Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

December 2007
Issue No. 9

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

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

Web site: www.noridianmedicare.com

Fax	
Reopenings and Redeterminations	888-408-7405
Administrative Simplification Compliance Act (ASCA)	888-523-8449
Refunds to Medicare	888-529-3666
MSP Inquires and Refunds	888-535-5114

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

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.

Holiday	Date
Christmas Day	December 24 and 25, 2007
New Year's Day	January 1, 2008
Martin Luther King's Day *	January 21, 2008
President's Day *	February 18, 2008
Good Friday	March 21, 2008
Memorial Day	May 26, 2008
Fourth of July Holiday	July 4, 2008
Labor Day	September 1, 2008
Columbus Day *	October 13, 2008
Veteran's Day *	November 11, 2008
Thanksgiving Day	November 27, 2008
Thanksgiving Holiday	November 28, 2008
Christmas Eve**	December 24, 2008
Christmas Day	December 25, 2008
** Partial day closure	

Sources for "Jurisdiction D Happenings" Articles

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

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

Summary of Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
Chapter 16	Level II HCPCS Codes	Removed J7318, invalid HCPCS code	11/20/07
Chapter 16	Modifiers	Added modifiers associated with the competitive bidding process	11/5/07
Chapter 16	Modifiers	Added KG and KK effective January 1, 2008	10/25/07

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

Medicare Learning Network Matters Disclaimer Statement

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

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

Items and Special Services Having Special DME Review Considerations

MLN Matters Number: MM5765
Related Change Request (CR) #: 5765
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R236PI
Effective Date: April 1, 2008
Implementation Date: April 1, 2008

Provider Types Affected

Suppliers who submit claims to Durable Medical Equipment Medicare Administrative Contractors (DME/MACs) for DME items and services furnished to Medicare beneficiaries

What Providers Need to Know

This article is informational for suppliers and is based on Change Request (CR) 5765 that alerts suppliers that the medical review (MR) function (Chapter 5 of the *Program Integrity Manual* (*PIM*) Items and Services Having Special DME Review Considerations) that was the responsibility of the DME Program Safeguard Contractors (PSCs) is being transitioned to the DME Medicare Affiliated Contractors (MACs).

Background

As a result of the MAC transition and effective April 1, 2008, the DME PSCs will be renamed Zone Program Integrity Contractors (ZPICs). This change of terminology from PSCs to ZPICs is noted in the *PIM* Chapter 5 revision. The *PIM* revision is attached to this CR5765 and the address is listed in the *Additional Information* section of this article.

Key Points

- DME/MACs will perform MR duties;
- DME/MACs will, at their discretion, recommend that the Centers for Medicare & Medicaid Services (CMS) initiate a potential Civil Monetary Penalty (CMP) case against the supplier; and
- DME/MACs will develop safeguards to investigate multiple claims for rental of the same or similar equipment from the same supplier within the same rental period.

Additional Information

To see the official instruction (CR5765) issued to your Medicare DME/MAC visit http://www.cms.hhs.gov/Transmittals/downloads/R226PI.pdf on the CMS web site.

DMEPOS Suppliers Should Not Register Now for Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC)

In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available. Recently, CMS announced that Medicare FFS providers should now register for IACS-PC; however, CMS does not expect any new online services will be available to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers in 2008. Therefore, DMEPOS suppliers should not register for IACS-PC, at this time. DMEPOS suppliers interested in the second round of DMEPOS competitive bidding should follow CMS DMEPOS Competitive Bid instructions which will be released closer to the 2008 bid window.

To learn more about IACS-PC in preparation for future registration, see the new MLN Matters article (the first in a new series on IACS-PC), which addresses key questions and answers about the registration process. The article is now available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf on the CMS web site.

Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC): The First In a Series of Articles

MLN Matters Number: SE0747

These articles will help providers to register for future access to CMS online computer services. This article contains:

- 10 questions and answers to get you started and
- Overview of the registration process for IACS-PC defined provider organization users.

Provider Types Affected

Physicians, providers, and suppliers who submit fee-for-service claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and Medicare Administrative Contractors (A/B MACs)).

Special Note: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers should not register for IACS -PC at this time. DMEPOS suppliers may want to review question # 10 below.

What Providers Need to Know

In the near future, the Centers for Medicare & Medicaid Services (CMS) will be announcing new online enterprise applications that will allow Medicare fee-for-service providers to access, update, and submit information over the Internet. Details of these provider applications will be announced as they become available.

Provider Action Needed

Even though these new internet applications are not yet available, CMS recommends that providers take the time now to set up their online account so they can access these applications as soon as they are available. The first step is for the provider or appropriate staff to register for access through a new CMS security system known as the Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC). See the following section for key questions and answers about the registration process.

10 Questions and Answers to Get You Started

1. What is IACS-PC?

IACS-PC is a security system CMS uses to control issuance of electronic identities and access to new CMS provider web-based applications. Through IACS-PC, provider organizations, as defined by IACS-PC (See question # 7 below), and their staff, as well as individual practitioners, will be able to access new CMS applications. Provider organizations will also be able to manage users who they authorize to conduct transactions on their behalf, which may include staff and contractors.

Note: This release of IACS-PC will not impact access to FI/Carrier/MAC internet applications or the DME Competitive Bidding System (DBidS) application. New enterprise CMS systems will not offer the internet services FIs/Carriers/MACs are providing in the near future.

2. Who can use this system?

Medicare providers and their designated representatives (e.g. clearinghouses, credentialing departments) may request access to CMS enterprise applications. At this time, the soon-to-be-announced online applications under IACS-PC do not include services to DMEPOS suppliers. (See question # 10 below.)

3. Why register NOW?

Since the new applications have not been announced at the time of this notice, it may be hard to decide if you should register to use the system. However, because IACS-PC registration must precede use, we recommend that individual practitioners and provider organizations (with the exception of DMEPOS suppliers) register now. Even if the IACS-PC registration process goes well and all documentation is in order, it can still take several weeks to finalize registration. Since the system is new, registering now gives you a "cushion" so that if there are delays in processing your registration, you will have the registration process complete in time to request access to the various CMS provider related computer services as soon as they are available early next year.

4. If I register now, how long is my password valid?

Passwords expire in 60 days. After that point, when you log into IACS-PC, you will be prompted to create a new password to re-activate your account. Therefore, we recommend that once registered, you sign on periodically to IACS-PC to keep your current password active.

5. How do I register as an IACS-PC user?

IACS-PC uses a self-registration process. The self-registration process that you will follow will depend on the type of IACS-PC user you are. There are two categories of user types: individual practitioners and provider organizations. There are step-by-step registration instructions to help you through this process.

NOTE: The CMS web site contains links to IACS user guides for other communities of users. Only use instruction links for the IACS-PC community as directed by CMS.

The External User Services (EUS) Help Desk will support this process for IACS-PC. It may be reached by email at EUSSupport@cgi.com or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

6. When would I register as an individual practitioner?

An individual practitioner is defined by IACS-PC as a physician or non- physician practitioner. This is intended for practitioners who will be conducting transactions with online applications personally and have no staff who will be accessing the applications.

More details can be found in the Individual Practitioner Registration- Quick Reference Guide, which can be found on the CMS web site at: http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Individual_Practitioner_Registration_QRG_111607.pdf

7. When would I register as an IACS-PC provider organization?

The term "organization", as defined by IACS-PC, should not be confused with the term organization as it applies to provider enrollment or the NPI. For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers and physician group practices.

It also includes individual physicians and non- physician practitioners who want to delegate staff to conduct transactions on their behalf. In this case, for IACS-PC registration purposes, registration must be as an organization.

IACS-PC provider organizations require Security Officials (see question # 9 below) that establish the provider organization in IACS-PC. All users will then be grouped together within IACS-PC under the provider organization Security Official.

8. What should I have in hand before I register?

For an individual practitioner (who will be conducting transactions with online applications personally and have no additional staff that will be accessing the applications) they will need to know their:

- Social Security Number and
- Correspondence Information.

For an IACS-PC provider organization, the Security Official (SO) of that organization will be the first person to register within IACS and create their organization. The SO should have the following organizational information available before they sign on to register:

- Taxpayer Identification Number (TIN);
- Legal Business Name;
- Corporate Address; and
- Internal Revenue Service (IRS) Issued CP-575 hard copy form.

9. How do I register my IACS-PC provider organization?

IACS-PC is based on a delegated authority model. Each organization must designate an SO who will register the organization via IACS-PC and then be accountable for users in the organization. Using information supplied via the IACS-PC registration as well as a mailed-in copy of the organization's CP-575 form, CMS will verify the SO's role in the organization, the TIN and the Legal Business Name of the organization. This can take several weeks. Once approved, the SO then has the ability to approve other registrants under the provider organization. For more detail, please read the Overview section, which follows question #10.

Once you understand IACS-PC user roles, and have designated an SO, the SO should register using the instructions in the Security Official Registration - Quick Reference Guide, which is available on the CMS web site at: http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf.

The next MLN article in this series of articles will provide instructions for additional users to register in IACS-PC.

10. Why are you excluding DMEPOS suppliers from IACS-PC?

DMEPOS suppliers should not register in IACS-PC at this time because we do not expect any new online services will be available to them in 2008. DMEPOS suppliers interested in the second round of DMEPOS competitive bidding should follow CMS DMEPOS Competitive Bid instructions which will be released closer to the 2008 bid window.

OVERVIEW: Registering in IACS-PC as a Provider Organization or a Provider Organization User

For IACS-PC registration purposes, "organization" includes providers and suppliers such as hospitals, home health agencies, skilled nursing facilities, independent diagnostic testing facilities, ambulance companies, ambulatory surgical centers, and physician group practices. It also includes individual physicians and non-physician practitioners who want to delegate employees to conduct transactions on their behalf.

I. The Registration Process

IACS-PC is based on a delegated authority model. Each user self-registers and is approved as shown below. The system is designed for flexibility to meet provider needs while assuring security of computer systems and privileged information. At this time, a provider organization must have at least 2 users, one of whom will be able to access IACS-PC applications.

The "delegated authority model" previously described is below. The EUS Help Desk will be responsible for approving the organization's Security Official. Then the Security Official may approve the Backup Security Official(s) etc.

II. Registration Roles

1. The first person to register must be the **Security Official.**

   The Security Official is the person who registers their organization in IACS-PC and updates the organization profile information in IACS-PC. There can be only one Security Official for an organization. The Security Official is trusted to approve the access request of Backup Security Official(s) and can approve the access requests of User Group Administrators and End Users. The Security Official will be approved by CMS through its EUS Help Desk. The Security Official is held accountable by CMS for the behavior of those they approve including the End Users for the organization.

   The Security Official Registration - Quick Reference Guide may be found on the CMS web site at: http://www.cms.hhs.gov/MMAHelp/downloads/IACS_Security_Official_Registration_QRG_111607.pdf

   Note: Additional employee and contractor users cannot be approved until the security official has been approved by the EUS Help Desk

2. An organization may choose to have one or more **Backup Security Officials**. (Optional)

   This is an optional role. You need not have a Backup Security Official. The Backup Security Official is approved by the Security Official. A Backup Security Official performs the same functions as a Security Official in an organization, with the exception of approving other Backup Security Officials. There can be one or more Backup Security Officials in an organization. The Backup Security Official can approve the access requests of User Group Administrators and End Users and may aid the Security Official with the administration of User Groups and User Group Administrators' accounts.

3. The next registrant must be a **User Group Administrator** (UGA).

   The UGA is approved by the Security Official or Backup Security Official. The UGA is trusted to approve the access requests of End Users for that User Group.

   Organizations with 2-9 IACS-PC users must, at a minimum, have a Security Official and one or more UGAs. If there will be only one user in a group, that user must register as a UGA.

   A UGA registers the User Group within an organization in IACS-PC and updates the User Group profile information in IACS-PC. There can be multiple UGAs for the same User Group within an organization.

4. Organizations with 10 or more IACS-PC users must also have **End Users**.

   An End User is a staff member who is trusted to perform Medicare business and conduct transactions for the provider organization. An End User is part of a User Group within the provider organization. An End User may be an employee of a provider/supplier/practitioner or a contractor working on the behalf of one of these entities. An End User may belong to multiple groups in one or more organizations. The End User is approved by the UGA.

   Note: End User requests cannot be approved until after the User Group Administrator has been approved.

FYI CONT'D

III. Surrogate User Groups

This applies to provider organizations that want to delegate online work to individuals or a company outside of the provider organization. Under this scenario, those working on behalf of the provider organization register as a **Surrogate User Group**. Examples include clearinghouses, credentialing departments, independent contractors. A Surrogate User Group has a direct contractual business relationship with the Medicare provider/supplier, but not with CMS. A Surrogate User Group may be associated with multiple provider organizations.

1. The first contractor employee to register in a Surrogate User Group must be the UGA.

   If there will be only one user in a Surrogate Group, that user must register as a UGA. The UGA for the Surrogate User Group will register the Surrogate User Group and update the User Group profile information in IACS-PC. There can be multiple UGAs within the same Surrogate User Group. The UGA is trusted to approve the access requests of End Users for their user group.

   The UGA of the Surrogate User Group must be approved by the Security Official or Backup Security Official in the provider organization on whose behalf it performs work. Once approved, the UGA of a Surrogate Group may request to associate with other provider organizations for which it performs work without registering again.

2. A contractor employee may also register as an **End User.**

   An End User is approved to perform Medicare business for a surrogate or provider User Group by their UGA. An End User may belong to multiple groups in one or more organizations.

ADDITIONAL HELP

The EUS Help Desk will support this process for IACS-PC. It may be reached by email at EUSSupport@cgi.com or by phone on 1-866-484-8049 or TTY/TDD on 1-866-523-4759.

EDUCATIONAL

Ask the Contractor Questions and Answers September 11, 2007

Prior to taking questions, NAS provided the following updates:

NPI

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

Effective October 29, 2007, all DME MACs will begin editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. Where a match cannot be located on the crosswalk, claims will be rejected or returned.

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

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

Suppliers are encouraged to send a small number of claims using only the NPI. If no claims are rejected, then suppliers can gradually increase the volume. If any claim is rejected, verify the correct NPI was submitted. If submitted correctly, then data in either NPPES or Medicare provider files should be corrected and testing done again. It is critical to start testing with your NPI now. For more information, see MLN Matters 5452, 5595, SE0725 and SE0659.

Effective July 1, 2007, the NPI is being reported on remittance advices when the NPI is reported on claims. For more information on this topic, see MLN Matters 5081 and 5452.

The NPI Registry is also available at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

The NPI Registry enables users to query the NPPES by the NPI or the provider name. The NPI Registry will return the results of the query and the user will click on the record to view it. The NPI Registry will then display the FOIA-disclosable data for those records.

Telephone Reopenings

NAS has expanded the phone reopenings hours. You can call phone reopenings between the hours of **8 am and 4 pm CT** Monday through Friday at **(888) 826-5708.** There is a limit of 5 reopenings per phone call. The types of inquires that can be handled as phone reopenings for any type of DMEPOS are minor, clerical errors, such as adding diagnoses and modifiers or correcting typos.

Some corrections cannot be requested as phone reopenings, but must be submitted in writing along with the supporting documentation. These include:

- Codes requiring review by our medical staff
- Timely denials/Late files
- Requests that require documentation
- ABN issues, i.e., adding GA or GY modifiers (changing liability)
- Medicare Secondary Payer (MSP) - MSP issues must be submitted in writing and mailed with an attention line of "MSP."

If the change will result in **reduction** of payment, the change cannot be initiated by the phone reopening area and should be sent in writing to the Recoupment team.

We also wanted to remind suppliers that written redetermination requests must contain an original signature. Any requests received on/after July 1, 2007, without signatures have been dismissed as invalid requests.

We are also pleased to announce that both written reopening and redetermination requests can now be faxed to NAS. This fax number is 1-888-408-7405.

MSP Inquiry/Refund Form

Suppliers will want to review the new MSP Inquiry and Refunds form, that was posted to our web site recently. Please use this new form for all MSP related inquiries, including refunds. This new form is located in the Forms section of our web site, www.noridianmedicare.com

The following questions and answers are from the September 11, 2007, Ask-the-Contractor conference call. In some cases, the original answers given during the call may have been expanded to provide further detail. These were current as of this event. Please check our web site for updates.

Q1. How do I bill Medicare for the denial of vancomycin when the patient is on an infusion pump? In this particular situation the patient's secondary insurance will only accept a two-line claim, one line with an S-code for the per diem and the other line with the J-code for the drug. Medicare does not cover this antibiotic for home infusion. We do not bill the pump to Medicare because payment for the pump is included in the per diem code that is used to bill the secondary insurance. We have billed A4222 (infusion supplies for external drug infusion pump, per cassette or bag) along with the J-code for the drug. Is this correct? Again, we can't use the Medicare codes E0781 (ambulatory infusion pump), A4221 (supplies for maintenance of drug infusion catheter), A4222, and J3370 (vancomycin) because the other insurance won't pay on a four-line claim.

A1. NAS is researching this question. When we finalize the answer, we will post it to our web site.

Q2. I have a question regarding Albuterol, which was initially billed with J7613 and now must be billed with Q4094. I billed the Q4094 in July and got paid appropriately. However, when I try billing it now EDI rejects it front end saying the code is not valid. I am not billing any modifier with this code. What should I do?

A2. The Q4094 must be billed with the KO (single drug unit dose formulation) modifier.

Q3. When billing E1399 (DME, miscellaneous) for the battery adapter and/or the battery converter for a CPAP, do I need an ABN signed by the beneficiary? Can I collect the payment from the beneficiary when Medicare does not cover the item? What modifier(s) do I use in this instance?

A3. When Medicare never covers an item like a battery adapter or battery converter, you do not need an ABN signed by the beneficiary. You would bill the item with the GY (item or service statutorily excluded or does not meet the definition of any Medicare benefit) modifier. Payment for the statutorily excluded item can be collected from the beneficiary prior to submitting the claim to Medicare for payment, however, if a secondary insurance possibly pays on the excluded item, you would need to refund to the patient the overpaid amount. You do not collect from the beneficiary for items that may be covered by Medicare if you accept assignment.

Q4. I am receiving two to three separate acknowledgements and redetermination decisions to my redetermination requests. Why are we receiving duplicate letters to the same request?

A4. NAS is researching this issue and hopes to have it corrected shortly. Thank you for bringing it to our attention.

Q5. I have a question regarding a revised Certificate of Medical Necessity (CMN) and adding portable oxygen. NAS published an article on September 6, 2007, which states that if a patient initially qualifies for oxygen based on a test taken during sleep, portable oxygen is denied as medically necessary. If the patient is later tested during exercise or at rest, a new initial CMN and recertification CMN will be required for the portable oxygen. The Local Coverage Determination (LCD) states that when portable oxygen is added subsequent to a standard oxygen system, a revised CMN is all that is required. Chapter 4 of the Supplier Manual states the same thing. My understanding is that the CMN is for oxygen service and when that service changes then we need to revise the CMN. Why is NAS going against the LCD and Supplier Manual?

A5. This is a revised answer to the answer that was provided during the teleconference.

NAS reconsidered this issue and retracted this statement on September 25, 2007, from the original article posted on September 6, 2007:

> If a patient initially qualifies for oxygen based on a test taken during sleep, portable oxygen is denied as not medically necessary. If the patient is later tested during exercise or at rest, a new initial CMN and recertification CMN will be required for the portable system. If the initial CMN date for the stationary equipment is within 90 days of the initial date for the portable system, the recertification for the stationary can also cover the recertification on the portable. Otherwise, a separate recertification will be required for portable oxygen.

Suppliers can continue to submit a revised oxygen CMN when adding portable oxygen equipment when an oxygen

CMN has already been submitted for stationary oxygen equipment. NAS, however, will deny a revised oxygen CMN and related claims if question 4 is marked as D, signifying that portable oxygen is not being ordered.

Follow-up Statement: NAS did not accept my revised CMN but rather denied the portable oxygen. Therefore, I have been required to send this denial to redeterminations.

Based on NAS' reconsideration of this issue as noted above, the supplier was contacted and provided NAS with a list of claims that had been denied. NAS reopened and paid these claims. The claims that had been sent to redeterminations were deleted and were addressed as reopenings.

