Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

February 2007
Issue No. 2

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.

Introducing Jurisdiction D Happenings

"Jurisdiction D Happenings" is the name of the Jurisdiction D DME Medicare Administrative Contract bulletin or newsletter. The bulletin will contain educational material, claim submissions reminders, reimbursement and coverage updates and much more for suppliers in Jurisdiction D. Jurisdiction D encompasses the states of Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, N. Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming.

Jurisdiction D Happenings will be available on our DME web site, www.noridianmedicare.com, in the News and Publications section approximately every six weeks in a PDF format. The bulletin will also include a Table of Contents that is both alphabetized and sorted by topic to allow for quick access to information.

Suppliers who have completed paperwork in the past to receive a hard-copy bulletin will continue to receive a hardcopy bulletin four times a year. At this time, NAS is not requiring new paperwork to be completed. The quarterly mailing will include two issues of Jurisdiction D Happenings.

We hope that you will find Jurisdiction D Happenings to be an informative and educational tool.

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CERT

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NPI

Enternal Nutrition

Prosthetics/Orthotics

Wheelchair/Power Mobility Device

Reimbursement

Coding

Coverage

Alphabetical Listing…

Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers

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

Web site: www.noridianmedicare.com

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 6736
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: AdminaStar Federal	1-877-299-7900	www.adminastar.com
Jurisdiction C: Palmetto GBA	1-866-270-4909	www.palmettogba.com

Other Resources

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

Holiday Schedule

Holiday Schedule for 2007:

Presidents Day* ..... February 19, 2007
Good Friday..... April 6, 2007
Memorial Day..... May 28, 2007
Independence Day ..... July 4, 2007
Labor Day ..... September 3, 2007
Columbus Day* ..... October 8, 2007
Veterans Day*..... November 12 (Observed)
Thanksgiving ..... November 22 and 23
Christmas Day ..... December 24 and 25

* The Federal Holidays, noted with an * are days that our contact center will be closed for receiving incoming calls. The contact center staff will be attending internal training and it may be possible that our staff could contact you on these days in regards to claims processing or education issues.

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.

Supplier Manual

NAS has received requests for hardcopies of the Jurisdiction D Supplier Manual. In order to continue to provide the most up-to-date information, NAS offers the Supplier Manual only in an electronic format on our website under the News and Publications section.

However, suppliers can either print a hardcopy of each chapter in the manual or download each chapter by following these instructions:

1. View the NAS Supplier Manual website after accepting the End User Agreement, www.noridianmedicare.com/dme/news/manual/index.html
2. Select the Chapter Title to open the file, for example: **Chapter 1 -** Introduction
3. Select "File / Save As" from your toolbar.
4. Browse to the drive location where you would like to save the content.
5. The "File name" field will automatically be entered.
6. The "Save as type" field must be changed to: "Web Page, complete (*.htm, .html)

The file is now available by browsing to the directory/drive selected in step 4. **Note**: The Supplier Manual chapter will not open by browsing for a .doc file type. A user must browse and search for the .htm file type to locate the information.

A summary of updates can be found at the top of the Supplier Manual home page. The summary provides the chapter, the subheading, the information that was changed and the date of the change. Updates to the manual are also provided through the NAS DME website, the email list and the bulletin. Suppliers can download, print and replace each chapter as often as needed.

Summary of Supplier Manual Updates

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

Chapter	Subheading	Supplier Manual Update	Change Date
Chapter 16	Level II HCPCS Coding	2007 HCPCS Changes	1/9/07
Chapter 1	What is Medicare?	Deductible amount changed from $124.00 (for 2006) to $131.00 (for 2007)	12/28/06
Chapter 16	K Codes	Effective dates for codes K0800-K0899 changed to 11/15/06	11/21/06

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

New Interactive Voice Response System Features

Several features have been added to the Interactive Voice Response system: Check Information, CMN Status and Pricing. Below is the information that is provided in these three categories. The IVR is accessed by dialing 1-877-320-0390 and is available between the hours of 6 am – 8 pm Central Time.

Check Information Status-Option 3

- Last three checks

- Check issue date
- Check amount
- Check number

CMN Status-Option 4

- Initial date of the CMN
- Certification date
- Length of need

Pricing-Option 5

- Individual pricing information on various HCPCS codes

The IVR User Guide has been updated with instructions for these new features and can be found in the Contact section of the DME Web site, www.noridianmedicare.com. The user guide also includes detailed instructions on how to use the touch key features.

In the past, suppliers may have experienced difficulty in accessing or retrieving information through the IVR. NAS understands how important the IVR system is to the operation of supplier's businesses. We have been working with the programming company and technical staff to address these issues with the IVR. NAS has done extensive testing on the IVR and is confident that the IVR problems have been corrected. We ask suppliers to attempt to utilize the IVR for eligibility, claim status and the recently added features to allow our contact center staff to focus on answering other types of DME questions. The contact center representatives are allowed to redirect the supplier community to the IVR before answering questions that can be responded to by the IVR.

If you experience any type of problem with the IVR, please report this to our contact center staff as soon as possible. We will ask for the time the error occurred, what data was being entered and what the specific error or IVR response was in order to troubleshoot and report the errors to our technical staff and to allow the quickest and most efficient resolution to the issue at hand.

Below are some important reminders about IVR usage:

- The IVR can be used with either voice or touch key features, however, a caller cannot utilize both types of features in the same phone call.
- The IVR only requires the last name and first initial of the beneficiary's name.
- Information about HMOs, MSP, home health and hospice care will only be provided if the patient is actively enrolled for the date of service given. The IVR will be "silent" if the patient is not enrolled.
- When utilizing the IVR voice features, call from a quiet environment. The IVR will pick up all background noise. Please do not call the IVR when using a speaker phone or cell phone.

Website Satisfaction Survey

NAS DME is encouraging suppliers to take part in our website survey. The survey is intended to obtain feedback from users of the NAS website regarding content, usability, reliability and overall satisfaction.

The Centers for Medicare & Medicaid Services has contracted with ForeSee Results to conduct the surveys on behalf of Medicare contractors. While navigating our website, users will be randomly selected to complete the ForeSee Results survey. If you are selected, a pop-up window will appear and we would appreciate you taking a few minutes to provide feedback.

Examples of the questions on the survey include:

- Please rate the convenience of the services on this site.
- Please rate the ability to find information you want on this site.
- How well does this site meet your expectations?

The feedback is anonymous and will help NAS evaluate how well the objectives of creating a website that meets the needs of our suppliers was accomplished. Your feedback will also help NAS enhance the website to serve our suppliers in the future.

The next time you visit our website, please take time to participate in the survey to identify areas for improvement as well as areas that work well for you.

Same or Similar Denials

Same or similar denials occur when the patient's CMN history indicates a piece of equipment is the same or similar to the equipment being billed. Some examples of same and similar items are E0196 (gel pressure mattress) with E0277 (powered pressure-reducing air mattress) and E0250 (hospital bed, fixed height, with any type side rails, with mattress) with E0261 (hospital bed, semi-electric, with any type side rails, without mattress).

To determine whether same or similar items have previously been provided, suppliers must obtain all possible information from a patient, which may include the following:

- Patient's correct Health Insurance Claim number;
- Whether the patient has employer insurance or is enrolled in a Health Maintenance Organization (HMO);
- If the patient currently has or had an identical or similar item in the past;
- When the patient received the items and whether or not the items have been returned;
- Where the item will be used; and
- CMN or DIF information, if required.

By using the Suggested Intake Form, it assures this information is obtained. This form is available on our website under the Forms section and it contains beneficiary information, ordering physician information and questions for the beneficiary and the supplier. Suppliers can customize their own intake form to meet their needs as well.

The supplier should also make sure the patient understands that items such as wheelchairs and power-operated vehicles are considered similar equipment and that Medicare usually will not cover both items at the same time. If submitting a claim for a POV and the patient already has a wheelchair, for example, include narrative information regarding the medical necessity for the previous equipment, when and why that need ended, the new or changed medical condition for the POV, when that need began and any additional required information.

To verify the patient has not had a same or similar item previously, suppliers can also call the IVR at 1-877-320-0390 or the Supplier Contact Center at 1-866-243-7272 for information.

After the supplier has entered their supplier number, patient Medicare number, patient first and last name, patient date of birth and the HCPCS code, the IVR provides the CMNs that are posted to the Common Working File for that code. The CWF is a Medicare system that stores claim history for verification, validation and payment authorization.

Representatives in the Supplier Contact Center can disclose the initial date of a CMN and the name and phone number of the previous supplier for a same or similar HCPCS code after the supplier name, supplier number, patient Medicare number, patient first initial and full last name, patient date of birth and the HCPCS code or a description of a code is verified.

DME suppliers are expected to be familiar with DME coverage policies and any additional pertinent information that may have an impact on medical necessity determinations. In order to be protected under the limitation of liability provision, a supplier must provide a proper advance beneficiary notice for each item that it believes is likely to be denied as not medically necessary.

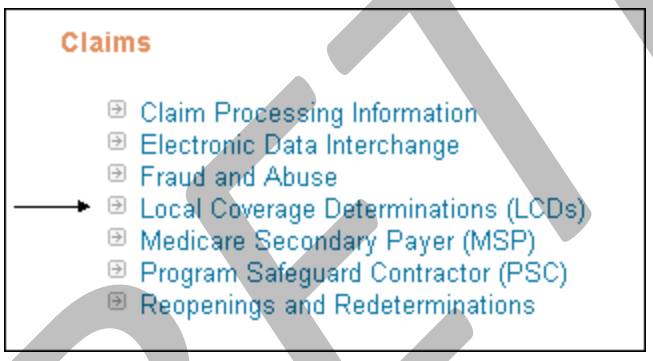
If there is no indication that same or similar equipment has been previously obtained, the supplier would not have reason to provide an ABN. If the beneficiary or the beneficiary's authorized representative is unable to respond fully on the issue of "same or similar equipment," the supplier may issue an ABN. In situations where the beneficiary is planning to use a piece of equipment as a backup (e.g., an extra wheelchair to keep in the car), the supplier should always obtain a signed ABN. A signed ABN is indicated on the claim form with a GA modifier. Please submit a copy of the ABN with each appeal request.

A supplier may request a redetermination on same or similar denials. Examples of additional documentation to submit include a CMN or DIF, physician order, signed pick up and delivery tickets, a detailed outline of events and any changes in medical need.

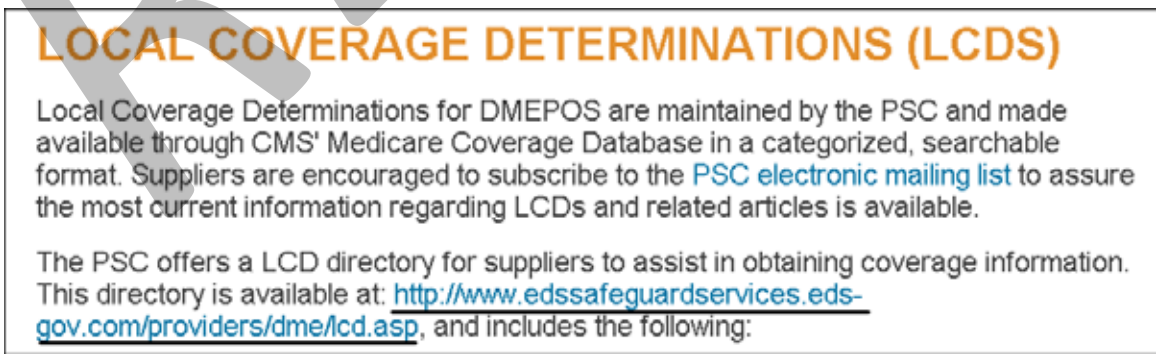
Local Coverage Determination Navigation

The Program Safeguard Contractor for Jurisdiction D, EDS, offers a LCD directory for DME suppliers to assist in obtaining coverage information. The directory is available through a NAS website link.

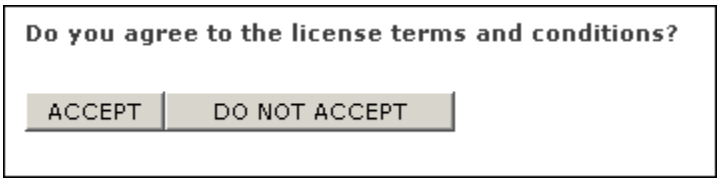
By visiting DME at www.noridianmedicare.com and accepting the End User Agreement, suppliers may choose Local Coverage Determinations under the Claims section.



From here, a link to the LCD directory is available at www.edssafeguardservices.eds-gov.com/providers/dme/lcd.asp.



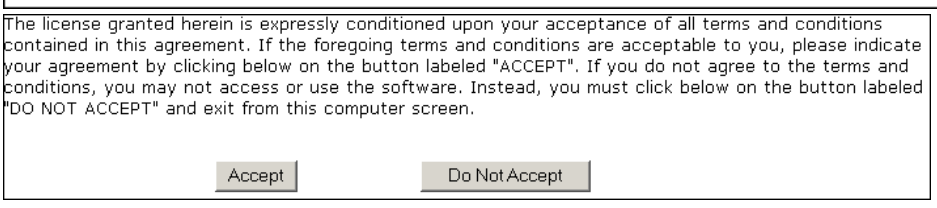
Once at the EDS site, suppliers need to accept the agreements for Current Procedural Terminology and Current Dental Terminology.



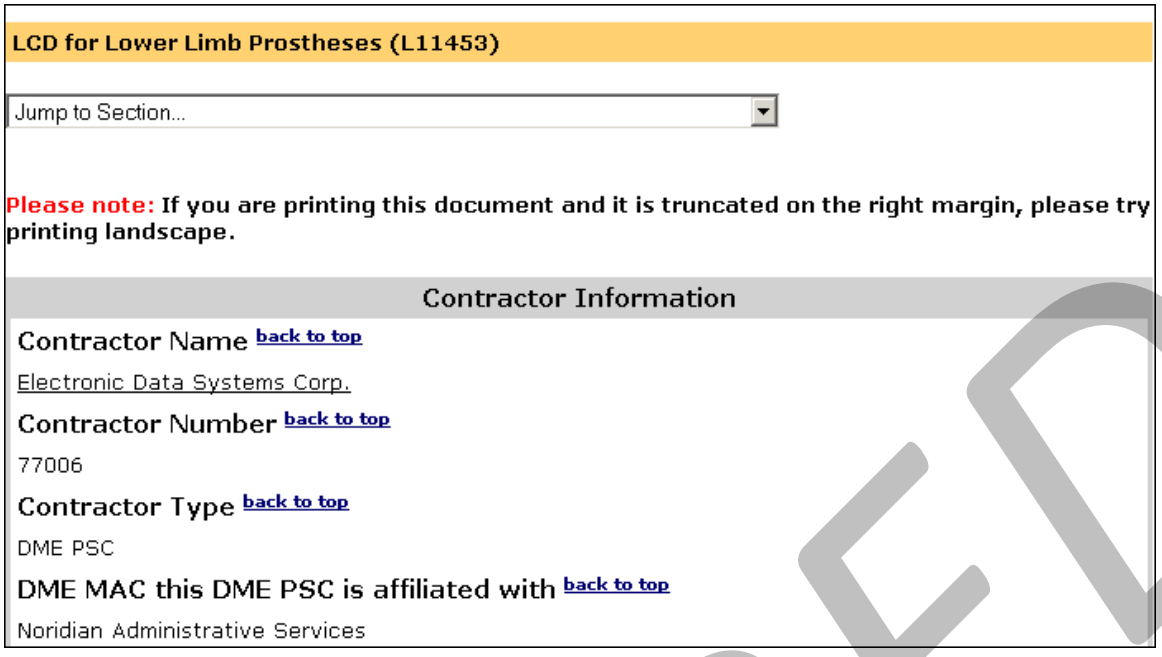
After accepting the agreements, many types of LCDs will be listed. To display the most up-to-date information, choose Current LCDs/Articles.

By choosing Current LCDs/Articles, a listing of both policies and policy articles is displayed. The policy describes indications and limitations of coverage and/or medical necessity, HCPCS codes and documentation requirements. The policy article provides non-medical necessity information and coding guidelines.

Once a specific LCD is chosen, the user must indicate they understand they are leaving the EDS website and also accept the End User Agreement for the CMS Medicare Coverage Database.



After these steps are followed, the policy will be displayed.



The LCD and related policy articles are the first place to look for coverage guidelines for DMEPOS. The supplier manual and the CMS web-based manuals are also resources to reference when searching for coverage and billing criteria.

NAS encourages suppliers to subscribe to the PSC electronic mailing list to receive the most current information regarding LCDs and related articles. Updates are also published on the NAS DME website, sent out through our email list and in the bulletin, Jurisdiction D Happenings.

Dispensing DMEPOS Items – Quantity Limits

For items that are provided on a recurring basis, including but not limited to DME accessories or supplies, urological and ostomy supplies, drugs, and dressings, the general rule is that suppliers may dispense no more than a three month supply at any one time. The exceptions to that rule are enteral and parenteral nutrients and supplies, immunosuppressive drugs, oral anticancer drugs, and oral antiemetic drugs. For these items, only a one month quantity of supplies may be dispensed. In addition, suppliers should be alert for situations in which the need for the item may change – for example, early in the course of treatment, an improving or worsening condition, etc. In such situations, suppliers should adjust the quantity and frequency of their dispensing based on a beneficiary's anticipated needs.

Medicare Learning Network Matters Disclaimer Statement

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

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

Correspondence Reminder

In order for NAS to process correspondence efficiently, suppliers should send information to the correct PO Box or courier address. NAS has been receiving EFT and Administrative Simplification Compliance Act (ASCA) paperwork in the Benefit Protection PO Box in error.

Below are addresses for DME correspondence. Please note that if submitting information to Noridian Medicare Part B also, the non-DME paperwork must be separated and sent to the appropriate Medicare address.

