary system (concentrator, gaseous, or liquid) and rents or owns a portable system.

If the criteria for separate payment of contents are met, they are separately payable regardless of the date that the stationary or portable system was purchased.

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