Jurisdiction D News from Noridian Administrative Services, LLC.

# Happenings

June 2007
Issue No. 5

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



## In This Issue…



## FYI



## Educational



## COMPETITIVE BIDDING



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## CERT



## APPEALS



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## CODING



## COVERAGE



## REIMBURSEMENT



## DRUG/BIOLOGICALS

# Alphabetical Listing...

# Jurisdiction D DME MAC Supplier Contacts and Resources

| Phone Numbers | | |
|---|---|---|
| Interactive Voice Response System | 1-877-320-0390 | 24 hours a day, 7 days a week for all functions except Claim Status and Beneficiary Eligibility, which are available 6 am to 8 pm CT Monday – Friday |
| Supplier Contact Center | 1-866-243-7272 | 8 am to 5:30 pm CT Monday – Friday |
| Beneficiary Customer Service | 1-800-633-4227 | 24 hours a day/7 days a week |
| Telephone Reopenings | 1-888-826-5708 | 10 am – 4 pm CT |
| 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**<br>Noridian Administrative Services<br>PO Box 6727<br>Fargo ND 58108-6727 | **Benefit Protection**<br>Noridian Administrative Services<br>Benefit Protection – DME<br>PO Box 6736<br>Fargo ND 58108-6736 |
| **Electronic Funds Transfer Forms**<br>Noridian Administrative Services<br>PO Box 6728<br>Fargo ND 58108-6728 | **Electronic Data Interchange**<br>CIGNA Government Services<br>Attn: DMERC EDI<br>PO Box 690<br>Nashville TN 37202<br>www.cignamedicare.com/edi/dmerc/index.html |
| **Administrative Simplification Compliance Act Exception Requests**<br>Noridian Administrative Services<br>PO Box 6737<br>Fargo ND 58108-6737<br>Fax: 888-523-8449 | **Program Safeguard Contractor**<br>Medical Review<br>IntegriGuard, LLC<br>2121 N 117 Avenue Suite 200<br>Omaha NE 68164<br>Fax: 402-498-2306<br>www.edssafeguardservices.eds-gov.com/providers/dme/default.asp |

| Reconsiderations and Administrative Law Judge Requests | |
|---|---|
| **Qualified Independent Contractor** | |
| **Mailing Address**<br>RiverTrust Solutions, Inc.<br>PO Box 180208<br>Chattanooga TN 37401-7208 | **Courier Address**<br>RiverTrust Solutions, Inc.<br>801 Pine Street<br>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: CIGNA Government Services | 1-866-270-4909 | www.cignamedicare.com |

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

# Holiday Schedule

**Holiday Schedule for 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

Noridian Administrative Services offices will be closed on the days listed above except for the federal holidays noted with a (*). These federal holidays are days that the NAS offices will be open but the Contact Center will be closed and will not be receiving incoming calls. On those days, Contact Center staff will be attending internal training, but you may receive calls from our staff about claims processing or education.

# Sources for "Jurisdiction D Happenings" Articles

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

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

# Summary of Supplier Manual Updates

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

| Chapter | Subheading | Supplier Manual Update | Change Date |
|---|---|---|---|
| Chapter 15 | DME MACs | Updated Jurisdiction C contact information and states served | 6/5/07 |
| Chapter 16 | Level II HCPCS Codes | Deleted J codes effective July 1, 2007 | 6/5/07 |
| Chapter 16 | Level II HCPCS Codes | Added Q codes effective July 1, 2007 | 6/5/07 |
| Chapter 4 | CMNs and DIFs | Revised to show effective dates refer to processing dates | 5/16/07 |
| Chapter 4 | CMNs and DIFs | Added CR 5771 and revised transition dates | 5/10/07 |
| Chapter 4 | Evidence of Medical Necessity for Oxygen CMN | Added PSC website link | 5/10/07 |
| Chapter 4 | Recertification for Long Term Therapy | Removed "will be requested by our office" | 5/10/07 |

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

# Website Survey

NAS is in the process of making improvements to our website. Please complete the ForeSee Results survey to let us know the areas of the website you appreciate and enjoy using. NAS will use these surveys to improve and enhance the content and functionality of our website.

While navigating the website, users will be randomly selected to complete the survey. NAS appreciates your time to provide feedback on the website, which is our main method of communication to suppliers.

# Providing Medical Records To DME Suppliers, Not a HIPAA Violation

As most suppliers are aware, many physicians' medical records departments are reluctant and/or refusing to provide medical records requested by suppliers. This article has been generated to provide suppliers with information that can be shared with the physician community.

Section 1842 (p)(4) of the Social Security Act states: "In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to

the entity at the time that the item or service is ordered by the physician or practitioner."

Despite this statute, many physicians are reluctant to release medical records because of Health Insurance Portability and Accountability Act (HIPAA) concerns. While the HIPAA Privacy Rule requires adoption of practices to safeguard protected health information (PHI), there are exceptions for disclosure of PHI for the purposes of treatment, payment or healthcare operations. Providing medical records to medical equipment suppliers falls under the disclosure of PHI for the purposes of payment. The Medicare statute requires that payment only be made for items or services that are "reasonable and necessary," and payment cannot be made or confirmed without these records. **Therefore, suppliers can assure physicians that it is not a violation of HIPAA to provide a DME supplier with medical records that support the medical necessity of prescribed equipment.** Furthermore, these records may be provided without having a Business Associate Agreement with the supplier requesting the records or a release of information from the beneficiary.