Q6. We use the "Refunds to Medicare" form from the NAS web site. We fax the forms to Medicare and assume that Medicare will take the refund request back in an offset. However, Medicare is charging us interest before doing the offset. How can the offsets be done in a timely manner without charging us interest?

A6. When using the "Refunds to Medicare" form for which you want Medicare to do an immediate offset, state that explicitly on the form. Without that instruction, Medicare will not proceed with an immediate offset.

If, instead, you receive a letter from Medicare asking for a refund of an overpayment, and you want Medicare to offset that amount in a timely fashion, include a copy of the demand letter with your request and indicate that you want the amount offset prior to the second demand letter. You will need to return the demand letter in a timely fashion to allow us the lead-time to complete the offset.

Q7. How long is it taking NAS to process redetermination requests? Does NAS have a backlog?

A7. Currently NAS is working receipts that are 50 days old. We have 60 days to complete redeterminations to meet the time line established by CMS. NAS does not have a backlog of redetermination requests.

Q8. We have been having a problem when billing E2402 (negative pressure wound therapy electrical pump). Some of our payers require us to bill daily while Medicare requires us to bill monthly. With this scenario, how do I bill Medicare as the secondary payer?

A8. When billing Medicare as the secondary payer, bill for the entire month, as you would bill if Medicare was the primary payer, using the total of the daily billings and include a copy of each explanation of benefits (EOB) with your claim. If you bill electronically, report the totals from EOBs in the appropriate fields.

Q9. We are billing for a wheelchair for a patient who initially was receiving this item from another supplier. This other supplier has since started to bill for the same item and they are getting paid while we are getting denied. How should we proceed with this problem? The other supplier isn't being very cooperative about refunding so we can rebill.

A9. You need to call the Supplier Contact Center at 1-866-243-7272 with all the specifics. The customer service representative (CSR) will take the lead from there.

Q10. I received a favorable decision on a redetermination request, but I have not received payment. When I call the Supplier Contact Center, I'm told the claim is still processing. The last time I called, I was told it was still in process; this is a stuck check. If I have a problem with that, I should contact CMS. What do you suggest?

A10. NAS researched the examples provided and found the claims have not processed to completion due to a problem with the Common Working File (CWF). We are working to fix that problem and as soon as it is corrected, the claims will process to completion. We apologize for the delay.

Q11. Since the implementation of the Deficit Reduction Act and the capped rental on certain items, is there going to be any data opened up so the supplier can look to see how many months of rental of an item have been paid prior to my billing my claim? This would avoid receiving possible denials. We do not like providing equipment that has already converted to a sale by another supplier. I would like to look this information up on the internet rather than bothering a CSR and using the time of my billing agent.

A11. NAS recommends that you provide this suggestion to CMS.

Q12. I have some oral anticancer drugs beginning with J85xx for which we haven't been paid however we have been paid the pharmacy dispensing fee. Whenever I call the Supplier Contact Center, I am told these are being processed as a mass adjustment. When will the mass adjustment be completed?

A12. The reason the oral anticancer drugs have not been paid when billed with a J85xx code is because oral anticancer drugs must be billed with the appropriate NDC code rather than a HCPCS (J85xx) code.

NAS is not mass adjusting any of these claims and the Supplier Contact Center has been made aware of this.

Q13. I have been faxing refund letters to NAS and asking for an immediate offset. A short time later I will receive a letter from NAS asking me to refund. When I call the Supplier Contact Center, they advise me that my fax had been received and that I should fax the refund request back to NAS asking for an immediate offset. It seems like I am sending my requests about three times before anything gets completed. Is there something that I should be doing differently?

A13. You should be aware that as soon as NAS receives notification of a refund request and sets up the accounts receivable (AR) for the claim at issue, the processing system automatically sends a demand letter to the supplier. The demand letter is your official notification that an overpayment occurred and you owe the paid amount back to Medicare. Therefore, when you notify NAS of an overpayment, the AR is built and the letter is generated. You do not need to fax the notification back to NAS asking for an offset. We know that from the original notification you sent us. If, however, you receive a follow-up letter 30 days later, then you should be concerned and should advise NAS that you had requested an immediate offset when you notified NAS of the overpayment.

Q14. If a patient returns a piece of equipment within the first month of rental, do we bill for the entire month, prorate the charge, or back out the charge completely?

A14. You are entitled the entire month's rent regardless of how many days the beneficiary actually had the equipment in their possession. However, if you desire, you can prorate your charge for the number of days used and bill Medicare a lesser amount.

Q15. When my facility calls NAS regarding redeterminations that were sent over 90 days ago, we are told they aren't on file. It seems the biggest hole is May 2007. Did something happen at that time where redetermination requests were misplaced? About 40% of what we sent cannot be located including some that were sent prior to the transition to NAS on September 29, 2006.

A15. Nothing unusual happened in May regarding redeterminations. Therefore, NAS requested and received three examples. When researching these examples, NAS found that the supplier had been notified of the results of the redetermination requests as follows:

- Example 1: First date of service was dismissed due to timely filing requirements and the second date of service was paid.
- Example 2: Services at issue were paid.
- Example 3: The previous contractor sent an affirmation letter to the supplier in June 2006.

Q16. If the initial oxygen CMN would have qualified the patient for portable oxygen, do I submit a revised CMN when the patient actually begins receiving portable oxygen? If that is the case then a recertification for the portable oxygen would not be required, correct?

A16. You are correct. A revised CMN is required when the patient initially qualified for portable oxygen when he qualified for stationary oxygen but didn't begin receiving portable oxygen until a later date.

Q17. Many times prior to requesting a reopening we call the Supplier Contact Center for the denial message. Then when we call the reopenings department we are told the change is too complex and we need to request a redetermination. However, we are only given 120 days following the initial determination date to request a redetermination while we are allowed one year following the initial determination date to request a reopening. If we need to request a redetermination, our request will be dismissed as untimely. What do you suggest we do in these instances?

A17. It is the supplier's responsibility to submit requests in a timely manner to NAS. Therefore, as soon as you receive a denial that you do not believe is appropriate, you should begin the process of determining whether the denial was a result of a clerical error or something more complex. If you aren't sure, then you should immediately begin the redetermination process within the 120-day time limit or call phone reopenings with your request.

Q18. We have instances where we ask to speak to a supervisor and are told one will call us back, however, that never happens. How can I get a return call from a supervisor when I ask for one?

A18. We have changed our process for escalated calls where the caller is transferred into a pilot for escalated calls only. Someone is always available in that pilot available to take an escalated call. We apologize for any inconvenience this may have caused you in the past.

Q19. Can I call NAS and speak to the person who actually reviewed my redetermination request and made the unfavorable decision? I found in the past that once I talked to the redetermination examiner, they reversed their decision because they realized they had errored.

A19. Redetermination examiners do not take telephone calls. They are responsible for reviewing your request and are not customer service representatives.

If you are not in agreement with the redetermination decision, you need to request a reconsideration with RiverTrust Solutions, PO Box 180208, Chattanooga, TN 37401-7208 within 180 days from the date of your redetermination decision.

Ask the Contractor Questions and Answers October 24, 2007

Prior to taking questions, NAS provided the following updates:

NPI

Effective October 29, 2007, all DME MACs will begin editing the NPI/legacy ID combinations for validity against the NPI crosswalk file. Where a match cannot be located on the crosswalk, claims will be rejected or returned.

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

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

Suppliers are encouraged to send a small number of claims using only the NPI. If no claims are rejected, then suppliers can gradually increase the volume. If any claim is rejected, verify the correct NPI was submitted. If submitted correctly, then data in either NPPES or the Medicare supplier file should be corrected and testing done again. It is critical to start testing with your NPI now. For more information, see MLN Matters 5452, 5595, SE0725 and SE0659.

EDUCATIONAL CONT'D

Below are some NPI guidelines to assist in avoiding claim rejections:

- A DME supplier is usually an entity type 2, organization, rather than entity type 1, individual. If a DME supplier is an organization, the NSC # should be listed as the "Other Provider Identifier" in the NPPES system. NAS has commonly seen where suppliers, who also have individual physicians in their company, are loading the NSC # in NPPES under the individual physician's NPI record, rather than entering this under the DME organization's NPI record.
- If a DME supplier is a sole proprietorship, he/she would enroll as entity type 1 and can have only one NPI.
- Federal regulations require that each DMEPOS supplier location, *other than sole proprietors*, have its own unique NPI.
- **The NSC number must be listed as a Medicare NSC number in the "Other Provider Identifiers" section of NPPES**-listing the NSC # as a DMERC or DME number will not create the crosswalk needed for matching the NPI and NSC number on claims.
- Only list legacy numbers that belong to the applicant's NPI in NPPES in the "Other Provider Identifiers" section in NPPES.
- DME MACs will not be matching data down to the address level when comparing the supplier information listed in NPPES and the NSC files.

The following questions and answers are from the October 24, 2007, Ask-the-Contractor Small Supplier conference call. In some cases, the original answers given during the call may have been expanded to provide further detail. These were current as of this event. Please check our web site for updates.

Q1. We understand that after five years of use, equipment can be replaced with new equipment if necessary. How is the replacement piece of equipment coded? Is it coded as a replacement or is it treated as a new piece of equipment?

A1. After five years, the item is coded as a new piece of equipment.

Follow-up Question: Then I should not use the RP (replacement or repair) modifier?

Using the RP modifier will not cause the claim to deny, but it is not needed for replacement equipment that is more than five years old.

Q2. We have a few oxygen patients where we are getting a CMN rejection after the fourth or fifth month. Why is this happening? We note on the CMN that the length of need is 12 months.

A2. This supplier faxed examples. We found that in one instance the oxygen for the beneficiary at issue had never been paid for this supplier and for the other beneficiary all claims had been paid to the supplier.

Reminder: When the patient is covered for oxygen based upon the group II coverage guidelines, the patient must be recertified for oxygen between the 61st and 90th day of home oxygen therapy. If the supplier neglects to have the patient recertified for oxygen at that time, the fourth month of home oxygen therapy will be denied as not a medical necessity.

Q3. I have a patient who has been renting a manual wheelchair; however, I recently received a denial based on the same/similar edits. I spoke with the patient and was advised that the patient purchased power equipment from another supplier. The denial message on the remittance notice doesn't tell me if I can/cannot bill the patient, but I feel the patient should be responsible because they did not tell us that they purchased a power chair from someone else.

A3. A same/similar denial, CO-57, is referred to as a contractual obligation, meaning the supplier is responsible for the denied charge unless an ABN was signed by the beneficiary prior to delivery.

In this case, the supplier advised NAS that this type of issue was becoming a problem in Southern California where buses pick up beneficiaries and take them to other suppliers where they are provided power mobility devices (PMDs). These PMDs are subsequently billed to Medicare and paid.

NAS advised this supplier that if she had an identified fraud issue, it should be reported.

Therefore, if you suspect fraud or abuse, please collect the following information and mail it to us:

- Date of service and name of the beneficiary
- Name of the physician and/or supplier
- Complete description of the problem

Any documentation you have that is related to the situation

- Name, address and phone number of the person making the complaint if it is someone other than the beneficiary

Medicare Benefit Protection - DME
PO Box 6736
Fargo ND 58108-6736

As an alternative, you may call the Supplier Contact Center at 1-866-243-7272 and relate the above information to the customer service representative.

Q4. I have a question on billing CPAP supplies when my company did not provide the original equipment. What information do I need on my claim for the supplies?

A4. If Medicare purchased the equipment, NAS has the type of equipment on file. Therefore, all you need to report in the narrative of your claim is information stating that the patient owns the equipment, and when it was purchased.

If the patient purchased the equipment prior to being eligible for Medicare and you are furnishing supplies now that the patient is receiving Medicare benefits, note in the narrative of your claim that private insurance paid for the equipment prior to the beneficiary being on Medicare and when that equipment was purchased. In this case, you also need documentation in your file to support the medical necessity for the initial equipment. This documentation must be available if requested by Medicare; it does not need to be submitted with the claim.

Follow-up question. When I am billing for maintenance and service (MS) of a capped rental CPAP rented prior to January 1, 2006, must there be six months of time separating that last rental month and the maintenance and service?

Yes, there must be six months between the last month of rent and the month of maintenance and service. In addition, the maintenance and service must be billed separately from the final month of rent, and Medicare must have paid the final month of rent.

Remember, there is no maintenance and service for capped rental items where the first rental month began on/after January 1, 2006. After 13 months those items become the property of the beneficiary and are repaired when needed.

Q5. Our facility moved to a new location in June 2007, and we began the address change process with the NSC in May 2007. The processing of this address change was completed September 5, 2007. All our Medicare checks for the months of June, July, and August were held pending the completion of the address change. We were told that once the address change was approved the checks would be released. However, we have received 16 remittance notices since that time, and we still haven't received any checks. Can you help me with the status of my checks?

A5. This supplier was contacted by the finance department after which it was found that although everything appeared to be in order when the supplier called the contact center regarding this issue, there was one change that needed to be made to the file based on information received from the NSC. Once this change was made, the checks were released.

Q6. Are we required to submit the completed CMN with the initial claim if we are billing, for example, oxygen?

A6. If you bill Medicare with the CMS-1500 claim form, you must include a copy of the completed CMN with the initial claim. If you bill Medicare electronically, you report the information from the completed CMN in the appropriate fields of the electronic claim.

NAS provides free billing software, Express Plus, that you can use for billing CMNs. For information on this free software, contact the EDI Jurisdiction D Help Desk at 1-866-224-3094, M -F from 8:00 am - 5:00 pm CT.

If you received your billing software from a vendor, you need to contact that vendor to determine if the software you purchased is capable of submitting a CMN. If it has the capability, the vendor will need to educate you as to where the CMN information is reported.

Q7. We have patients who purchased their manual wheelchairs at the appropriate time during a capped rental period. These patients have had these wheelchairs for more than five years, and they need replacement. Can these patients do an outright purchase of this equipment, or must they go through the capped rental procedure again?

A7. A manual wheelchair that is being replaced after the useful lifetime period of five years must again be rented for 13 months. Manual wheelchairs are not classified as inexpensive and routinely purchased items and cannot be purchased outright.

Q8. We have noticed that the customer service representatives (CSRs) have gotten very particular about providing us information when we call. For example, if we give the CSR the name John Doe but the beneficiary's actual name is Jonathan Doe or John Doe Jr., the CSR will tell us that we have not provided the actual name. When we look at our remittance advices (RA), the name we gave to the CSR is on the RA. When we provide the CSR the date of birth, the HICN, and the name that is on the RA, shouldn't that be enough to get the information we need? Should we really need to give the correct middle initial or a suffix like Jr. or II?

A8. CMS provides all DME MACs very strict requirements that must be followed. These requirements are addressed in CR 5597 and the Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6. Based on these requirements, CSRs are quality monitored. The CSR can fail a call for quality if the CSR doesn't adhere to the federal law regarding the beneficiary name. What this means is the CSR must verify specific information before health insurance information can be released. It may seem like the CSR is being difficult, but the CSR is only doing what is required by law before any health insurance information can be released.

Please be advised that the name on the RA may be a shortened version or not contain the middle initial or the appropriate suffix when compared to the name on the beneficiary's Medicare card due to printing constraints. Therefore, we suggest that you always make a copy of the beneficiary's Medicare card so you have all the specifics when you make that call to the contact center for additional information.

Q9. I have been having trouble getting my claims accepted electronically. What can I do?

A9. After researching the faxed examples, NAS contacted the supplier and explained the reason for her rejections. The supplier was also educated on how to get more details on rejections from the EDI Manual .

Q10. What is the official document that we should have on file that allows us to bill Medicare for patient supplies? Currently we are using a blank CMS-1500 claim form.

A10. You can continue to have the patient sign a blank CMS-1500 claim form for each service that is being billed to Medicare, or you can have the beneficiary sign a one-time authorization form. An example of a one-time authorization is found in Chapter Six of the Supplier Manual located on our web site. Remember, however, that the one-time authorization can only be used when billing the same item or service, and if you file non-assigned claims for DME rentals, you need to obtain the beneficiary's authorization on every rental claim you intend to submit to Medicare for processing.

Q11. Prior to NAS being the contractor for Jurisdiction D, I was able to call the IVR to get information on the dollar volume of claims currently in process. Am I able to locate that information through the NAS IVR?

A11. This information currently isn't available on the IVR, but we are looking at getting that information added within the next few months.

Follow-up Question. Is there any way this information can be gotten from the Internet? Medicaid allows us to locate this information on the Internet.

CMS does not allow us, as a Medicare contractor, to use the Internet to do Medicare business. The reason Medicaid allows this information is because they are state operated and have a bit more leniency.

There is, however, some claim status information and eligibility that can be accessed through Direct Data Entry (DDE) if you submit claims electronically to NAS. In order to do this the supplier needs a third party vendor. For additional information, see the article entitled Claims Status Inquiry located on the NAS web site.

Q12. My company has been in business since 2003, however, in April 2007 we made some changes to our information, which resulted in Medicare issuing us a new supplier number. How should we bill the services that were provided prior to our receiving the new number?

A12. For all services provided prior to the effective date of the new number, you should use your original number that was provided in 2003. That original number can be used for all services provided until that number's termination date. If you have questions about the end date and effective date of both NSC numbers, we suggest you contact the NSC at 1-866-238-9652, M - F from 9:00 am - 4:00 pm ET.

FAQs from Urological Workshops

The following questions and answers are from the Urological Supplies web-based workshops. In some cases, the original answers given during the workshops may have been expanded to provide further detail.

Q1. Why is a catheter not necessary if it is routine?

A1. Catheters are covered routinely for patients with permanent urinary incontinence or permanent urinary retention. However, routine intermittent or continuous irrigation of a catheter will be denied as not medically necessary as it is deemed a preventative measure. Irrigation is covered, as needed, in the presence of an acute obstruction of the catheter.

Q2. What type of documentation is required for accidental removal of an indwelling catheter?

A2. The patient's medical record should reflect why the physician is re-inserting the catheter and how the catheter was accidentally removed.

Q3. Please clarify how many leg bags can be provided and reimbursed per month.

A3. The usual maximum quantity of urinary leg bag; latex (A5112) is one per month, as stated in the urological suppliers medical policy.

Q4. Are electronic signatures acceptable on written orders from physicians?

A4. Yes, handwritten, electronic or signature stamps are acceptable. Refer to the *Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.1 B and Chapter 5, Section 5.2.3.*

Q5. If a physician's written order for urological supplies states a lifetime length of need, is a new order required every year?

A5. A new order for urological supplies would be required if the elements within the written order change (i.e., frequency of change, quantities or type of supplies). If the state licensure or state practice regulations require a new written order every year, that state law applies. Otherwise, a new order is not required for lifetime length of need patients.

Q6. What do we do when a Medicare beneficiary does not want us to bill the supplies to Medicare or does not want to get a physician's order?

A6. Suppliers should have a business practice in place for this situation, keeping in mind the mandatory claim submission laws as outlined in the *Medicare Claims Processing Manual, Chapter 1, Section 30.3.9*. Claims submitted without a complete written order must have an EY modifier appended to the HCPCS code. Unless the supply requires an order by statute, items submitted with an EY modifier will deny contractual obligation (CO denial) and a properly executed Advance Beneficiary Notice is recommended. If a valid ABN is obtained and the GA modifier reported on the claim, the supplies will then be the beneficiary's responsibility for payment.

Q7. Code A5105 is a urinary suspensory with or without leg bag and with or without tube. However, the Policy Article states that if the urinary suspensory has a leg bag it will be covered and coded as A5105, but if it does not have a leg bag it will be denied and coded as A9270. This seems to be a conflict with the definition of A5105.

A7. The appearance and definition of a code in the CPT/HCPCS Codes section of the LCD does not necessarily indicate coverage. Urinary suspensory without a leg bag is non-covered by Medicare and therefore must be coded as A9270 which indicates a non-covered item or service.

Q8. Where can the medical necessity criteria for urological supplies be found?