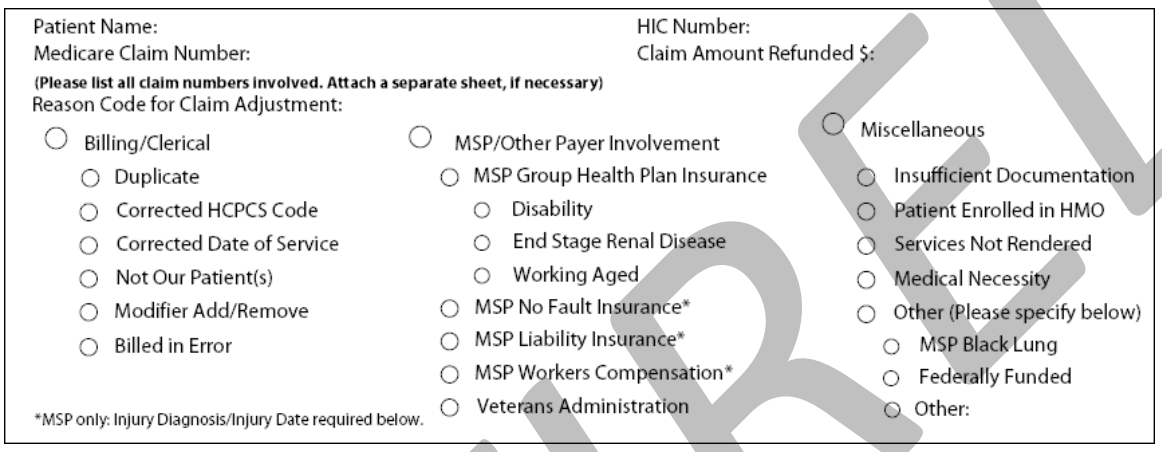
Claims, Redetermination Requests, Correspondence	**Mailing Address** Noridian Administrative Services PO Box 6727 Fargo ND 58108-6727 **Courier Address** Noridian Administrative Services 901 40th Street South Suite 1 Fargo ND 58103-2146
EFT	Noridian Administrative Services PO Box 6728 Fargo ND 58108-6728
EDI	CIGNA Government Services Attn: DMERC EDI PO Box 690 Nashville TN 37202
Supplier Enrollment	**Mailing Address** National Supplier Clearinghouse PO Box 100142 Columbia SC 29202-3142 **Courier Address** National Supplier Clearinghouse 2300 Springdale Drive Bldg 1 GM-219 Camden SC 29020
ASCA	Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737
Benefit Protection Inquiries	Noridian Administrative Services Benefit Protection- DME PO Box 6736 Fargo ND 58108-6736
Documentation • Requested by Medical Review • ADMC Documentation	IntegriGuard, LLC Region D DME PSC 2301 N 117 Avenue Suite 200 Omaha NE 68164
Reconsiderations and Administrative Law Judge Requests	**Mailing Address** RiverTrust Solutions, Inc PO Box 180208 Chattanooga TN 37401-7208 **Courier Address** RiverTrust Solutions, Inc 801 Pine Street Chattanooga TN 37402

Reminders for Completing the Refunds to Medicare Form

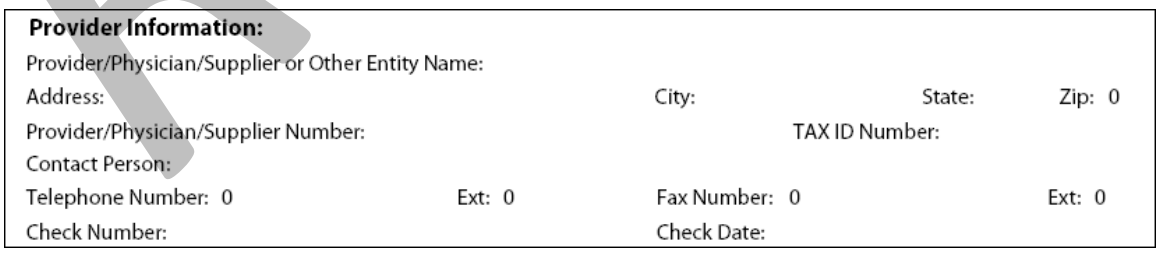
In order for NAS to process refunds efficiently, the Refunds to Medicare form must be thoroughly completed. Incomplete forms lead to delays or errors in processing refunds. Follow the instructions below when completing the Refunds to Medicare form. As a reminder, only one beneficiary per form is allowed.

Required Information: (Please provide the following information for each claim.)

- Name of the patient in the Patient Name field.
- Health Insurance Claim number in the HIC Number field.
- Medicare Internal Control Number (ICN) in the Medicare Claim Number field. (Please list all claim numbers involved. Attach a separate sheet, if necessary)
- Amount refunded for the claim in the Claim Amount Refunded $ field.
- The circle should be filled in for the appropriate reason for the refund.


Patient Name:
HIC Number:
Medicare Claim Number:
Claim Amount Refunded $:
(Please list all claim numbers involved. Attach a separate sheet, if necessary)
Reason Code for Claim Adjustment:
○ Billing/Clerical
○ Duplicate
○ Corrected HCPCS Code
○ Corrected Date of Service
○ Not Our Patient(s)
○ Modifier Add/Remove
○ Billed in Error
○ MSP/Other Payer Involvement
○ MSP Group Health Plan Insurance
○ Disability
○ End Stage Renal Disease
○ Working Aged
○ MSP No Fault Insurance*
○ MSP Liability Insurance*
○ MSP Workers Compensation*
○ Veterans Administration
*MSP only: Injury Diagnosis/Injury Date required below.
○ Miscellaneous
○ Insufficient Documentation
○ Patient Enrolled in HMO
○ Services Not Rendered
○ Medical Necessity
○ Other (Please specify below)
○ MSP Black Lung
○ Federally Funded
○ Other:

- Complete name in the Provider/Physician/Supplier or Other Entity Name field.
- Address in the Address field.
- City in the City field.
- State in the State field.
- Zip code in the Zip field.
- Supplier number in the Provider/Physician/Supplier Number field.
- Supplier's tax identification number in the TAX ID Number field.
- Contact name that Medicare can call with any questions in the Contact Person field.
- Contact name's phone number in the Telephone Number field.
- Contact name's fax number in the Fax Number field.
- Check number in the Check Number field.
- Check date in the Check Date field.


Provider Information:
Provider/Physician/Supplier or Other Entity Name:
Address:
City:
State:
Zip: 0
Provider/Physician/Supplier Number:
TAX ID Number:
Contact Person:
Telephone Number: 0
Ext: 0
Fax Number: 0
Ext: 0
Check Number:
Check Date:

Medicare Secondary Payer

MSP information is important to timely processing of the refund request and updating beneficiary insurance records.

REMINDERS CONT'D

When Medicare is the Secondary Payer, the supplier enters:

- Name of the insurance company in the Insurer Name field.
- Name of the policyholder or the subscriber in the Subscriber Name field.
- Number of the subscriber's policy in the Policy Number field.
- Number of the subscriber's group policy in the Group Number field.
- Address of the insurance company in the Insurer Address field.
- City, state, and zip code of the insurance company in the City, State, Zip field.
- Phone number of the insurance company in the Telephone Number field.
- Fax number of the insurance company in the Fax Number field.
- When the reason code for the claim adjustment listed in the table has an * at the end of the reason (i.e., MSP No Fault Insurance, MSP Liability Insurance, MSP Workers Compentsion), enter the injury diagnosis in the *Injury Diagnosis field.
- When the claim adjustment reason listed in the table has an * at the end of the reason, enter the injury date in the *Injury Date field.

MEDICARE SECONDARY PAYER: Complete the following Primary Insurance information and attach a copy of the primary payer EOB or payment sheet and the Medicare EOB.

Insurer Name:		Subscriber Name:		
Policy Number:		Group Number:		
Insurer Address:		City:	State:	Zip: 0
Telephone Number: 0	Ext: 0	Fax Number: 0		Ext: 0
*Injury Diagnosis:		*Injury Date:		

IMPORTANT REMINDER: When Medicare is the secondary payer, include a copy of the primary EOB or payment sheet and the Medicare EOB.

Note: If Specific Patient/HIC/Claim #/Claim Amount data is not available for all claims due to Statistical Sampling, please indicate methodology and formula used to determine amount and reason for overpayment.

The form also includes two questions regarding the Office of Inspector General that need to be completed.

For OIG Reporting Requirements:

Do you have a Corporate Integrity Agreement with OIG? ○ Yes ○ No

Are you a participant in an OIG Self-Disclosure Protocol? ○ Yes ○ No

NAS offers an interactive Refunds to Medicare form that can be completed and printed from our website. It is found in the Forms section.

EDUCATIONAL

Upcoming Ask the Contractor Teleconferences

Noridian Administrative Services (NAS) is pleased to announce our upcoming schedule of teleconferences for 2007. We will be continuing with our current format of brief opening remarks followed by the question and answer (Q&A) session.

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

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

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

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

- Conference Name: DME Jurisdiction D Ask the Contractor Teleconference

- Your name
- Name of the organization you represent
- State from which you are calling

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

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

- March 13, 2007
- June 12, 2007
- September 11, 2007
- December 11, 2007

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

Ask the Contractor Teleconference for Small Suppliers – February 21, 2007

On February 21, 2007, at 3:00 pm CT Noridian Administrative Services will conduct the first DME Ask the Contractor Teleconference to assist **small suppliers**. CMS has defined a small supplier as a supplier with ten or fewer full time equivalent employees. During this teleconference, knowledgeable NAS staff representing a variety of functions will be available to answer your questions. If we cannot answer your question during the teleconference, we will research the issue and then call you with the answer.

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

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

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- Name of the organization you represent
- State from which you are calling

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

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

- April 18, 2007
- June 20, 2007
- August 22, 2007
- October 24, 2007
- December 19, 2007

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

Questions and Answers Resulting from the Claim Form Changes Workshops

The following questions and answers are from the December 13 and 19, 2006, CMS 1500 Claim Form Changes WebEx workshops. In some cases, the original answers given during the workshop may have been expanded to provide further detail.

Q1. Should we notify other providers of our NPIs now?

A1. Yes, as soon as you receive your NPI you should share it with your health care partners so they can begin integrating it into their systems and processes. Testing transactions using your NPI with your health care partners may take some time and cannot even begin until after you obtain your NPI. If you delay applying for your NPI, you risk your ability to meet the NPI compliance date and jeopardize that of your health care partners as well.

Q2. Is item 24J used for the ordering physician number or for the performing supplier number?

A2. Item 24J is used for the performing supplier number.

Q3. Is the NSC number required in item 24J for all DME claims until May 23, 2007?

A3. During the transition period ending May 22, 2007, you can bill either your NSC number only in the shaded portion of 24J or your NPI, your NSC, and the ID qualifier 1C in items 24I and 24J. However, when the claims are submitted, NAS first looks for the valid supplier information item 33. Therefore, item 24J is not a required field for DME suppliers and is only referenced if the information in item 33 is invalid.

Q4. Where do I put the 1G qualifier in item 17a?

A4. The 1G qualifier is placed in the small shaded box next to 17a; the provider's UPIN would then be placed in the large shaded box to the right of the small shaded box.

Q5. Will item 24E allow multiple diagnosis code pointers in the future?

A5. Multiple diagnosis code pointers will not be used in the future unless the 1500 (08-05) form is again revised for that purpose, or CMS provides this direction.

Q6. Is NAS accepting the paper claim submission waivers granted by the previous contractor?

A6. Yes, if you received a waiver from the previous contractor, that waiver is accepted by NAS.

Q7. Is item 24J required even if it contains the same information that is placed in item 33?

A7. Item 24J is not required if it contains the same supplier number as item 33.

Q8. We recently submitted a CMS855B due to a demographics change. Although we currently have NSC supplier numbers for each location and have obtained corresponding NPIs, the applications were rejected due to the lack of a group NPI. Which NPI do I use for billing, the organization or the supplier NPI?

A8. When billing the DME MAC for equipment and supplies, use the supplier NPI for the location that provided the item.

Q9. Does the claim status inquiry have to be done through Express Plus? If so, how do I obtain that software?

A9. This is a correction to the previously published questions and answers resulting from the CMS-1500 claim form workshops. The questions and answers were placed on our Web site on January 8, 2007.

Claim status inquiry can be done through Express Plus or through other software products. To obtain the Express Plus software call the Jurisdiction D help desk at 866-224-3094 or see their Web site at www.cignamedicare.com/edi/dmerc/support.html

Q10. I have a question regarding item 24E and entering only one diagnosis code pointer. Is that for all Noridian Medicare or for DME only?

A10. Entering only one diagnosis code pointer in item 24 E is the guideline for all Medicare Part B and DME 1500 claim form submissions, whether you are billing to NAS or another Medicare Part B or DME contractor. The CMS 1500 claim form instructions are established by CMS and can be found in the Internet Only Manual, Publication 100-04, Chapter 26, Sections 10.2 through 10.4. This instruction states as follows:

Item 24E - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

Q11. Is the ID qualifier only to be used when submitting claims to the DME MAC?

A11. No, the ID qualifiers 1C and 1G are to be used whenever you are billing your legacy number and your NPI on the CMS 1500 claim form to any Medicare contractor through May 22, 2007. This is so CMS can establish a crosswalk between your supplier number, provider identification number, UPIN, etc. and your NPI number.

Q12. Are physicians also to use the ID qualifiers?

A12. Yes, physicians also use the ID qualifiers during the transition period ending May 22, 2007.

Q13. Are the doctors' UPINs being replaced with their NPIs and if so, how do I get their NPI numbers?

A13. Yes, UPINs are being replaced with the medical professionals' NPIs. You will need to contact your health care partners and ask for their NPIs. CMS states: Once a covered health care provider has an NPI, it must share the NPI with any entity that needs it to identify the covered health care provider in a standard transaction.

Q14. What is a legacy number?

A14. For DME suppliers the legacy number is your current NSC number, which is being replaced by your NPI number.

Q15. Will there be a search resource available for suppliers to locate referring physicians' NPI numbers?

A15. No, there will not be a search resource available to locate referring physicians' NPI numbers. You will need to contact the physicians and ask for their NPI numbers.

Q16. Will claims be denied if the NPI number is not provided after May 23, 2007?

A16. Yes, claims will be denied or returned as unprocessable if NPI numbers are not provided on/after May 23, 2007.

Q17. If we are a mail order DME facility, what do we use in item 32b?

A17. For durable medical, orthotic, and prosthetic claims enter the PIN (of the location where the order was accepted) if the name and address was not provided in item 32 (DMERC only). You would also place the ID qualifier 1C followed by a space in front of the PIN.

Q18. Where may we obtain new CMS 1500 claim forms if the U.S. Printing Office will not have them available until April?

A18. CMS 1500 claim forms can be purchased from any office supply or local printing office. You can also purchase them off the Internet from numerous vendors.

Q19. If we only use the paper claim forms for rebilling and don't send any paper claims prior to May 23, 2007, how will CMS build the crosswalk with the legacy number and the NPI?

A19. If you normally bill your claims electronically, the crosswalk with your legacy number and your NPI will be built from your electronic claim information.

Q20. Does the date requirement (8-digits) on the new forms for date of birth also apply to the old forms currently in use?

A20. Yes, the 8-digit date requirement for all date of birth fields applies to both the current CMS 1500 (12/90) form and the revised CMS 1500 (08/05) form, as CMS has provided this guidance.

Q21. Is the one diagnosis code pointer in item 24E a recent change or does it apply to the 12/90 form as well?

A21. CMS instructed suppliers/providers to use one diagnosis code pointer in item 24E at least as far back as 1995; however, many contractors did not enforce this guideline until more recently. NAS began enforcing this guideline for all claims received on/after May 1, 2005.

Q22. For therapy, do I use the treating diagnosis or the primary diagnosis for the diagnosis pointer?

A22. The Jurisdiction D DME MAC does not process therapy services. This is a Medicare Part B Fee for Service benefit. You need to contact your Medicare Part B contractor to answer this question.

Q23. How can I get a copy of this PowerPoint presentation?

A23. A copy of the PowerPoint presentation was included in your confirmation packet. We will also place the presentation on our Web site after all the workshops are concluded.

Q24. When billing for lenses following cataract surgery, do I place the RT and LT modifiers in item 19?

A24. No, modifiers are not placed in item 19. Modifiers are used to further describe a procedure code. Therefore, the RT and LT modifiers are placed in item 24D following the HCPCS code. If the patient is receiving one lens, then place the appropriate RT or LT modifier to the right of the lens HCPCS code. When lenses are provided bilaterally and the same code is used for both lenses, bill both on the same claim line using the LTRT modifiers and 2 units of service in item 24G. You also need to append the KX modifier to your HCPCS code. This is done to advise Medicare that you have the required documentation on file to support the need for the lenses after cataract surgery.

Q25. Is it absolutely necessary to include RT/LT modifiers in item 24D or is this optional?

A25. It is necessary to place the RT/LT modifiers in item 24D when billing for lenses after cataract surgery. If you omit this modifier, for example on the first lens used for the right eye and then bill for the left eye sometime in the future, the lens for the left eye may deny on the basis that Medicare has previously paid for this service. The reasoning behind this denial is that Medicare would have no way of knowing for which eye the first lens was provided. Without a modifier the first lens could belong to either eye, and Medicare only allows for one lens per eye per cataract surgery.

Use the LT and RT modifiers whenever appropriate.

Q26. If I use CPR+ for submitting claims, can I use the alt-n field to supply additional notes?

A26. Please contact your CPR+ software vendor for assistance with claim submission using this software.

Q27. Is Express Plus software different from Cahaba?

A27. Express Plus, the fee billing software used in Jurisdiction D, is a program created by AdminaStar Federal Jurisdiction B and has been developed based on the requirements of the HIPAA-standard ANSI X12N version 4010A1 format. This software program is currently being used by Jurisdictions A, B and D.

Q28. What do I do if I have more than six items to submit to Medicare for payment?

A28. The CMS 1500 claim form allows you to submit up to six items. If you are submitting more than six items, you need to submit the additional items on a second CMS 1500 claim form.

No Payment on Paper Claims- Common Unprocessable Claim Problems

If a **paper claim was submitted over 28 days ago and an education status letter has not been received and the claim is not found on the IVR**, suppliers should review the claim to determine if information was missing or incorrectly entered. NAS is receiving many paper claims that have not been properly completed and is informing suppliers of these unprocessable paper claims by mailing an Education Status letter.

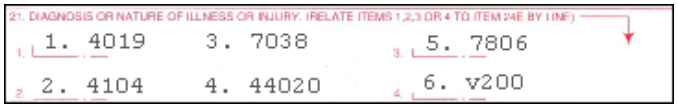
The Education Status letters provide the claim control number, the patient's name, Health Insurance Claim Number and the date(s) of service to identify which claim could not be processed. The original claim will not be returned.

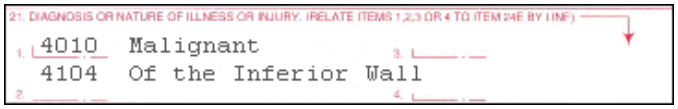
Below are the top five reasons for paper claim errors, along with helpful hints on ways to reduce or eliminate these top claim errors. You must correct the claim error and resubmit these claims. Unprocessable claims are not entered, nor are they visible, in the claims processing system and do not have reopening or redetermination rights.