**Providing requested documentation does not violate the minimum necessary provision of the HIPAA Privacy Rule and does not require beneficiary authorization.** When Medicare beneficiaries enroll in the program, they are informed of Medicare's use of their PHI to carry out health care operations. After enrollment, Medicare does not need any further releases from the beneficiary.

Failure to provide this information could lead to denial of suppliers' claims under Section 1833(e) of the Social Security Act which precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due."

If you have additional questions, please refer to the final HIPAA Privacy Regulation on the Office of Civil Rights Web site at www.hhs.gov/ocr/hipaa/finalreg.html. Also, see the CMS Web site at www.cms.hhs.gov/Transmittals/downloads/AB03034.pdf for the CMS guidance to contractors, including a Question and Answer document with commonly asked questions.

## Third Party Additional Documentation Requests

Medicare contractors, including IntegriGuard, LLC, may request documentation for the purposes of determining if a claim met or meets the Medicare coverage criteria for payment. Suppliers are notified of these requests through additional documentation request (ADR) letters.

According to the Centers for Medicare & Medicaid Services (CMS), Publication 100-8, Medicare Program Integrity Manual (PIM), Chapter 3-Verifying Potential Errors and Taking Corrective Actions, Section 3.4.1.1 – Documentation Specifications for Areas Selected for Prepayment and Postpayment Medical Review (MR):

> "The contractor may use any information they deem necessary to make a prepayment or postpayment claim review determination. This includes reviewing any documentation submitted with the claim as well as soliciting documentation from the provider or other entity when the contractor deems it necessary and in accordance with PIM, Chapter 3, Section 3.4.1.2."

In addition, PIM Chapter 3 - Verifying Potential Errors and Taking Corrective Actions, Section 3.4.1.2 – Additional Documentation Requests (ADR) During Prepayment and Postpayment MR states:

> "When contractors cannot make a coverage or coding determination based upon the information on the claim and its attachments, the contractors may solicit additional documentation from the provider or supplier by issuing an additional documentation request (ADR). Contractors shall request records related to the claim(s) being reviewed. Contractors may collect documentation related to the patient's condition before and after a service in order to get a more complete picture of the patient's clinical condition. The contractor shall not deny other claims related to the documentation of the patient's condition before and after the claim in question unless appropriate consideration is given to the actual additional claims and associated documentation."
>
> "Documentation provided for pre- or post-payment medical review shall support the medical necessity of the item(s) or service(s) provided. The treating physician, another clinician or provider, or supplier may supply this documentation. This documentation may take the form of clinical evaluations, physician evaluations, consultations, progress notes, physician letters, or other documents intended to record relevant information about a patient's clinical condition and treatment(s)."

Failure to provide this information could lead to denial of suppliers' claims under Section 1833(e) of the Social Security Act which precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due."

IntegriGuard, LLC, recognizes many physicians' offices are reluctant and/or refusing to provide medical records requested by suppliers; **consequently, suppliers' claims are being denied for lack of documentation to support medical necessity for the item(s) billed.** Upon receipt of ADR letters, suppliers are encouraged to notify IntegriGuard, LLC, if they experience any difficulty in obtaining medical records from physicians. Medicare does allow Medical Review contractors to request documentation from a third party, including physician's offices, once an ADR has been sent to the billing supplier - PIM, Chapter 3, Section 3.4.1.2.

## 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."

# Disclosure Desk Reference for Provider Contact Centers

**MLN Matters Number: MM5089 Revised**
**Related Change Request (CR) #: 5089**
**Related CR Release Date: July 21, 2006**
**Related CR Transmittal #: R16COM**
**Effective Date: October 1, 2006**
**Implementation Date: October 2, 2006**

**Note:** This article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

**Provider Types Affected**

All physicians, providers, and suppliers billing Medicare.

**Provider Action Needed**

When you call or write a Medicare fee-for-service provider contact center (PCC) to request beneficiary protected health information, the PCC staff, in order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, will authenticate your identity prior to disclosure.

CR5089 revises *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 3, Section 30, and Chapter 6, Section 80, to update the guidance to PCCs for authenticating providers who call or write to request beneficiary protected health information, and to clarify the information they may disclose after authentication.

Be prepared to supply the required authentication information when contacting a PCC to request protected health information.

**Background**

In order to protect the privacy of Medicare beneficiaries and to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare PCCs must first authenticate the identity of providers/staff that call or write to request beneficiary protected health information before disclosing it to the requestor.

CR5089, from which this article is taken, completely revises Section 30 in Chapter 3 and Section 80 in Chapter 6 of the *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100-9). It updates the PCC Disclosure Desk Reference, the main purpose of which is to protect the privacy of Medicare beneficiaries by ensuring that protected health information is disclosed to providers only when appropriate, to include:

- Guidance for authenticating providers who call or write to request beneficiary protected health information; and
- Clarification of the information that may be disclosed after authentication of writers and callers.

Please note that while new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements.

Below is the authentication guidance that the PCCs will be using:

**Telephone Inquiries**

**Provider Authentication**

**CSR Telephone Inquiries**-Through May 22, 2007, Customer Service Representatives (CSR) will authenticate providers using provider number and provider name.

**Interactive Voice Response (IVR) Telephone Inquiries**-Through May 22, 2007, IVRs will authenticate providers using only the provider number.

**Note:** See "Final Note" below to learn more about provider authentication after May 22, 2007.

**Written Inquiries**

**Provider Authentication**

Through May 22, 2007, for written inquiries, PCCs will authenticate providers using provider number and provider name.