A8. This information can be found in the Local Coverage Determination (LCD) and Policy Article documents located on the Program Safeguard Contractor's web site: www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp

Q9. If a patient is catheterized in the physician's office, is the catheter included in the catheterization?

A9. Since the catheter is not provided for home use, coverage would fall under Medicare Part B, as "incident to" the office visit. Consult your Medicare Part B carrier for more information.

Q10. Will Medicare cover a male external catheter used at night and an intermittent catheter used during the day?

A10. No, this would be considered usage for convenience or patient preference. Only one type of catheter is covered per day.

Q11. Is the NU modifier required for urological supplies along with the KX modifier?

A11. The NU modifier is not used with urological supplies.

Suppliers must add a KX modifier to a code only if the order indicates patient has permanent urinary incontinence or urinary retention, and if the item is a catheter, an external urinary collection device, or a supply used with one of these items.

Q12. Could you explain the use of sterile water/saline solution in the urological policy?

A12. Sterile water/saline, code A4217, may be used for non-routine intermittent or non-routine continous irrigation of indwelling catherters. When this code is billed, the AU modifier should be added when billing for urological supplies.

Q13. Could it be considered medically necessary for a patient to use a leg bag during the daytime and a larger drain bag at night?

A13. Yes.

Q14. I recently submitted a claim for a beneficiary who moved from Jurisdiction D to Jurisdiction C. This claim was denied as needing to be submitted to the correct contractor (Jurisdiction C). In the past, my claims would automatically be transferred to the correct Jurisdiction as I am registered with all four Jurisdictions EDI. I have now been told that Jurisdiction D no longer transfers claims to the other three jurisdictions and if I resubmit the claim it will be denied as a duplicate. Is this correct?

A14. All automatic transfer rules still apply. Specific examples would need to be investigated by the call center. Please keep in mind that automatic transfers are only done for electronic claims, not paper claims. In addition, the electronic transfer of claims also is based on the address submitted on the electronic claim, not based on the beneficiary address that the claims processing system has on file at that time.

Search Available for Partial Words

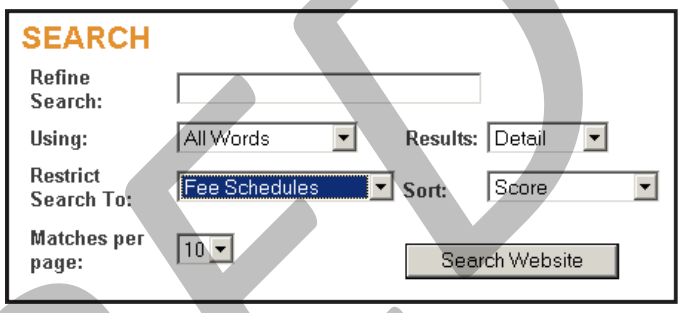
Suppliers are now able to conduct searches on the www.noridianmedicare.com web site using a wildcard feature. Wildcard searches allow a user to enter the first three or more characters of a word followed by the asterisk (*). The search results will include terms that begin with the entered characters. Glu* will now return glucose, glucometer, etc. Prior to this improvement, the searched term glu and or glu* returned no results.

NAS appreciates the feedback our supplier community offers through the "Web site Feedback" link as well as through the online, random survey coordinated at the request of CMS by a third party company.

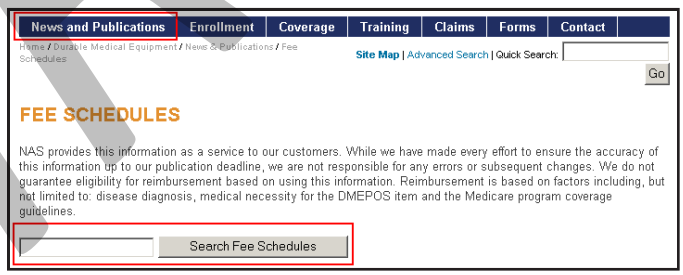
DME Fee Schedule Results Now Separately Searched

The DME fee schedule contents available on the NAS web site are directly available from the www.noridianmedicare.com homepage under the "DME Quick Links" tool. As of October 26, 2007, enhancements to the search engine provide for targeted searching of the fee schedules.

From the Advanced Search option in the upper right hand corner of the DME web pages, select "Fee Schedules" from the "Restrict Search To:" options available in the drop-down-box. This will allow for the searched HCPCS to return fee schedule contents while restricting all other DME web content from the search results.

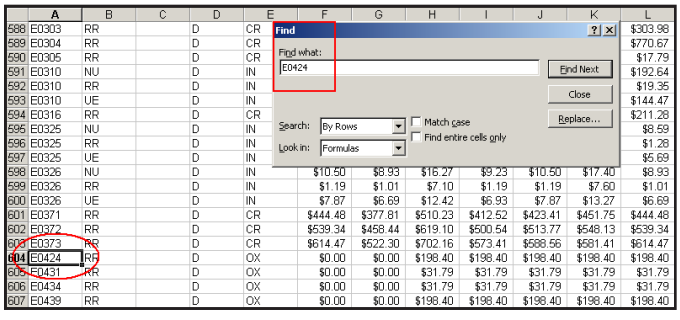


Suppliers may also easily search for fee schedule content from the News and Publications/Fee Schedule category on the web site. It is important to note that fee schedule content is removed from the default "Quick Search" and/or "*All of DME" searched content.

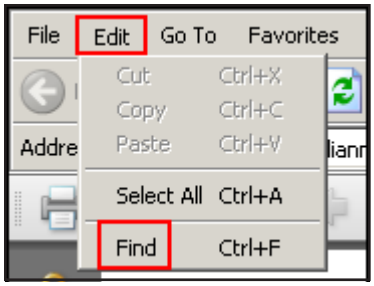


Fee Schedule Helpful Hints

To find a specific HCPCS code in any of the fee schedule formats (Excel, PDF or CSV), use Ctrl + F.

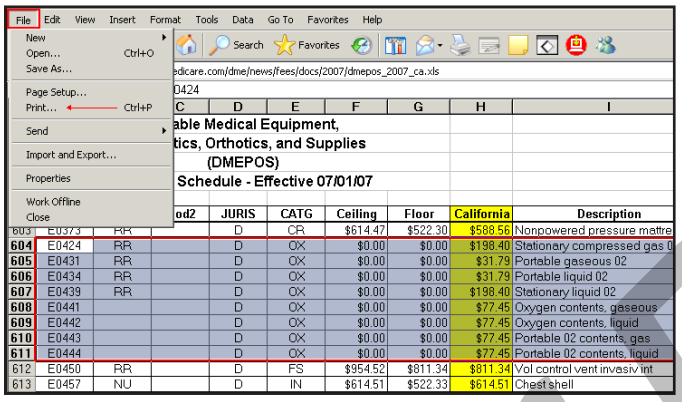


In the PDF version, selecting Find from the Edit menu also searches the fee schedule for a specific HCPCS code.

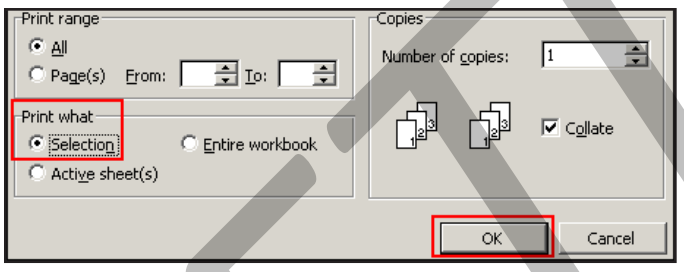


The entire fee schedule can be printed using the Excel or PDF version, but if you only bill a certain range of codes, you can restrict your print to just the pages needed.

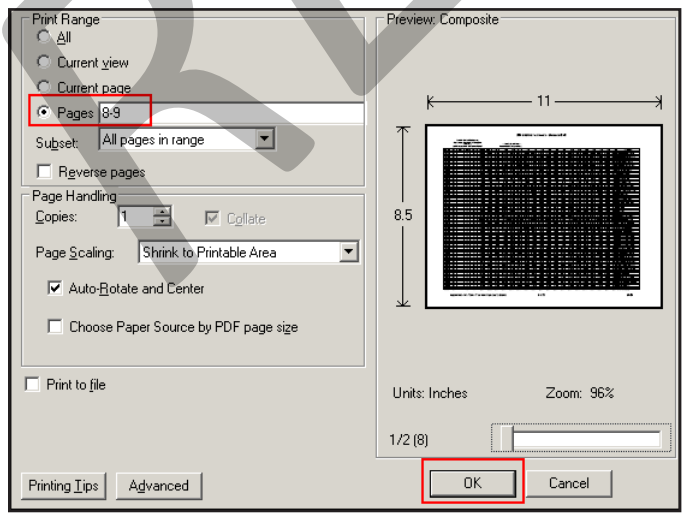
In Excel, highlight the area to print and choose Print from the File menu.



In the Print menu, choose Selection from "Print what" and click OK.



In the PDF version, the page numbers are located at the bottom of each page. To print, for example, pages 8 and 9, choose Print from the File menu as in the Excel format. Under "Print Range" select "Pages," enter the page numbers and click OK.



NAS appreciates the feedback our supplier community offers through the "Web site Feedback" link as well as through the online, random survey coordinated at the request of CMS by a third party company. These fee schedule search enhancements were made based on comments received from suppliers via these feedback tools.

Medical Review Program Brochure Available

CMS has created *The Medicare Medical Review Program* brochure to provide a general overview of the Medical Review (MR) program. This brochure assists suppliers and providers gain a better understanding of their role in the MR process.

This brochure covers objectives of the MR program, National Coverage Determinations and Local Coverage Determinations, the MR process, corrective actions and provider rights.

A link to *The Medicare Medical Review Program* brochure is available in the Coverage section of our web site under Program Safeguard Contractor and also on the CMS web site at www.cms.hhs.gov/MLNGenInfo/ in the MLN Products Catalog.

Medicare Preventive Services Series

The Centers for Medicare & Medicaid Services (CMS) has updated the following web-based (WBT) training course: ***Medicare Preventive Services Series: Part 3 Expanded Benefits.*** This web-based training course provides information to help fee-for-service providers and suppliers understand Medicare's coverage and billing guidelines for the following services: the initial preventive physical exam (also known as, the "Welcome to Medicare" physical exam), diabetes screenings, diabetes self management training, medical nutrition therapy and diabetes supplies covered by Medicare as well as colorectal, prostate, and glaucoma screenings, and bone mass measurements. Note: CMS has been reviewed and approved as an Authorized provider by the International Association for Continuing Education and Training (IACET), (IACET), 8405 Greensboro Drive, Suite 800, McLean, VA 22102. Participants who successfully complete this course may receive .2 IACET CEU. To register, free of charge for this course, please visit, http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1 on the CMS web site.

Visit the Medicare Learning Network ~ it's free!

November Was American Diabetes Month

Diabetes continues to be a prevalent health concern in the United States. Approximately 20.8 million Americans, or 7.0% of the population, have diabetes. Of these, 10.3 million people are age 60 and over. Left undiagnosed, diabetes can lead to serious complications such as heart disease, stroke, blindness, kidney damage, lower-limb amputations and premature death. The Centers for

Medicare & Medicaid Services (CMS) reminds health care professionals that Medicare provides coverage of diabetes screening tests for beneficiaries at risk for diabetes or those diagnosed with pre-diabetes.

Covered diabetes screening tests include the following:

- A fasting blood glucose test, **and**
- A post-glucose challenge test (an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults), **or**
- A 2-hour post-glucose challenge test alone.

We Need Your Help!

CMS needs your help to ensure that people with Medicare are assessed for and informed about their risk factors for diabetes or pre-diabetes, and that those who are eligible take advantage of the diabetes screening tests.

In addition to providing coverage for diabetes screenings, Medicare also provides coverage for a variety of preventive care and other services for people with diabetes, such as the initial preventive physical examination (must be received within the first six months of the beneficiary's initial Medicare Part B coverage period), cardiovascular screening blood tests, diabetes self-management training, medical nutrition therapy, diabetes supplies, glaucoma screening, and influenza and pneumococcal immunizations. These services can help beneficiaries manage the disease and lower the risk of complications. Talk with your Medicare patients about the preventive services that are right for them and encourage utilization by providing referrals for appropriate services for which they may be eligible. Working together, we can help people with diabetes take steps to reduce the occurrence of serious complications through early detection and treatment, controlling the levels of blood glucose, blood pressure, and blood lipids, life style modifications (diet and exercise), and by receiving other preventive care practices as appropriate.

For More Information

- For more information about Medicare's coverage of diabetes screening services, initial preventive physical examination, cardiovascular screening blood tests, diabetes self management training, medical nutrition therapy, diabetes supplies, influenza and pneumococcal immunizations, and glaucoma screening services, including coverage, coding, billing, and reimbursement guidelines, please visit the CMS Medicare Learning Network (MLN) Preventive Services Educational Products web page http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp
- For literature to share with your Medicare patients, please visit http://www.medicare.gov
- For more information about American Diabetes Month, please visit http://www.diabetes.org/communityprograms-and-localevents/americandiabetesmonth.jsp

Thank you for partnering with CMS during American Diabetes Month as we strive to make sure that people with Medicare learn more about diabetes and their risk factors for the disease and that they take full advantage of the diabetes screening tests and other Medicare-covered preventive services for which they may be eligible.

Flu Shot Reminder

"Flu season is here! Medicare patients give many reasons for not getting their annual flu shot, including—"It causes the flu"; "I don't need it"; "It has side effects"; "It's not effective"; "I didn't think about it"; "I don't like needles!" The fact is that every year in the United States, on average, about 36,000 people die from influenza. Greater than 90 percent of these deaths occur in individuals 65 years of age and older. You can help your Medicare patients overcome these odds and their personal barriers through patient education. Talk with your Medicare patients about the importance of getting their annual flu shot--and don't forget to immunize yourself and your staff. Protect yourself, your patients, and your family and friends. **Get Your Flu Shot – Not the Flu.** Remember - Influenza vaccination is a covered Part B benefit but the influenza vaccine is NOT a Part D covered drug. For more information about Medicare's coverage of flu vaccine and its administration as well as related educational resources for health care professions, please go to http://www.cms.hhs.gov/MLNProducts/Downloads/flu_products.pdf on the CMS web site."

Overview of Medicare Covered Diabetes Supplies and Services

MLN Matters Number: SE0738

Provider Types Affected

Physicians, providers, suppliers, and other health care professionals who furnish or provide referrals for and/or file claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for Medicare-covered diabetes benefits.

Provider Action Needed

This article is informational only and represents no Medicare policy changes.

Background

Diabetes is the sixth leading cause of death in the United States, and approximately 20 million Americans have diabetes with an estimated 20.9 percent of the senior population age 60 and older being affected. Millions of people have diabetes and do not know it. Left undiagnosed, diabetes can lead to severe complications such as heart disease, stroke, blindness, kidney failure, leg and foot amputations, and death related to pneumonia and flu. Scientific evidence now shows that early detection and treatment of diabetes with diet, physical activity, and new medicines can prevent or delay much of the illness and complications associated with diabetes.

This special edition article presents an overview of the diabetes services and supplies covered by Medicare (Part B and Part D) to assist physicians, providers, suppliers, and other health care professionals who provide diabetic supplies and services to Medicare beneficiaries.

Medicare Part B Covered Diabetic Supplies

Medicare covers certain supplies if a beneficiary has Medicare Part B and has diabetes. These supplies include:

- Blood glucose self-testing equipment and supplies;
- Therapeutic shoes and inserts; and
- Insulin pumps and the insulin used in the pumps

Blood Glucose Self-testing Equipment and Supplies

Blood glucose self-testing equipment and supplies are covered for all people with Medicare Part B who have diabetes. This includes those who use insulin and those who do not use insulin. These supplies include:

- Blood glucose monitors;
- Blood glucose test strips;
- Lancet devices and lancets; and
- Glucose control solutions for checking the accuracy of testing equipment and test strips.

Medicare Part B covers the same type of blood glucose testing supplies for people with diabetes whether or not they use insulin. However, the amount of supplies that are covered varies.

If the beneficiary;

- **Uses insulin**, they may be able to get up to 100 test strips and lancets every month, and 1 lancet device every 6 months.
- **Does not use insulin**, they may be able to get 100 test strips and lancets every 3 months, and 1 lancet device every 6 months.

If a beneficiary's doctor says it is medically necessary, Medicare will cover additional test strips and lancets for the beneficiary.

Medicare will only cover a beneficiary's blood glucose self-testing equipment and supplies if they get a prescription from their doctor. Their prescription should include the following information:

- That they have diabetes;
- What kind of blood glucose monitor they need and why they need it (i.e., if they need a special monitor because of vision problems, their doctor must explain that.);
- Whether they use insulin;
- How often they should test their blood glucose; and
- How many test strips and lancets they need for one month.

A beneficiary needing blood glucose testing equipment and/or supplies:

- Can order and pick up their supplies at their pharmacy;
- Can order their supplies from a medical equipment supplier, but they will need a prescription from their doctor to place their order. Their doctor cannot order it for them;
- Must ask for refills for their supplies; and
- Needs a new prescription from their doctor for their lancets and test strips every 12 months.

Note: Medicare will not pay for any supplies not asked for, or for any supplies that were sent to a beneficiary automatically from suppliers. This includes blood glucose monitors, test strips, and lancets. Also, if a beneficiary goes to a pharmacy or supplier that is not enrolled in Medicare, Medicare will not pay. The beneficiary will have to pay the entire bill for any supplies from non-enrolled pharmacies or non-enrolled suppliers.

All Medicare-enrolled pharmacies and suppliers must submit claims for blood glucose monitor test strips. A beneficiary cannot submit a claim for blood glucose monitor test strips themselves. The beneficiary should make sure that the pharmacy or supplier accepts assignment for Medicare-covered supplies. If the pharmacy or supplier accepts assignment, Medicare will pay the pharmacy or supplier directly. Beneficiaries should only pay their coinsurance amount when they get their supply from their pharmacy or supplier for assigned claims. If a beneficiary's pharmacy or supplier **does not** accept assignment, charges may be higher, and the beneficiary may pay more. They may also have to pay the entire charge at the time of service and wait for Medicare to send them its share of the cost.

Before a beneficiary gets a supply, it is important for them to ask the supplier or pharmacy the following questions:

- Are you enrolled in Medicare?
- Do you accept assignment?

If the answer to either of these two (2) questions is "no," they should call another supplier or pharmacy in their area who answers "yes" to be sure their purchase is covered by Medicare, and to save them money.

If a beneficiary can not find a supplier or pharmacy in their area that is enrolled in Medicare and accepts assignment, they may want to order their supplies through the mail, which may also save them money.

Therapeutic Shoes and Inserts

If a beneficiary has Medicare Part B, has diabetes, and meets certain conditions (see below), Medicare will cover therapeutic shoes if they need them. The types of shoes that are covered each year include one of the following:

- One pair of depth-inlay shoes **and** three pairs of inserts; or
- One pair of custom-molded shoes (including inserts) if the beneficiary cannot wear depth-inlay shoes because of a foot deformity and two additional pairs of inserts.

Note: In certain cases, Medicare may also cover separate inserts or shoe modifications instead of inserts.

In order for Medicare to pay for the beneficiary's therapeutic shoes, the doctor treating their diabetes must certify that they meet **all** of the following three conditions:

- They have diabetes;
- They have at least 1 of the following conditions in one or both feet:

  - Partial or complete foot amputation;
  - Past foot ulcers;
  - Calluses that could lead to foot ulcers;
  - Nerve damage because of diabetes with signs of problems with calluses;
  - Poor circulation; or
  - Deformed foot;
- They are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires the following:

- A podiatrist or other qualified doctor must prescribe the shoes, and
- A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes to the beneficiary.

Medicare helps pay for one pair of therapeutic shoes and inserts per calendar year, and the fitting of the shoes or inserts is covered in the Medicare payment for the shoes.

Insulin Pumps and the Insulin Used in the Pumps

Insulin pumps worn outside the body (external), including the insulin used with the pump, may be covered for some people with Medicare Part B who have diabetes and who meet certain conditions. If a beneficiary needs to use an insulin pump, their doctor will need to prescribe it. In the Original Medicare Plan, the beneficiary pays 20% of the Medicare-approved amount after the yearly Part B deductible. Medicare will pay 80% of the cost of the insulin pump. Medicare will also pay for the insulin that is used with the insulin pump.