1. Description in Item 21-Diagnosis

- Enter the patient's diagnosis/condition. **Enter the diagnosis code only, not the description.**
- Enter up to four codes in priority order.

Below are examples of **incorrect** diagnosis placement in Item 21.





Below is an example of **correct** diagnosis code placement in Item 21.

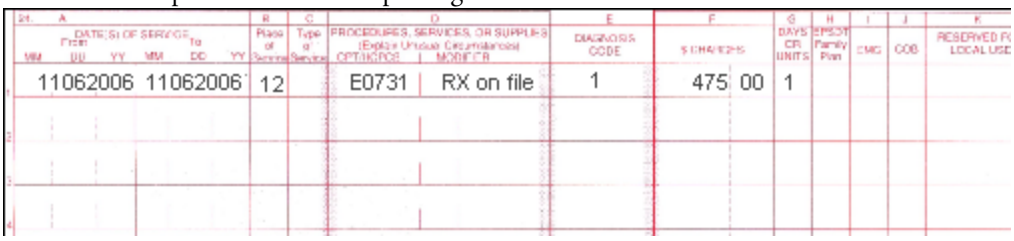
2. Description in Item 24D-HCPCS/Modifier

- Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code.
- Enter the specific procedure code **without** a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise

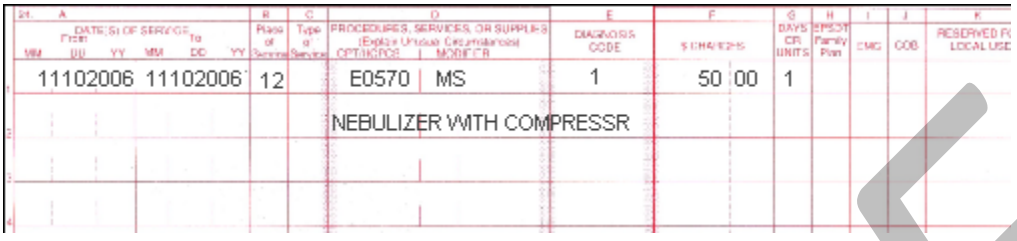
classified" (NOC) code, include a narrative description in Item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.

- Modifiers must be two alpha/numeric characters. **Do not place extra narrative after or under the procedure code**

Below are examples of **incorrect** reporting in Item 24D.

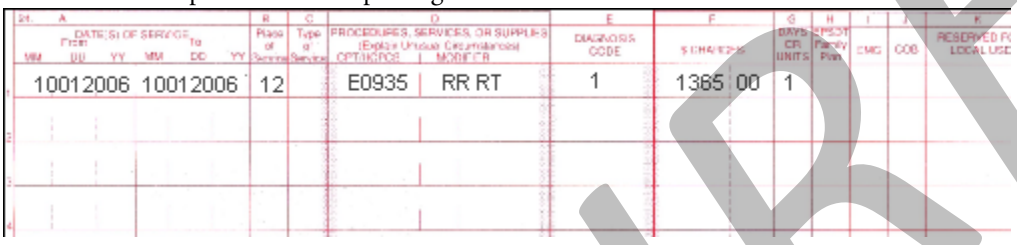


DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
11062006			11062006			12		E0731	RX on file	1	475 00	1				



DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
11102006			11102006			12		E0570	MS	1	50 00	1				
								NEBULIZER WITH COMPRESSR								

Below is an example of **correct** reporting in Item 24D.



DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
10012006			10012006			12		E0935	RR RT	1	1365 00	1				

3. Diagnosis Pointer in Item 24E

- Enter the diagnosis code reference number as shown in Item 21 to relate the date of service and the procedures performed to the primary diagnosis. **Enter only one reference number per item**. When multiple services are performed, enter the primary reference number for each service, **either a 1, or a 2, or a 3, or a 4**.
- If a situation arises where two or more diagnoses are required for a procedure code, the supplier must reference only one of the diagnoses in Item 21.
- Place only a single diagnosis pointer on each line. The actual diagnosis should not be placed in this item. Diagnosis narrative should not be placed in this item.

Below is an example of **incorrect** reporting in Item 24E for the diagnosis pointer.

E
DIAGNOSIS CODE
5
1,2,3,4
7806
410.4

Below is an example of the **correct** reporting of the diagnosis pointer in Item 24E.

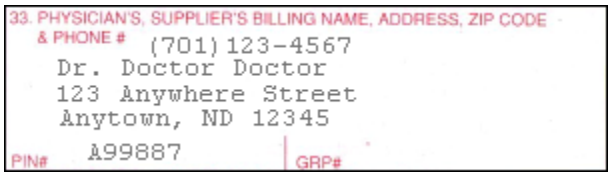
E
DIAGNOSIS CODE
1
2
3
4

CLAIM SUBMISSION CONT'D

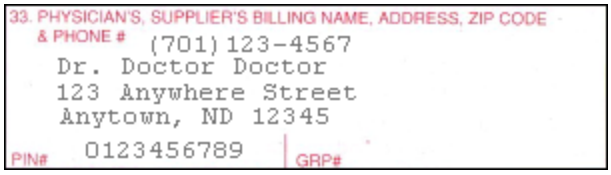
4. Supplier Number in Item 33-Incorrect Format

- Supplier numbers are ten digits as assigned by the National Supplier Clearinghouse. **Do not report an NPI or a UPIN in Item 33 or 24K**.

Below is an example of **incorrect** reporting of the supplier number in Item 33.



Below is an example of **correct** supplier number reporting in Item 33.



5. Black and white claim forms

- Submit the scannable, red-ink version of the CMS-1500 claim form. Black and white copies of the claim form are not accepted and will be returned, rather than an education status letter being sent.

Below are other reminders and common mistakes which also will result in unprocessable claims.

Font and Printing

- Use Courier New font for computer-generated claims. Do not print in italics, bold or script. Do not mix fonts.
- Use Pica 10 or 12-point typeface for claims typed on a typewriter.
- Do not type in italics or script.
- Use upper case letters for all claim data.
- Ensure none of the characters touch.
- Ensure no lines from the printer cartridge are anywhere on the claim.
- Do not use special characters, (dollar signs, decimals, asterisk or backslashes) unless otherwise specified.
- Use an ink jet or laser printer to complete the CMS-1500 claim form. Because claims submitted with dot matrix printers have breaks in the letters and numbers, the optical character recognition (OCR) equipment is unable to properly read these claims. Suppliers using dot matrix printers risk slow or incorrect processing of their claims.

Ink Color

- Do not use red ink to complete a CMS-1500 claim form. OCR scanners "drop out" any red that is on the paper.
- Use true black ink. Do not use any other color ink.
- Avoid using old or worn ink cartridges, toner cartridges or printer ribbons.

Alignment

- Center information vertically within the confines of each box on the CMS-1500 claim form.
- Align all information on the same horizontal plane.
- Do not include more than six lines on the claim form.
- Do not squeeze two lines of information on one line.

Claim Item Specifics

Item Number	Item Specifics	Common Errors
Item 1a	Insured's I.D. Number	Missing, contains invalid information or is unreadable
Item 3	Patient's Sex	Left blank or both sexes are marked
Item 12	Patient's or Authorized Person's Signature	Does not contain a signature or a signature on file statement
Item 17a	I.D. Number of Referring Physician	Invalid information or is unreadable
Item 21	Diagnosis	Contains more than four diagnosis codes, codes are single spaced or diagnosis code is unreadable
Item 24	Procedure Code/ Modifier	Contains more than six detail lines or has no detail lines
Item 24a	Date(s) of Service	Missing date of service or the date of service has invalid date format
Item 24g	Days or Units	Contains zeros or decimals
Item 24k or 33	Provider Information	Contains invalid provider information
Item 28	Total Charge	Contains invalid information
Item 29	Amount Paid	Contains invalid information or is unreadable
Item 31	Signature of Supplier	Does not contain both a signature and a date

Complete CMS-1500 claim form instructions can be found on www.noridianmedicare.com under the Claims section in the Claims Filing Information area.

CLAIM SUBMISSION CONT'D

Span Dates & Calendar Year

The current DME MAC claim processing system cannot accept claims with dates of service spanning two calendar years (i.e., 11/12/2006 – 02/11/2007). When billing for diabetic testing supplies, which span two calendar years, you should file your claim with the "to date" being 12/31/06. In the NTE (note or narrative) segment of your claim you should include the actual "to date". On paper claims the "to date" should be included in Item 19 on the CMS-1500 claim form. This process is for diabetic testing supplies only.

When billing for other items that require date spans (i.e., enteral or perenteral nutrition) you must file two separate claims for each calendar year.

APPEALS

Revisions to Procedures to Establish Good Cause and Qualified Independent Contractor Jurisdictions

MLN Matters Number: MM5386
Related Change Request (CR) #: 5386
Related CR Release Date: December 22, 2006
Related CR Transmittal #: R1136CP
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

Physicians, providers and suppliers who bill Medicare contractors (A/B Medicare Administrative Contractors (A/B MACs), fiscal intermediaries (FIs), carriers, regional home health intermediaries (RHHIs), durable medical equipment regional carriers (DMERCs) or durable medical equipment Medicare administrative contractors (DME MAC)) for services provided to Medicare beneficiaries.

Background

The purpose of CR 5386 is to notify providers and suppliers of the restructured **Part B/DME QIC** jurisdictions. Under the new jurisdictions, three QICs will process reconsiderations as follows:

- Two QICs will process reconsiderations of carrier and A/B MAC re-determinations effective November 15, 2006 for contractors that process claims in the North jurisdiction and January 1, 2007 for contractors that process claims in the South jurisdiction. Your contractor will reference the appropriate QIC in the Medicare Redetermination Notice (MRN). In order to expedite your request for appeal, please make sure you follow the instructions on your MRN regarding where to submit your request for reconsideration. If you have already submitted a reconsideration request with the incumbent QIC, please do not submit a duplicate request; and
- The third QIC will process all reconsiderations of DMERC and DME MAC re-determinations effective December 1, 2006.

Key Points

- Your contractor will reference the appropriate QIC with jurisdiction in the redetermination letter.
- One QIC will process all reconsiderations of DME claims.
- There are two QIC jurisdictions for Part B claims: a North jurisdiction and a South jurisdiction.
- **The North** QIC jurisdiction includes the following states: Alaska, Arizona, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, District of Columbia, New York, Pennsylvania, New Jersey, Delaware, Maryland, Ohio, Kentucky, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Missouri, Iowa, Washington, Oregon, Nevada, Idaho, Wyoming, Montana, California, Utah, Kansas, Nebraska, North Dakota, South Dakota, Hawaii, American Samoa, Guam, and the Northern Marianas Islands.
- **The South** QIC jurisdiction is comprised of the following states: Colorado, Connecticut, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, Florida, North Carolina, South Carolina, Virginia, West Virginia, Puerto Rico, and Virgin Islands.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5386) issued to your Medicare A/B MAC, FI, carrier, RHHI, DMERC or DME MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1136CP.pdf on the CMS website.

For additional supporting information that details the general appeals process in initial determinations please see MLN Matters article MM4019 at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4019.pdf on the CMS website.

MLN Matters article MM3530, which can be found at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3530.pdf on the CMS website, provides a detailed explanation of the term '*vacate a dismissal*' as well as more background information about the second level of appeals process for Medicare Part A and Part B claims called 'reconsiderations.'

BILLING

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

MLN Matters Number: MM5346
Related Change Request (CR) #: 5346
Related CR Release Date: October 27, 2006
Related CR Transmittal #: R1087CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs),

regional home health intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs)) for services.

Provider Action Needed

CR 5346, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective January 2, 2007.

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. The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5346, effective on and after January 1, 2007.

CMS has also developed a new tool to help you search for a specific category of code and that tool is at http://www.cmsremarkcodes.info. Note that this website does not replace the 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 can see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest remittance advice remark code and claim adjustment reason code updates by going to CR 5346, located at http://www.cms.hhs.gov/Transmittals/downloads/R1087CP.pdf on the CMS website.

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

Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
N370	New	Billing exceeds the rental months covered/approved by the payer.	Medicare initiated
N371	New	Alert: title of this equipment must be transferred to the patient. *	Medicare initiated
N372	New	Only reasonable and necessary maintenance/ service charges are covered.	Medicare initiated
MA02	Modified	If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.	Modified effective 8/1/06
M114	Modified	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, contact your local contractor.	Modified effective 8/1/06
N199	Modified	Additional payment/ recoupment approved based on payer-initiated review/audit.	Modified effective 8/1/06
There are no deactivated remittance advice remark code changes			

***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. Newly created informational codes 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

Reason Code Changes

Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
196	New	Claim/service denied based on prior payer's coverage determination	New as of June, 2006
16	Modified	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
17	Modified	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
96	Modified	Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
125	Modified	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	Modified as of February, 2002 and June, 2006
43	Retired	Gramm-Rudman reduction.	Modified as of June, 06, and deactivated on July 1, 2006

Medicare Fee-for-Service and Medicare Advantage Eligibility System Issues

MLN Matters Number: SE0681

Provider Types Affected

Physicians and providers who bill Medicare carriers, fiscal intermediaries (FIs), or Part A/B Medicare Administrative Contractors (A/B MACs).

Provider Action Needed

Be aware that Medicare reverses FFS payments when MA enrollments with retroactive dates are processed by CMS systems. Also know what action to take when there are conflicts in CMS eligibility data.

Background

In some cases, MA enrollments with retroactive dates are processed by CMS systems. The result is that Medicare may pay for the services rendered twice; once under fee-for-service and second by the MA payment systems in the monthly capitation rate to the plan.

The FFS contractor reverses the fee-for-service payment, recovers from the provider, and the provider then bills the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the Medicare fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary.

FFS Claims Paid in Error

Due to CMS beneficiary eligibility system updates, beneficiaries enrolled in MA organizations may be identified as having been inappropriately paid on a fee-forservice basis. FIs, carriers, and A/B MACs will adjust these claims and seek overpayments. Where such an overpayment is recovered from a provider, the related remittance advice for the claim adjustment will indicate Reason Code 24, which states: 'Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan'.

Whenever CMS reverses fee-for-service payments as a result of confirmed retroactive enrollment in an MA plan, the provider must bill the MA plan. The plan adjudicates the claim and pays the claim at the plan's rate (if the provider is part of the network) or pays the provider at the fee-for-service rate if the provider is not part of the network. If the plan denies payment then the provider may bill the beneficiary.

Information on which plan to contact can be determined through an eligibility inquiry or by contacting the beneficiary directly. To associate plan identification numbers with the plan name, go to http://www.cms.hhs.gov/HealthPlansGenInfo/claims_processing_20 060120.asp#TopOfPage on the CMS web site.

The Medicare beneficiary call center representatives at 1-800-MEDICARE have been trained to answer beneficiary inquiries that may arise in these situations.

Eligibility Data Discrepancies: Provider Action

Despite system corrections, there remains a small number (under 1000) of beneficiary eligibility records that have not been updated. CMS is working to correct this. In the interim, if a provider has information from the MA plan that conflicts with information received from an FI, carrier, or A/B MAC in reply to an eligibility inquiry, the provider should call the FI/carrier/MAC provider call center. The call center representative will check Medicare's Common Working File System and if the conflict is confirmed the provider will be referred to the CMS Regional Office for resolution.

Payment by DME MACs and DMERCs for the Administration of Part D Vaccines

MLN Matters Number: MM5486
Related Change Request (CR) #: 5486
Related CR Release Date: December 29, 2006
Related CR Transmittal #: R1146CP
Effective Date: January 1, 2007
Implementation Date: January 29, 2006

Provider Types Affected

Medicare-enrolled pharmacies who bill Durable Medical Equipment Regional Carriers (DMERCs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for administration of Part D vaccines to Medicare beneficiaries.

What You Need to Know

CR 5486, from which this article was taken, implements the payment policy for the administration of Part D-covered vaccines furnished by Medicare-enrolled pharmacies.

During calendar year 2007, you may be paid under Medicare Part B for the administration of a Part D-covered vaccine furnished to a Medicare beneficiary during 2007 only if you are enrolled with the National Supplier Clearinghouse and the beneficiary is enrolled in Part D.

Background

Section 202(b) of the Tax Relief and Health Care Act of 2006 (TRHCA) establishes a permanent policy for, and resolves any potential ambiguity about, payment by Medicare for administration of Part D-covered vaccines, beginning with 2008. The payment policy for services furnished by physicians and other practitioners was implemented in a previous Change Request (CR 5459), and CR 5486 implements the payment policy for the administration of Part D-covered vaccines furnished by Medicare-enrolled pharmacies.

Specifically, effective January 1, 2008, the administration of a Part D-covered vaccine is included in the definition of "covered Part D drug" under the Part D statute. Until this effective date, Section 202(a) of TRHCA provides for a transition policy **(in effect for 2007 only)** which permits payment under Medicare Part B for administration of a Part D-covered vaccine. For this 2007 transition period, payment will be made under Part B for the administration of a covered Part D vaccine "as if it were the administration of a vaccine described in section 1861(s)(10)(B) [hepatitis B vaccine.]"

Since payment for administration of a hepatitis B vaccine requires the application of Part B coinsurance and deductible, and involves other statutory requirements such as assignment; these requirements also apply (during 2007) to a payment for the administration of a Part D-covered vaccine. Moreover, payment under Part B for administration of a Part D-covered vaccine is available only if 1) On the date of service, the pharmacy is enrolled as such with the National Supplier Clearinghouse; and 2) The Medicare beneficiary, to whom the Part D-covered vaccine is furnished, is enrolled in a Part D Prescription Drug Plan.

Here are some details that you should know:

1. **Neither this CR nor CR 5459 addresses payment for a Part D-covered vaccine itself. Payment for Part D-covered vaccines is made solely by participating Part D Prescription Drug Plans.**
2. You should use G code (G0377: Administration of vaccine for Part D drug) for the administration of Part D-covered vaccines in 2007. The Part B allowed charge for this code (effective for 2007) is $19.33. Thus, the Medicare payment would be 80% of that amount or $15.46, assuming the beneficiary's Part B deductible is met. The beneficiary would pay $3.87 as a coinsurance payment, plus any Part B deductible payment that may be due.
3. Claims must be submitted in the 837 or the CMS 1500 paper form, billed with Indicator 05 –Pharmacy, and indicating the Place of Service (POS) as either home or pharmacy.