**Note:** See "Final Note" below to learn more about provider authentication after May 22, 2007.

At this point, there are some specific details about provider authentication in written inquiries of which you should be aware.

There is one exception for the requirement to authenticate a written inquiry. An inquiry received on the provider's official letterhead (including e-mails with an attachment on letterhead) will meet provider authentication requirements (no provider identification number required) if the provider's name and address are included in the letterhead and clearly establish the provider's identity.

Further, if multiple addresses are on the letterhead, authentication is considered met as long as one of the addresses matches the address that Medicare has on record for that provider. Thus, make sure that your written inquiries contain all provider practice locations or use the letterhead that has the address that Medicare has on record for you.

Also, please note that requests submitted via fax on provider letterhead will be considered to be written inquiries and are subject to the same authentication requirements as those received in regular mail. However, for such fax (and also for e-mail) submissions, even if all authentication elements are present, the PCC will not fax or e-mail their responses back to you.

Rather, they will send you the requested information by regular mail, or respond to these requests by telephone. In either of these response methods, or if they elect to send you an automated e-mail reply (containing no beneficiary-specific information), they will remind you that such information cannot be disclosed electronically via email or fax and that, in the future, you should send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

And lastly, inquiries received without letterhead, including hardcopy, fax, e-mail, pre-formatted inquiry forms, or inquiries written on Remittance Advice (RAs) or Medicare

## FYI CONT'D

Summary Notices (MSNs), will be authenticated the same as written inquiries,(explained above) using provider name and the provider number.

**Insufficient or Inaccurate Requests**

You should also understand that for any protected health information request in which the PCC determines that the authentication elements are insufficient or inaccurate, you will have to provide complete and accurate input before the information will be released to you.

Such requests that are submitted in written form and those on pre-formatted inquiry forms, will be returned in their entirety by regular mail, with a note stating that the requested information will be supplied upon submission of all authentication elements, and identifying which elements are missing or do not match the Medicare record.

Alternatively, if you sent the request by e-mail (containing no protected health information), the PCC may return it by e-mail, or may elect to respond by telephone to obtain the rest of the authentication elements.

**Beneficiary Authentication**

Regardless of the type of telephone inquiry (CSR or IVR) or written inquiry, PCCs will authenticate four beneficiary data elements before disclosing any beneficiary information:

1. Last name;
2. First name or initial;
3. Health Insurance Claim Number; and
4. Either date of birth (eligibility, next eligible date, Certificate of Medical Necessity (CMN)/Durable Medical Equipment Medicare Administrative Contractor Information Form (DIF) [pre-claim]) **or** date of service (claim status, CMN/DIF [post-claim]).

Please refer to the disclosure charts attached to CR5089 for specific guidance related to these data elements as well as details on the beneficiary information that will be made available in response to authenticated inquiries. CR5089 is available at http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf on the CMS web site.

**Special Instances**

Below are three special instances that you should know about.

**Overlapping Claims**

Overlapping claims (multiple claims with the same or similar dates of service or billing period) occur when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

Sometimes this happens when the provider is seeking to avoid have a claim be rejected, for example:

- When some End State Renal Disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated, thus allowing the facility to code the claim appropriately and bill around the inpatient hospital stay/stays; or
- Skilled nursing facility and inpatient hospital stays.

These situations fall into the category of disclosing information needed to bill Medicare properly, and information can be released as long as all authentication elements are met.

**Pending Claims**

A pending claim is one that is being processed, or has been processed and is pending payment. CSRs can provide information about pending claims, including Internal Control Number (ICN), pay date/amount or denial, as long as all authentication requirements are met.

Providers should note, however, that until payment is actually made or a remittance advice is issued, the information provided could change.

**Deceased Beneficiaries**

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, PCCs will comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

**Final note:** More information will be provided in a future MLN Matters article about authentication on and after May 23, 2007, the implementation date for the National Provider Identifier or NPI

**Additional Information**

You can find more information about Provider Contact Center guidelines concerning authentication by going to http://www.cms.hhs.gov/Transmittals/downloads/R16COM.pdf on the CMS web site.

Attached to that CR, you will find the updated *Medicare Contractor Beneficiary and Provider Communications Manual* (Publication 100.09), Chapter 3 (Provider Inquiries), Section 30 (Disclosure of Information); and Chapter 6 (Provider Customer Service Program), Section 80 (Disclosure of Information).

## EDUCATIONAL

# CMS-1500 Claim Form Tutorial Now Available on NAS Web Site

Noridian Administrative Services (NAS) has placed a tutorial for the revised *CMS-1500 Paper Claim Form (08/05)* on the NAS website. The tutorial, in combination with the text instructions, provides an item-by-item guide for Medicare paper claim submitters to follow while entering data on the paper claim form. The tutorial is conveniently located at www.noridianmedicare.com/dme/ under the Claims tab.