Medicare Part B covers the cost of insulin pumps and the insulin used in the pumps. However, if the beneficiary injects their insulin with a needle (syringe), Medicare Part B does not cover the cost of the insulin, but the Medicare prescription drug benefit (Part D) covers the insulin and the supplies necessary to inject it. This includes syringes, needles, alcohol swabs and gauze. The Medicare Part D plan will cover the insulin and any other medications to treat diabetes at home as long as the beneficiary is on the Medicare Part D plan's formulary.

Coverage for diabetes-related durable medical equipment (DME) is provided as a Medicare Part B benefit. The Medicare Part B deductible and coinsurance or copayment applies after the yearly Medicare part B deductible has been met. In the Original Medicare Plan, Medicare covers 80% of the Medicare-approved amount (after the beneficiary meets their annual Medicare Part B deductible of $131 in 2007), and the beneficiary pays 20% of the total payment amount (after the annual Part B deductible of $131 in 2007). This amount can be higher if the beneficiary's doctor does not accept assignment, and the beneficiary may have to pay the entire amount at the time of service. Medicare will then send the beneficiary its share of the charge.

Medicare Part D Covered Diabetic Supplies and Medications

This section provides information about Medicare prescription drug coverage (Part D) for beneficiaries with Medicare who have or are at risk for diabetes. If a beneficiary wants Medicare prescription drug coverage, they must join a Medicare drug plan. The following diabetic medications and supplies are covered under Medicare drug plans:

- Diabetes supplies;
- Insulin; and
- Anti-diabetic drugs.

Diabetes Supplies

Diabetes supplies associated with the administration of insulin may be covered for all people with Medicare Part D who have diabetes. These medical supplies include the following:

- Syringes;
- Needles;
- Alcohol swabs;
- Gauze; and
- Inhaled insulin devices.

Insulin

Injectable insulin **not** associated with the use of an insulin infusion pump is covered under Medicare Part D drug plans.

Anti-diabetic Drugs

Blood glucose that is not controlled by insulin may be maintained by anti-diabetic drugs, and Medicare drug plans can cover anti-diabetics drugs such as:

- Sulfonylureas (i.e. Glipizide, Glyburide);
- Biguanides (i.e. metformin);
- Thiazolidinediones (i.e. Starlix® and Prandin®); and
- Alpha glucosidase inhibitors (i.e. Precose®).

Medicare Part B Covered Diabetic Services

All of the diabetes services listed in this section are covered by Medicare Part B unless otherwise noted. For people with diabetes, Medicare covers certain services. A doctor must write an order or referral for the beneficiary to get these services. These services include the following:

- Diabetes screenings;
- Diabetes self-management training;
- Medical nutrition therapy services;
- Hemoglobin A1c tests; and
- Special eye exams.

Diabetes Screenings

Medicare pays for a beneficiary to get diabetes screening tests if they are at risk for diabetes. These tests are used to detect diabetes early, and some, but not all, of the conditions that may qualify a beneficiary as being at risk for diabetes include:

- High blood pressure;
- Dyslipidemia (history of abnormal cholesterol and triglyceride levels);
- Obesity (with certain conditions);
- Impaired blood glucose tolerance; and
- High fasting blood glucose.

Diabetes screening tests are also covered if a beneficiary answers "yes" to two or more of the following questions:

- Are you age 65 or older?
- Are you overweight?
- Do you have a family history of diabetes (parents, siblings)?
- Do you have a history of gestational diabetes (diabetes during pregnancy),or
- Did you deliver a baby weighing more than 9 pounds?

Based on the results of these tests, a beneficiary may be eligible for up to 2 diabetes screenings every year at no cost (no coinsurance, or copayment or Part B deductible). Medicare will pay for a beneficiary to get 2 diabetes screening tests in a 12-month period, but not less than 6 months apart. After the initial diabetes screening test, the beneficiary's doctor will determine when to do the second test. Diabetes screening tests that are covered include the following:

- Fasting blood glucose tests; and
- Other tests approved by Medicare as appropriate.

Diabetes Self-management Training (DSMT)

Diabetes self-management training helps a beneficiary learn how to successfully manage their diabetes. Their doctor or qualified non-physician practitioner must prescribe this training for them for Medicare to cover it. A beneficiary can get diabetes self-management training if they met one (1) of the following conditions during the last twelve (12) months:

- They were diagnosed with diabetes;
- They changed from taking no diabetes medication to taking diabetes medication, or from oral diabetes medication to insulin;
- They have diabetes and have recently become eligible for Medicare;
- They are at risk for complications from diabetes. A doctor may consider the beneficiary at increased risk if they have any of the following:
    - They had problems controlling their blood glucose, have been treated in an emergency room or have stayed overnight in a hospital because of their diabetes,
    - They have been diagnosed with eye disease related to diabetes,
    - They had a lack of feeling in their feet or some other foot problems like ulcers, deformities, or have had an amputation, or
    - Been diagnosed with kidney disease related to diabetes.

A beneficiary must get this training from an accredited diabetes self-management education program as part of a plan of care prepared by their doctor or qualified non-physician practitioner. These programs are accredited by the American Diabetes Association or the Indian Health Service. Classes are taught by health care providers who have special training in diabetes education.

A beneficiary is covered by Medicare to get a total of 10 hours of initial training within a continuous 12-month period. One of the hours can be given on a one-on-one basis. The other 9 hours must be training in a group class. The initial training must be completed no more than 12 months from the time the beneficiary starts the training.

A doctor or qualified non-physician practitioner may prescribe 10 hours of individual training if the beneficiary is blind or deaf, has language limitations, or no group classes have been available within 2 months of the doctor's order. To be eligible for 2 more hours of follow-up training each year after the year the beneficiary received initial training, they must get another written order from their doctor. The 2 hours of follow-up training can be with a group or they may have one-on-one sessions. A doctor or qualified non-physician practitioner must prescribe the follow-up training each year for Medicare to cover it.

Beneficiaries learn how to successfully manage their diabetes in DSMT classes, and the training includes information on self-care and making lifestyle changes. The first session consists of an individual assessment to help the instructors better understand the beneficiary's needs. Classroom training includes topics such as the following:

- General information about diabetes, and the benefits and risks of blood glucose control;
- Nutrition and how to manage ones diet;
- Options to manage and improve blood glucose control;
- Exercise and why it is important to ones health;
- How to take ones medications properly;
- Blood glucose testing and how to use the information to improve ones diabetes control;
- How to prevent, recognize, and treat acute and chronic complications from ones diabetes;
- Foot, skin, and dental care;
- How diet, exercise, and medication affect blood glucose;
- How to adjust emotionally to having diabetes;
- Family involvement and support; and
- The use of the health care system and community resources.

Note: If a patient lives in a rural area, they may be able to get DSMT in a Federally Qualified Health Center (FQHC). For more information about FQHCs, visit http://www.cms.hhs.gov/center/fqhc.asp on the CMS web site. FQHCs are special health centers, usually located in urban or rural areas, and they can give routine health care at a lower cost. Some FQHCs are Community Health Centers, Tribal FQHC

Clinics, Certified Rural Health Clinics, Migrant Health Centers, and Health Care for the Homeless Programs.

Medical Nutrition Therapy (MNT) Services

In addition to DSMT, medical nutrition therapy services are also covered for people with diabetes or renal disease. To be eligible for this service, a beneficiary's fasting blood glucose has to meet certain criteria. Also, their doctor must prescribe these services for them. These services can be given by a registered dietitian or certain nutrition professionals, and the services include the following:

- An initial nutrition and lifestyle assessment;
- Nutrition counseling (what foods to eat and how to follow an individualized diabetic meal plan);
- How to manage lifestyle factors that affect diabetics; and
- Follow-up visits to check on progress in managing diet.

Medicare covers 3 hours of one-on-one medical nutrition therapy services the first year the service is provided, and 2 hours each year after that. Additional MNT hours of service may be obtained if the beneficiary's doctor determines there is a change in their diagnosis, medical condition, or treatment regimen related to diabetes or renal disease and orders additional MNT hours during that episode of care.

Foot Exams and Treatment

If a beneficiary has diabetes-related nerve damage in either of their feet, Medicare will cover 1 foot exam every 6 months by a podiatrist or other foot care specialist, unless they have seen a foot care specialist for some other foot problem during the past 6 months. Medicare may cover more frequent visits to a foot care specialist if a beneficiary has had a non-traumatic (not because of an injury) amputation of all or part of their foot or their feet have changed in appearance which may indicate they have serious foot disease.

Hemoglobin A1c Tests

A hemoglobin A1c test is a lab test ordered by the beneficiary's doctor. It measures how well a beneficiary's blood glucose has been controlled over the past 3 months. Anyone with diabetes is covered for this test if it is ordered by their doctor. Medicare may cover this test when a beneficiary's doctor orders it.

Glaucoma Tests

Medicare will pay for a beneficiary to have their eyes checked for glaucoma once every 12 months. This test must be done or supervised by an eye doctor who is legally allowed to give this service in their state.

Special Eye Exam

People with Medicare who have diabetes can get special eye exams to check for eye disease (called a dilated eye exam). These exams must be done by an eye doctor who is legally allowed to provide this service in their state. The dilated eye exam is recommended once a year and must be performed by an eye doctor who is legally allowed to provide this service in the beneficiary's state.

Diabetes Supplies and Services Not Covered by Medicare

The Original Medicare Plan and Medicare drug plans (Part D) don't cover everything. Diabetes supplies and services not covered by Medicare include:

- Eye exams for glasses (eye refraction);
- Orthopedic shoes (shoes for people whose feet are impaired, but intact);
- Routine or yearly physical exams (Medicare will cover a one-time initial preventive physical exam (the "Welcome to Medicare" physical exam) within the first 6 months of the beneficiary enrolling in Part B—coinsurance and Part B deductible applies.); and
- Weight loss programs.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) has developed a variety of educational resources for use by health care professionals and their staff as part of a broad outreach campaign to promote awareness and increase utilization of preventive services covered by Medicare. For more information about coverage, coding, billing, and reimbursement of Medicare-covered preventive services and screenings, visit http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage on the CMS web site.

- **Medicare Learning Network** - The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at http://www.cms.hhs.gov/MLNGenInfo on the CMS web site.
- **Patient Resources** - For literature to share with Medicare patients, please visit http://www.medicare.gov on the Internet.
- **The National Diabetes Education Program** - NDEP (http://ndep.nih.gov/) provides a wealth of resources for health care professionals, educators, business professionals, and patients about diabetes, its complications, and self-management.

2007 - 2008 Influenza (Flu) Season Resources for Health Care Professionals

MLN Matters Number: SE0748

Provider Types Affected

All Medicare fee-for-service (FFS) physicians, non-physician practitioners, providers, suppliers, and other health care professionals who bill Medicare for flu vaccines and vaccine administration provided to Medicare beneficiaries

Provider Action Needed

- Keep this Special Edition *MLN Matters* article and refer to it throughout the 2007 - 2008 flu season.
- Talk with your patients about their risk of contracting the flu virus and complications arising from the virus and encourage them to get the flu shot. (Medicare provides coverage of the flu vaccine and its administration without

any out-of-pocket costs to the Medicare beneficiaries, (i.e., no deductible or copayment/coinsurance.)

- Stay abreast of the latest flu information and inform your patients.
    - Order appropriate provider resources for yourself and your staff.
    - Have appropriate literature on hand about seasonal flu that can be handed out to your patients during the flu season.
- Don't forget to immunize yourself and your staff – **Get the Flu Shot – Not the Flu!**

Introduction

Historically the flu vaccine has been an under-utilized benefit by Medicare beneficiaries. Yet, of the nearly 36,000 people who, on average, die every year in the United States from seasonal flu and complications arising from the flu, the majority of deaths occur in persons 65 years of age and older. People with chronic medical conditions such as diabetes and heart disease are considered to be at high risk for serious complications from the flu, as are people in nursing homes and other long-term care facilities. Complications of flu can include bacterial pneumonia, ear infections, sinus infections, dehydration, and worsening of chronic medical conditions, such as congestive heart failure, asthma, or diabetes.

Prevention is Key to Public Health!

- While flu season can begin as early as October and last as late as May the optimal time to get a flu vaccine is in October or November. However, protection can still be obtained if the flu vaccine is given in December or later. The flu vaccine continues to be the most effective method for preventing flu virus infection and its potentially severe complications. You can help your Medicare patients reduce their risk for contracting seasonal flu and serious complications by recommending that they take advantage of the annual flu shot covered by Medicare.
- Medicare Part B reimburses health care professionals who accept the Medicare-approved payment amount for the flu vaccine and its administration. There is no beneficiary coinsurance or copayment and beneficiaries do not have to meet their deductible to receive the flu shot.
- Health care providers and their staff are also at risk for contracting the flu, so do not forget to immunize yourself and your staff. Protect yourself, your patients, your staff, and your family and friends. **Get Your Flu Shot – Not the Flu!**

Helping You Stay Informed

- CMS has developed a variety of educational resources to help promote increased awareness and utilization of the flu vaccine among beneficiaries, providers, and their staff and to ensure that Medicare FFS health care professionals have the information they need to bill Medicare correctly for the flu vaccines and their administration.

Products

The following products have been developed by CMS to be used by Medicare FFS health care professionals and are not intended for distribution to Medicare beneficiaries.

1. **MLN Matters Articles**
    - **MM5744**: Payment Allowances for the Influenza Virus Vaccine and the Pneumococcal Vaccine When Payment is Based on 95 Percent of the Average Wholesale Price (AWP) located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5744.pdf on the CMS web site.
    - **MM5511**: Update to Medicare Claims Processing Manual (Publication 100-04), Chapter 18, Section 10 For Part B Influenza Billing located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5511.pdf on the CMS web site.
    - **MM4240**: Guidelines for Payment of Vaccine (Pneumococcal Pneumonia Virus, Influenza Virus, and Hepatitis B Virus) Administration located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4240.pdf on the CMS web site.
    - **MM5037**: Reporting of Diagnosis Code V06.6 on Influenza Virus and/or Pneumococcal Pneumonia Virus (PPV) Vaccine Claims and Acceptance of Current Procedural Terminology (CPT) Code 90660 for the Reporting of the Influenza Virus Vaccine located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5037.pdf on the CMS web site.
2. **MLN Influenza Related Products for Health Care Professionals**
    - **Quick Reference Information: Medicare Immunization Billing** - This two-sided laminated chart provides Medicare FFS physicians, providers, suppliers, and other health care professionals with quick information to assist with filing claims for the influenza, pneumococcal, and hepatitis B vaccines and their administration. Available in print and as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/qr_immun_bill.pdf on the CMS web site.
    - **The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals, Second Edition** - This updated comprehensive guide to Medicare-covered preventive services and screenings provides Medicare FFS physicians, providers, suppliers, and other health care professionals information on coverage, coding, billing, and reimbursement guidelines of preventive services and screenings covered by Medicare. The guide includes a chapter on influenza, pneumococcal, and hepatitis B vaccines and their administration. Also includes suggestions for planning a flu clinic and information for mass immunizers and roster billers. Available as a downloadable PDF file. Updated August 2007 at http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf on the CMS web site.

- **Medicare Preventive Services Adult Immunizations Brochure** - This two-sided tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration. Updated August 2007. Available in print and as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf on the CMS web site.
- **Medicare Preventive Services Series: Part 1 Adult Immunizations Web-based Training (WBT) Course** - This WBT course contains four modules that include information about Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Module Four includes lessons on mass immunizers, roster billing, and centralized billing. This course was updated September 2007 and has been approved for .1 IACET* CEU for successful completion. This course can be accessed through the MLN Product Ordering web page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1 on the CMS web site.
- **An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals video program** - This educational video program provides health care professionals with an overview of Medicare-covered preventive services. The program includes a segment on Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines. Included in the segment are strategies that providers may use to increase the use of these vaccines in their practices and tips for setting up a flu clinic. This educational video has been approved for .1 IACET* CEU for successful completion. This video program can be ordered through the MLN Product Ordering web page located at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS web site.
- **Quick Reference Information: Medicare Preventive Services** - This two-sided laminated chart gives Medicare FFS physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. This chart includes influenza, pneumococcal, and hepatitis B. Available in print or as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf on the CMS web site.
- **Medicare Preventive Services Bookmark** - This bookmark lists the preventive services and screenings covered by Medicare (including influenza) and serves as a handy reminder to health care professionals about the many preventive benefits covered by Medicare. Appropriate for use as a give away at conferences and other provider related gatherings. Available in print or as a downloadable PDF file at http://www.cms.hhs.gov/MLNProducts/downloads/medprevsrvcesbkmrk.pdf on the CMS web site.
- **MLN Preventive Services Educational Products Web Page** - This Medicare Learning Network (MLN) web page provides descriptions of all MLN preventive services related educational products and resources designed specifically for use by Medicare FFS providers. PDF files provide product ordering information and links to all downloadable products, including those related to the influenza vaccine and its administration. This web page is updated as new product information becomes available. Bookmark this page (http://www.cms.hhs.gov/MLNProducts/35_PreventiveServices.asp#TopOfPage) for easy access.

3. Other CMS Resources

- **CMS Adult Immunizations Web Page** located at http://www.cms.hhs.gov/AdultImmunizations/ on the CMS web site.
- **CMS Frequently Asked Questions** located at http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=I3ALEDhi on the CMS web site.
- **Medicare Benefit Policy Manual - Chapter 15, Section 50.4.4.2 – Immunizations** located at http://www.cms.hhs.gov/manuals/downloads/bp102c15.pdf on the CMS web site.
- **Medicare Claims Processing Manual – Chapter 18, Preventive and Screening Services** located at http://www.cms.hhs.gov/manuals/downloads/clm104c18.pdf on the CMS web site.

4. Other Resources

The following non-CMS resources are just a few of the many available in which clinicians may find useful information and tools to help increase flu vaccine awareness and utilization during the 2007 – 2008 flu season:

- **Advisory Committee on Immunization Practices** located at http://www.cdc.gov/vaccines/recs/acip/default.htm on the Internet.
- **American Lung Association's Influenza (Flu) Center** located at http://www.lungusa.org on the Internet. - This site provides a flu clinic locator at http://www.flucliniclocator.org on the Internet. Individuals can enter their zip code to find a flu clinic in their area. Providers can also obtain information on how to add their flu clinic to this site.
- **Centers for Disease Control and Prevention** - http://www.cdc.gov/flu
- **Immunization Action Coalition** - http://www.immunize.org
- **Immunization: Promoting Prevention for a Healthier Life** - http://www.nfid.org/pdf/publications/naiaw06.pdf
- **Medicare Quality Improvement Community** - http://www.medqic.org

EDUCATIONAL CONT'D

- **National Alliance for Hispanic Health** - http://www.hispanichealth.org/
- **The National Center for Immunization and Respiratory Diseases (NCIRD)** (established spring 2007) replaces the name National Immunization Program (NIP) - http://www.cdc.gov/vaccines/about/
- **National Foundation For Infectious Diseases** - http://www.nfid.org/influenza
- **National Network for Immunization Information** - http:/www.immunizationinfo.org
- **National Vaccine Program** - http://www.hhs.gov/nvpo
- **Office of Disease Prevention and Promotion** - http://odphp.osophs.dhhs.gov
- **Partnership for Prevention** - http://www.prevent.org
- **World Health Organization** - http://www.who.int/csr/disease/influenza/en/

Additional Information

For information to share with your Medicare patients, please visit, http://www.medicare.gov on the Web.