4. The Administration of Part D vaccine claims is subject to mandatory assignment. Your DMERC/DME MACs will therefore ensure that you accept assignment for claims associated with the administration of a Part D vaccine; and if you should submit a claim for G0377 as unassigned, will process that claim as though it were assigned. Further, since beneficiaries can not submit assigned claims, beneficiary-submitted claims for the administration under the Tax Relief and Health Care Act of 2006 legislation can not be paid.
5. You must retain in your records the physician orders/ prescription of record for claims associated with the administration a Part D vaccine.
6. DMERCs/DME MACs will return/reject claims for the administration of a Part D vaccine with dates of service after December 31, 2007, and they will use existing Medicare Summary Notice and remittance advice messages for claims associated with the administration of a vaccine.
7. Note that the implementation date for this change is January 29, 2007 in Medicare systems. Thus, your DMERC or DME MAC may not actually process any 2007 claims for payment until that date.

Additional Information

CR5486 is the official instruction issued to your DMERC/ DME MAC and you can find CR 5486 at http://www.cms.hhs.gov/Transmittals/downloads/R1146CP.pdf on the CMS website.

Medically Unlikely Edits

MLN Matters Number: MM5402
Related Change Request (CR) #: 5402
Related CR Release Date: December 8, 2006
Related CR Transmittal #: R178PI
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

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

Background

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

- An MUE is defined as an edit that tests claim lines for the same beneficiary, Health Care Common Procedure Code System (HCPCS) code, date of service, and billing provider against a criteria number of units of service.
- The MUEs will auto-deny claim line items containing units of service billed in excess of the MUE criteria or Return to Provider (RTP) claims that contain lines that have units of service that exceed an MUE criteria.

Key Points

- CR5402 states that Medicare contractors will deny the claim line or RTP claims with units of service that exceed MUE criteria and pay the other services on the claim as part of initial claims processing activities.
- The MUEs that will be implemented by this notice are based on anatomic considerations. CMS believes that most MUEs based on anatomic considerations are not controversial, but CMS will allow and require an appeals process for those claim line items that are denied as a result of an MUE edit.
- An appeals process will not be allowed or required for claims that are RTP'ed as a result of an MUE edit. Instead, providers should resubmit corrected claims.
- This set of MUEs that is based on anatomical considerations addresses approximately 2,800 codes.
- Excess **charges due to units of service greater than the MUE** may not be billed to the beneficiary (this **is a "provider liability"**), and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

Additional Information

For complete details regarding CR 5402 please see the official instruction issued to your Medicare FI, Carrier or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R178PI.pdf on the CMS web site.

RAC

Recovery Audit Contractors

Section 306 of the Medicare Modernization Act required CMS to complete a demonstration project using recovery audit contractors (RAC) to identify Medicare underpayments and overpayments and to recoup overpayments for both Part A and Part B services. This project is taking place in the states of California, Florida and New York. The RACs are tasked with identifying improper Medicare payments that may have been made to providers that were not detected through existing efforts.

The demonstration is scheduled to last no longer than three years. The contractor performing the RAC functions for California, including Durable Medical Equipment overpayments, is PRG Schultz, International. NAS, as the DME MAC for California, interacts with the RAC and completes administrative functions relative to the RAC.

In the process of performing overpayment and underpayment identification and recovery efforts, the RAC will request medical records from suppliers. Suppliers must respond to such requests within 45 days. An extension may be requested at any time prior to the 45th day by contacting the RAC.

The RAC may also perform automated review (where no medical record is involved in the review). This occurs only in situations where there is certainty that the claim contains an overpayment. Automated review must:

RAC CONT'D

- Have clear policy that serves as the basis for the overpayment ("clear policy" means a statute, regulation, National Coverage Determination, coverage determination in an interpretive manual, or Local Coverage Determination that specifies the circumstances under which a service will ALWAYS be considered an overpayment);
- Be based on a medically unbelievable service; or
- Occur when no timely response is received in response to a medical record request letter.

Once an overpayment is identified, the RAC will send a demand letter to the supplier. The demand letter will instruct the supplier to send a check to the appropriate address at NAS. NAS will be responsible for setting up the overpayment request, adjusting claims as necessary and reporting on RAC overpayment activities.

The demand letter will also instruct the supplier of their appeal rights. NAS will conduct all appeals relating to RAC overpayments within the mandated 60-day CMS timeframe. Upon receiving an appeal request for a RAC identified overpayment, NAS will request the case file from the RAC. When the appeal is completed, either repayment will be made or a redetermination letter will be sent explaining the appeal decision.

The following MLN Matters provide more information on the RAC demonstration project:

www.cms.hhs.gov/MLNMattersArticles/downloads/SE0469.pdf

www.cms.hhs.gov/MLNMattersArticles/downloads/SE0565.pdf

www.cms.hhs.gov/MLNMattersArticles/downloads/SE0617.pdf

Providers with questions concerning the RAC may contact PRG Schultz, International at 1-866-638-1766 during the hours of 8:30-4:30 Pacific Time.

Suppliers may also contact CMS with questions regarding the RAC demonstration via email at CMS recoveryauditdemo@cms.hhs.gov

EFT

Electronic Funds Transfer

Electronic Funds Transfer (EFT) is a process whereby your Medicare payments are directly deposited into your bank account. It is safe and results in faster payment. In addition, direct deposit eliminates the possibility of lost or delayed checks, and there is a reduced probability of human error.

Effective immediately, CMS requires that all providers that are enrolling as Medicare DME suppliers or making any changes to their enrollment files, must use EFT. To sign up, you must fill out an Authorization Agreement for Electronic Funds Transfer at www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf. Complete the form and have it signed and dated by the supplier or authorized/delegated official. This signature must be the same as the original signature on file with the National Supplier Clearinghouse; it cannot be a copied or stamped signature

Under the Physician/Provider/Supplier Information section, the form asks for your "Medicare Identification Number". In this field, please indicate your National Supplier Clearinghouse number or your National Provider Identifier number. If you have not yet applied for an NPI, do so as soon as possible by applying at NPPES.cms.hhs.gov/NPPES/Welcome.do.

When submitting your form, include a voided check or deposit ticket with a pre-printed name on it. Copies of checks or deposit slips are not acceptable. It will take approximately three weeks before the EFT will take effect. You will be informed of the exact date through a letter.

- To change accounts or banks, fill out a new EFT form, using the new account information and a voided check or deposit ticket from the new account.
- If you close your bank EFT account, NAS will place you on payment withhold until a new EFT agreement (and CMS 855, if applicable) is submitted and approved. If such an agreement is not submitted within 90 days after NAS first learned that the account was closed, NAS will commence revocation procedures.

Return the form to:

Noridian Administrative Services
PO Box 6728
Fargo, ND 58108-6728

After enrolling for EFT, your office will continue to receive remittance advices, either on paper or electronically, as you do today.

We also encourage suppliers to consider receiving an electronic remittance advice. Your electronic remittance advice will arrive sooner than a paper advice. By receiving electronic remittance advices, you also may be able to take advantage of auto-posting of accounts and financial reporting provided by many software vendors. CMS provides free software, Medicare Remit Easy Print, to download and print electronic remittance advices. To download this software, see the CMS Web site, www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp. Please keep in mind that if you take advantage of the electronic remittance advice option, paper remittances will be discontinued after 45 days.

Contact the Jurisdiction D EDI contractor at 1-866-224-3094 with any questions about requesting to receive an electronic remittance advice for your office.

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

MSP

DME MAC MSP Transition

As of January 2, 2007, Noridian will no longer be handling any Medicare Secondary Payment recovery functions. The Centers for Medicare and Medicaid Services has consolidated these functions with the MSP Recovery Contractor, the MSPRC. All Group Health Plan and Retro Recovery Medicare Secondary Payer post-payment recoveries/cases will be handled by the MSPRC.

In preparation for this change, CMS has scheduled a period known as "dark days" for Medicare DME MAC recovery contractors, which will start on January 2, 2007 and last until January 12, 2007.

Therefore, beginning on January 2, 2007, Medicare DME MAC recovery contractors will focus their efforts on boxing and shipping MSP recovery work to the new national contractor. As a result, the Medicare DME MAC recovery contractors will no longer be able to provide MSP recovery services (i.e., demand notices for repayment, responding to correspondence, etc.) to employers, insurers, TPAs, beneficiaries and other MSP post-payment recovery customers.

Since GHP and Retro Recovery cases will be in transient during this time period, CMS asks that any inquiries that you need to make on these cases be sent in writing to the MSPRC at the following address:

MSPRC GHP
PO BOX 33829
Detroit, MI 48232-3829

The MSPRC may be contacted, on or after January 22, 2007, regarding these case files at 1-866-MSP-RC20 (1-866-677-7220). They are available from 8 AM to 8 PM Eastern Time, Monday through Friday, with the exception of holidays.

The CMS acknowledges and realizes that this change will cause a short-term disruption in operations. Please be patient with us as we work to ensure an effective transition to a more streamlined way of doing business, one that should enhance the level of service that the Medicare program can deliver to you.

EDI

Electronic Claims Rejected with Edit Code 40076

On January 3, 2007, a problem was identified with the electronic front end edit 40076 for EDI claims submitted on or after 1/2/07. This edit was setting in error requiring that all electronic oxygen claims submitted on/after 1/1/07 contain the new CMN version no matter what the date of service. This was corrected on January 4, 2007. Suppliers may resubmit the claims denied with edit 40076.

Revised Oxygen CMN Mapping

Suppliers are reminded that the newly revised oxygen CMN requires the use of segments not previously used for oxygen CMNs. To complete the new oxygen CMN, suppliers must send the new form and version number in the 2440 loop of the ANSI X12 4010A1 format. This information is placed in the LQ segment. Question 2 of the oxygen CMN is answered by using the FRM segment. Please see the example below:

Loop 2440
LQ*UT*48403~
FRM*2** __~ The blank space represents the response to question 2 with either a 1, 2 or 3.

All other questions on the newly revised oxygen CMN are answered as they previously were using the segments provided in the 2400 loop specific to oxygen CMNs. If the LQ segment and question 2 in the FRM segment are not submitted appropriately, the EDI front end will consider the Oxygen CMN to be the "prior" version, which may mean that the oxygen claim is processed inappropriately or will result in claim denials. Please ensure that you are submitting the correct oxygen CMN based on the date of service on the claim.

For questions regarding the mapping of the new CMNs, please contact the EDI department at 1-866-224-3094. Previous articles have been provided on all of the recent changes to the CMNs and DIFs.

CMS-1500 (08-05) Instructions

The CMS-1500 claim form has been revised to accommodate reporting of the National Provider Identifier. Below are the CMS-1500 (08-05) instructions for completing the items that have changed.

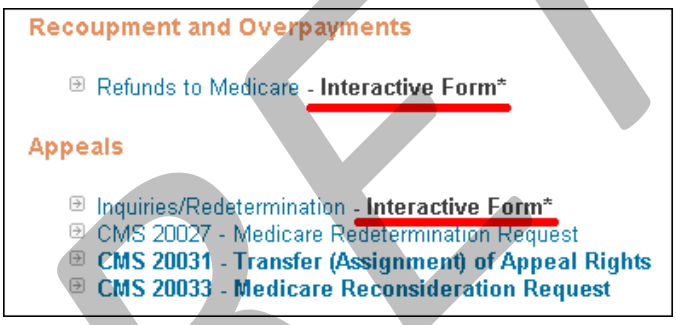
Item 17a - Form CMS-1500 (08-05)	When entering the CMS assigned UPIN of the referring/ordering physician listed in item 17, use the qualifier 1G in the small shaded portion of 17a followed by the 6-digit UPIN number in the larger shaded portion of 17a. The UPIN may be reported on the Form CMS-1500 until May 22, 2007, and MUST be reported if an NPI is not available. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician. All physicians who order or refer Medicare beneficiaries or services must report either an NPI or UPIN or both prior to May 23, 2007. After that date, an NPI (but not a UPIN) must be reported even though they may never bill Medicare directly.
Item 17b - Form CMS-1500 (08-05)	Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007. **NOTE**: Field 17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.
Item 24 - Form CMS-1500 (08-05)	The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines. At this time, the shaded area in 24a through 24h is not used by Medicare. Future guidance will be provided on when and how to use this shaded area for the submission of Medicare claims.
Item 24D	Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. **The Form CMS-1500 (08-05) has the ability to capture up to four modifiers.** (The bolded direction is the only change to this instruction.)
Item 24I - Form CMS-1500 (08-05)	Enter the ID qualifier 1C in the shaded portion.

Item 24J - Form CMS-1500 (08-05)	Prior to May 23, 2007, enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion. Effective May 23, 2007 and later, do not use the shaded portion. Beginning no earlier than January 1, 2007, enter the rendering provider's NPI number in the lower portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower portion.
Item 24K - Form CMS-1500 (08-05)	There is no Item 24K on this version.
Item 32a - Form CMS-1500 (08-05)	Enter the NPI of the service facility as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007, and must be reported May 23, 2007, and later.
Item 32b - Form CMS-1500 (08-05)	Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility. Effective May 23, 2007, and later, 32b is not to be reported. Providers of service (namely physicians) shall identify the supplier's PIN when billing for purchased diagnostic tests. For durable medical, orthotic, and prosthetic claims, enter the PIN (of the location where the order was accepted) if the name and address was not provided in item 32 (DMERC only).
Item 33a - Form CMS-1500 (08-05)	Effective May 23, 2007, and later, you MUST enter the NPI of the billing provider or group. The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007. This is a required field.
Item 33b - Form CMS-1500 (08-05)	Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. Effective May 23, 2007, and later, 33b is not to be reported. Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this item.

Interactive Forms

Noridian DME offers interactive forms to provide for easier form completion for suppliers. These interactive forms also assist NAS in processing requests timely and accurately.

The interactive forms are located on the Forms page of our website. Just look for the "Interactive Form" phrase in the heading.



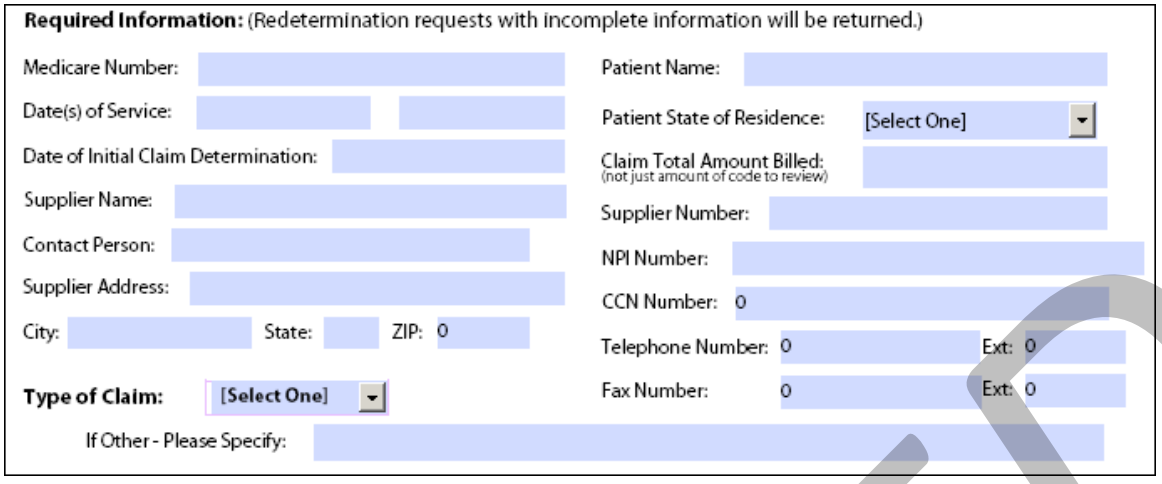
Interactive forms are completed online by using the drop down menus and completion blanks. Content on these forms is entered within the form and printed by selecting the "print form" button at the bottom of each form. The information entered cannot be saved.

Some helpful hints for completion of the interactive forms are:

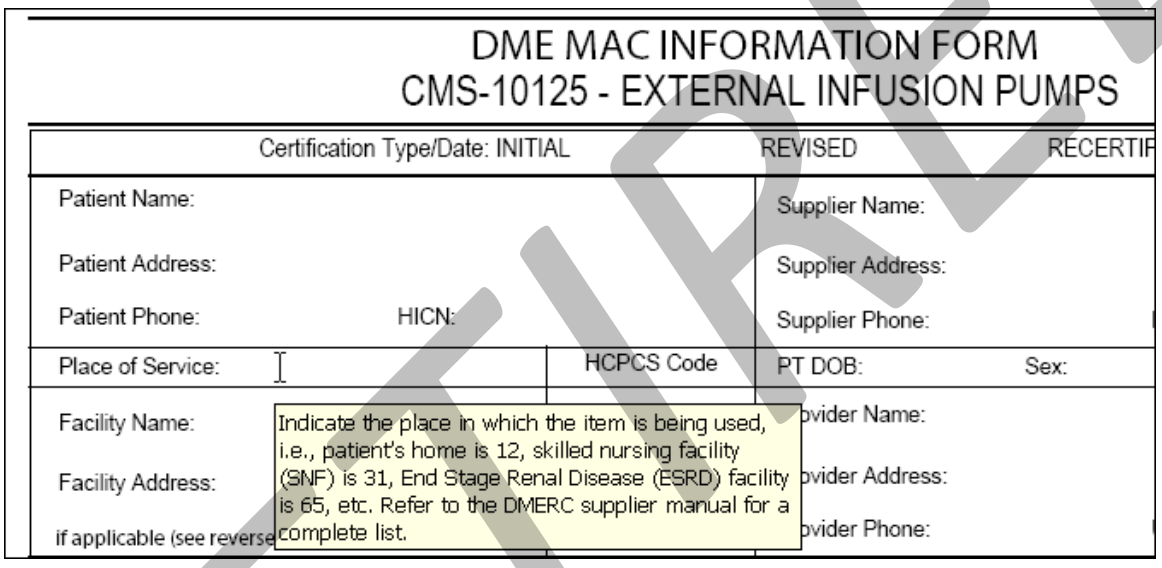
- Select the "Highlight fields" and/or "Highlight required fields" box located above the form to view editable fields and assure the form is completed in its entirety.
- Use the mouse to hover over the editable fields to receive supplemental instructions.
- Use one form per beneficiary to ensure efficient processing of the request.
- Attach appropriate documentation and mail to the applicable PO Box.

FORMS CONT'D

Below is an example of the Inquiries/Redetermination interactive form with the editable areas highlighted.



Below is an example of using the mouse to receive supplemental instructions on the CMS 10125 DIF for External Infusion Pumps. The mouse was held in the Place of Service area and the additional information was provided in the yellow box.



As a reminder, do not use the previous contractor's forms. By using the interactive forms from our website, you will always be assured that you are using the most current version of the form. As new interactive forms are developed, our website will be updated and suppliers will also be informed through the NAS DME email list.