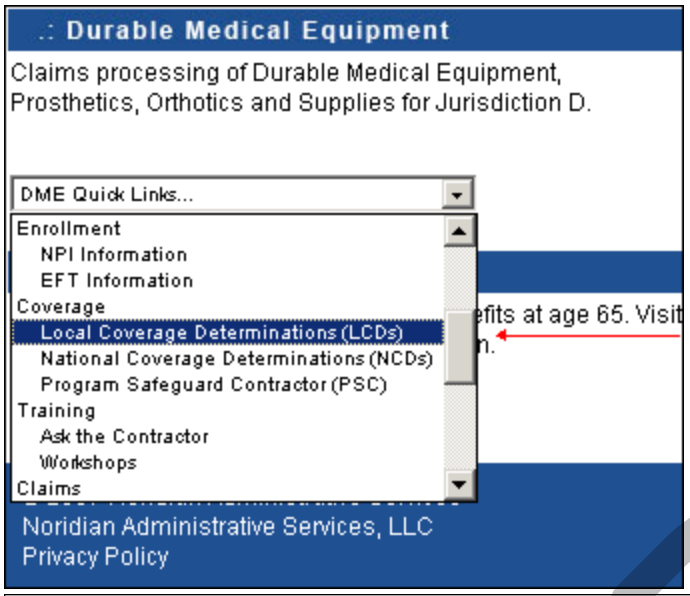
Providers may print the instructions in their entirety, hold a cursor over an item on the 1500 form tutorial to view the text for that item, or click on an item to be transferred to the text instructions concerning that item.

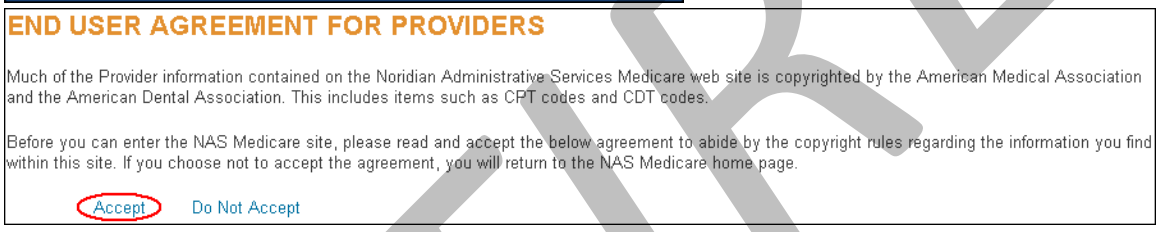
To view the Centers for Medicare & Medicaid Services (CMS) instructions for the 1500 Claim Form versions 12/90 and 08/05 refer to the Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 26 at: www.cms.hhs.gov/manuals/downloads/clm104c26.pdf.

# Accessing Local Coverage Determinations-Current and Retired

NAS has improved the navigation to Local Coverage Determinations from our website.

From the NAS homepage, www.noridianmedicare.com, select "Local Coverage Determinations" under Coverage from the DME Quick Links drop-down menu and "Accept" the End User Agreement.




On the LCD web page, select either "CMS Medicare Coverage Database-Current LCDs" or "CMS Medicare Coverage Database-Retired LCDs" from the Helpful Links area.


This brings the user directly to the list of LCDs on the CMS website.

List of LMRPs/LCDs

**Please note: If you are printing this document and it is truncated on the right margin, please try printing landscape.**

The following results include only currently in effect documents. To see additional policies for this contractor you may select from a link immediately below.

Display Retired Documents
Display Future Effective Documents
Display Draft Documents

**Total Active LMRPs/LCDs: 52**

Sort by: LMRP/LCD Title

| LMRP/LCD ID | LMRP/LCD Title | Effective Date | Revision Effective Date | End Date | Last Approval / Revision Date |
|---|---|---|---|---|---|
| L142 | Ankle-Foot/Knee-Ankle-Foot Orthosis | 10/01/1993 | 03/01/2006 | N/A | 03/01/2006 |

List of LMRPs/LCDs

**Please note: If you are printing this document and it is truncated on the right margin, please try printing landscape.**

The following results include only retired documents. To see additional policies for this contractor you may select from a link immediately below.

Display Active Documents
Display Future Effective Documents
Display Draft Documents

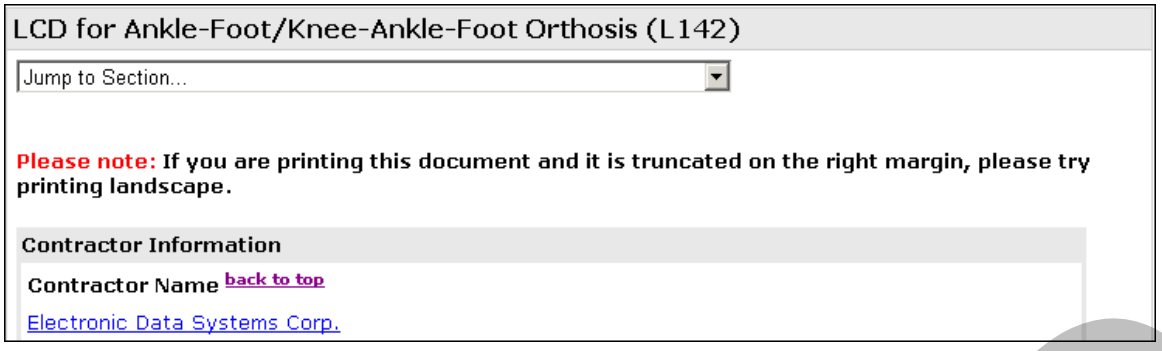
**Total Retired LMRPs/LCDs: 2**

Sort by: LMRP/LCD Title

| LMRP/LCD ID | LMRP/LCD Title | Effective Date | Revision Effective Date | End Date | Last Approval / Revision Date |
|---|---|---|---|---|---|
| L11455 (retired) | Motorized/Power Wheelchair Bases | 10/01/1993 | 06/05/2006 | 11/14/2006 | 11/17/2006 |
| L11458 (retired) | Power Operated Vehicles | 10/01/1993 | 06/05/2006 | 11/14/2006 | 11/17/2006 |

Select a policy and accept the CMS terms and conditions.