NPI

Social Security Numbers Should Not Be Reported in FOIA-Disclosable NPPES Fields

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

As CMS has mentioned in previous outreach messages and on the CMS NPI web site, some health care providers have reported their Social Security Numbers (SSNs), or the SSNs of other health care providers, in their NPPES records in fields that the Freedom of Information Act (FOIA) requires that CMS make publicly available. For example, there are instances where SSNs are reported in the "Other Provider Identification Numbers," "License Number," and "Employer Identification Number (EIN)" fields in providers' NPPES records. The information that providers report in these (and certain other) fields is fully disclosable by CMS to the public and, therefore, **SSNs should never be reported in any of these fields.**

Because SSNs are 9-digit numbers, CMS has been suppressing all 9-digit numbers found in any FOIA-disclosable field except for ZIP code and telephone/fax number fields. This means that these 9-digit numbers—whether or not they are SSNs--are not displayed in the NPI Registry and cannot be found in the monthly NPPES downloadable file. If these 9-digit numbers are legitimate EINs, "Other Provider Identification Numbers," or "License Numbers," health plans and others who are using the NPI Registry and the downloadable file are not able to see them, which means that they cannot see all of the NPPES data they may need in order to accurately match providers in NPPES to the providers in their own files, thus making it more difficult to link NPIs to legacy identifiers. In some cases, this may adversely affect payments to providers by health plans.

It is imperative that providers immediately look at their NPPES records to ensure that they did not inadvertently report their, or someone else's, SSN in a FOIA-disclosable field; if they did, they need to delete that SSN immediately and, if appropriate, replace it with the correct information (e.g., an EIN). Providers must look in their NPPES records (https://nppes.cms.hhs.gov/) in order to view all of the information they reported. If they need assistance in deleting inappropriately reported SSNs, they may contact the NPI Enumerator at 1-800-465-3203. If they need assistance in knowing which NPPES fields are disclosable under FOIA, they should review the document entitled, "National Plan and Provider Enumeration System (NPPES) Data Elements Data Dissemination – Information for Providers," dated June 20, 2007, and found at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf on the CMS NPI web page.

Providers cannot rely on the information disclosed in the NPI Registry or in the downloadable file in trying to determine if they inappropriately reported SSNs in FOIA-disclosable fields because CMS suppresses these numbers, as explained above; these numbers will not be seen in the NPI Registry or the downloadable file. In order to protect your personal information from public disclosure, please correct this information immediately if this situation pertains to you.

When to Contact the NPI Enumerator for Assistance

The topics with which the NPI Enumerator can assist providers are listed below:

- Status of an NPI application, update, or deactivation
- How to apply, update, or deactivate
- Forgotten/lost NPI
- Lost NPI notification
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application

Health care providers needing assistance on any of the above topics may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at CustomerService@NPIenumerator.com.

The NPI application form, itself, is also a good source of information. Please refer to the NPI application instructions for clarification on information to be submitted in order to obtain an NPI or update an NPPES record. Refer to the 'Application Help' tab located on the NPPES web site for additional assistance while online.

Important Information for Medicare Providers

As of 10/29/07 all Medicare contractors have lifted the bypass logic and are editing against the Medicare crosswalk. As a result, claims that include non-matching NPIs and legacy identifiers are now rejecting. The following table is a review of the next set of dates which are crucial for compliance with the NPI regulations.

NPI CONT'D

Medicare's Key Dates

Date	Implementation Steps
January 1, 2008	837I electronic claims and UB-04 paper claims without an NPI in fields identifying the primary provider (billing and pay-to) will be rejected. Legacy identifiers paired with NPIs in the primary provider fields on the claim will still be acceptable as will legacy-only numbers in secondary provider fields.
March 1, 2008	Medicare FFS 837P and CMS-1500 claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable. Until further notice, you may continue to include legacy identifiers only for the provider secondary fields.
May 23, 2008	In keeping with the Contingency Guidance issued on April 3, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted and sent on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims and SPR remittance advice. This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction. CMS will also stop sending legacy identifiers on COB crossover claims at this time.

Be Sure to List Medicare Legacy Identifiers in the Appropriate Fields in NPPES!

It is important for Medicare providers to note that the Medicare crosswalk only uses numbers listed in the **Medicare fields within the "Other Provider Identification Numbers" section** of the NPPES application; this section has fields for Medicare UPIN, Medicare OSCAR/Certification, Medicare PIN and Medicare NSC as noted in the following sample of the section:

Issuer	Number	State	Issuer (for Other Number Type only)
Medicare UPIN			
Medicare Oscar/ Certification			
Medicare PIN			
Medicare NSC			
Medicaid		State is required if Medicaid number is furnished	
Other, Specify:			

If claims are rejecting, providers should review their NPPES records (not their NPI Registry records) to confirm that Medicare legacy identifiers are reported in the appropriate fields of the "Other Provider Identification Numbers" section.

Correct Way to List a Railroad Retirement (RR) Number in NPPES

It has come to our attention that certain clearinghouses are incorrectly instructing Medicare providers who bill as part of the Railroad Retirement (RR) Board program to list their Medicare RR PIN in the "Other" section in the "Other Provider Identification Numbers" field of NPPES (see the diagram in the above paragraph to view a sample of this NPPES field). An RR PIN is a Medicare PIN, and therefore, should be listed in the Medicare PIN section within this field of NPPES. RR providers should double check their NPPES records and update their information, if necessary. Because Medicare RR PINs are 9-digit numbers, they are temporarily being suppressed and will not be displayed in the NPI Registry or the downloadable file. Providers should review their NPPES records, not their NPI Registry records, to determine if corrections are needed.

What is meant by the Term "Billing Provider"?

The term "Billing Provider" means the provider that is identified in the following loops, field locators, or items in the 837I/UB-04 and the 837P/CMS-1500 claim formats, respectively. Although the name of this loop/segment is "Billing Provider", the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop.

Institutional Claims

- 837I (electronic claim)
  - Billing Provider 2010AA
- UB-04 (paper claim)
  - Form Locator (FL) 01

Professional Claims

- 837P (electronic claim)
  - Billing Provider 2010AA
- CMS-1500 (paper claim)
  - Field 33

Test Your Claims Now!

Medicare also continues to urge providers to send a small batch of claims now with only the NPI. If the results are positive, begin increasing the number of claims in the batch.

NPI CONT'D

If claims are rejecting, first go into the NPPES web site located at https://nppes.cms.hhs.gov/ and validate that your NPPES information is correct and that you reported your Medicare legacy identifier(s) in the appropriate Medicare sections of the "Other Provider Identification Numbers" field. Your Medicare legacy identifier(s) would be the number(s) that you used—prior to using the NPI—as the Billing/Pay-to and Rendering Providers. If the information in your NPPES record is correct and you reported your Medicare legacy identifier(s), print the screen (so you have a copy of your NPPES record on paper), call your contractor and ask they validate what is in their system.

Reminder: Medicare Is Issuing Informational Warnings to Those Who Are Not Submitting NPIs on Part B Claims

As stated in an earlier November NPI message, since October 15, 2007, Medicare physicians, non-physician practitioners and other providers and suppliers who bill carriers and Medicare Administrative Contractors (MACs) using the ASC X12N 837P receive informational warnings that indicate if there was no NPI shown in the primary provider fields in those claim(s). Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

The informational warnings consist of one or more of the following messages:

M389 - 2010AA NM108 Billing Provider Identification Code Qualifier Invalid value.

The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M390 - 2010AB NM108 Pay To Provider Identification Code Qualifier Invalid value.

The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M391 - 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid value.

The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M392 - 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid value.

The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

Medicare informational warnings, called "Provider Identification Code Qualifier Invalid Value" messages, will be labeled M389, M390, M391, and/or M392, but again, these are only reminders. If you receive one of these messages and you are certain that your claim was submitted with an NPI, you may wish to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

Many Medicare physicians, non-physician practitioners, and other providers and suppliers are not using NPIs in their Medicare claims, even in the primary provider fields (Billing/pay-to and Rendering). While, until March 1, 2008, you may continue to submit legacy identifiers in these fields, we strongly encourage you to begin using your NPI as well. You may use the NPI/PIN pair or the NPI-only to identify the Billing/pay-to and Rendering Providers. By doing so, you should have sufficient time to correct any problems that came about prior to the requirement to use only the NPI in claims.

Need More Information?

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

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

Claims Must Include NPI March 1, 2008

Effective March 1, 2008, your Medicare fee-for-service claims must include an NPI in the primary provider fields on the claim (i.e., the billing, pay-to provider, and rendering provider fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI. The secondary provider fields (i.e., referring, ordering and supervising) may continue to include only your legacy number, if you choose. Failure to submit an NPI in the primary provider fields will result in your claim being rejected, beginning March 1, 2008.

In addition, if you already bill using the NPI/legacy pair in the primary provider fields, and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI in the primary provider fields. This test will serve to assure your claims will successfully process when only the NPI is mandated on all claims.

Information Regarding NPI Implementation

As we get closer to May 23, 2008, be sure to pay attention to information from Medicare and other health plans regarding NPI implementation timelines.

NPI CONT'D

Important Message for Residents at Teaching Hospitals and Academic Medical Centers: Why get your NPI now?

- If the hospitals' residents want to enroll in Medicare, you will need to obtain NPIs before applying (enrolling) as a Medicare provider.
- Other health plans may require you to obtain NPIs as a condition of enrollment.
- If you prescribe medication, the pharmacies may need to know your NPI before dispensing the medications and submitting claims to health plans.
- If you order or refer services, your NPI may be required on the claims from providers who actually furnished the services.
- Future employers may require you to obtain NPIs as a condition of employment.

Important Information for Medicare Providers

Summary of Key Medicare Dates:

October 29, 2007 - By this date, all carriers, A/B MACs and DME MACs will be rejecting claims where the NPI/legacy identifier combination used in claims cannot be validated against the NPI crosswalk. Informational edits will no longer be issued once this happens but will be replaced by reject reports that will assist providers in determining why the claim is being rejected.

January 1, 2008 - As of this date, 837I electronic claims and UB04 paper claims without an NPI in fields identifying the primary provider (billing and pay-to) will be rejected. Legacy identifiers paired with NPIs in the primary provider fields on the claim will still be acceptable as will legacy-only numbers in secondary provider fields (see clarification below).

CMS has not yet announced the date by which an NPI will be required for primary provider fields on 837 professional electronic claims and 1500 paper claims processed by carriers, A/B MACs and DME MACs. This will occur prior to May 23, 2008; a specific date will be announced once available.

May 23, 2008 - In keeping with the Contingency Guidance issued on April 3, 2007, CMS will lift its NPI contingency plan, meaning that only the NPI will be accepted on all HIPAA electronic transactions (837I, 837P, NCPDP, 276/277, 270/271 and 835), paper claims and SPR remittance advice. This also includes all secondary provider fields on the 837P and 837I. The reporting of legacy identifiers will result in the rejection of the transaction. CMS will also stop sending legacy identifiers on COB crossover claims at this time.

Common Claims Problems/Errors Causing Rejections

The following problems/errors are due to providers billing with incompatible NPI/legacy pairs:

- The type of NPI you use (Entity Type 1 or Entity Type 2) must match your Medicare enrollment PIN (individual or organization). When compatible NPI/legacy pairs are submitted on a claim, there is a much higher success rate for finding a match on the NPI crosswalk, thus further ensuring timely and accurate processing of your claim.
- Those who are enrolled with Medicare as individuals but obtained an Organization (Entity type 2) NPI through NPPES (or vice versa) need to ensure their enrollment records are correct and their NPIs were obtained appropriately.
- On professional claims (837P and CMS-1500), the NPI/PIN combination should identify the Billing, Pay-to, and Rendering Provider (the Pay-to Provider is identified only if it is different from the Billing Provider). This includes claims that are submitted by corporations that physicians and non-physician practitioners have formed or by physicians and non-physician practitioners who bill Medicare directly. For more information, please refer to MLN Matters article SE0744 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0744.pdf on the CMS web site.

Other problems identified include:

- Providers are not taking proactive action based on the Part B informational edits and reject reports, despite extensive outreach and educational activities designed to make providers aware of the need to take action. Don't let this happen to you. Pay attention to the informational edits prior to October 30 and the reject messages thereafter.
- CMS has received reports of clearinghouses and billing services that may be stripping the NPI from the claim and later adding the NPI back on the remittance advice. Make sure this is not unknowingly happening to your claims. If you suspect that your clearinghouse or billing service is stripping your NPI from claims, please contact your contractor to confirm that an NPI was not received.

Clarification: NPI Requirement on Medicare Institutional Claims for 1/1/08

At the beginning of October, CMS issued a notice that referred to institutional claims. We are further clarifying that effective 1/1/08 NPIs will be required to identify the primary providers (the Billing and Pay-to Providers) in Medicare electronic and paper institutional claims (i.e. 837I and UB-04 claims). You may continue to use the legacy identifier in these fields as long as you also use the NPI in these fields. This means that 837I and UB-04 claims with ONLY legacy identifiers in the Billing and Pay-to Provider fields will be rejected starting on 1/1/08. (Pay-to Provider is identified only if it is different from the Billing Provider.)

You may continue to use only legacy identifiers for the secondary provider fields in the 837I and UB-04 claims until 5/23/08 if you choose.

Test Your Claims Now!

Medicare encourages submitters to send a small number of claims using NPIs **only** (no legacy identifiers). If no claims are rejected, the submitter may gradually increase the volume. And remember, Medicare will require the NPI on paper claims – be sure to begin the testing process now even if you bill paper!

Upcoming WEDI NPI Audiocast on Using the NPI Registry and the NPPES Downloadable File

The Workgroup for Electronic Data Interchange will host an NPI audiocast on October 31st. Visit http://www.wedi.org/npioi/index.shtml on the WEDI web site to learn more. Please note that there is a cost to participate in WEDI events.

NPI CONT'D

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 web site. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Requirement to Update Information in NPPES

Health care providers who are covered entities under HIPAA are required by the National Provider Identifier (NPI) Final Rule to update their NPPES data. The Final Rule [at (162.410(a)(4)] states that covered health care providers must notify the NPPES of changes in their required NPPES data elements within 30 days of the changes. Failure to provide updated information may be considered an act of non-compliance with the NPI regulation, and a complaint may be filed against covered health care providers who do not comply with this provision or any other provisions of the rule.

Most updates and changes can be made by health care providers over the web, using the User IDs and passwords they selected when they first applied for their NPIs. If they applied on paper, most health care providers can submit updates or changes over the web and can select User IDs and passwords at the time of the update. Certain changes or updates, however, must be made on paper (form CMS-10114), as they require the original signature of the health care provider or, for an organization health care provider, the signature of the Authorized Official. Such changes include:

1. Applications for NPIs, and all updates/changes, from individuals who do not have SSNs or who do not want to report their SSNs to NPPES;
2. All requests to deactivate NPIs;
3. All requests to reactivate NPIs;
4. All changes to incorrectly submitted SSNs;
5. All changes to incorrectly submitted dates of birth;
6. All changes to incorrectly submitted Employer Identifier Numbers (EINs);
7. All changes of EINs;
8. Password resetting changes due to changes to the Contact Person or Authorized Official.

When to Contact the NPI Enumerator for Assistance

Your health plans cannot assist you with NPI questions that should be directed to the NPI enumerator. However, the issues with which the NPI Enumerator can assist you are also limited to the following topics:

- Status of an NPI application, update, or deactivation
- Forgotten/lost NPI
- Lost NPI notification
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application

Health care providers needing this type of assistance may contact the NPI Enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at CustomerService@NPIenumerator.com.

The NPI application is also a good source of information. Please refer to the NPI application instructions for clarification on information to be submitted in order to obtain an NPI or update your record. You can also refer to the 'Application Help' tab located on the NPPES web site for additional assistance while you are online.

Resources for other kinds of questions can be found at the end of this document.

Please Note: The NPI Enumerator's operation is closed on federal holidays

Important Information for Medicare Providers

Medicare Announces a New "Key" NPI Date

This is an important message for physicians, other practitioners, providers, and suppliers that bill Medicare carriers, A/B Medicare Administrative Contractors (MACs), and DME MACs Using an Electronic Claim Form (ASC X12 837P) or Paper Claim Form (CMS-1500)

The Centers for Medicare & Medicaid Services (CMS) is pleased to report that the vast majority of Medicare claims are being sent to Medicare with a National Provider Identifier (NPI). Moreover, the Medicare NPI crosswalk is successfully crosswalking NPIs to legacy numbers for most claims. Given these favorable results, we are taking the next step towards full implementation of the NPI in Medicare.

Effective **March 1, 2008**, your Medicare fee-for-service claims must include an NPI in the primary fields on the claim (i.e., the billing, pay-to, and rendering fields). You may continue to submit NPI/legacy pairs in these fields or submit only your NPI on the claim. You may not submit claims containing only a legacy identifier in the primary fields. Failure to submit an NPI in the primary fields will result in your claim being rejected or returned as unprocessable beginning March 1, 2008. Until further notice, you may continue to include legacy identifiers only for the secondary fields.

Medicare Informational Warnings to Those Who Are Not Submitting NPIs on Claims

Since October 15, 2007, Medicare physicians, non-physician practitioners and other providers and suppliers who bill carriers and Medicare Administrative Contractors (MACs) using the ASC X12 837P or CMS-1500 receive informational warnings that indicate there was no NPI shown in the primary provider fields on your claim(s). Medicare is including these informational warnings on your pre-pass reject reports provided to you directly or to your bulletin board.

NPI CONT'D

Many Medicare physicians, non-physician practitioners, and other providers and suppliers are not using NPIs in their Medicare claims, even in the primary provider fields (Billing/pay-to and Rendering). While, until March 1, you may continue to submit legacy identifiers in these fields, we strongly encourage you to begin using your NPI as well. You may use the NPI/PIN pair or the NPI-only to identify the Billing/pay-to and Rendering Providers.

Medicare informational warnings, called "Provider Identification Code Qualifier Invalid Value" messages, will be labeled M389, M390, M391, and/or M392, but, again, these are only reminders. If you receive one of these messages and you are certain that your claim was submitted with an NPI, you may wish to contact your clearinghouse or billing agent to ascertain the reason behind the message. It is possible that the clearinghouse or billing agent removed the NPI prior to submitting the claim to Medicare. You may also want to call your carrier/MAC to ask about the message and how you can correct future claims.

The informational warnings consist of one or more of the following messages:

M389 2010AA NM108 Billing Provider Identification Code Qualifier Invalid value.

The edit sets when the 2010AA loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M390 2010AB NM108 Pay To Provider Identification Code Qualifier Invalid value.

The edit sets when the 2010AB loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M391 2310B NM108 Claim Level Rendering Provider Identification Code Qualifier Invalid value.

The edit sets when the 2310B loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

M392 2420A NM108 Detail Level Rendering Provider Identification Code Qualifier Invalid value.

The edit sets when the 2420A loop and NM1 are submitted but NM108 does not contain XX. If the claim contains a 2300 REF01 = P4 and REF02 = 31 (VA claim), the edit does not set.

Testing Claims with Only the NPI

If you already bill using the NPI/legacy pair in the primary fields and your claims are processing correctly, now is a good time to submit to your contractor a small number of claims containing only the NPI. This test will serve to assure your claims will successfully process when only the NPI alone is mandated on all claims. If the results are positive, begin increasing the number of claims in the batch. If your claims reject, first go into the NPPES web site located at https://nppes.cms.hhs.gov/ and validate that your information is correct and that you reported your Medicare legacy identifier(s) in the Other Provider Identification Numbers section. Your Medicare legacy identifier(s) would be the number(s) that you used—prior to using the NPI—as the Billing/Pay-to and Rendering Providers. If the NPPES information is correct and you reported your Medicare legacy identifier(s), call your contractor and ask that they validate what is in their system.

Need More Information?

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

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

How to Handle NPI for Ordering/ Referring and Attending/ Operating/ Other/ Service Facility for Medicare Claims

MLN Matters Number: MM5674 Revised
Related Change Request (CR) #: 5674
Related CR Release Date: October 26, 2007
Related CR Transmittal #: R225PI
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Note: This article was revised on November 1, 2007, to delete the parenthetical phrase (MD and DO) from the 8th bullet point under "Key Points." All other information remains the same.

Provider Types Affected

Physicians and providers who bill Medicare Carriers, fiscal intermediaries (FI), and Medicare Administrative Contractors (A/B MAC) for claims for services provided to Medicare beneficiaries.