CMN/DIF

CMN and DIF Submission Reminders

NAS has received a number of different invalid versions of CMNs and DIFs. Listed below are some reminders to follow when submitting these forms.

- When a CMN or DIF is submitted with a paper claim, the hardcopy must be an exact reproduction of the CMS form.
- When the CMN or DIF is submitted electronically and the supplier chooses to maintain a hardcopy form, the guidelines below must be followed:
  - Pitch may vary from 10 characters per inch (cpi) to 17.7 cpi;
  - Line spacing must be 6 lines per inch;
  - Each form must have a minimum ¼ inch margin on all four sides.
- The modified forms must contain identical questions/wording to the CMS forms, in the same sequence, with the same pagination and identical instructions/definitions printed on the back. CMN question sets may not be combined.
- If there is a change made to any section of the CMN after the physician has signed the form, the physician must line through

the error and then initial and date the correction. The supplier may also choose to have the physician complete a new CMN, in lieu of noting the correction.

CMS has developed improved CMNs and DIFs.

CMN

Below is a table identifying the acceptable CMNs for services provided during the transition period from October 1, 2006 through December 31, 2006.

DME MAC Form	CMS Form	Items Addressed
484.2	484	Home Oxygen Therapy
01.02A	841	Hospital Beds
01.02B	842	Support Surfaces
04.03B	846	Lymphedema Pumps (Pneumatic Compression Devices)
04.03C	847	Osteogenesis Stimulators
06.02B	848	Transcutaneous Electrical Nerve Stimulators (TENS)
07.02A	849	Seat Lift Mechanisms
09.02	851	External Infusion Pumps
10.02A	852	Parenteral Nutrition
10.02B	853	Enteral Nutrition
11.01	854	Section C Continuation Form

Below is a table identifying the revised CMNs acceptable for services provided during the transition period from October 1, 2006 through December 31, 2006. **For services on or after January 1, 2007, these forms are mandatory for items requiring a CMN.**

DME MAC Form	CMS Form	Items Addressed
484.03	484	Oxygen
04.04B	846	Pneumatic Compression Devices
04.04C	847	Osteogenesis Stimulators
06.03B	848	Transcutaneous Electrical Nerve Simulators (TENS)
07.03A	849	Seat Lift Mechanisms
11.02	854	Section C Continuation Form

The following table identifies the CMNs that were eliminated for services provided on or after October 1, 2006.

DME MAC Form	CMS Form	Items Addressed
01.02A	841	Hospital Beds
01.02B	842	Support Surfaces

DIF

The following table identifies the new DIFs that are acceptable during the transition period from October 1, 2006 through December 31, 2006. **For services on or after January 1, 2007, these new forms are mandatory for items requiring a DIF.**

DME MAC Form	CMS Form	Items Addressed
09.03	10125	External Infusion Pumps
10.03	10126	Enteral and Parenteral Nutirition

All CMNs and DIFs have a CMS form number in the bottom left corner of the form in addition to the DME MAC form number. CMNs and DIFs are referred to by their CMS form numbers. DME MAC form numbers identify the CMN on electronic claims submitted to the DME MAC.

NAS provides fillable CMNs and DIFs that allow for data to be entered and printed. These interactive forms can be found on our website, www.noridianmedicare.com in the Forms section under the CMS forms category.

Completing Revised CMNs and New DIFs Correctly

CMS CR 4296 revised several CMNs. It also replaced three CMNs with DIFs. This change was effective October 1, 2006, with a transition period from October 1 through December 31, 2006. Ensure you are completing these revised CMNs and DIFs correctly. Your claim will deny if the information provided is incomplete or incorrect.

When these forms were revised, some of the questions and possible answers may have changed. For example, the old CMN for home oxygen (DME 484.2) provided you with a yes or no answer to Question 2:

> Was the test in Question 1 performed EITHER with the patient in a chronic stable state as an outpatient OR within two days prior to discharge from an inpatient facility to home?

The revised oxygen CMN (DME 484.03) reworded question two and provided possible answers of 1, 2, or 3:

> Was the test in Question 1 performed (1) with the patient in a chronic stable state as an outpatient, (2) within two days prior to discharge from an inpatient facility to home, or (3) under other circumstances?

If you are submitting your claims electronically, your CMN is also submitted electronically. When you submit the revised oxygen CMN form, the answer to Question 2 must be either 1 or 2 or 3. A yes or no is not appropriate on the revised form. If you use a yes or no answer on the revised form and it is not appropriate, your claim will deny.

Therefore, as a reminder, read the revised CMN and DIFs carefully and respond with appropriate answers to the questions.

Get It. Share It. Use It.

A recent survey of the health care industry, conducted by the Workgroup for Electronic Data Interchange (WEDI) indicates that providers should be moving from the enumeration stage into the implementation stage to ensure NPI readiness by the compliance date. The following steps will assist you in your preparation:

Enumerate: Have you applied for you NPI(s)? Not only should individual providers (Type 1) have enumerated, but organizations and subparts (Type 2) should have enumerated also.

Update: Have you received your software application updates, upgrades and/or changes relevant to NPI? Be sure that the updates not only address the HIPAA Transactions, but include the CMS1500, UB04 and/or Dental claim form information.

Communicate: Have you communicated your NPI(s) to your health plans and other organizations you work with? Keep in mind, as outlined in current regulation, all covered providers must share their NPI with other providers, health plans, clearinghouses, and any entity that my need it for billing purposes—including designation of ordering or referring physician.

Collaborate: Do you know the readiness of your trading partners (such as health plans, TPAs, clearinghouses, ect…)? It's important to work with your trading partners to know their readiness with NPI and how it impacts you.

Test: Have you started testing the NPI, both internally and externally? Not only do you need to test the HIPAA Transactions such as 837 Claims, but if you process 835 Remittance Advice, be sure to test that your system can process the NPI appropriately. Also, if you submit paper claims, be sure that you've tested the data being printed in the correct fields.

Educate: have you educated your staff on what the NPI is and the use of I? It's important that staff who may be using the NPI in day-to-day work, such as verification of eligibility, or other tasks that may need the NPI, be aware of the NPI and the provider identifiers that it replaces. The staff may have to change policies and procedures.

Implement: Have you implemented the NPI into your business practices? Once testing is complete, changes will go into production. Prior to doing this, you'll need to make sure your trading partners are ready to process with the NPI only.

Given all the steps above, will you be ready by May 23, 2007?

Enumeration Advice for Incorporated Individual Providers

Health care providers who are individuals are eligible for an Entity Type 1 (Individual) NPI. If these individuals incorporate themselves (i.e., if they form corporations) and the corporations are health care providers, the corporations are organization providers that are eligible for an Entity Type 2 (Organization) NPI. If either of these health care providers (the individual or the corporation) are covered providers (i.e. providers that send electronic transactions) under HIPAA, the NPI Final Rule requires them to obtain NPIs.

Reminder to Supply Legacy Identifiers on NPI Application

If reporting a Medicaid legacy number, include the associated State name. If providers have already been assigned NPIs, CMS asks them to consider going back into the NPPES and updating their information with their legacy identifiers if they did not include those identifiers when they applied for NPIs. This information is critical for health plans and health care clearinghouses in the development of crosswalks to aid in the transition to the NPI.

Common Testing Error Identified

Given recent testing experience, one common testing error found is that claims submitters check that they are submitting and NPI in the 2010AA Billing Provider REF02 segment instead of NM109. The REF segment is situational, but required if it is necessary to report a secondary ID, such as a legacy identifier and a taxpayer identification number. NM109 is where the NPI is to be submitted, but the claim submitter incorrectly submits a legacy identifier instead. Remember to make sure you correctly designate they type of identifier you are submitting to aid in crosswalk development during this testing phase.

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

National Provider Identifier Reference Document

Listed below are the loop IDs, loop names, element and segment details used for submitting NPI information electronically in a DMEPOS claim. This is a reference document. It does not replace the American National Standards Institute (ANSI) X12N 837 professional implementation guide, companion document or trading partner agreements.

2010AA - Billing Provider
Always required

NM101 = 85
NM108 = XX
NM109 = NPI
REF01 = SY or EI
REF02 = SSN or EIN
REF01 = 1C
REF02 = PROVIDER #

2310D - Service Facility Location
Required if the place of service was somewhere other than the beneficiary's home

NM101 = 77
NM108 = XX
NM109 = NPI
REF01 = 1C or 1G
REF02 = FACILITY ID or UPIN

2420C - Service Facility Location
Only required if the facility where this service was rendered is different that the facility where other services in this claim were rendered

NM101 = FA
NM108 = XX
NM109 = NPI
REF01 = 1G or 1C
REF02 = UPIN or PROVIDER #

2420E - Ordering Provider
Only required if the physician who ordered this service is other than the physician who ordered other services in this claim

NM101 = DK
NM108 = XX
NM109 = NPI
REF01 = 1G
REF02 = UPIN

For more information pertaining to the placement of the NPI in your electronic claim file, refer to the ANSI X12N 837 4010A1 Implementation Guide (available at www.wpc-edi.com) or contact the Jurisdiction D EDI Helpdesk at 866-224-3094.

Claims Submitted With Only a National Provider Identifier During the Stage 2 NPI Transition Period

MLN Matters Number: MM5378
Related Change Request (CR) #: 5378
Related CR Release Date: November 13, 2006
Related CR Transmittal #: R249OTN
Effective Date: October 1, 2006
Implementation Date: November 20, 2006

Provider Types Affected
Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries, with Medicare.

Provider Action Needed
Beginning October 1, 2006 and until further notice, claims that you submit containing only an NPI will be returned you as unprocessable if a properly matching legacy number cannot be found.

From the beginning of Medicare's Stage 2 NPI transition period on October 1, 2006 and until further notice, you should submit both NPIs and legacy provider numbers on your Medicare claims to ensure that they are properly processed. During this period, claims submitted with only a NPI that Medicare systems are unable to properly match with a legacy number (e.g., PIN, OSCAR number), may be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

You should make sure that when submitting Medicare claims with dates of service on or after October 1, 2006, your billing staff submit both your NPI and legacy provider numbers until further notice from CMS.

Background

As previously announced, the Centers for Medicare & Medicaid Services (CMS) plans to begin testing new software it has been developed to use the NPI in the existing Medicare fee-for-service claims processing systems. (Remember that you will be required to submit claims and other HIPAA transactions with only an NPI beginning on May 23, 2007).

During the Stage 2 NPI transition period of October 1, 2006, through May 22, 2007, Medicare will accept claims having only NPIs (as well as those having only legacy provider numbers); however in CR 5378, from which this article is taken, CMS recommends that during this period you submit claims using:

- The provider's legacy number, such as a Provider Identification Number (PIN), NSC number, OSCAR number or UPIN; or
- Both the provider's NPI and legacy number.

Note: Until January 2, 2007, NPIs are not to be submitted on paper claims via CMS 1500 forms. Institutional providers are advised that the NPI will not be accepted on paper claims by FIs or A/B MACs until implementation of the UB-04 on May 23, 2007.

Until testing of Medicare's new software is complete, if you submit Medicare claims with only your NPI:

1) They may be processed and paid, or

2) If the Medicare systems are unable to properly match the incoming NPI with a legacy number (e.g., PIN, OSCAR number), they may be rejected, and you will be required to resubmit the claim with the appropriate legacy number.

Additional Information

The official instruction issued to your Medicare contractor on this issue, CR 5378, is available at http://www.cms.hhs.gov/Transmittals/downloads/R249OTN.pdf on the CMS website.

Medicare Fee for Service Implementation of the National Provider Identifier

MLN Matters Number: SE0679

Provider Types Affected

All FFS providers who bill Medicare.

Background

The Centers for Medicare & Medicaid Services (CMS) is publishing this Special Edition (SE) article to remind providers that on May 23, 2007, the NPI will replace health care provider identifiers that are in use today in HIPAA standard transactions. Health care providers should remember that getting an NPI is free and easy. Time is running out! It is estimated that, once a provider obtains an NPI, it may take up to 120 days to implement the NPI in current business practices. The following key points will assist Medicare providers as they transition from the application stage to the implementation stage to ensure NPI readiness.

Applying for an NPI

Visit the official CMS source for NPI-related information, including how to apply for an NPI, as well as free educational products, at http://www.cms.hhs.gov/

NationalProvIdentStand/ on the CMS website.

Key Points

The following are the critical content areas for the Medicare FFS Health plan implementation of the NPI.

Medicare Legacy Numbers

After the compliance date, Medicare providers must begin submitting their NPIs instead of their Medicare legacy identifiers on claims they send to Medicare. A provider's Taxpayer Identification Number (TIN), which is the provider's Social Security Number or Employer Identification Number, will continue to be used when a provider needs to be identified as a taxpayer in HIPAA standard transactions. The Implementation Guides for each of the standard transactions indicate when it is necessary to identify a provider as a taxpayer.

- A related *MLN Matters* article, MM4023, may be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf on the CMS website.

Electronic File Interchange (EFI)

Health industry organizations that are approved by CMS as Electronic File Interchange Organizations (EFIOs) can submit NPI application data for health care providers, including Medicare providers, in electronic files to the National Plan and Provider Enumeration System (NPPES) after obtaining the permission of the health care providers to do so. This process is called Electronic File Interchange (EFI). For health care providers who are approached by EFIOs, EFI is an alternative to having to apply for their NPIs via the web-based or paper application process. Providers who are enumerated via EFI, receive their NPI notifications from the EFIO that had them enumerated. These notifications are not generated from NPPES.

Designation of Subparts

CMS reminds Medicare providers to visit Medicare's Subparts Expectation Paper (entitled, "Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA," and located at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/Medsubparts01252006.pdf on the CMS NPI web page) for suggestions on how to determine their subparts. Remember, no health plan, not even Medicare, can instruct a provider on how to enumerate subparts. This is a business decision that the organization provider must make considering its unique business operations.

Durable Medical Equipment (DME) Enumeration Requirement

As mentioned in the paper entitled, "Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA" (see link in preceding paragraph), Medicare DME suppliers are required to obtain an NPI for every location. The only exception to this requirement is the situation in which a Medicare DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI (the individual's NPI) regardless of the number of locations the DME supplier may have.

Submitting your NPI on Medicare Electronic Claims

Until further notice, CMS recommends that Medicare providers submit claims using both the NPI and legacy number. Claims submitted with **only an NPI** may be rejected/returned as unprocessable if Medicare systems are unable to properly match the incoming NPI with a legacy number. The provider will then need to resubmit the claim with the appropriate legacy number.

A related MLN Matters article, MM5378, may be viewed at http://www.cms.hhs.gov/mlnmattersarticles/downloads/mm5378.pdf on the CMS website.

Required Use of the NPI on Medicare Paper Claims

Medicare, as a health plan, will require the use of the NPI on its paper claims. The paper claim forms used by Medicare have been revised to accommodate use of the NPI. There will be transition periods for each of the revised forms. While the NPI cannot be used on the current paper claim forms, providers may begin using the NPI on the revised forms once the transition period for each form begins.

- The *MLN Matters* article related the transition from UB-92 to UB 04 can be viewed at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf on the CMS website.
- The *MLN Matters* article related to the transition from CMS 1500 (12/90) to CMS 1500 (08/05) can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf on the CMS website.

Required Use of Taxonomy Codes on Institutional Provider Claims

Effective January 1, 2007, institutional Medicare providers who submit claims for their primary facility and its subparts (such as psychiatric unit, rehabilitation unit, etc.) must report a **taxonomy code** on all claims submitted to their FI. Taxonomy codes shall be reported by these facilities whether or not the facility has applied for NPIs for each of their subparts. Institutional providers that do not currently bill Medicare for services performed by their subparts are not required to use taxonomy codes on their claims to Medicare.

A recent *MLN Matters* article, MM5243, discusses this requirement in more detail and may be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5243.pdf on the CMS website.

National Council of Prescription Drug Plans (NCPDP) Claims

The NCPDP format was designed to permit a prescription drug claim to be submitted with either an NPI or a legacy identifier, but no more than one identifier may be reported for a provider (retail pharmacy or prescribing physician) per claim. From October 1, 2006, through May 22, 2007, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have this information). (Refer to *MLN Matters* article MM4023 at the link provided earlier in this article.)

NPI CONT'D

Medicare Remittance Advice Print Software

The 835-PC-Print and Medicare Remit Easy Print software were modified to enable either the NPI or a Medicare legacy number, or both, if included in the 835. (Refer to *MLN Matters* article MM4023.)

Communicating Your NPI to Medicare

Medicare providers should know that there is no "special process" or any need to call to communicate NPIs to the Medicare program. NPIs can be shared with the Medicare program by using them on your claims along with your legacy identifier. Secondly, for providers applying for Medicare enrollment, an NPI must be reported on the CMS-855 enrollment application (along with a photocopy of the NPI notification received by the provider from the NPPES or from an EFIO). Existing Medicare providers must provide their NPIs when making any changes to their Medicare provider enrollment information

Sharing NPIs

Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business, and with health plans that request their NPIs. In fact, as outlined in current regulation, all providers, including Medicare providers, that are HIPAA covered providers **must** share their NPI with other providers, health plans, clearinghouses, and any entity that may need those NPIs for use in standard transactions, including the need to identify an ordering or a referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their NPIs for them.

Additional Information

NPI Questions

CMS continues to update our Frequently Asked Questions (FAQs) to answer many of the NPI questions we receive on a daily basis. Visit the following link to view all NPI FAQs: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=Qjr3YRYh&p_lva=&p_li=&p_page=1&p_cv=&p_pv=&p_prods=0&p_cats=&p_hidden_prods=&prod_lvl1=0&p_search_text=NPI&p_new_search=1&p_search_type=answers.search_nl

Providers should remember that the NPI Enumerator can only answer/address the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter (i.e., for those providers enumerated via paper or web-based applications)
- Trouble accessing NPPES
- Forgotten password/User ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

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

Please Note: The NPI Enumerator's operation is closed on federal holidays. The federal holidays observed are: New Year's Day, Independence Day, Veteran's Day, Christmas Day, Martin Luther King's Birthday, Washington's Birthday, Memorial Day, Labor Day, Columbus Day, and Thanksgiving.

ENTERNAL NUTRITION

Correction to Enteral Nutrition LCD

The Enteral Nutrition LCD published in December 2006 contains an error in the Documentation Requirements section regarding the DME Information Form (DIF). The LCD instructs suppliers to have the DIF signed by the treating physician. This is incorrect. Suppliers are required to sign the document. The correct wording for the instruction should be:

A DME Information Form (DIF) which has been completed, signed, and dated by the supplier, must be kept on file by the supplier and made available upon request. The DIF for Enteral Nutrition is CMS Form 10126. The initial claim must include an electronic copy of the DIF.