The policy will then be displayed.


LCD for Ankle-Foot/Knee-Ankle-Foot Orthosis (L142)

Jump to Section...

**Please note:** If you are printing this document and it is truncated on the right margin, please try printing landscape.

**Contractor Information**

**Contractor Name** back to top

Electronic Data Systems Corp.

The NAS LCD page offers links to several other areas, including: PSC LCD directory, PSC email list subscription page, CMS Medicare Coverage Database for current and retired policy articles and a link to add the PSC LCD directory to your Favorites. A table of all policies and policy articles, including the ID number, is also located on the LCD page. The table links directly to the list of current LCDs and articles on the PSC website.

## New and Improved NAS Medicare E-mail List Format and Function

Noridian Administrative Services (NAS) is announcing a "new and improved" version of the NAS Medicare Part A, Part B and DME E-Mail Lists. Beginning May 22, 2007, current e-mail list recipients will notice major improvements in the look and functionality of information and personal control of the e-mails delivered to their desktops by NAS.

**New E-mail List Interface Features Include:**

- **Twice Weekly Distributions:**

Each list will now be delivered to your e-mail inbox twice a week on Tuesday and Friday morning to keep you abreast of all the new informational releases. This will reduce the overall number of e-mails that you receive.

- **Personal Control Features of Your User Interface:**
  - Subscribe and unsubscribe
  - Suspend receiving e-mails during times away from your job
  - Subscribe to multiple lists for NAS' different lines of business (i.e., Part A, Part B or DME) through one easy interface
  - Redirect e-mails to another address for a period of time or even permanently change your e-mail address
  - Larger selection of areas of interest and medical specialties
  - Ability to change your areas of interest any time your personal situation changes
  - Update or change passwords or any element of your personal profile
- **Customized Delivery of Your Personally Structured E-mail:**
  - Your selection of one or more "areas of interest" (available under the "Edit Profile" link in your line of business) will cause related information to appear at the beginning of your personally designed e-mail in the first section subtitled "**Subscribed Interests**." For example, if your profile shows that you are primarily interested in the topic of "oxygen," all articles containing oxygen information will appear at the top of your personal e-mail information under the Subscribed Interests subtitle. You will not have to look through all the information releases to find those of special interest to you.
  - The second section of your personal e-mail will contain all "**General Announcements**." These are announcements of general or multi-specialty interest, not confined to any one narrow area of interest or specialty. You will be able to quickly examine these releases to see if any are in need of your attention. These releases will have a brief descriptive paragraph accompanying the title to help you decide if this is something you need to know.
  - The third section of the e-mail is devoted to "**Other Topics**." This is information of interest to designated specialties other than your areas of special interest. These will appear with a title only and can be accessed by selecting the link following the title.
  - The final section will be utilized when important issues need to be called to your attention.
  - The right column of the new interface will provide you with direct access to the list of workshops and important training opportunities for your business.

**Current Subscribers Must Establish a Password to Edit Your Profile:**

As a current e-mail list subscriber, your existing information will be automatically transferred into the new delivery system. Once

you receive your first e-mail, you will be able to change and manage the features of your beginning profile simply by selecting the link "Edit Preferences / Unsubscribe" under the subtitle "**Manage Your Subscription**" in the lower right hand corner of the e-mail.

**Follow these easy steps to establish a password for your personal e-mail profile:**

1. Select "Edit Preferences / Unsubscribe."
2. From the LOGIN FOR NAS MEDICARE E-MAIL LISTS screen select the link "Request your password."
3. Enter your e-mail address in the box provided and select the "Mail My Password" box.
4. A password will be mailed to the e-mail address if you are already a member with the e-mail address you entered in the box.
5. Return to the LOGIN page by selecting Edit Preferences / Unsubscribe on the new e-mail format and enter your e-mail address and the password e-mailed to you. You are able to subscribe to new lists or edit your information by selecting the "Edit Profile" link next to the "List Name." You may now also change your password, e-mail list, name etc. by selecting the "My Profile" link.

## Help Document for Bi-Weekly NAS E-mail Listing

A guide to assist suppliers in customizing their new bi-weekly e-mail listing is available at www.noridianmedicare.com/p-docs/Email_Signup_Instructions.pdf.

This guide includes information on:

- Registering a new subscriber
- Subscribing to a list
- Changing your personal profile
- Requesting a password

Get information fast! Signup for the NAS Medicare E-mail lists to receive the latest Medicare information.

## Web Tour Video

NAS has posted a web tour video to assist with navigating our website. It is found on the DME homepage, www.noridianmedicare.com/dme, in the Contact section.

In order to view the tour, your computer must have Flash installed. If you need to download Flash, select "Help with File Formats and Plug-ins" located at the bottom of the DME homepage. NAS has provided a link for installation and support.

To view the tour, select "Web Tour Video" and click on the Noridian graphic. The tour provides a brief overview of the headings, navigation tools and updates area.

Watch the What's New section for announcements of web tour workshops in the months to come.

## Q & As Resulting from March 2007 CMS-1500 Claim Form Workshops

The following questions and answers are from the March 20, 2007, CMS-1500 Claim Form Changes web-based workshops. In some cases, the original answers given during the workshop may have been expanded to provide further detail. These were current answers as of this event. Please check our website for updates.