What Providers Need to Know

Be cognizant of the fact that in accordance with the NPI final rule, when an identifier is reported on a claim for ordering/ referring/attending provider, operating/other/service facility provider, or for any provider that is not a billing, pay-to or rendering provider, that identifier **must be an NPI. For Medicare purposes this means that submission of an NPI for an ordering/ referring provider is mandatory effective May 23, 2008. Legacy numbers cannot be reported on any claims sent to Medicare on or after May 23, 2008.**

Medicare has always required that a provider identifier be reported for ordering/ referring providers. Effective May 23, 2008, that number **must be an NPI**, regardless of whether that referring or ordering provider participates in the Medicare program or not or is a covered entity.

NPI CONT'D

Key Points

- Medicare will not pay for referred/ ordered services or items unless the name and NPI number of the referring/ ordering/ attending/ operating/ other/ service facility provider is on the claim.
- It is the responsibility of the claim/bill submitter to obtain the ordering/ referring/ attending/ operating/ other/ service facility NPI for health care providers.
- Providers whose business is largely based upon provision of services or items referred/ ordered by other providers must be careful furnishing such services/ items unless they first obtain the NPI of the referring/ ordering individual. If they furnish services/ items and do not obtain that person's NPI prior to billing Medicare, their claim will be denied.
- If the NPI is not directly furnished by the ordering/ referring provider at the time of the order, the provider expected to furnish the services or items should contact that provider for his/ her NPI prior to delivery of the services/ items.
- Providers who have not obtained an NPI by May 23, 2008, are not permitted to refer/ order services or items for Medicare beneficiaries.
- Legacy numbers, such as provider identification numbers (PINs) or unique physician identification numbers (UPINs), cannot be reported on any claims sent to Medicare on or after May 23, 2008.
- Physicians and the following non physician practitioners are the only types of providers allowed to refer/ order services or items for beneficiaries:
  - Nurse practitioners (NP);
  - Clinical nurse specialists (CNS);
  - Physician assistants (PA); and
  - Certified nurse midwives (CNM).
- Established NPI business requirements for beneficiary submitted (CR 5328), deceased physician (CR 5416), adjustments (CR 5416), beneficiary submitted (CR 4169), flu claims (CR 4169), foreign claims (CR 4169) and pandemic flu claims (CR 4169) remain as written.

Background

This article is based on Change Request (CR) 5674. Please note that the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for each health care provider. The (NPI) final rule, published on January 23, 2004, establishes the NPI as this standard. All health care providers covered under HIPAA must comply with the requirements of the NPI final rule (45 CFR Part 162, CMS-045-F). All entities covered under HIPAA must comply with the requirements of the NPI final rule.

Additional Information

You may see the official instruction (CR5674) issued to your Medicare A/B MAC, FI, or carrier by going to http://www.cms.hhs.gov/Transmittals/downloads/R225PI.pdf on the CMS web site.

NCPDP Inbound Claim and COB Companion Documents Updated for NPI Reporting

MLN Matters Number: MM5716 Revised
Related Change Request (CR) #: 5716
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R299OTN
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Note: This article was revised on December 4, 2007, to clarify the language in the bullet points on page 3 to more closely align with CR5716. All other information remains the same.

Provider Types Affected

Suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for providing Medicare Part B drugs to Medicare beneficiaries.

What You Need to Know

CR 5716, from which this article is taken, announces that the original Medicare fee-for-service National Council for Prescription Drug Programs (NCPDP) inbound claim and coordination of benefits (COB) companion documents have been updated to address the use of the National Provider Identifier (NPI).

You can find these updated documents (entitled "NCPDP 5.1/1.1 Inbound NPI Companion Document" and "NCPDP 5.1/1.1 COB NPI Companion Document") at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp#TopOfPage on the CMS web site, and as attachments to CR5716.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 adopted the NCPDP Telecommunication Standard 5.1 and NCPDP Batch Standard 1.1 as the national standard for submitting retail drug claims. Medicare DME MACs are responsible for processing all retail drug claims for those limited prescription drugs covered under Medicare Part B; and this national standard applies both to claims sent inbound to DME MACs as well as those sent outbound by the DME MACs to COB trading partners.

In addition to such national standards, HIPAA also mandated that covered entities use NPIs as the sole means to identify providers who prepare electronic data interchange (EDI) transactions. However, NCPDP standards were not designed to enable a health care provider to report more than one identifier during this transition period. Thus, in NCPDP claims, you can report either a provider's legacy number, such as National Supplier Clearinghouse (NSC) identification numbers used for retail pharmacy identification and the Unique Physician Identification Numbers (UPINs) used to identify prescribers of retail drugs, or the NPI, but not both.

Further, when the original Medicare fee-for-service NCPDP inbound claim and COB companion documents (which provide Medicare-specific information related to the use of the relevant HIPAA standards) were issued, they did not address use of NPIs. CR5716, from which this article is taken, announces that an updated version of those

NPI CONT'D

companion documents, that does include NPI reporting, is now available to be downloaded under the titles of "NCPDP 5.1/1.1 Inbound NPI Companion Document" and "NCPDP 5.1/1.1 COB NPI Companion Document" at: http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp#TopOfPage.

You should be aware that for retail drug claims prior to May 23, 2008 (the date when the NPI is to be used exclusively to identify providers on NCPDP claims) the NCPDP implementation guide calls for the use of qualifiers to indicate the type of provider identifier being reported.

On NCPDP claims that you submit prior to May 23, 2008, you can choose to use either legacy numbers or NPIs for provider identification. If you choose to use legacy numbers, the pre-NPI companion document (not containing "NPI" in the title) applies. If you choose to use NPIs, the new companion documents (containing "NPI" in the titles) apply. Lastly, prior to May 23, 2008, if you use a legacy identifier for the retail pharmacy and an NPI for the prescriber (or vice versa); the non-NPI companion document will apply for reporting the legacy identifier, and the NPI companion document will apply for reporting the NPI.

There are some specific details related to the completion of NCPDP claims that will be of interest to you:

- Effective for claims received by Medicare on or after May 23, 2008, your inbound claims will be returned if they do not contain an 01 (NPI) qualifier in Transaction Header segments 202-B2 (retail pharmacy identification) and/or 466-EZ (prescriber identification), and if included in a claim, 468-2E (primary care provider identification) and 465-EY (pharmacy identification).
- If an inbound claim contains a reported NPI in a provider identification number field (210-B1, 411-DB, 421-DL, or 449-E9), but one or more of those numbers do not meet NPI validity criteria (i.e., does not begin with a 1, 2, 3, or 4; does not have 10-digits; includes any special characters; or does not have a valid check digit in the 10th position), the claim will reject.
- Medicare systems will not check the Medicare NPI Crosswalk to try to locate an NPI for any provider identification fields (qualifier and provider identification number fields) for any provider for which information is included in a claim in fields which are not used for Medicare claim processing (e.g., fields 468-2E and 421-DL or 465-EY and 449-E9). The editing for such provider qualifiers and identification numbers in the fields not used by Medicare will be limited to NPI validity edits.
- Medicare legacy numbers will not be reported on the outbound coordination of benefits (COB) transaction. However, an exception is permitted for those claims that have not cleared the system by the date CMS ends its' NPI contingency. Those "pending" claims may contain legacy number, so the COB will also include the legacy number.

Additional Information

You can find the official instruction, CR5716, issued to your DME MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R299OTN.pdf on the CMS web site. The two updated companion documents: "NCPDP 5.1/1.1 Inbound NPI Companion Document" and "NCPDP 5.1/1.1 COB NPI Companion Document" are attached to that CR.

For more information on the NPI contingency, providers may visit http://www.cms.hhs.gov/NationalProvIdentStand/08_NPI%20Contingency%20Planning.asp#TopOfPage on the CMS web site.

Rejection of Electronic Claim Status Requests That Lack NPIs

MLN Matters Number: MM5726
Related Change Request (CR) #: 5726
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R302OTN
Effective Date: May 23, 2008
Implementation Dates: January 7, 2008 and April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit claims status requests using the electronic data interchange (EDI) standard Health Insurance Portability and Accountability Act (HIPAA) transactions to Medicare contractors (carriers, Fiscal Intermediaries, (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), and DME Medicare Administrative Contractors (DME MACs))

Provider Action Needed

This article is based on CR5726, which describes policy changes that are a result of HIPAA requirements that prohibit the acceptance of EDI transactions that contain legacy provider numbers. CR5726 specifically address changes around the processing of electronic claim status requests and the responses to such requests.

Beginning May 23, 2008, Medicare will return to sender any electronic claim status request (X12 276 transactions) that contain legacy provider numbers instead of or in addition to the NPI number. This policy also applies to direct data entry (DDE) claim status inquiries and to Internet claim status screens operated as demonstration projects by some contractors.

No later than May 23, 2008, providers should ensure that all electronic claim status requests sent to Medicare contractors contain only NPI numbers (no legacy provider numbers.)

NPI CONT'D

Background

All electronics claim status requests submitted using the EDI standards (X12 276) adopted under HIPAA for national use must use the HIPAA-mandated NPI exclusively for provider identification no later than May 23, 2008. Those that do not are to be returned to the sender beginning May 23, 2008. All claims status responses (X12 277 transactions) will also contain only NPIs as of May 23, 2008. The same policy applies to direct data entry claim status inquiries and to those Internet claim status screens some contractors are permitted to operate under an Internet demonstration program. The absence of an NPI or the presence of a legacy number as of May 23, 2008, will result in rejection of the inquiry by these direct data entry processes.

Providers are advised that Medicare will return an NPI on the claims status response on or after May 23, 2008, even if the claim status request is received prior to May 23, 2008, using a legacy number. In returning the NPI, Medicare will use a crosswalk file that relates the legacy number to the provider's NPI. If the legacy number maps to more than one NPI, Medicare will return the first active NPI in the 277 response.

To avoid confusion, Medicare encourages providers to begin including their NPIs in their X12 276 inquiries as soon as possible prior to May 23, 2008, particularly if the provider has more than one NPI, but was assigned only one legacy number by Medicare for claims submission purposes.

Additional Information

The official instruction, CR5726, issued to your Medicare contractor can be found at http://www.cms.hhs.gov/Transmittals/downloads/R302OTN.pdf on the CMS web site.

Medicare Fee for Service NPI Final Implementation

MLN Matters Number: MM5728
Related Change Request (CR) #: 5728
Related CR Release Date: October 5, 2007
Related CR Transmittal #: R1349CP
Effective Date: No later than May 23, 2008
Implementation Date: January 7, 2008 and April 7, 2008

Provider Types Affected

Physicians, providers, and suppliers who submit any HIPAA standard transactions to Medicare contractors (carriers, Fiscal Intermediaries, (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (A/B MACs), and DME Medicare Administrative Contractors (DME MACs))

Provider Action Needed

This article is based on CR5728, which describes the policy change brought about as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, that requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions.

Once CMS ends its' NPI contingency, the legacy number will NOT be permitted on any inbound electronic and outbound electronic transaction (there are exceptions to the 835 remittance advice (see CR5452)). Medicare contractors will begin rejecting claims, electronic, including direct data entry, that contain legacy provider numbers for any primary provider instead of or in addition to the NPI number. The following HIPAA transactions are also affected:

- X12N 276/277 Claim Status Inquiry/Response – (see CR5726 for details.)
- X12N 837 Coordination of Benefits (COB) – NPI only will be sent on the 837 coordination of benefits. Legacy numbers are not allowed. An exception will exist for claims that have not cleared the system by the date that CMS ends its NPI contingency plan. Such claims may contain the legacy number and, therefore, the COB transaction will also include the legacy number.

No later than May 23, 2008, providers should ensure that all HIPAA transactions sent to Medicare contractors contain only valid NPI numbers (no legacy provider numbers.)

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions. The Centers for Medicare & Medicaid Services (CMS) began to issue NPIs on May 23, 2005. CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers. They are:

- NPI only;
- Medicare legacy only; or
- NPI and legacy combination.

On April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance to covered entities regarding contingency planning for the implementation of the NPI. As long as a health plan is compliant, meaning they can accept and send NPIs on electronic transactions, they may establish contingency plans to facilitate the compliance of their trading partners. As a compliant health plan, Medicare fee for service (FFS) established a contingency plan on April 20, 2007, that followed this guidance. CR5728 directs Medicare contractors to begin rejecting HIPAA inbound claims when directed by CMS, if they contain legacy provider identifiers.

Since paper claims are not HIPAA transactions, these requirements do not apply to paper claims, however, providers should not submit legacy numbers on paper claims once CMS ends its NPI contingency plan.

Additional Information

The official instruction, CR5728, issued can be found at http://www.cms.hhs.gov/Transmittals/downloads/R1349CP.pdf on the CMS web site.

NPI CONT'D

Reporting NPI and "EY" Modifier on Claims for DMEPOS Items Dispensed without Physician's Order to Obtain Medicare Denial for Coordination of Benefits

MLN Matters Number: MM5771
Related Change Request (CR) #: 5771
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R1368CP
Effective Date: May 23, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Suppliers who bill for DMEPOS for Medicare beneficiaries and require a Medicare Denial for COB purposes

Provider Action Needed

- For Coordination of Benefit purposes, DMEPOS suppliers should use the modifier EY (no physician or other licensed health care provider order for this item or service) on each line item on the claim and report their own name and National Provider Identifier (NPI) in the "Ordering/ Referring Provider Name" fields on claims submitted on or after May 23, 2008, to secure a Medicare denial. Failure to include the EY modifier on all line items will result in return of your claim as unprocessable. On such returned claims, the Medicare contractor will include Reason Code 4 to show that "The procedure code is inconsistent with the modifier used or a required modifier is missing."
- If you have obtained a physician's order for some, but not all, of the items provided to the Medicare beneficiary, submit a separate claim for the items dispensed without a physician's order.

Background

Chapter 5, section 5.2.1 of the *Medicare Program Integrity Manual (PIM)* states that a supplier must have an order (prescription) from the treating physician prior to dispensing any DMEPOS item to a beneficiary and must keep the prescription for the item on file. However, although Medicare requires a physician's order for payment of all DMEPOS items, not all secondary insurers maintain a similar requirement.

The Centers for Medicare & Medicaid Services (CMS) instituted modifier "EY" (no physician or other licensed health care provider order for this item or service) to allow DMEPOS suppliers to submit claims to Medicare for items without a prescription. Since there is no physician or provider information to report on claims for these items, the "EY" modifier is used in conjunction with a surrogate Unique Physician Identification Number (UPIN) in the ordering/ referring provider name fields of the claim. This protocol was adopted so that suppliers could obtain a Medicare denial that could be sent to a secondary insurer for COB purposes.

In accordance with the NPI final rule, when an identifier is reported on a claim for the ordering/referring provider, i.e., any provider that is not a billing, pay-to or rendering provider, that identifier must be an NPI (See 45 CFR Part 162, CMS- 045-F). For Medicare purposes, this means that submission of an NPI for an ordering/referring provider is mandatory, effective May 23, 2008, and legacy numbers may not be reported on any claims sent to Medicare as of this date. Therefore, Medicare will discontinue the use of all surrogate values on claims with dates of service on or after May 23, 2008.

To assure prompt processing of your claims affected by this issue:

- Your name should be reported in item 17 and your NPI in 17b of the CMS-1500 claim form, version 08-05; or
- Your name and NPI should be reported in both the 2420E (ordering provider name) and 2420F (referring provider name) loops of the ASC X12N 837 professional claim format.
- Make sure the "EY" modifier is present on each line item on the claim.

Additional Information

You may see the official instruction (CR5771) issued to your Medicare DME MAC by going to http://www.cms.hhs.gov/Transmittals/downloads/R1368CP.pdf on the CMS web site.

ENROLLMENT

Important Changes to NSC Development Process

The Centers for Medicare &Medicaid Services (CMS) recently made some changes to how the NSC will develop for data elements missing from the CMS 855S or information that needs clarification.

The National Supplier Clearinghouse (NSC) processes durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) enrollment documentation following Medicare guidelines and regulations published in the Code of Federal Regulation (CFR) and the Medicare Program Integrity Manual (PIM).

Publication 100-8, Chapter 10, Section 3 of the PIM and 42 CFR 424.525 provide instruction on the application pre-screening and rejection processes. Below are the changes that effect DMEPOS enrollment:

Pre-screening

Verifies if all data elements are completed and all required documentation submitted

If any information is missing:

- Suppliers will be notified via e-mail or fax.
- This will be the only request made.
- Suppliers will have 60 days from date of notification to return all required information.

Rejection

Information received must be accurate and complete:

- The NSC is not required to contact the supplier again to request information; therefore it is imperative that all information be accurate and complete.
- If additional requests are made based on the supplier's inquiry or site visit results, information must be submitted within the initial 60 days.
- Good faith effort - if the supplier is making a concerted effort, the NSC may continue to process the enrollment documentation.

Application will be closed if information not received within 60-day timeframe:

- Suppliers will be required to resubmit.
- Suppliers are not able to appeal this decision.

Helpful Hints

- Review enrollment documentation prior to submission to ensure all information is accurate and complete and that all required documentation is included.
- Utilize the helpful hints and check lists available on the NSC Web site, www.palmettogba.com/nsc
- Make sure to retain your fax confirmation indicating the requested information was successfully transmitted to the NSC.
- Ensure the response is addressed to a specific analyst. Many times responses are received, but addressed to the NSC and not to the analysts processing the documentation.

DMEPOS Demonstration Project Commences November 1, 2007

The Centers for Medicare & Medicaid Services (CMS) has instructed the National Supplier Clearinghouse (NSC) to begin the DMEPOS demonstration project on November 1, 2007. This demonstration project will involve **all** DMEPOS suppliers located in the following counties:

South Florida – Miami-Dade, Broward and Palm Beach

Southern California – Los Angeles, Orange, Riverside and San Bernardino.

There are three major components to this demonstration:

1. Immediate submission of CMS 855S application - Each DMEPOS supplier in the demonstration locales will be required to submit a CMS 855S Medicare enrollment application to the NSC within 30 days after the NSC requests such data.

The NSC will notify suppliers by letter to submit the CMS 855S. The letter will contain instructions and indicate a date by which the form must be received by the NSC. If the form is not received timely, the supplier's billing privileges will be revoked. No extensions will be granted. The NSC will begin mailing these letters on October 31, 2007.

Note: In order to properly administer this project, please do not submit a CMS 855S reenrollment application until notified to do so by the NSC.

2. **Revocation of billing privileges** - Under this demonstration, a DMEPOS supplier's Medicare billing privileges will be revoked in the following circumstances:

- The DMEPOS supplier failed to submit a CMS 855S application within the aforementioned 30-day timeframe.
- The DMEPOS supplier failed to report a change in ownership or address at least 30 days prior to the effective date of the change.
- The DMEPOS supplier failed to obtain accreditation from an approved DMEPOS accrediting organization within 120 days of notification from the NSC to do so.

  Note: Not every DMEPOS supplier will be required to obtain accreditation under this demonstration. Only those that are notified by the NSC to become accredited will be subject to that requirement.
- The DMEPOS supplier has an owner or managing employee that has had a felony conviction within the last 10 years.
- The DMEPOS supplier no longer meets each and every requirement necessary for enrollment as a DMEPOS supplier.
- If the supplier's billing privileges are revoked, CMS will implement recoupment measures as appropriate.

3. **Enhanced review of "remaining" DMEPOS suppliers** DMEPOS suppliers that do not have their Medicare billing privileges revoked based on the information contained in the CMS 855S application they submitted will be subject to an enhanced review

This may include but is not limited to, additional unannounced site visits and targeted claims reviews.

For Additional Information:

Visit www.cms.hhs.gov/MedicareProviderSupEnroll and click on the "Enrollment Demonstrations" link on the left-hand side of the page.

To review notices, alerts and bulletins, visit www.cms.hhs.gov/medlearn

Modifiers for DME Services

Missing or incorrect modifiers is the top reason for front-end EDI errors. To help prevent these errors, 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.

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 web site.

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.

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.

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 web site. 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 web site, see the Accessing Local Coverage Determinations article from the What's New section for instructions.