The LCD will be updated in a future revision.

PROSTHETICS/ORTHOTICS

Lower Limb Prostheses – Suction Sockets

The current Policy Article for Lower Limb Prostheses contains a paragraph discussing the appropriate coding of L5647 and L5652, suction socket/suspension. That paragraph in the Coding Guidelines section is being revised as follows:

Codes L5647 and L5652 describe a modification to a prosthetic socket that incorporates a suction valve in the design. The items described by these codes are not components of a suspension locking mechanism (L5671).

This change is effective immediately. It will be formally incorporated into the Lower Limb Prostheses policy in a future revision.

A suction valve (L5647, L5652) is rarely needed when a suspension locking mechanism is being used. If both are provided, there should be documentation in the supplier's records that describes the medical necessity of each for the specific patient.

WHEELCHAIR/POWER MOBILITY DEVICE

Revised Power Mobility Device Fee Schedule

The fee schedule amounts for codes K0813 thru K0864 have been further refined for dates of services on/after November 15, 2006.

The revised fees are for the rental fees for the first three months. The rental fee is reduced by 25% for months 4-13. These fees apply to all states and territories within Jurisdiction D.

In addition, CMS has provided pricing for codes K0800-K0812 effective for dates of service on/after January 1, 2007. From dates of service 11/15/06-12/31/06, these codes will be manually priced by the DME MACs.

Proc	Mod	Mod	Fee
K0813	RR		$241.24
K0814	RR		$308.78
K0815	RR		$351.63
K0816	RR		$336.74
K0820	RR		$257.66
K0821	RR		$330.77
K0822	RR		$400.81
K0823	RR		$402.37
K0824	RR		$484.27
K0825	RR		$422.96
K0826	RR		$626.93
K0827	RR		$480.93
K0828	RR		$690.82
K0829	RR		$601.18
K0830	RR		$391.41
K0831	RR		$391.41
K0835	RR		$413.23
K0836	RR		$420.75
K0837	RR		$484.27
K0838	RR		$437.22
K0839	RR		$626.93
K0840	RR		$949.83
K0841	RR		$431.86
K0842	RR		$431.86
K0843	RR		$519.96
K0848	RR		$543.36
K0849	RR		$508.07
K0850	RR		$613.99
K0851	RR		$574.14
K0852	RR		$708.26
K0853	RR		$727.56
K0854	RR		$963.86
K0855	RR		$910.51
K0856	RR		$567.23
K0857	RR		$578.60
K0858	RR		$703.76
K0859	RR		$653.81
K0860	RR		$1,005.41
K0861	RR		$568.14
K0861	RR	KF	$614.19
K0862	RR		$703.76
K0863	RR		$1,005.41
K0864	RR		$1,256.75

Fee Schedule Amounts for K0827, K0829 and K0864 Further Refined

The revised DMEPOS fee schedule has been released by the Centers for Medicare & Medicaid Services (CMS). DME code revisions for codes K0813 thru K0864 have been made available to Noridian Administrative Services (NAS) by CMS. Within the revised fee schedule, the payment amounts for Power Mobility Device (PMD) codes K0827, K0829 and K0864 have been further refined by CMS and were made available on December 21, 2006.

NAS will adjust previously processed claims for codes K0827, K0829, and K0864 with dates of service on or after November 15, 2006, if they are resubmitted as adjustments.

Proc	Mod	Fee
K0827	RR	$533.09
K0829	RR	$634.37
K0864	RR	$1,196.45

REIMBURSEMENT

Reasonable Charge Update for 2007 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Intraocular Lenses

MLN Matters Number: MM5382
Related Change Request (CR) #: 5382
Related CR Release Date: November 24, 2006
Related CR Transmittal #: R1118CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Physicians, suppliers and providers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), DME Medicare Administrative Contractors (DME MACs), or Part A/B Medicare Administrative Contractors (A/B MACs) for splints, casts, dialysis supplies, dialysis equipment, and certain intraocular lenses.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment and intraocular lenses in calendar year 2007 as required by regulations contained in 42 CFR 405.501 (http://www.gpoaccess.gov/cfr/retrieve.html).

For splints and casts, Q-codes are to be used when supplies are indicated for cast and splint purposes. Current Procedural Terminology (CPT) codes should be used as indicated in the CPT section "Application of Casts and Strapping" for the specified CPT procedure codes in the 29XXX series. This payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.

For intraocular lenses, payment is only made on a reasonable charge basis for lenses implanted in a physician's office. Change Request (CR) 5282 instructs your carrier, DMERC, DME MAC, or A/B MAC to compute 2007 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, 2005, through June 30, 2006.

Carriers, and A/B MACs will compute 2007 Inflation-Indexed Charge (IIC) amounts for the V2630, V2631, and V2632 that were not paid using gap-filled payment amounts in 2006.

DMERCs and DME MACs will compute 2007 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2005, through June 30, 2006. For these same codes, they will compute 2007 IIC amounts for the codes identified in the following tables that were not paid using gap-filled amounts in 2006. 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 2007 based on the lower of the actual charge or the payment limits established for these codes. **Carriers, DMERCs and DME Medicare Administrative Contractors (MACs)** to will use the 2007 reasonable charges or the same payment limits to pay claims for items furnished from January 1, 2007 through December 31, 2007. **Those 2007 payment limits are in the table at the end of this article.**

Additional Information

Instructions for calculating:

- Reasonable charges are located in chapter 23 (section 80) of the Medicare Claims Processing Manual (Pub. 100-04);
- Customary and prevailing charge are locate in section 80.2 and 80.4 of chapter 23 of the Medicare Claims Processing Manual (Pub 100-04); and
- The IIC (Inflation Indexed Charge) are located in section 80.6 of chapter 23 of the Medicare Claims Processing Manual (Pub. 100-04). The IIC update factor for 2007 is 4.3 percent.

You can find chapter 23 of the Medicare Claims Processing Manual (Pub. 100-04) at the following CMS website: http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf

For complete details, please see the official instruction issued to your carrier, DMERC, DME MAC, or A/B MAC regarding this change. That instruction may be found at http://www.cms.hhs.gov/Transmittals/downloads/R1118CP.pdf on the CMS website.

2007 Payment Limits for Splints and Casts

Code	Payment Limit	Code	Payment Limit
A4565	$7.19	Q4025	$31.60
Q4001	$40.91	Q4026	$98.64
Q4002	$154.63	Q4027	$15.80
Q4003	$29.39	Q4028	$49.33
Q4004	$101.74	Q4029	$24.16
Q4005	$10.83	Q4030	$63.59
Q4006	$24.42	Q4031	$12.08
Q4007	$5.43	Q4032	$31.79
Q4008	$12.21	Q4033	$22.53
Q4009	$7.23	Q4034	$56.05
Q4010	$16.28	Q4035	$11.27
Q4011	$3.61	Q4036	$28.03
Q4012	$8.14	Q4037	$13.75
Q4013	$13.16	Q4038	$34.44
Q4014	$22.21	Q4039	$6.89
Q4015	$6.58	Q4040	$17.22
Q4016	$11.10	Q4041	$16.71
Q4017	$7.61	Q4042	$28.53
Q4018	$12.14	Q4043	$8.36
Q4019	$3.81	Q4044	$14.27
Q4020	$6.08	Q4045	$9.70
Q4021	$5.63	Q4046	$15.61
Q4022	$10.17	Q4047	$4.84
Q4023	$2.83	Q4048	$7.81
Q4024	$5.08	Q4049	$1.77

Fee Schedule Update for 2007 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

MLN Matters Number: MM5417
Related Change Request (CR) #: 5417
Related CR Release Date: December 8, 2006
Related CR Transmittal #: R1125CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Physicians, suppliers, and providers who bill Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), carriers, and/or regional home health intermediaries (RHHIs)), for services paid under the DMEPOS Fee Schedule.

Provider Action Needed

This article is based on Change Request (CR) 5417, and it provides specific information regarding the annual update for the 2007 DMEPOS Fee Schedule.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to:

- Implement fee schedule amounts for new codes; and
- Revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for:

- Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)); and
- Parenteral and Enteral Nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

Note: DMERCs and DME MACS will use the 2007 PEN fee schedule payment amounts to pay claims for items furnished from January 1, 2007 through December 31, 2007

Deleted HCPCS Codes

The following codes are being **deleted** from the HCPCS effective January 1, 2007, and are therefore being removed from the DMEPOS and PEN fee schedule files.

A4348	L0100	L6740	L6825	L6872
A4359	L0110	L6745	L6830	L6873
A4462	L3902	L6750	L6835	L6875
A4632	L3914	L6755	L6840	L6880
E0164	L6700	L6765	L6845	L7010
E0166	L6705	L6770	L6850	L7015
E0180	L6710	L6775	L6855	L7020
E0701	L6715	L6780	L6860	L7025
E0977	L6720	L6790	L6865	L7030
E0997 thru E0999	L6725	L6795	L6867	L7035
	L6730	L6800	L6868	
E2320	L6735	L6806 thru L6809	L6870	
K0090 thru K0097				
K0099				

Added HCPCS

The HCPCS codes listed below are being **added to the HCPCS** on January 1, 2007:

A4461	A9279	L1001	L6703
A4463	E0676	L3806	L6704
A4559	E0936	L3808	L6706
A4600	E2373 thru E2377	L3915	L6707 thru L6709
A4601		L5993	
A8000	E2381 thru E2396	L5994	L7007 thru L7009
A8001		L6611	
A8002	K0733 thru K0737	L6624	L8690
A8003		L6639	L8691
A8004			L8695

Payment Rates for Oxygen and Oxygen Equipment

As part of this fee schedule update, the Centers for Medicare & Medicaid Services (CMS) is implementing national monthly payment rates for oxygen and oxygen equipment effective for claims with dates of service on or after January 1, 2007. The 2007 national monthly payment rates are listed in the table below. As a result of these changes, CMS is revising the fee schedule amounts for codes E1405 and E1406. Since 1989, the fees for E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

As part of these changes, suppliers must submit claims with both the code for stationary oxygen contents (E0441 or E0442) and the code for portable oxygen contents (E0443 or E0444) when billing for payment for furnishing both stationary and portable oxygen contents for beneficiary-owned gaseous or liquid stationary and portable oxygen equipment.

HCPCS Codes	Amount	Class
E0424, E0439, E1390, and E1391	$198.40	Stationary Oxygen Equipment (including stationary concentrator, liquid and gaseous equipment) and Oxygen Contents (stationary and portable)
E0431 and E0434	$31.79	Portable Equipment Only (gaseous or liquid tanks)
E1392 and K0738	$51.63	Oxygen Generating Portable Equipment (OGPE) Only
E0441 and E0442	$77.45	Oxygen Contents for Beneficiary-Owned Stationary Gaseous or Liquid Oxygen Equipment
E0443 and E0444	$77.45	Oxygen Contents for Beneficiary-Owned Portable Gaseous or Liquid Oxygen Equipment

The fee schedules for HCPCS code E0461 (Volume Control Ventilator, Without Pressure Support Mode, May Include Pressure Control Mode, Used with Non-Invasive Interface (E.G. Mask)) are being revised as part of this update to correct calculation errors and are effective for dates of service on or after January 1, 2007.

Gap-Fill Items

The Medicare DMERCS and DME MACs will gap-fill base fee schedule amounts for each State in their region for the following new and revised HCPCS codes that will be subject to the DMEPOS fee schedules in 2007:

- Inexpensive or routinely purchased DME for codes A8002, A8003, A8004, E2373, E2374, E2375, E2376, E2377, E2388, E2389, E2390, E2391, E2392, E2393, E2394, E2395
- Capped rental DME codes of E0639 and E0640
- Prosthetics and Orthotics codes of L1001, L3806, L3808, L3915, L5993, L5994, L6611, L6624, L6639
- Surgical Dressings codes of A4463
- DME supplies codes of A4559

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5417) issued to your Medicare A/B MAC, DMERC, DME MAC, FI, RHHI, or carrier. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1125CP.pdf on the CMS web site.

Additional Provider Education for Changes in Payment for Oxygen Equipment and Capped Rentals for DME Based on the Deficit Reduction Act

MLN Matters Number: MM5370
Related Change Request (CR) #: 5370
Related CR Release Date: November 24, 2006
Related CR Transmittal #: R1120CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

Suppliers and providers billing Medicare durable medical equipment regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs) for oxygen equipment/services or other rentals of capped DME. Physicians treating Medicare patients using oxygen equipment or other rentals of capped DME may also want to be aware of this issue.

Background

Recent legislative changes mandated by sections 5101(a) and 5101(b) of the Deficit Reduction Act (DRA) of 2005 require changes to the way Medicare makes payment for certain items of DME. The DRA provisions and associated regulations will begin to impact capped rental claims as of February 2007. The purpose of this article and related CR 5370 is to provide DME suppliers with an explanation of how these changes will impact them.

Key Points for Suppliers

Payments for Capped Rental DME

- Section 5101(a) revises the payment rules in accordance with the DRA and states that after 13 months the beneficiary owns the capped rental DME item, and after that time, Medicare pays for reasonable and necessary maintenance and servicing (i.e., for parts and labor not covered by a supplier's or manufacturer's warranty) of the item.
- The beneficiary may not, as in years past, choose to continue to rent the item and leave the supplier with the title to the item. The title transfer must occur on the first day after the last rental month. The provision applies to items for which the first rental month occurs on or after January 1, 2006.
- This provision does not affect parenteral nutrition (PEN) pumps, because PEN is not considered to be a capped rental DME, but rather is covered under the prosthetic benefit.
- Beneficiaries may still elect to obtain power-driven wheelchairs on a lump-sum purchase agreement basis. Should the beneficiary choose not to obtain the power-driven wheelchair on a lump sum purchase basis, title to the wheelchair will still transfer to the beneficiary after 13 continuous rental months have been paid.
- Capped rental items furnished to beneficiaries prior to January 1, 2006 will continue to be paid under the payment rules in effect prior to the DRA changes.

Payments for Oxygen Equipment

- Section 5101(b) of the DRA specifically provided that Medicare will continue to pay for oxygen contents (i.e. oxygen, regardless of modality) for beneficiary-owned stationary or portable gaseous or liquid systems. Payment for oxygen contents will continue to be made as long as the oxygen remains medically necessary.
- Section 5101 (B) of the DRA limits the total number of continuous rental months for which Medicare will pay for oxygen equipment to 36 months. After the 36th month, the supplier must transfer title to the equipment to the beneficiary on the first day of the last rental month. The supplier must follow applicable state and federal laws when transferring title to the beneficiary.
- The DRA further stipulates that payment for reasonable and necessary maintenance and servicing of beneficiary-owned oxygen equipment will be made for parts and labor that are not covered by a supplier's or manufacturer's warranty. This provision is effective January 1, 2006.
- For beneficiaries who were receiving oxygen equipment on December 31, 2005, the 36-month rental period begins on January 1, 2006, regardless of how many months rental has been paid prior to January 1, 2006.

Additional Information

The official instruction, CR5370, issued to your Medicare DMERC or DME MAC may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1120CP.pdf on the CMS web site.

In addition, you can find a related *MLN Matters* article, MM5010 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5010.pdf on the CMS website.

January 2007 Quarterly Average Sales Price Drug Pricing File, Effective January 1, 2007, and Revisions to April, July and October 2006 Quarterly ASP Drug Pricing Files

MLN Matters Number: MM5413
Related Change Request (CR) #: 5413
Related CR Release Date: December 15, 2006
Related CR Transmittal #: R1129CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5413 which informs Medicare contractors to download the January 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2006, April 2006, July 2006, and October 2006 files.

Background

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

The ASP methodology is based on quarterly data submitted to the Centers for Medicare & Medicaid Services (CMS) by manufacturers, and CMS supplies Medicare contractors (carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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

ASP Methodology

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

Beginning January 1, 2006, payment allowance limits are paid based on 106 percent (106%) of the ASP for the following:

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

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.
- Payment allowance limits for **infusion drugs furnished through a covered item of durable medical equipment** on or after January 1, 2005, will continue to be 95 percent (95%) of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. **The payment allowance limits will not be updated in 2007.** Payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent (95%) of the first published AWP unless the drug is compounded.
- Payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent (95%) of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. Where the vaccine is administered in the hospital outpatient department, the vaccine is paid at reasonable cost.
- The payment allowance limits for **drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File**, other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration, are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the Medicare contractors follow the methodology specified in the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 17, Drugs and Biologicals) for calculating the AWP but substitute WAC for AWP. The payment limit is 100 percent (100%) of the lesser of the lowest-priced brand or median generic WAC. For 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file. For 2007, the blood clotting furnishing factor of $0.152 per I.U. is added to the payment amount for the blood clotting factor when the blood clotting factor is not included on the ASP file.
- The payment allowance limits for **new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration (FDA)** and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent (106%) of the WAC or invoice pricing, if the WAC is not published. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio.

On or after December 19, 2006, the revised April, July and October 2006 and January 2007 ASP file and ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP webpage, and the payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The revised files are applicable to claims based on dates of service as shown in the following table:

Payment Allowance Limit Revision Date	Applicable Dates of Service
April 2006	April 1, 2006 through June 30, 2006.
July 2006	July 1, 2006 through September 30, 2006.
October 2006	October 1, 2006 through December 31, 2006.
January 2007	January 1, 2007 through March 31, 2007.

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

Physicians (or a practitioner described in the Social Security Act (Section 1842(b) (18) (C); http://www.ssa.gov/OP_Home/ssact/title18/1842.htm) may be paid for filling or refilling an implantable pump or reservoir when it is

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medically necessary for the physician (or other practitioner) to perform the service. Contractors must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for the professional service to fill or refill the implantable pump or reservoir and to allow payment for drugs furnished incident to the professional service.

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

Additional Information

For complete details, please see the official instruction issued to your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1129CP.pdf on the CMS web site.

CODING

2007 HCPCS Update

The following tables identify changes to the Healthcare Common Procedure Coding System (HCPCS) for 2007.

Codes that have been added are effective for dates of service on/after January 1, 2007. The footnote (n) is used for items that are statutorily noncovered by Medicare for reasons other than medical necessity. The footnote (x) is used for items that are denied as not medically necessary based on Medicare national policy.

The second and third tables include the codes discontinued as of December 31, 2006, and the codes, which have a narrative change in 2007. The codes listed as discontinued will continue to be valid for claims with dates of service through December 31, 2006.

If there is a direct crosswalk for a discontinued code, it is listed in the final table. If the crosswalk is not an exact crosswalk (i.e., if there has been a significant change in the narrative description or unit of service), the phrase "with changes" follows the code. Most of the crosswalked codes are added codes that are effective for dates of service on/after January 1, 2007.