**Q1. Are assisted living centers, group homes, custodial care facilities and intermediate care facilities required to obtain NPI numbers? These have typically been facilities where clients live.**

A1. Under the NPI Final Rule, a healthcare provider who is a covered entity under HIPAA is required to obtain an NPI and to use it to identify itself as a healthcare provider in HIPAA transactions. A healthcare provider is a covered entity if it transmits any health information in electronic form. Healthcare providers who are not covered entities may elect to apply for NPIs but are not required to do so.

**Q2. Where is the best place to purchase the revised CMS-1500 claim forms?**

A2. The revised CMS-1500 claim forms can be ordered from the U.S. Printing Office by calling 202-512-1800. They can also be purchased from printing companies in your area, office supply stores, or numerous vendors found on the Internet.

**Q3. Do I need to provide NSC/NPI information in item 32?**

A3. Currently, for DMEPOS claims, NAS is not looking for information in item 32.

**Q4. As a DMEPOS supplier, do I need to complete items 24I and 24J?**

A4. No. For DMEPOS suppliers, NAS currently looks for supplier information in items 33, 33a, and/or 33b only. However, if you submit your claim with invalid information in item 33, then NAS will look to items 24I and 24J for a supplier billing number (NSC/NPI) information.

**Q5. How do I report more than four modifiers?**

A5. You report your three most important modifiers first, beginning with any pricing modifiers, followed by either modifier 99 or modifier KB in item 24D. The additional modifiers are reported in item 19. If your claim has more than one line item, you will also need to note the line item number that the modifiers correspond with in item 19.

**Q6. Where can I locate the complete billing instructions for both versions of the CMS-1500 claim form?**

A6. NAS has the complete instructions for both versions of the CMS-1500 claim form in the Claims section of our web site at www.noridianmedicare.com/dme/.

**Q7. Please clarify the use of the qualifying codes 1C and 1G. Are these qualifiers mandatory?**

A7. The ID qualifiers 1C and 1G are mandatory when billing both the NSC number, the UPIN and the NPI during the transition period to the NPI compliance regulations. The 1C qualifier indicates the number billed represents a Medicare

billing number and the 1G qualifier indicates that the number billed represents a UPIN.

**Q8. Are items 24I and 24J required for a physician billing for orthotics?**

A8. As previously stated, NAS does not look to items 24I and 24J for DME suppliers unless there is invalid information in item 33. In this case, remember the physician is not billing orthotics as a single physician or as a physician as part of a medical group practice, but rather as a DME supplier.

**Q9. Do I need software that is compatible with the revised CMS-1500 claim form?**

A9. Yes, you may need new software that is compatible with the revised CMS-1500 claim so your printing lines up correctly in the appropriate boxes. The printing specifications for the revised CMS-1500 claim form can be found in the Internet Only Manual, Publication 100-04, Chapter 26, Section 30 at www.cms.hhs.gov/manuals/downloads/clm104c26.pdf.

**Q10. Can I continue using the older form through May 22, 2007?**

A10. Yes, CMS has extended the acceptance period of the 12-90 version of the CMS-1500 claim form until at least June 1, 2007. However, the use the NPI is still mandated for May 23, 2007.

**Q11. I have a patient in a SNF. Therefore, don't I need to report my supplier NPI, the physician's NPI and the SNF's NPI?**

A11. That is correct. The supplier's NPI is reported in item 33a, the physician's NPI is reported in item 17b, and the SNF's NPI can be reported in item 32a. In this case the SNF's NPI is reported because the DMEPOS is provided in that location rather than the patient's home.

**Q12. If I need to report four digit years in all date of birth fields, why doesn't the CMS-1500 claim form show YYYY in those items?**

A12. I do not have an answer to this question. The form was revised by the National Uniform Claim Committee (NUCC) and was approved by CMS in 2005 without the change in the DOB fields to CCYY (century year).

**Q13. My facility employs less than ten employees, and therefore, I feel that I qualify for an Administrative Simplification Compliance Act (ASCA) exemption. Do I need to prove this before I am exempt from billing electronically?**

A13. Yes, you must provide evidence that shows you qualify for an ASCA exemption. However, do not provide this evidence until or unless you receive a Request for Documentation (Exhibit C) letter from NAS. The Exhibit C letters are sent approximately four times a year after NAS has analyzed reports displaying the number of paper claims that all suppliers in Jurisdiction D submit each quarter. Selected suppliers who have submitted the highest numbers of paper claims will be reviewed. If you are one of the selected suppliers with a large number of paper claims being submitted under your supplier number, you will receive an Exhibit C letter. For additional information on ASCA, please see the Claims section of our web site at www.noridianmedicare.com/dme/.

**Q14. I have been attaching documentation when submitting dump codes but am getting denials stating nothing was attached or noted in item 19. How should I bill dump codes?**

A14. When billing a dump code, place a description in item 19. If additional space is required then include an attachment with the additional information. Remember, however, that for claims received on/after May 1, 2007, if there is a valid HCPCS code for the item you are submitting for payment, you must use it rather than a dump code. NAS will reject claims as unprocessable on/after May 1, 2007, if an appropriate HCPCS code is available but not reported.

**Q15. Does item 11 still require the word NONE if there is no insurance primary to Medicare?**

A15. The direction for item 11 has not changed for the revised CMS-1500 claim form. If there is no insurance primary to Medicare, you enter the word NONE in item 11 and proceed to item 12. If, however, the insured reports a terminating event with regard to insurance which has been primary to Medicare (i.e., insured retired), enter the word NONE and proceed to item 11b.