ASCA Enforcement Review Decisions, Elimination of References to Claim Status and COB Medicare HIPAA Contingency Plans and Changes to Reflect Transfer of Responsibility for Medigap Claims to COBC Contractor

MLN Matters Number: MM5606
Related Change Request (CR) #: 5606
Related CR Release Date: October 15, 2007
Related CR Transmittal #: R1583CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Provider Types Affected

Physicians, providers, and suppliers submitting claims to the Railroad Medicare carrier, and other Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs), and/or DME Medicare Administrative Contractors (DME MACs) for services provided to both Railroad and non-Railroad Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 5606, which implements a process to enable the application of the Administrative Simplification Compliance Act (ASCA) enforcement review decisions made by non-Railroad (non-RR) Medicare Contractors to the same providers when they bill the Railroad (RR) Medicare Carrier (RMC).

Due to distribution of RR retirees, many providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and these providers have been allowed to continue to submit paper claims to the RMC. The same providers may also treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors. ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. By adding ASCA enforcement review decision information to the file sent from non-RR Medicare contractors to the RMC to share provider data, the RMC can apply decisions that providers are ineligible to submit paper claims to those same providers when they bill the RMC.

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Administrative Simplification Compliance Act (ASCA) requires that providers submit claims to Medicare electronically to be considered for payment, with a limited number of exceptions including an exception that allows providers that submit fewer than 120 claims per year (no more than 10 claims per month or 30 claims per quarter) to Medicare to continue to submit paper claims. See the *Medicare Claims Processing Manual*, Chapter 24, Sections 90-90.6 at http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf.

Due to the dispersion of railroad (RR) retirees in the United States, however, few physicians/practitioners/suppliers treat a large number of RR Medicare beneficiaries. As result, many of these providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC), and they have been allowed to continue to submit paper claims to the RMC. In addition, the same providers generally treat non-RR Medicare beneficiaries and submit more than 10 claims a month to other Medicare contractors.

However, ASCA electronic claim filing exceptions apply to Medicare overall, and do not differentiate based on contractors or between RR and non-RR contractors. Providers that submit paper claims to multiple Medicare contractors, including both RR and non-RR Medicare contractors, are subject to ASCA Enforcement Review by each of those contractors.

If a non-RR Medicare contractor 1) determines that a provider does not meet criteria which would permit that provider to continue to submit Medicare claims on paper and 2) notifies the provider that all paper claims submitted on or after a specific date will be denied, then that same decision is to be applied to that provider if submitting paper claims to the RMC even if that provider would not normally submit 10 or more paper claims to the RMC monthly.

If a provider reports that another Medicare contractor has reversed a decision that the provider is ineligible to submit paper claims, the RMC will ask that provider to submit a copy of the reversal letter from that contractor and to hold all new paper claims until such time as the RMC reviews the reversal letter and can advise the provider by letter that they can submit the paper claims.

Effective with the implementation date of CR5606, the Medicare Claims System (MCS) maintainer that prepares the provider files for transfer to the RMC will add ASCA Enforcement Review information when that information is in the non-RR provider files used to prepare the report for the RMC. Once added to the file, information concerning ASCA Enforcement decisions made by the non-RR Medicare contractors (such as providers are ineligible to submit paper claims) will be accessible to the RMC so the same decisions can be applied to the same providers when they bill the RMC.

CR5606 also updates the *Medicare Claims Processing Manual* to eliminate references to Claims Status and Coordination of Benefits ((COB) Medicare HIPAA Contingency Plans and changes to reflect transfer of responsibility for Medigap claims to the COB contractor.

Additional Information

The official instruction, CR5606, issued to your Medicare carrier, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1353CP.pdf on the CMS web site.

Medicare Summary Notice Message: Revised 38.13

MLN Matters Number: MM5722
Related Change Request (CR) #: 5722
Related CR Release Date: September 27, 2007
Related CR Transmittal #: R1347CP
Effective Date: October 29, 2007
Implementation Date: October 29, 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), and DME Medicare Administrative Contractors (DME MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

This article is informational for providers and the article is based on Change Request (CR) 5722, which outlines a change to MSN message 38.13 that will advise beneficiaries that they may need to pay their provider before receiving their MSN due to the change to quarterly mailing schedule (see CR 5062.)

Background

In an effort to reduce overall operating costs, CR5062 changed the No-Pay MSN mailing schedule from a monthly schedule to a quarterly schedule. As a result, it is possible that a beneficiary may receive a bill from a provider before receiving the MSN and may not be able to wait for the MSN before provider payment is due. The change to MSN Message 38.13 clarifies this potential timing conflict to beneficiaries. The revised MSN message is as follows:

> "If you aren't due a payment check from Medicare, your Medicare Summary Notices (MSN) will now be mailed to you on a quarterly basis. You will no longer get a monthly statement in the mail for these types of MSNs. You will now get a statement every 90 days summarizing all of your Medicare claims. Your provider may send you a bill that you may need to pay before you get your MSN. When you get your MSN, look to see if you paid more than the MSN says is due. If you paid more, call your provider about a refund. If you have any questions about the bill from your provider, you should call your provider. "

Additional Information

You can review the official instruction issued to you're A/B MAC, FI, carrier, DME MAC, or RHHI regarding this message modification by going to CR 5722, located at http://www.cms.hhs.gov/transmittals/downloads/R1347CP.pdf on the CMS web site.

You can review CR5062 at http://www.cms.hhs.gov/transmittals/downloads/R955CP.pdf on the CMS web site. The related MLN Matters article (MM5062: Quarterly Medicare Summary Notice (MSN) Printing Cycle) is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5062.pdf on the CMS web site.

DME MACs - Discontinuance/ Cancellation of "WL" Modifier on Claims for DeWall Posture Protector Orthotic Body Jacket HCPCS Code (L0430)

MLN Matters Number: MM5758
Related Change Request (CR) #: 5758
Related CR Release Date: October 15, 2007
Related CR Transmittal #: R295OTN
Effective Date: July 16, 2007
Implementation Date: November 16, 2007

Provider Types Affected

All suppliers who submit claims to durable medical equipment Medicare Administrative Contractors (DME MACs) for the DeWall Posture Protector Orthotic Body Jacket.

What Providers Need to Know

This article is based on Change Request (CR) 5758, which states that DME/MACs shall accept claims billed with Healthcare Common Procedure Coding System (HCPCS) Code L0430 with no modifier requirements for the DeWall Posture Protector Orthotic Body Jacket. See "Key Points" for specific details.

Background

On November 2, 2004, the Centers for Medicare & Medicaid Services (CMS) entered into a settlement agreement ("Stipulation for Compromised Settlement") resolving the DeWall court case. The United States District Court for the District of Nebraska approved of the settlement and dismissed the DeWall case by Order dated November 3, 2004, (Filing 121). The settlement agreement stipulates that "code L0430 be reinstated for a period of five years from the date of reinstatement, with no modifiers, as a HCPCS L code, with a descriptor that indicates that it describes only the Dewall Posture Protector."

On January 1, 2005, CMS reinstated code L0430 for the DeWall Posture Protector only, for a five-year period ending on December 31, 2009. By agreement of the parties, the **five-year duration of the settlement agreement ending December 31, 2009, will be extended to August 1, 2012**.

On July 16, 2007, CMS issued further instructions to the DME MACs to reiterate the terms of this court order and ensure compliance with the stipulation to **accept and process claims using the L0430 code, when the item furnished is a DeWall Posture Protector, without requiring any modifiers**.

Key Points

In accordance with CR5758, DME MACs shall:

- Accept and process claims for the DeWall Posture Protector Spinal Orthosis, submitted using HCPCS code L0430, when the item furnished is a DeWall Posture Protector, without requiring any modifiers, including the "KX" or "WL" modifiers;
- Apply all other current applicable Medicare edits to such claims; and
- Upon implementation of CR5758, retire all use of the "WL" modifier.

Additional Information

To see the official instruction (CR5758) issued to your Medicare DME MAC visit http://www.cms.hhs.gov/Transmittals/downloads/R295OTN.pdf on the CMS web site.

Update to Place of Service Code Set: New Code for Temporary Lodging

MLN Matters Number: MM5777
Related Change Request (CR) #: 5777
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R1366CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Providers, physicians, and suppliers who submit claims to Medicare carriers, Medicare Administrative Contractors (A/B MAC), or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services rendered to Medicare beneficiaries living in temporary lodging settings

What You Need to Know

CR 5777, from which this article is taken updates the current Centers for Medicare & Medicaid Services (CMS) place of service (POS) code set to add a new code, "16," for temporary lodging and implements the systems and local-contractor-level changes needed for Medicare to adjudicate claims with the new code.

You should make sure that your billing staffs are aware of this new POS code and also aware that (effective for claims initiated as of April 1, 2008) carriers, A/B MACs, and DME MACs will pay for covered services that are payable in the temporary lodging setting (POS code 16) at the non-facility rate.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not the date of service. Therefore, you may begin using this code, if appropriate, on claims initiated on or after April 1, 2008, regardless of date of service.

Background

Medicare, as a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, must comply (by regulation) with the statute's standards and their implementation guides. The implementation guide currently adopted for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the CMS POS code set.

One requirement of this standard's implementation guide is that each professional claim contain a valid POS code from the POS code set maintained by CMS. Under HIPAA, as a payer, Medicare complies with this requirement by itself requiring a valid POS code on each 837 professional claim it receives. Similarly, when processing professional claims, Medicare must recognize as valid all valid codes from the POS code set. In addition, although not required by HIPAA, Medicare also requires a valid POS code on professional claims submitted on paper (the CMS 1500 form).

The POS code set provides setting information necessary to pay appropriately both Medicare and Medicaid claims. Historically, Medicaid has had a greater need for POS specificity than Medicare, and many of the new codes developed over the past few years have been to meet Medicaid's needs. While Medicare does not always need this greater specificity in order to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

Effective for claims initiated on or after April 1, 2008, CMS is adding to the POS code set a new code for temporary lodging, "16," and Medicare is preparing its systems to accept and adjudicate professional claims with this code when it is in effect. Under HIPAA, the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.

Additional Information

You can find the official instruction, CR5777, issued to your carrier, A/B MAC, or DME MAC by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1366CP.pdf on the CMS web site.

Crossover of Assignment of Benefits Indicator (CLM08) From Paper Claim Input

MLN Matters Number: MM5780
Related Change Request (CR) #: 5780
Related CR Release Date: November 2, 2007
Related CR Transmittal #: R1369CP
Effective Date: April 1, 2008
Implementation Date: April 7, 2008

Provider Types Affected

Physicians and suppliers submitting paper claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Part A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries

Provider Action Needed

This article is based on Change Request (CR) 5780 which makes system changes to the manner in which the Medicare sets the CLM08 value in the Coordination of Benefits (COB) flat file for transmission of claims to COB partners.

CR 5780 will result in changes to Medicare systems to appropriately set the correct indicator in CLM08 based on the presence of or lack of a patient signature in box/item 13 of the Form CMS-1500.

See the Background and Additional Information Sections of this article for further details regarding these changes and be sure billing personnel complete box/item 13 of the Form CMS-1500 in accordance with the revised instructions.

Background

The basic claims form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program is the Form CMS-1500. It answers the needs of many health insurers, and it is only accepted from physicians and suppliers

that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 (http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr424_02.html).

Coordination of Benefits (COB) trading partners requested that CMS change the current process of automatically setting a "Y" value in the CLM08 segment of the 837 Professional Coordination of Benefits (COB) claim crossover file. Trading partners may use the CLM08 value to determine where the claim reimbursement is to go and have, in some cases, reimbursed the provider instead of the beneficiary.

Note: CLM08 is the assignment of benefits indicator, and a "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

CR 5780 initiates system changes to appropriately set the correct indicator in CLM08 based on the presence of or lack of a signature in box/item 13 of the Form CMS-1500. In addition, CR5780 revises the Form CMS-1500 claim completion instructions in order to inform providers regarding how the presence or lack of a signature in box 13 will affect downstream patient assignment of benefits. Specifically, the *Medicare Claims Processing Manual* (Chapter 26, Section 10.3 – Items 11a-13 – Patient and Insured Information) is revised (***changes are bolded and italicized***) as follows:

"Item 13 - The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream Coordination of Benefits trading partners (supplemental insurers) with whom we have a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may or may not affect supplemental payments to providers and/or their patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked."

NOTE: This can be "Signature on File" signature and/or a computer generated signature."

The business requirements in CR 5780 do not affect inbound claims or current Medicare claims processing guidelines. They specifically address COB claims only which are sent to trading partners.

Additional Information

The official instruction, CR5680, issued to your carrier, DME MAC, and A/B MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1369CP.pdf on the CMS web site.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

MLN Matters Number: MM5800
Related Change Request (CR) #: 5800
Related CR Release Date: November 30, 2007
Related CR Transmittal #: R1384CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

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), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for services.

Impact on Providers

CR 5800, from which this article is taken, announces the latest update of Remittance Advice Remark Codes used in electronic and paper remittance advice and Claim Adjustment Reason Codes used in electronic and paper remittance advice and coordination of benefits (COB) claim transactions. These changes will be effective January 1, 2008. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits transactions.

The remittance advice remark code list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at http://wpc-edi.com/codes on the Internet. The lists at the end of this article summarize the latest changes to the remark code lists, as announced in CR 5800, effective on January 1, 2008. As a reminder, CMS notes that the claim adjustment reason code of A2 (Contractual adjustment) is deactivated effective January 1, 2008.

CMS has developed a new web site to help navigate the RARC database more easily. A tool is provided to help search

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if you are looking for a specific category of code. At this site, you can find some other information that is also available from the Washington Publishing Company (WPC) web site. The new web site address is http://www.cmsremarkcodes.info/ on the Internet.

Note that this web site does not replace the Washington Publishing Company (WPC) site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You may see the official instruction (CR5800) issued to your Medicare Carrier, A/B MAC, FI, DME MAC or RHHI by going to http://www.cms.hhs.gov/Transmittals/downloads/R1384CP.pdf on the CMS web site.

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers at:* http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS web site.

Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Comment
N388	Missing/incomplete/invalid prescription number. **Note: (New Code 8/1/07)**	Medicare initiated
N389	Duplicate prescription number submitted. **Note: (New Code 8/1/07)**	Medicare initiated
N390	This service cannot be billed separately. **Note: (New Code 8/1/07)**	Medicare initiated
N391	Missing emergency department records. **Note: (New Code 8/1/07)**	Not Medicare initiated
N392	Incomplete/invalid emergency department records. **Note: (New Code 8/1/07)**	Not Medicare initiated
N393	Missing progress notes or report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N394	Incomplete/invalid progress notes or report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N395	Missing laboratory report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N396	Incomplete/invalid laboratory report. **Note: (New Code 8/1/07)**	Not Medicare initiated
N397	Benefits are not available for incomplete service(s)/undelivered item(s). **Note: (New Code 8/1/07)**	Not Medicare initiated
N398	Missing elective consent form. **Note: (New Code 8/1/07)**	Not Medicare initiated
N399	Incomplete/invalid elective consent form. **Note: (New Code 8/1/07)**	Not Medicare initiated
N400	Alert: Electronically enabled providers should submit claims electronically. **Note: (New Code 8/1/07)**	Not Medicare initiated
N401	Missing periodontal charting. **Note: (New Code 8/1/07)**	Not Medicare initiated
N402	Incomplete/invalid periodontal charting. **Note: (New Code 8/1/07)**	Not Medicare initiated
N403	Missing facility certification. **Note: (New Code 8/1/07)**	Not Medicare initiated
N404	Incomplete/invalid facility certification. **Note: (New Code 8/1/07)**	Not Medicare initiated
N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service. **Note: (New Code 8/1/07)**	Not Medicare initiated
N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service. **Note: (New Code 8/1/07)**	Not Medicare initiated
N407	You are not an approved submitter for this transmission format. **Note: (New Code 8/1/07)**	Medicare Initiated

N408	This payer does not cover deductibles assessed by a previous payer. **Note: (New Code 8/1/07)**	Not Medicare initiated
N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident. **Note: (New Code 8/1/07)**	Not Medicare initiated
N410	This is not covered unless the prescription changes. **Note: (New Code 8/1/07)**	Not Medicare initiated
N411	This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N412	This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N413	This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N414	This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N415	This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N416	This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N417	This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.) **Note: (New Code 8/1/07)**	Not Medicare initiated
N418	Misrouted claim. See the payer's claim submission instructions. **Note: (New Code 8/1/07)**	Not Medicare initiated
N419	Claim payment was the result of a payer's retroactive adjustment due to a retroactive rate change. **Note: (New Code 8/1/07)**	Not Medicare initiated
N420	Claim payment was the result of a payer's retroactive adjustment due to a Coordination of Benefits or Third Party Liability Recovery. **Note: (New Code 8/1/07)**	Not Medicare initiated
N421	Claim payment was the result of a payer's retroactive adjustment due to a Peer Review Organization decision. **Note: (New Code 8/1/07)**	Not Medicare initiated

N422	Claim payment was the result of a payer's retroactive adjustment due to a payer's contract incentive program. **Note: (New Code 8/1/07)**	Not Medicare initiated
N423	Claim payment was the result of a payer's retroactive adjustment due to a non standard program. **Note: (New Code 8/1/07)**	Not Medicare initiated
N424	Patient does not reside in the geographic area required for this type of payment. **Note: (New Code 8/1/07)**	Medicare initiated
N425	Statutorily excluded service(s). **Note: (New Code 8/1/07)**	Medicare initiated
N426	No coverage when self-administered. **Note: (New Code 8/1/07)**	Medicare initiated
N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery. **Note: (New Code 8/1/07)**	Medicare initiated
N428	Service/procedure not covered when performed in this place of service.**Note: (New Code 8/1/07)**	Medicare initiated
N429	This is not covered since it is considered routine. **Note: (New Code 8/1/07)**	Medicare initiated

*__NOTE:__ Some remark codes may provide only information. They may not necessarily supplement the explanation provided through a reason code, or, in some cases another/other remark code(s), for an adjustment. Codes that are informational will have "Alert" in the text to identify them as informational rather than explanatory codes. For example, this informational code is sent per state regulation, but does not explain any adjustment:

> *N369 Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.*

These informational codes will be used only if specific information needs to be communicated but not as default codes.

Modified Codes

Code	Current Modified Narrative	Comment
M27	**Alert:** The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07
M70	**Alert:** The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
MA14	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	Modified 4/1/07, 8/1/07
M62	**Alert:** This is a telephone review decision.	Modified 4/1/07, 8/1/07

BILLING CONT'D

N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.)	Modified 8/1/07
N84	**Alert:** Further installment payments are forthcoming.	Modified 4/1/07, 8/1/07
N85	**Alert:** This is the final installment payment.	Modified 4/1/07, 8/1/07
N129	Not eligible due to the patient's age.	New Code 10/31/02, Modified 8/1/07

CERT

CERT Documentation

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

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

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

The secure fax number for submitting documentation to the CDC is (240) 568-6222.

Mail all requested documentation to:

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

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

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

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

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

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.

APPEALS

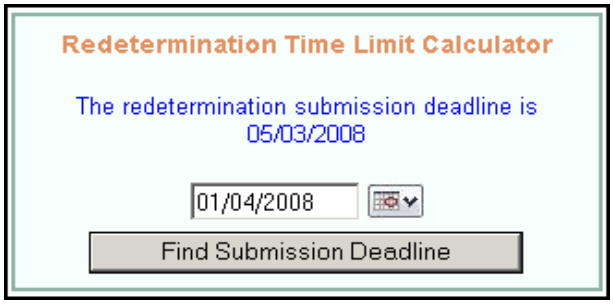
Redetermination Time Limit Calculator Available

To assist providers/suppliers in submitting timely redetermination requests, a Redetermination Time Limit Calculator is now available in the Claims / Reopenings and Redeterminations section of the www.noridianmedicare.com web site. This calculator allows suppliers to enter the date of their initial claim determination (remittance advice date) and receive the date by which the request must be received in the Medicare office, based on the 120 day filing limit established by CMS.

Follow the directions to enter the Remittance Advice date in mm/dd/yyyy format or use the calendar tool to quickly navigate to the correct month, day and year. Select "Find Submission Deadline". The redetermination submission deadline will be returned as the result of the inquiry.