There is no grace period that allows submission of a discontinued code for a date of service in 2007. In addition, the K codes that were previously published or codes that have been invalid for claim submission to the DME MAC and that are being officially discontinued in 2007 are not listed in this article.

The appearance of a code in this article does not necessarily indicate coverage.

New Codes Effective 1/1/2007

Code	Description
A4461	Surgical dressing holder, non-reusable, each
A4463	Surgical dressing holder, reusable, each
A4559	Coupling gel or paste, for use with ultrasound device, per oz
A4600	Sleeve for intermittent limb compression device, replacement only
A4601	Lithium ion battery for non-prosthetic use, replacement
A8000	Helmet, protective, soft, prefabricated, includes all components and accessories (Footnote: N)
A8001	Helmet, protective, hard, prefabricated, includes all components and accessories (Footnote: N)
A8002	Helmet, protective, soft, custom fabricated, includes all components and accessories (Footnote: N)
A8003	Helmet, protective, soft, custom fabricated, includes all components and accessories (Footnote: N)
A8004	Soft interface for helmet, replacement only
A9279	Monitoring feature/device, stand-alone or integrated, any type
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified
E0936	Continuous passive motion exercise device for use other than knee (Footnote: X)
E2373	Power wheelchair accessory, hand or chin control interface, mini-proportional, compact, or short throw remote joystick or touchpad, proportional, including all related electronics and fixed mounting hardware
E2374	Power wheelchair accessory, hand or chin control interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only
E2375	Power wheelchair accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only
E2376	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, replacement only
E2377	Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue
E2381	Power wheelchair accessory, pneumatic drive wheel tire, any size, replacement only, each
E2382	Power wheelchair accessory, tube for pneumatic drive wheel tire, any size, replacement only, each

CODING CONT'D

E2383	Power wheelchair accessory, insert for pneumatic drive wheel tire (removable), any type, any size, replacement only, each
E2384	Power wheelchair accessory, pneumatic caster tire, any size, replacement only, each
E2385	Power wheelchair accessory, tube for pneumatic caster tire, any size, replacement only, each
E2386	Power wheelchair accessory, foam filled drive wheel tire, any size, replacement only, each
E2387	Power wheelchair accessory, foam filled caster tire, any size, replacement only, each
E2388	Power wheelchair accessory, foam drive wheel tire, any size, replacement only, each
E2389	Power wheelchair accessory, foam caster tire, any size, replacement only, each
E2390	Power wheelchair accessory, solid (rubber/plastic) drive wheel tire, any size, replacement only, each
E2391	Power wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each
E2392	Power wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each
E2393	Power wheelchair accessory, valve for pneumatic tire tube, any type, replacement only, each
E2394	Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each
E2395	Power wheelchair accessory, caster wheel excludes tire, any size, replacement only, each
E2396	Power wheelchair accessory, caster fork, any size, replacement only, each
J0129	Injection, abatacept, 10 mg
J0348	Injection, anidulafungin, 1 mg
J0594	Injection, busulfan, 1 mg
J0894	Injection, decitabine, 1 mg
J1458	Injection, galsulfase, 1 mg
J1562	Injection, immune globulin, subcutaneous, 100 mg
J2248	Injection, micafungin sodium, 1 mg
J3243	Injection, tigecycline, 1 mg
J7607	Levalbuterol, inhalation solution, compounded product, administered through DME, concentrated form, 0.5 mg
J7609	Albuterol, inhalation solution, compounded product, administered through DME, unit dose, 1 mg
J7610	Albuterol, inhalation solution, compounded product, administered through DME, concentrated form 1 mg
J7615	Levalbuterol, inhalation solution, compounded product, administered through DME, unit dose, 0.5 mg
J7634	Budesonide, inhalation solution, compounded product, administered through DME, concentrated form, per 0.25 milligram
J7645	Ipratropium bromide, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7647	Isoetharine HCl, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7650	Isoetharine HCl, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7657	Isoproterenol HCl, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7660	Isoproterenol HCl, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7667	Metaproterenol sulfate, inhalation solution, compounded product, concentrated form, per 10 milligrams
J7670	Metaproterenol sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per 10 milligrams
J7685	Tobramycin, inhalation solution, compounded product, administered through DME, unit dose form, per 300 milligrams
J8650	Nabilone, oral, 1 mg
J9261	Injection, nelarabine, 50 mg
L1001	Cervical thoracic lumbar sacral orthosis, immobilizer, infant size, prefabricated, includes fitting and adjustment
L3806	Wrist hand finger orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface material, straps, custom fabricated, includes fitting and adjustment
L3808	Wrist hand finger orthosis, rigid without joints, may include soft interface material, straps, custom fabricated, includes fitting and adjustment
L3915	Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, includes fitting and adjustment
L5993	Addition to lower extremity prosthesis, heavy duty feature, foot only, (for patient weight greater than 300 lbs)
L5994	Addition to lower extremity prosthesis, heavy duty feature, knee only, (for patient weight greater than 300 lbs)

CODING CONT'D

L6611	Addition to upper extremity prosthesis, external powered, additional switch, any type
L6624	Upper extremity addition, flexion/extension and rotation wrist unit
L6639	Upper extremity addition, heavy duty feature, any elbow
L6703	Terminal device, passive hand/mitt, any material, any size
L6704	Terminal device, sport/recreational/work attachment, any material, any size
L6706	Terminal device, hook, mechanical, voluntary opening, any material, any size, line or unlined
L6707	Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined
L6708	Terminal device, hand, mechanical, voluntary opening, any material, any size
L6709	Terminal device, hand, mechanical, voluntary closing, any material, any size
L7007	Electric hand, switch or myoelectric controlled, adult
L7008	Electric hand, switch or myoelectric, controlled, pediatric
L7009	Electric hook, switch or myoelectric controlled, adult
Q4081	Injection, epoetin alfa, 100 units (for ESRD on dialysis)

Codes Discontinued December 31, 2006

Code	Description
A4348	Male external catheter with integral collection compartment, extended wear, each (e.g., 2 per month)
A4359	Urinary suspensory without leg bag, each
A4462	Abdominal dressing holder, each
E0164	Commode chair, mobile, with fixed arms
E0166	Commode chair, mobile, with detachable arms
E0180	Pressure pad, alternating with pump
E0701	Helmet with face guard and soft interface material, prefabricated (Footnote: n)
E2320	Power wheelchair accessory, hand or chin control interface, remote joystick or touchpad, proportional, including all related electronics, and fixed mounting hardware
K0090	Rear wheel tire for power wheelchair, any size, each
K0091	Rear wheel tire tube other than zero pressure for power wheelchair, any size, each
K0092	Rear wheel assembly for power wheelchair, complete, each
K0093	Rear wheel zero pressure tire tube (flat free insert) for power wheelchair, any size, each
K0094	Wheel tire for power base, any size, each
K0095	Wheel tire tube other than zero pressure for each base, any size, each
K0096	Wheel assembly for power base, complete, each
K0097	Wheel zero pressure tire tube (flat free insert) for power base, any size, each
K0099	Front caster for power wheelchair, each
L0100	Cranial orthosis (helmet), with or without soft interface, molded to patient model (Footnote: n)
L0110	Cranial orthosis (helmet), with or without soft-interface, non-molded (Footnote: n)
L3902	Wrist hand finger orthosis, external powered, compressed gas, custom fabricated
L3914	Wrist hand orthosis, wrist extension cock-up, prefabricated, includes fitting and adjustment
L6700	Terminal device, hook, Dorrance, or equal, model #3
L6705	Terminal device, hook, Dorrance, or equal, model #5
L6710	Terminal device, hook, Dorrance, or equal, model #5X
L6715	Terminal device, hook, Dorrance, or equal, model #5XA
L6720	Terminal device, hook, Dorrance, or equal, model #6
L6725	Terminal device, hook, Dorrance, or equal, model #7
L6730	Terminal device, hook, Dorrance, or equal, model #7LO
L6735	Terminal device, hook, Dorrance, or equal, model #8
L6740	Terminal device, hook, Dorrance, or equal, model #8X
L6745	Terminal device, hook, Dorrance, or equal, model #88X
L6750	Terminal device, hook, Dorrance, or equal, model #10P
L6755	Terminal device, hook, Dorrance, or equal, model #10X
L6765	Terminal device, hook, Dorrance, or equal, model #12P
L6770	Terminal device, hook, Dorrance, or equal, model #99X
L6775	Terminal device, hook, Dorrance, or equal, model #555
L6780	Terminal device, hook, Dorrance, or equal, model #SS555
L6790	Terminal device, hook-Accu hook, or equal

CODING CONT'D

L6795	Terminal device, hook-2 load, or equal
L6800	Terminal device, hook-APRL VC, or equal
L6806	Terminal device, hook, TRS Grip, Grip III, VC, or equal
L6807	Terminal device, hook, Grip I, Grip II, VC, or equal
L6808	Terminal device, hook, TRS Adept, infant or child, VC, or equal
L6809	Terminal device, hook, TRS Super Sport, passive
L6825	Terminal device, hand, Dorrance, VO
L6830	Terminal device, hand, APRL, VC
L6835	Terminal device, hand, Sierra, VO
L6840	Terminal device, hand, Becker Imperial
L6845	Terminal device, hand, Becker Lock Grip
L6850	Terminal device, hand, Becker Plylite
L6855	Terminal device, hand, Robin-Aids, VO
L6860	Terminal device, hand, Robin-Aids, VO Soft
L6865	Terminal device, hand, passive hand
L6867	Terminal device, hand, Detroit Infant Hand (Mechanical)
L6868	Terminal device, hand, passive infant hand, (Steeper, Hosmer or equal)
L6870	Terminal device, hand, child mitt
L6872	Terminal device, hand, NYU child hand
L6873	Terminal device, hand, mechanical infant hand, Steeper or equal
L6875	Terminal device, hand, Bock, VC
L6880	Terminal device, hand, Bock, VO
L7010	Electronic hand, Otto Bock, Steeper or equal, switch controlled
L7015	Electronic Hand, System Teknik, Variety Village or equal, switch controlled
L7020	Electronic Greifer, Otto Bock or equal, switch controlled
L7025	Electronic hand, Otto Bock or equal, myoelectronically controlled
L7030	Electronic hand, System Teknik, Variety Village or equal, myoelectronically controlled
L7035	Electronic Greifer, Otto Bock or equal, myoelectronically controlled

Narrative Changes

Code	Old Narrative	New Narrative
A4216	Sterile water, saline and/or dextrose (diluent), 10 ml	Sterile water, saline and/or dextrose, diluent/flush, 10 ml
A4306	Disposable drug delivery system, flow rate of 5 ml or less per hour (Footnote: n)	Disposable drug delivery system, flow rate of less than 50 ml per hour
A4326	Male external catheter specialty type with integral collection chamber, each	Male external catheter with integral collection chamber, any type, each
A4394	Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce	Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce
A5105	Urinary suspensory, with leg bag, with or without tube	Urinary suspensory, with or without leg bag, with or without tube, each
E0163	Commode chair, stationary, with fixed arms	Commode chair, mobile or stationary, with fixed arms
E0165	Commode chair, stationary, with detachable arms	Commode chair, mobile or stationary, with detachable arms
E0167	Pail or pan, for use with commode chair	Pail or pan for use with commode chair, replacement only
E0181	Pressure pad, alternating with pump, heavy duty	Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty
E0182	Pump for alternating pressure pad	Pump for alternating pressure pad, for replacement only
E0190	Positioning cushion/ pillow/wedge, any shape or size (Footnote: n)	Positioning cushion/ pillow wedge, any shape or size, includes all components and accessories
E0720	TENS, two lead, localized stimulation	Transcutaneous electrical nerve stimulation (TENS) device, two lead, localized stimulation
E0730	Transcutaneous electrical nerve stimulation device, four or more leads, for multiple nerve stimulation	Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation
E0967	Manual wheelchair accessory, hand rim with projections, any type, replacement only, each	Manual wheelchair accessory, hand rim with projections, any type, each

CODING CONT'D

E2209	Wheelchair accessory, arm trough, each	Accessory, Arm trough, with or without hand support, each
J7611	Albuterol, inhalation solution, administered through DME, concentrated form, 1 mg	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg
J7612	Levalbuterol, inhalation solution, administered through DME, concentrated form, 0.5 mg	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
J7613	Albuterol, inhalation solution, administered through DME, unit dose, 1 mg	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg
J7614	Levalbuterol, inhalation solution, administered through DME, unit dose, 0.5 mg	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg
J7620	Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, non-compounded inhalation solution, administered through DME	Albuterol, up to 2.5 mg and ipratropium bromide up to 0.5 mg, FDA-approved final product, noncompounded, administered through DME
J7622	Beclomethasone, inhalation solution administered through DME, unit dose form, per milligram	Beclomethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7624	Betamethasone, inhalation solution administered through DME, unit dose form, per milligram	Betamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7626	Budesonide inhalation solution, non-compounded, administered through DME, unit dose form, up to 0.5 mg	Budesonide inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, up to 0.5 mg
J7627	Budesonide, powder, compounded for inhalation solution, administered through DME, unit dose form, up to 0.5 mg	Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg
J7628	Bitolterol mesylate, inhalation solution administered through DME, concentrated form, per milligram	Bitolterol mesylate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7629	Bitolterol mesylate, inhalation solution administered through DME, unit dose form, per milligram	Bitolterol mesylate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7633	Budesonide, inhalation solution administered through DME, concentrated form, per 0.25 milligram	Budesonide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 0.25 mg
J7635	Atropine, inhalation solution administered through DME, concentrated form, per milligram	Atropine, inhalation solution compounded product, administered through DME, concentrated form, per milligram
J7636	Atropine, inhalation solution administered through DME, unit dose form, per milligram	Atropine, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7637	Dexamethasone, inhalation solution administered through DME, concentrated form, per milligram	Dexamethasone, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7638	Dexamethasone, inhalation solution administered through DME, unit dose form, per milligram	Dexamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram

CODING CONT'D

J7640	Formoterol, inhalation solution administered through DME, unit dose form, 12 micrograms	Formoterol, inhalation solution, compounded product, administered through DME, unit dose form, 12 micrograms
J7641	Flunisolide, inhalation solution administered through DME, unit dose, per milligram	Flunisolide, inhalation solution, compounded product, administered through DME, unit dose, per milligram
J7642	Glycopyrrolate, inhalation solution administered through DME, concentrated form, per milligram	Glycopyrrolate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7643	Glycopyrrolate, inhalation solution administered through DME, unit dose form, per milligram	Glycopyrrolate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7644	Ipratropium bromide, inhalation solution administered through DME, unit dose form, per milligram	Ipratropium bromide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram
J7648	Isoetharine HCl, inhalation solution administered through DME, concentrated form, per milligram	Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per milligram
J7649	Isoetharine HCl, inhalation solution administered through DME, unit dose form, per milligram	Isoetharine HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram
J7658	Isoproterenol HCl, inhalation solution administered through DME, concentrated form, per milligram	Isoproterenol HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per milligram
J7659	Isoproterenol HCl, inhalation solution administered through DME, unit dose form, per milligram	Isoproterenol HCl, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram
J7668	Metaproterenol sulfate, inhalation solution administered through DME, concentrated form, per 10 milligrams	Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 10 milligrams
J7669	Metaproterenol sulfate, inhalation solution administered through DME, unit dose form, per 10 milligrams	Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 milligrams
J7680	Terbutaline sulfate, inhalation solution administered through DME, concentrated form, per milligram	Terbutaline sulfate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7681	Terbutaline sulfate, inhalation solution administered through DME, unit dose form, per milligram	Terbutaline sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7682	Tobramycin, unit dose form, 300 mg, inhalation solution, administered through DME	Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, per 300 milligram
J7683	Triamcinolone, inhalation solution administered through DME, concentrated form, per milligram	Triamcinolone, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7684	Triamcinolone, inhalation solution administered through DME, unit dose form, per milligram	Triamcinolone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram

L0631	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, pendulous abdomen design, prefabricated, includes fitting and adjustment	Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment
L5848	Addition to endoskeletal, knee-shin system, hydraulic stance extension, dampening feature, with or without adjustability	Addition to endoskeletal knee-shin system, fluid stance extension, dampening feature, with or without adjustability
L5995	Addition to lower limb extremity prosthesis, heavy duty feature (for patient weight > 300 lbs)	Addition to lower extremity prosthesis, heavy duty feature, other than foot or knee, (for patient weight greater than 300 lbs)
L6805	Terminal device, modifier wrist flexion unit	Addition to terminal device, modifier wrist unit
L6810	Terminal device, pincher tool, Otto Bock or equal	Additional to terminal device, precision pinch device
L6881	Automatic grasp feature, addition to upper limb prosthetic terminal device	Automatic grasp feature, addition to upper limb electric prosthetic terminal device
L6884	Replacement socket, above elbow disarticulation, molded to patient model, for use with or without external power	Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power
L7040	Prehensile actuator, Hosmer or equal, switch controlled	Prehensile actuator, switch controlled
L7045	Electronic hook, child, Michigan or equal, switch controlled	Electric hook, switch or myoelectric controlled, pediatric
Q4080	Iloprost, inhalation solution, administered through DME, 20 mcg	Iloprost, inhalation solution, administered through DME, up to 20 micrograms

Crosswalk for Discontinued Codes

Codes	Discontinued as of	Replaced with	Valid as of
A4348	12/31/2006	A4326	1/1/2007
A4359	12/31/2006	A5105	1/1/2007
A4462	12/31/2006	A4461 or A4463	1/1/2007
E0164	12/31/2006	E0163	1/1/2007
E0166	12/31/2006	E0165	1/1/2007
E0180	12/31/2006	E0181	1/1/2007
E0701	12/31/2006	A8000 or A8001 with changes	1/1/2007
E2320	12/31/2006	E2373	1/1/2007
K0090	12/31/2006	E2381, E2386 or E2390 with changes	1/1/2007
K0091	12/31/2006	E2382 with changes	1/1/2007
K0094	12/31/2006	E2384, E2387 or E2391 with changes	1/1/2007
K0095	12/31/2006	E2385 with changes	1/1/2007
L0100	12/31/2006	A8002 or A8003 with changes	1/1/2007
L0110	12/31/2006	A8000 or A8001 with changes	1/1/2007
L3914	12/31/2006	L3908	1/1/2007
L6700	12/31/2006	L6704	1/1/2007
L6705	12/31/2006	L6706	1/1/2007
L6710	12/31/2006	L6706	1/1/2007
L6715	12/31/2006	L6706	1/1/2007
L6720	12/31/2006	L6704	1/1/2007
L6725	12/31/2006	L6704	1/1/2007
L6730	12/31/2006	L6704	1/1/2007
L6735	12/31/2006	L6706	1/1/2007
L6740	12/31/2006	L6706	1/1/2007
L6745	12/31/2006	L6706	1/1/2007
L6750	12/31/2006	L6706	1/1/2007
L6755	12/31/2006	L6706	1/1/2007
L6765	12/31/2006	L6706	1/1/2007
L6770	12/31/2006	L6706	1/1/2007
L6775	12/31/2006	L6706	1/1/2007
L6780	12/31/2006	L6706	1/1/2007

L6790	12/31/2006	L6706	1/1/2007
L6795	12/31/2006	L6706	1/1/2007
L6800	12/31/2006	L6707	1/1/2007
L6806	12/31/2006	L6707	1/1/2007
L6807	12/31/2006	L6707	1/1/2007
L6808	12/31/2006	L6707	1/1/2007
L6809	12/31/2006	L6704	1/1/2007
L6825	12/31/2006	L6708	1/1/2007
L6830	12/31/2006	L6709	1/1/2007
L6835	12/31/2006	L6708	1/1/2007
L6840	12/31/2006	L6708	1/1/2007
L6845	12/31/2006	L6708	1/1/2007
L6850	12/31/2006	L6708	1/1/2007
L6855	12/31/2006	L6708	1/1/2007
L6860	12/31/2006	L6708	1/1/2007
L6865	12/31/2006	L6703	1/1/2007
L6867	12/31/2006	L6708	1/1/2007
L6868	12/31/2006	L6703	1/1/2007
L6870	12/31/2006	L6703	1/1/2007
L6872	12/31/2006	L6708	1/1/2007
L6873	12/31/2006	L6708	1/1/2007
L6875	12/31/2006	L6709	1/1/2007
L6880	12/31/2006	L6708	1/1/2007
L7010	12/31/2006	L7007	1/1/2007
L7015	12/31/2006	L7008	1/1/2007
L7020	12/31/2006	L7009	1/1/2007
L7025	12/31/2006	L7007	1/1/2007
L7030	12/31/2006	L7008	1/1/2007
L7035	12/31/2006	L7009	1/1/2007

Nabilone (Cesamet®) Coverage as Oral Antiemetic

Nabilone was approved for use in the treatment of nausea and vomiting associated with cancer chemotherapy in patients who do not respond to conventional antiemetic treatments. It is eligible for reimbursement under the **Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)** LCD for claims with dates of service on or after May 8, 2005.