**Q16. Does Express Plus have the capability to pull up physicians by their NPIs?**

A16. If, when you are inputting the physician and his NPI information into your claim and save all this information correctly, then the next time you need this same physician's NPI, it will be available in a drop down box for you to select.

**Q17. Can I have a copy of this workshop?**

A17. The CMS-1500 claim form changes workshop presentation was sent to you along with the workshop confirmation documents. It has also been placed on the NAS web site in the Training section.

**Q18. Is my NSC number the same as my supplier number?**

A18. Yes, your NSC number is your supplier number.

**Q19. I have a patient who resides in an intermediate care facility. Do I use the facility NPI number in item 32a or 32b?**

A19. The facility NPI number would be reported in item 32a.

**Q20. I file paper claims for eyeglasses after cataract surgery. In the 12-90 version of the CMS-1500 claim form I placed my supplier name and address in item 32. Do I continue with that process in the revised 08-05 CMS-1500 claim form?**

A20. No, you do not place your supplier name and address in item 32. You only need to report that information in item 33.

**Q21. Do I currently only report my NPI on the revised CMS-1500 form?**

A21. Currently you can report only your NSC number or your NSC number and your NPI number on the revised 1500-CMS claim form. Once the crosswalk has been built between your NSC number and your NPI number and all health care plans have successfully transitioned to NPI, then you will report your NPI number only when submitting claims for payment.

**Q22. Will my claim reject if I report information in item 32b after May 23, 2007?**

A22. This answer is revised from the answer provided on March 20, 2007.

We were recently advised by CMS of a contingency plan for covered entities that have been making a good faith effort to become compliant with the NPI regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Based on the CMS contingency plan, Medicare will not reject claims with information reported in item 32b if the supplier is making a good faith effort to be compliant with the NPI regulations.

**Q23. When billing for eyeglasses I handwrite in item 16 either left or right to note which eye had the cataract surgery. Will I continue with this process on the revised 1500 claim form?**

A23. Item 16 of the claim form is used when a patient is employed and is unable to work in his current occupation. The dates that the patient is unable to work are placed in this item.

You report the date and eye involved in cataract surgery in item 19 of the CMS-1500 claim form. In addition, the RT and LT modifiers must be used with all HCPCS codes in the refractive lenses' policy except with codes V2020, V2025 and V2600. 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. The refractive lenses' policy can be accesses at www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp

**Q24. It is possible that a physician will have a personal NPI and an NPI for the clinic where he/she is employed? Do I use the physician's personal NPI in item 17b?**

A24. It is not possible for a physician to have two NPIs; the physician is given his own personal NPI when making an application. However, if the physician is employed by a group practice, the group practice would have its own NPI and the group practice could require these physicians to obtain NPIs and use the NPIs to identify them as the rendering providers in the claims that the group submits to Part B for payment.

In addition, DME suppliers require the physician's personal NPI for the claims they submit to the DME MAC for payment. The supplier reports the physician's personal NPI in item 17b, as it is replacing the physician's UPIN.

**Q25. When billing for services provided to a beneficiary in a long-term care facility, where do I report that facility's NPI?**

A25. The long-term care facility's NPI is reported in item 32a of the revised CMS-1500 claim form.

# FAQ from April DME MAC Reopening and Appeal Process Workshop

The following questions and answers are from the April 12, 2007, Reopenings and Appeals Process web-bases workshops. In some cases, the original answers given during the workshops may have been expanded to provide further detail. These were current answers as of this event. Please check our website for updates.

**Q1. What is a DIF?**

A1. The DME MAC Information Form (DIF) is a form required to help document the medical necessity and other coverage criteria for selected DMEPOS items. The current DME categories that require DIFs are External Infusion Pumps and Enteral and Parenteral Nutrition.

**Q2. What is the address for submitting written reopenings?**

A2. Medicare DME
Attn: Reopenings
PO Box 6727
Fargo ND 58108 – 6727

**Q3. Do I need to attach a new CMS-1500 claim form with a reopening?**

A3. A corrected claim form should not be submitted with a reopening or redetermination request. If a corrected claim is submitted, the claim may be processed as a new claim and the inquiry will be not handled as a reopening or redetermination. We strongly encourage suppliers to use the DME Reopening Interactive Form located on our web site under the Forms tab and to clearly indicate the change to the claim that is being requested.

**Q4. Did I see correctly that enteral claims may not be submitted as a telephone reopening?**

A4. Due to the complexity of enteral and parenteral claims, denials concerning these services may not be done as a telephone reopening. These requests should be submitted as written reopenings or redetermination requests. Include supporting documentation for the change or reason why you feel the claim is payable.

**Q5. How long does it take to receive payment after a telephone reopening is requested?**

A5. The length of time it takes to receive payment after a telephone reopening request has been made will vary depending on the complexity of the claim and the various processing steps that the claim must undergo. Per CMS guidelines, telephone reopenings are to be completed within 60 days of receipt. Many reopenings are completed in just a few days.

**Q6. Reopenings requesting a correction due to a clerical error are being forwarded to redeterminations then being denied as unfavorable. Why is this happening?**

A6. Simple clerical errors or omissions should not be handled as redeterminations. A request for examples has been initiated and corrective action will be taken.