Entry:

Result:



APPEALS CONT'D

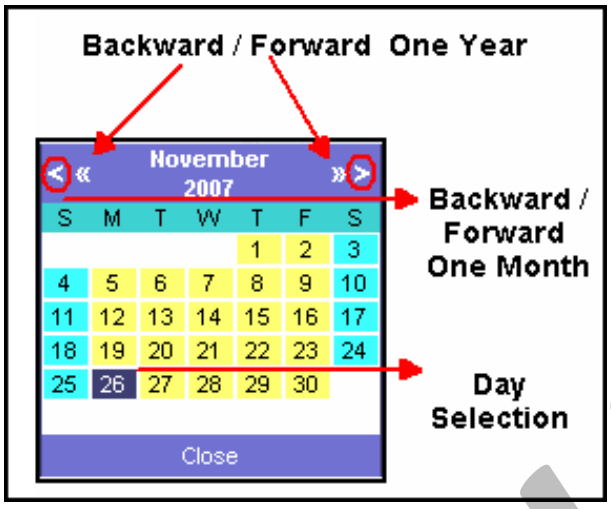
Entry Tips

Do not enter the Remittance Advice date using a 1/1/08 date format; instead, enter 01/01/2008 to avoid errors. The system does not recognize '1' as a valid month but is looking for 01, 11 or 12 as a valid month.

Calendar Tool Usage

Use the < and > options to navigate backward or forward one month, respectively.

Use the << and >> options to navigate backward or forward one year. Select the numeric date for the correct month and year.



A redetermination is a request to review a claim when there is dissatisfaction with the original determination. A redetermination is the first level of the appeals process and is an independent re-examination of an initial claim determination. A claim must be appealed within 120 days from Medicare's initial determination.

NAS encourages suppliers to provide all required medical documentation with their request to avoid delays in the redetermination process. For a guide of what documentation is requested to support redeterminations, reference the document titled "Documentation Guide for DME Redeterminations" that was posted to the What's New section of the NAS DME web site, www.noridianmedicare.com on July 27, 2007.

Email Available Soon for Redetermination and Reopening Questions

Effective January 1, 2008, suppliers may email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Communication with suppliers is important to NAS so we wanted to provide an additional avenue of communication for redetermination and reopening questions.

Questions and concerns may include but are not limited to:

- Timely filing inquiries
- Appeal regulations
- Coverage questions
- Appeal rights
- Documentation requirements for redeterminations
- Redetermination/reopening request forms
- Redetermination letter wording
- Social Security laws
- Interpretation of denial messages

Confidential information cannot not be e-mailed. This includes Protected Health Information (PHI), such as patient names, claim information, Health Insurance Claim (HIC) numbers, Social Security numbers, Claim Control numbers (CCNs) or supplier numbers. This type of information cannot be e-mailed because it may be possible for others to view the contents. If you have a question that would contain PHI, please call our Contact Center at 1-866-243-7272.

The Centers for Medicare & Medicaid Services (CMS) state that PHI cannot be transmitted via e-mail, therefore, NAS will not respond to any requests that contain PHI. Those requests that do not contain PHI will be answered within two business days.

This e-mail option is for suppliers only and is not to be used by beneficiaries. All beneficiary inquiries should be directed to 1-800-MEDICARE (1-800-633-4227).

EDI

Medicare Remit Easy Print New Version Available

Medicare Remittance Easy Print (MREP) version 2.3 is now available for download and includes the following changes:

- A change was made so that the third line of header information (Check/EFT #, Date, page #, and the word 'Notice') displays on all subsequent pages of a multiple page MREP Remittance Advice.
- A change was made to display the appropriate sub-heading information when generating a print preview or printing from the Claims List tab. When you perform a print preview or print from the Claims List tab, the subheading contains "Claim List" inside the square brackets.

Note: Since changes are being made to the MREP software, the updated CARC/RARCs file is included with version 2.3 of the MREP software. However, the separate Codes.ini file is provided when the MREP software is distributed.

Remember: You can save time and money by taking advantage of **FREE** Medicare Remit Easy Print software available to view and print the HIPAA compliant 835!

EDI Test Process Change

Effective November 5, 2007, a change was made to the EDI testing process, as a result of the change to the Enterprise Data Center environment. Rather than being able to generate test results back to our submitters hourly, the results will be available the morning after the batch cycle has completed.

The process completed by the submitter remains the same; a test file is created and sent to Jurisdiction D EDI. Jurisdiction D EDI will produce a 997 Functional Acknowledgement report within an hour of receiving your test file. If the test file receives a status of A on the 997, the file will be moved to the second step and the test Electronic Receipt Listing will be generated and available for downloading the next business day.

Removal of EDI Voice Mail

The Jurisdiction D EDI department will be modifying the phone system that supports the EDI Helpdesk on December 1, 2007. The most notable difference to EDI customers will be the elimination of the voice mail system during normal operating hours, as you will be able to reach a call center representative during these hours. The phone number and hours of operation will remain the same and the EDI Helpdesk remains committed to responding with prompt, courteous responses to questions, concerns and issues. If the EDI Helpdesk will not be available due to a meeting or training, a message will inform callers of this down time.

The Jurisdiction D EDI department is continually adding materials to the EDI section of the CIGNA Government Services web site to better assist customers in finding the answers they need as an alternative to calling. For example, a web site feature was recently added allowing suppliers to request that an electronic report be reposted in a Stratus mailbox, as this is one of the most common calls received. The EDI Helpdesk will continue to look for items they can offer online in order to free up suppliers time and provide the ability to request information in a convenient manner. If there are items you don't see on the EDI web site that you feel would be beneficial, please let an EDI representative know.

The EDI Helpdesk also offers the ability to send questions to them via email. This email address is jurisdictiondedi@cigna.com. An EDI representative will respond to your email within 24 hours.

Correction to Revised HCPCS Codes Relating to Immune Globulin (CR 5635)

MLN Matters Number: MM5741 Revised
Related Change Request (CR) #: 5741
Related CR Release Date: October 5, 2007
Related CR Transmittal #: R1350CP
Effective Date: July 1, 2007
Implementation Date: November 5, 2007

Note: This article was revised on October 15, 2007, to show that CR5741 and this article relate to suppliers billing DME MACs. Other provider types billing Medicare for Immune Globulin should continue to follow the information contained in article MM5635 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5635.pdf on the CMS web site.

Provider Types Affected

Suppliers who bill Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for Immune Globulin.

What You Need to Know

CR 5741, from which this article is taken, corrects CR5635 to show that it applies to suppliers billing DME MACs. CR5635 revised Healthcare Common Procedure Coding System (HCPCS) codes relating to immune globulin. (**Basically, the information in this article restates the requirements of CR5635 that apply to suppliers billing Medicare DME MACs**.) CR 5741 announces that on and after July 1, 2007:

- Code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg) **is no longer payable by Medicare**.
- It is being replaced by the following codes, which are effective for payment on July 1, 2007: **Q4087** (Octagam Injection), **Q4088** (Gammagard Liquid Injection), **Q4091** (Flebogamma Injection), and **Q4092** (Gamunex Injection).
- In addition, two new codes are payable for services on or after July 1, 2007:
  - **Q4089** (Rhophylac injection). Note that 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.
  - **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.*

CODING CONT'D

- As described in CR 5428, Medicare contractors will pay for preadministration-related services (G0332) associated with IVIG administration when Q4087, Q4088, Q4091, or Q4092 is billed in lieu of J1567.

Make sure that your billing staffs are aware of these Immune Globulin HCPCS code changes.

Background

CR 5741 announces that effective July 1, 2007, Medicare will no longer pay for HCPCS code J1567 (injection, immune globulin, intravenous, non-lyophilized (e.g. liquid), 500 mg). In its place, effective July 1, 2007, codes Q4087, Q4088, Q4091, Q4092, and two new codes (Q4089, Q4090) become effective for payment. Table 1, below, displays these codes and their descriptions.

Table 1

HCPCS Code Changes for Immune Globulin

Effective July 1, 2007

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

Additional Information

You can find the official instruction issued to your Medicare DME MAC about the revised HCPCS codes relating to Immune Globulin by going to CR5741, located at http://www.cms.hhs.gov/Transmittals/downloads/R1350CP.pdf on the CMS web site.

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 web site.

REIMBURSEMENT

DMEPOS Fourth Quarter Fees

Please be advised that there are no updates to the Jurisdiction D fourth quarter DMEPOS fee schedule.

Reasonable Charge Update for 2008 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

MLN Matters Number: MM5740 Revised
Related Change Request (CR) #: 5740
Related CR Release Date: September 28, 2007
Related CR Transmittal #: R1344CP
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Note: This article was revised on November 7, 2007 to change the title to the chart showing the payment limits. That chart should have read "2008" and not "2007". All other information is unchanged.

Provider Types Affected

Physicians, providers, and suppliers billing Medicare contractors (carriers, Fiscal Intermediaries, (FIs), Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for splints, casts, dialysis equipment, and certain intraocular lenses.

Background

For calendar year 2008, Medicare will continue to pay on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses. For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. This payment is in addition to the payment made under the Medicare physician fee schedule for the procedure for applying the splint or cast.

Change Request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: http://www.gpoaccess.gov/cfr/retrieve.html on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The MLN Matters

article related to CR 5382 can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf on the CMS web site.

For intraocular lenses, payment is made **only on a reasonable charge basis for lenses implanted in a physician's office**. Change Request 5740 instructs your carrier, or A/B MAC to compute 2008 customary and prevailing charges for the V2630, V2631, and V2632 (Intraocular Lenses Implanted in a Physician's Office) using actual charge data from July 1, 2006, through June 30, 2007.

Carriers and A/B MACs will compute 2008 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2007.

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

Dialysis Supplies Billed With AX Modifier

A4216	A4217	A4248	A4244	A4245	A4246
A4247	A4450	A4452	A6250	A6260	A4651
A4652	A4657	A4660	A4663	A4670	A4927
A4928	A4930	A4931	A6216	A6402	

Dialysis Supplies Billed Without AX Modifier

A4653	A4671	A4672	A4673	A4674	A4680
A4690	A4706	A4707	A4708	A4709	A4714
A4719	A4720	A4721	A4722	A4723	A4724
A4725	A4726	A4728	A4730	A4736	A4737
A4740	A4750	A4755	A4760	A4765	A4766
A4770	A4771	A4772	A4773	A4774	A4802
A4860	A4870	A4890	A4911	A4918	A4929
E1634					

Dialysis Equipment Billed With AX Modifier

E0210NU	E1632	E1637	E1639

Dialysis Equipment Billed Without AX Modifier

E1500	E1510	E1520	E1530	E1540	E1550
E1560	E1570	E1575	E1580	E1590	E1592
E1594	E1600	E1610	E1615	E1620	E1625
E1630	E1635	E1636			

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes.

Contractors will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008 through December 31, 2008. **Those 2008 payment limits are in Attachment A at the end of this article**.

Additional Information

Detailed instructions for Calculating:

- Reasonable charges are located in Chapter 23 (Section 80) of the *Medicare Claims Processing Manual*;
- Customary and prevailing charge are located in Section 80.2 and 80.4 of Chapter 23 of the *Medicare Claims Processing Manual*; and
- The IIC (Inflation Indexed Charge) are located in Section 80.6 of Chapter 23 of the *Medicare Claims Processing Manual*. The IIC update factor for 2008 is 2.7 percent.

You can find Chapter 23 of the *Medicare Claims Processing Manual* at http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf on the CMS web site.

For complete details regarding this Change Request (CR) please see the official instruction (CR5740) issued to your Medicare FI, carrier, DME MAC, or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/transmittals/downloads/R1344CP.pdf on the CMS web site.

2008 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit
A4565	$7.38	Q4025	$32.45
Q4001	$42.01	Q4026	$101.30
Q4002	$158.81	Q4027	$16.23
Q4003	$30.18	Q4028	$50.66
Q4004	$104.49	Q4029	$24.81
Q4005	$11.12	Q4030	$65.31
Q4006	$25.08	Q4031	$12.41
Q4007	$5.58	Q4032	$32.65
Q4008	$12.54	Q4033	$23.14
Q4009	$7.43	Q4034	$57.56
Q4010	$16.72	Q4035	$11.57
Q4011	$3.71	Q4036	$28.79
Q4012	$8.36	Q4037	$14.12
Q4013	$13.52	Q4038	$35.37
Q4014	$22.81	Q4039	$7.08
Q4015	$6.76	Q4040	$17.68
Q4016	$11.40	Q4041	$17.16
Q4017	$7.82	Q4042	$29.30
Q4018	$12.47	Q4043	$8.59
Q4019	$3.91	Q4044	$14.66
Q4020	$6.24	Q4045	$9.96
Q4021	$5.78	Q4046	$16.03
Q4022	$10.44	Q4047	$4.97
Q4023	$2.91	Q4048	$8.02
Q4024	$5.22	Q4049	$1.82

COVERAGE

Vancomycin Administered Via an External Infusion Pump

The *National Coverage Determination Manual*, Chapter 1, Part 4, Section 280.14 C.1.a states "Medicare coverage of Vancomycin as a durable medical equipment external infusion pump benefit is *not covered*. There is insufficient evidence to support the necessity of using an external infusion pump, instead of a disposable elastomeric pump or the gravity drip method, to administer vancomycin in a safe and appropriate manner."

When J3370, Vancomycin, is billed with an external infusion pump, both J3370 and the pump will be denied as non-covered. The remittance advice message will read, "This service/equipment/drug is not covered under the patient's current benefit plan." This denial will be a patient responsibility (PR) denial.

WHEELCHAIR/POWER MOBILITY DEVICE

ATP Requirement on Power Wheelchairs

The DME PSC medical directors received LCD reconsideration requests to revise the Power Mobility Devices LCD from the American Occupation Therapy Association, the American Physical Therapy Association, and the American Association for Homecare. Each group asked for deletion of the requirement that patients receiving rehab power wheelchairs on or after April 1, 2008, be evaluated by a RESNA-certified Assistive Technology Practitioner.

The current LCD lists two requirements that were scheduled to be implemented for claims with dates of service on or after April 1, 2008:

1. The specialty evaluation for patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be performed by a RESNA-certified Assistive Technology Practitioner (ATP) specializing in wheelchairs or a physician who is board-certified in Physical Medicine and Rehabilitation.

After consideration of the issues, the PSCs have decided to remove this requirement from the policy.

2. A Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must be provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient.

This requirement is being retained and will be effective for claims with dates of service on or after April 1, 2008.

The following requirement which is in the current LCD will remain in place: Patients receiving a Group 2 single power option or multiple power option PWC, any Group 3 or Group 4 PWC, or a push rim activated power assist device for a manual wheelchair must have a "specialty evaluation that was performed by a licensed/certified medical professional, such as a PT or OT, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features."

This information will be incorporated in a future revision of the Power Mobility Devices LCD.

MMA - Evidence of Medical Necessity: Power Wheelchair and POV/PMD Claims

Related Change Request (CR) #: 3952 Revised
MLN Matters Number: MM3952
Related CR Release Date: October 28, 2005
Related CR Transmittal #: 128
Effective Date: May 5, 2005
Implementation Date: The implementation date for the Medicare system changes contained in CR3952 is April 3, 2006; otherwise, implementation will occur on October 25, 2005.

Note: This article was changed on October 24, 2007, to refer to Change Request (CR) 5128, which is a supplement to CR3952. CR5128 contains updated changes based on the final regulation that differ from CR3952. The key points are outlined in MLN Matters article MM5128, which is related to CR5128 and located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5128.pdf on the CMS web site.

Provider Types Affected

Providers prescribing Power Mobility Devices (PMDs) and suppliers billing Medicare Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for PMDs

Provider Action Needed

Effective for dates of service on or after May 5, 2005, the procedure for documenting and submitting a claim for a wheelchair or PMD has changed.

Make certain to meet criteria regarding who can prescribe PMDs, retain appropriate prescribing documentation, and understand the boundaries for prescribing and billing for PMDs.

Background

This article includes information from Change Request (CR) 3952 that outlines the changes regarding Medicare adjudication of claims for PMDs as set forth in Section 302 (a) (2) (E) (iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Also outlined are criteria determining who can prescribe PMDs and a definition of the devices. The following rules are in place for claims with dates of service on or after May 5, 2005:

WHEELCHAIR/POWER MOBILITY DEVICE CONT'D

Rules for Adjudicating Claims for PMDs

Physicians should be aware of the critical role they play in prescribing power wheelchairs. Specifically, physicians evaluate a patient's medical conditions and need for mobility and, as such, are the primary gatekeepers of the information CMS uses to base decisions for payment.

To this end, physicians should be conscientious when documenting patient encounters and pay particular attention to describing the patient's clinical condition (e.g., medical history, disease progression, changes in health status), as well as their need for mobility, their living situation (e.g., family support and caregivers), and other treatments that have been tried and considered. All of this information is used by our contractors (Medicare's DME MACs) when evaluating a claim for payment.

Face-to-Face Examination and Prescription

A condition for payment for motorized or power wheelchairs is that the PMD must be prescribed by a physician or treating practitioner (a physician assistant, nurse practitioner, or a clinical nurse specialist) who has conducted a face-to-face examination of the beneficiary and has written a prescription for the PMD. The face-to-face examination requirement does not apply when only accessories for PMDs are being ordered.

The written prescription (order) must include the following:

- Beneficiary's name;
- Date of the face-to-face examination;
- Diagnoses and conditions that the PMD is expected to modify;
- Description of the item;
- How long it is needed;
- The physician or treating practitioner's signature; and
- The date the prescription is written.

The written prescription (order) must be:

- In writing;
- Signed and dated by the physician or treating practitioner (a physician assistant, nurse practitioner or clinical nurse specialist) who performed the face-to-face examination; and
- Be received by the supplier within 30 days after the face-to-face examination.

The physician or treating practitioner must submit a written prescription (order) for the PMD to the supplier. This prescription must be received by the supplier within 30 days of the face-to-face evaluation, or, in the case of a recently hospitalized beneficiary, within 30 days after the date of discharge from the hospital.

Additional Documentation

The physician or treating practitioner must also provide the supplier with additional documentation describing how the patient meets the clinical criteria for coverage as described in the National Coverage Determination (NCD), as documented in CR3791. (Instructions for accessing CR3791 are in the *Related Instructions* section of this article.)

The actual documentation needed to describe how the coverage is met varies, but may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans, along with any other information explaining the patient's need for the equipment.

DME suppliers should retain on file the prescription (written order), signed and dated by the treating physician or treating practitioner, along with the supporting documentation that supports the PMD as reasonable and necessary.

Other Rules

- It is no longer necessary to require a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology to provide a written order for Power Operated Vehicles (POVs).
- The use of the Certificates of Medical Necessity (CMNs) for motorized wheelchairs, manual wheelchairs, and POVs will be phased out for claims with Dates of Service (DOS) on or after May 5, 2005.
- Until Medicare systems changes are fully implemented in April 2006, for claims with dates of service on or after May 5, 2005, suppliers must submit a partially completed and unsigned CMN.
- For claims with dates of service before May 5, 2005, claims must be submitted and processed using the appropriate fully completed and signed CMN.

Related Instructions

MM3791 provides additional information that describes the steps the healthcare provider must take to justify the POV. MM3791 lists the *Clinical Criteria for MAE Coverage*, along with the *MAE Coverage Flow Chart*. Go to http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3791.pdf on the CMS web site to view that information.

For complete details, please see the official instruction regarding this change. The instruction includes the complete section 280.3; it may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R574CP.pdf and http://www.cms.hhs.gov/Transmittals/downloads/R37NCD.pdf on the CMS web site.

The file reflecting transmittal number 37 contains the revisions to the *Medicare National Coverage Determinations Manual*, and the file with transmittal number 574 contains the Medicare claims processing business requirements/instructions.

Additional Information

For more information regarding wheelchair coverage, visit http://www.cms.hhs.gov/CoverageGenInfo/06_wheelchair.asp - TopOfPage on the CMS web site.

For complete details regarding CR3952, please see the official instruction issued to your DME MAC regarding this change. The instruction may be viewed at http://www.cms.hhs.gov/Transmittals/Downloads/R128PI.pdf on the CMS web site.

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