For dates of service May 8, 2005, through December 31, 2006, use code:

Q0181 – Unspecified oral dosage form, FDA-approved prescription antiemetic, for use as a complete therapeutic substitute for an IV antiemetic at the time of chemotherapy treatment, not to exceed a 48-hour dosage regimen

For dates of service on or after January 1, 2007, use code:

J8650 – Nabilone, oral, 1mg

Suppliers are reminded of the following statutory coverage criteria for oral antiemetics used as a full substitute for intravenous antiemetics described in the LCD Policy Article.

From the Policy Article, an oral antiemetic drug is covered if all of the following criteria (1-4) are met:

1. The drug has been approved by the Food and Drug Administration (FDA) for use as an antiemetic, and
2. The drug has been ordered by the treating physician as part of a cancer chemotherapy regimen, and
3. The drug is used as a full therapeutic replacement for an intravenous antiemetic drug that would otherwise have been administered at the time of the chemotherapy treatment, and
4. The initial dose of the oral antiemetic drug is administered within 2 hours before or 48 hours after the administration of the chemotherapy drug.

If all of the criteria are not met, the oral antiemetic drug will be denied as non-covered.

Criterion 3 is not met when the chemotherapy drug is an oral drug or when the chemotherapy drug is administered intravenously in the home setting because the type and dosage of chemotherapy drugs administered in these situations do not require intravenous antiemetic drugs.

If all of the above criteria (1-4) are met, the quantity of oral antiemetic drugs covered for each episode of chemotherapy cannot exceed the initial loading dose plus 48 hours of therapy. Quantities of drugs in excess of these amounts are non-covered.

Refer to the LCD and associated Policy Article on **Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)** for additional information.

Nebulizers – Code Changes and Revised Billing Instructions

Many changes to the codes for nebulizer drugs are included in the 2007 HCPCS update. The major change is to distinguish FDA-approved, non-compounded final products from compounded inhalation solutions. A compounded inhalation solution is one in which the product that is delivered to the patient is not an FDA-approved preparation. It is produced by a pharmacy that is not an FDA-approved manufacturer and involves the mixing, combining, or altering of ingredients. Even if one of the ingredients is an FDA-approved product (e.g., an injectable form of the drug), if that is mixed by the pharmacy with other ingredients, the solution that is dispensed to the patient is considered to be a compounded product.

The following list provides the narrative descriptions of all nebulizer drugs codes that are effective for dates of service on or after January 1, 2007 – including those few codes for which there were no changes.

CODING CONT'D

HCPCS Code	Description
J2545	Pentamidine isethionate, inhalation solution, per 300 mg, administered through DME
J7607	Levalbuterol, inhalation solution, compounded product, administered through DME, concentrated form, 0.5 mg
J7608	Acetylcysteine, inhalation solution, administered through DME, unit dose form, per gram
J7609	Albuterol, inhalation solution, compounded product, administered through DME, unit dose form, 1 mg
J7610	Albuterol, inhalation solution, compounded product, administered through DME, concentrated form, 1 mg
J7611	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg
J7612	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg
J7613	Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 1 mg
J7614	Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, 0.5 mg
J7615	Levalbuterol, inhalation solution, compounded product, administered through DME, unit dose form, 0.5 mg
J7620	Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, non-compounded, administered through DME
J7622	Beclomethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7624	Betamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7626	Budesonide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, up to 0.5 mg
J7627	Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg
J7628	Bitolterol mesylate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7629	Bitolterol mesylate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7631	Cromolyn sodium, inhalation solution, administered through DME, unit dose form, per 10 milligrams
J7634	Budesonide, inhalation solution, compounded product, administered through DME, concentrated form, per 0.25 milligram
J7635	Atropine, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7636	Atropine, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7637	Dexamethasone, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7638	Dexamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7639	Dornase alpha, inhalation solution, administered through DME, unit dose form, per milligram
J7640	Formoterol, inhalation solution, compounded product, administered through DME, unit dose form, 12 micrograms
J7641	Flunisolide, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7642	Glycopyrrolate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7643	Glycopyrrolate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7644	Ipratropium bromide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram
J7645	Ipratropium bromide, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7647	Isoetharine HCl, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7650	Isoetharine HCl, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7657	Isoproterenol HCl, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7660	Isoproterenol HCl, inhalation solution, compounded product, administered through DME, unit dose form, per milligram

CODING CONT'D

J7667	Metaproterenol sulfate, inhalation solution, compounded product, administered through DME, concentrated form, per 10 milligrams
J7669	Metaproterenol sulfate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 10 milligrams
J7670	Metaproterenol sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per 10 milligrams
J7680	Terbutaline sulfate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7681	Terbutaline sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7682	Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, per 300 milligrams
J7683	Triamcinolone, inhalation solution, compounded product, administered through DME, concentrated form, per milligram
J7684	Triamcinolone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram
J7685	Tobramycin, inhalation solution, compounded product, administered through DME, unit dose form, per 300 milligrams
J7699	NOC drugs, inhalation solution, administered through DME
Q4080	Iloprost, inhalation solution, administered through DME, 20 micrograms

The following coding guidelines are effective for claims with dates of service on or after January 1, 2007.

There are no FDA-approved final products that are described by the following codes: J7633 (budesonide, concentrate), J7648 (isoetharine, concentrate), J7649 (isoetharine, unit dose), J7658 (isoproterenol, concentrate), J7659 (isoproterenol, unit dose), and J7668 (metaproterenol, concentrate). Therefore, these codes (or any combination of these codes and a KO, KP, or KQ modifier) are invalid for claim submission.

Codes J2545 (pentamidine), J7608 (acetylcysteine), J7631 (cromolyn), J7639 (dornase alpha), and Q4080 (iloprost) may only be used for inhalation solutions which are FDA-approved. If compounded versions of these drugs are provided, they must be billed using code J7699.

The only FDA-approved unit dose preparation containing more than one drug is the combination of albuterol and ipratropium (e.g., DuoNeb) and there is a unique code, J7620, for this combination. Therefore, if the following FDA-approved unit dose codes are billed with a KP or KQ modifier, they will be rejected as invalid for claim submission: J7608, J7613, J7614, J7631, J7639, J7644, J7649, J7659, J7669, and J7682. (Note: The KP and KQ modifiers are already invalid for use with the following unit dose codes – J2545, J7626 and Q4080.)

The following is a list of codes for **FDA-approved** concentrate and unit dose inhalation solutions that will remain valid: J2545, J7608KO, J7611, J7612, J7613KO, J7614KO, J7620, J7626KO, J7631KO, J7639KO, J7644KO, J7669KO, J7682KO and Q4080.

Codes for **compounded** unit dose inhalation solutions will continue to be billed using the KO, KP and KQ modifiers. For dates of service on or after 01/01/2007, when billing for compounded unit dose inhalation solutions containing more than one drug, the supplier may put the KP modifier on any one of the drugs and the KQ modifier on the other(s). The reason for this is that fee schedule allowances will not be established for compounded inhalation solutions and therefore the supplier cannot know which use of the modifiers would result in the lowest allowance.

Code J7699 (not otherwise classified inhalation solution) will continue to be used when billing for drugs in inhalation solutions that do not have a specific HCPCS code. For these claims, the narrative field of the electronic claim must contain the name of the drug, a statement of whether it is an FDA-approved final product or a compounded solution, the manufacturer (if it is an FDA-approved product), the number of milligrams (mg) of drug in each vial, and the number of vials dispensed. The units of service should be the total number of mg of drug dispensed.

These changes will be included in a future revision of the Nebulizers LCD and Policy Article.

Questions concerning the coding of specific products should be directed to the SADMERC.

COVERAGE

Jurisdiction D LCD and PA Revisions Summary for December 2006

The following is a summary of the principal changes to the Local Coverage Determinations and Policy Articles that have been revised and were posted to the Jurisdiction D DME PSC Website at www.edssafeguardservices.eds-gov.com/providers/dme/default.asp in December 2006. Please review the entire LCD and related Policy Article for complete information. All LCDs and PAs are effective January 1, 2007.

Enteral Nutrition

LCD - Revision Effective Date: 01/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Removed CMN references
- Added DIF instructions

DOCUMENTATION REQUIREMENTS:

- Removed CMN requirements
- Added DIF instructions

COVERAGE CONT'D

External Infusion Pumps

LCD - Revision Effective Date: 01/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Added clarification about subcutaneous immune globulin
- Revised liposomal amphotericin B LCD statement

HCPCS CODES:

- Added: J1562
- Revised: A4306

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

- Replaced HCPCS code J7799 with HCPCS code J1562

DOCUMENTATION REQUIREMENTS:

- Removed CMN requirements
- Added DIF instructions
- Added KX modifier for liposomal amphotericin B
- Removed DMERC references

Policy Article - Revision Effective Date: 01/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Revised DMERC references to reflect change to DME MAC

CODING GUIDELINES:

- Revised DMERC references to reflect change to DME MAC
- Corrected subcutaneous immune globulin code to E0780 in paragraph that addresses K0552
- Removed coding guideline for disposable drug delivery systems with flow rates of 5-50 ml/hour

Glucose Monitors

LCD - Revision Effective Date: 01/01/2007

Clarified Revision History entry for 07/01/2005

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Clarification of claims processing contractor – DME MAC
- Clarified visual acuity criteria for E2100 and E2101
- Removal of the paragraph addressing the renewal order from the treating physician

Policy Article - Revision Effective Date: 01/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Added non-coverage statement regarding continuous glucose monitors

Hospital Beds and Accessories

LCD - Revision Effective Date: 01/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Clarified noncoverage of fully electric beds with LCA statement

HCPCS CODES AND MODIFIERS:

- Added KX modifier

DOCUMENTATION REQUIREMENTS:

- Removed requirement to submit a CMN
- Added KX modifier use

Policy Article - Revision Effective Date: 01/01/2007

CODING GUIDELINES:

- Removed examples from E1399 guidelines

Immunosuppressive Drugs

LCD - Revision Effective Date: 01/01/2007

DOCUMENTATION REQUIREMENTS:

- Removed language discussing details of the DIF instructions

Policy Article - Revision Effective Date: 01/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Added Medicare coverage benefit language for pancreas transplants alone (PA)

Oral Anticancer Drugs

Policy Article – Revision Effective Date: 01/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Specified that the quantity of drugs dispensed should be limited to a one month supply

ICD-9 Codes That Are Covered:

- Expanded range of payable codes
- Added: V58.0 – V58.12

Osteogenesis Stimulators

LCD - Revision Effective Date: 01/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Eliminated the requirement to report ICD-9 code 733.82 for nonunions

HCPCS CODES AND MODIFIERS:

- Removed HCPCS Modifier KX
- Added: A4559
- Deleted: E1399

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY:

- Eliminated 733.82 from the code set for E0747 and E0760

DOCUMENTATION REQUIREMENTS:

COVERAGE CONT'D

- CMN form revised – added new DME MAC form number and new requirement of completed CMN for ultrasonic osteogenesis stimulators
- Removed statement regarding using KX HCPCS Modifier when submitting claims for ultrasonic osteogenesis stimulator(s)

Oxygen and Oxygen Equipment

LCD - Revision Effective Date: 01/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

- Added statement about coverage of oxygen used in approved clinical trials
- Added requirements for supplier involvement with home oximetry studies

HCPCS CODES AND MODIFIERS:

- Added QR modifier
- Added: K0738

DOCUMENTATION REQUIREMENTS:

- Noted the form number of the new CMN
- Added use of QR modifier for patients in an approved clinical trial
- Added clarification about the need for a CMN or order when switching to K0738

Policy Article - Revision Effective Date 01/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Added statement about noncoverage of respiratory therapist services

CODING GUIDELINES:

- Revised billing instructions for oxygen contents
- Revised definition of a portable oxygen concentrator
- Added guidelines for code K0738

Parenteral Nutrition

LCD - Revision Effective Date: 01/01/2007

DOCUMENTATION REQUIREMENTS:

- Removed CMN requirements
- Added DIF instructions

Patient Lifts

Policy Article – Effective Date: 01/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

- Moved bundling table to Coding Guidelines Section

CODING GUIDELINES:

- Included heavy duty and bariatric lifts in the existing lift codes
- Added E0625 definition

Pneumatic Compression Devices

LCD - Revision Effective Date: 01/01/2007

DOCUMENTATION REQUIREMENTS:

- Added revised CMN form changes and information

LCD ATTACHMENTS:

- Removed previous CMN
- Added new CMN

Pressure Reducing Support Surfaces - Group 3

LCD - Revision Effective Date: 01/01/2007

HCPCS CODES AND MODIFIERS:

- Added KX modifier

DOCUMENTATION REQUIREMENTS:

- Removed requirement to submit a CMN
- Revised the monthly physician certification requirement
- Added the use of the KX modifier

Seat Lift Mechanisms

LCD - Revision Effective Date: 01/01/2007

DOCUMENTATION REQUIREMENTS:

- CMN form revised - added new DME MAC form number

LCD ATTACHMENTS:

- Removed previous CMN
- Added new CMN

Transcutaneous Electrical Nerve Stimulators (TENS)

LCD - Revision Effective Date: 01/01/2007

DOCUMENTATION REQUIREMENTS:

- Removed DMERC references
- Removed reference to HCFA CMN Form; changed to read CMS Form
- Provided new DME MAC CMN Form number
- Revised instructions for use of CMN

LCD ATTACHMENTS:

- Attached newly revised CMN Form for TENS

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

Infrared Therapy Devices

MLN Matters Number: MM5421
Related Change Request (CR) #: 5421
Related CR Release Date: December 15, 2006
Related CR Transmittal #: R1127CP and R62NCD
Effective Date: October 24, 2006
Implementation Date: January 16, 2007

Provider Types Affected

Physicians, suppliers, and providers who submit claims to Medicare carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), DME Medicare administrative contractors (DME/MACs), fiscal intermediaries (FIs), and/or regional home health intermediaries (RHHIs), for the use of infrared therapy devices for treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 5421. Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services (CMS) has made a National Coverage Determination (NCD) stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), **is non-covered for the treatment,** including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries.

Background

The use of infrared therapy devices has been proposed for a variety of disorders, including treatment of diabetic neuropathy, other peripheral neuropathy, skin ulcers and wounds, and similar related conditions, including symptoms such as pain arising from these conditions. A wide variety of devices are currently available. Previously there was no NCD concerning the use of infrared therapy devices, leaving the decision to cover or not cover up to local Medicare contractors.

The following requirements are in effect as of October 24, 2006:

- **Effective for services performed on or after October 24, 2006**, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) **are non-covered** as DME or PT/OT services when used for the treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.
- Claims will be denied with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9 codes:
- 250.60-250.63,
- 354.4, 354.5, 354.9,
- 355.1-355.4,
- 355.6-355.9
- 356.0, 356.2-356.4, 356.8-356.9,
- 357.0-357.7,
- 674.10, 674.12, 674.14, 674.20, 674.22, 674.24,
- 707.00-707.07, 707.09-707.15, 707.19,
- 870.0-879.9,
- 880.00-887.79,
- 890.0-897.7, or
- 998.31-998.32.
- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects Types of bills (TOBs) 12X, 13X, 22X, 23X, 34X, 74X, 75X and 85X.
- If you submit a claim for one of the non-covered services, your patient will receive the Medicare Summary Notice (MSN) message stating "This service was not covered by Medicare at the time you received it". The Spanish translation is: "Este servicio no estaba cubierto por Medicare cuando usted lo recibió."
- If you submit a claim for one of the non-covered services you will receive a remittance advice notice that reads: Claim Adjustment Reason Code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."
- Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospital outpatient departments should note that **you are liable** if the service is performed, unless the beneficiary signs an Advanced Beneficiary Notice (ABN).
- DME suppliers and HHA be aware that **you are liable** for the devices when they are supplied, unless the beneficiary signs an ABN.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5421) issued to your Medicare A/B MAC, FI, DME MAC, RHHI, or carrier. There are actually two transmittals associated with CR5421. The first is the national coverage determination transmittal, located at http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf on the CMS website. In addition, there is a transmittal related to the *Medicare Claims Processing Manual* revision, which is at http://www.cms.hhs.gov/Transmittals/downloads/R1127CP.pdf on the CMS site.

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