**Q7. I am having trouble sending the CMN form electronically. Can I send an initial claim hardcopy?**

A7. The Administrative Simplification Compliance Act (ASCA) requires all initial claims to be submitted electronically. There are few exceptions to this provision. For a complete list of those situations, refer to MLN Matters Article 3440 at www.cms.hhs.gov/MLNMattersArticles/downloads/MM3440.pdf We encourage you to contact your software vendor for assistance in getting the CMN form submitted electronically.

**Q8. Can you submit a refund as a fax so that it could be recouped instead of a refund being done?**

A8. A fax is not required to request an offset, but you can make this request by calling the Supplier Contact Center. The call center representative will complete the appropriate paperwork asking for an immediate offset to be done.

**Q9. We're finding that documentation attached to paper claims is being separated from the claim and then we get the CO-16 denial (not enough information to adjudicate the claim). Is there something in place to have this addressed? In the mean time, can we do phone reopenings for these claims?**

A9. In the process of scanning claims and attachments, the clated. We would need examples to research further. It's also possible that the CO-16 has to do with not the right type of information being submitted on the claim. If the denial is an unprocessable denial, the claim and attachments will need to be resubmitted. If the denial was not unprocessable, we would suggest calling telephone reopenings to discuss the situation.

**Q10. If a claim denies incorrectly as a CO denial, can we request a reopening to get the correct PR denial?**

A10. Reopenings can only be requested to change the CO denial to a PR denial in instances where the claim has denied for not medically necessary and the GY modifier has been billed on the line item in accordance with the specific LCD. Issues regarding the GA modifier or an ABN must be requested as a redetermination.

**Q11. When we call the Supplier Contact Center to find out what the problem is with a claim, can we also initiate the reopening with the customer service representative?**

A11. Suppliers will be asked to initiate telephone reopenings by calling the telephone reopenings team. This will allow for correct reporting of workload between the call center and the telephone reopening team.

**Q12. Will NAS be holding "face-to-face" seminars?**

A12. NAS education respresentatives have attended a number of state and national association meetings since the implementation of the DME MAC contract and will continue to be available to the supplier community through these avenues. Additional face-to-face seminars are being discussed. Our main method of education, however, will be through Web-based workshops.

**Q13. We are being told reopenings are taking up to 60 days to process. Is that true?**

A13. NAS is currently processing reopenings within 54 days on the average. Per the CMS guidelines, DME MACs have 60 days to complete reopenings.

**Q14. Is a redetermination the same as an appeal?**

A14. Yes, a redetermination is the first level within the five levels of the appeals process.

**Q15. I submitted a reopening on 1-8-07 and have not received payment or denial. Should I re-send it or call to check on the status?**

A15. Per CMS guidelines, reopenings are to be completed within 60 days of receipt. If you do not have a response within that time frame, follow up with the Supplier Contact Center

**Q16. Where can we find the form to have the patient allow us to do an appeals on their behalf for non-assigned claims?**

A16. The beneficiary can transfer his/her appeal rights to his health care provider by completing the transfer of appeal rights form (CMS-20031). This form is located on our DME web site, www.noridianmedicare.com, under the Forms section or can be accessed at www.cms.hhs.gov/cmsforms/downloads/cms20031.pdf.

**Q17. We sometimes receive confirmation that an appeal has been received and sometimes we don't. It would be helpful that we know when they have been received so that we know when to follow up.**

A17. All redeterminations receive a notification letter, whereas written reopening requests do not.

**Q18. We have been waiting one year for an answer from Q2 Administrators and they do not return phone calls. What can a provider do?**

A18. NAS may be able to provide assistance in determining the status of your reconsideration or ALJ request if you have a favorable letter and payment has not been made on the claim. Contact the Supplier Contact Center for assisstance.

**Q19. How long should we allow to receive payment on a fully favorable ALJ decision?**

A19. NAS has 30 days from the time we are notified by the ALJ to reverse the claim. Contact the Supplier Contact Center for further assistance.

**Q20. How should we handle denials for diabetic supplies that are billed with a GA modifier when the patient received more test strips than was medically necessary, but Noridian denied as a duplicate claim?**

A20. A supplier may request a telephone reopening in this situation.

**Q21. Can claims be aggregated to meet the $1130 amount in contoversy for a federal court review?**

A21. Yes. Refer to the Medicare Claim Processing Manual, Chapter 29 - Appeals of Claims Decisions at www.cms.hhs.gov/manuals/downloads/clm104c29.pdf for more information.

**Q22. The previous contractor had failed to complete a redetermation and we were instructed by Noridian to send a letter to Noridian with this explanation along with the redetermination request. This request was dismissed as an untimely request. What can we do to get this redetermination processed?**

A22. The supplier needs to call into the DME Supplier Contact Center so that the redetermination can be worked appropriately. A faxed copy of the CIGNA letter may be requested by the representative.

**Q23. Can we still have an attorney represent us and can we and our expert witnesses appear in person to present our case?**

A23. You are allowed to have an attorney represent you but you and/or your attorney can only appear in person for appeals at the ALJ level or above. You can no longer appear in person for reconsideration requests.

**Q24. Can Medicare Secondary Payor claims be submitted**

**as a paper claim?**

A24. Only if you have an ASCA exception as outlined in MLN Matters Article CR3440 referenced in A7 above. If your software does not allow for MSP submission, suppliers can also use the free billing software offered by Noridian. For more information on this free software, see www.noridianmedicare.com/dme/claims/edi.html.

**Q25. Is there a reason why certain patient's receive CERT documentation requests on a monthly basis?**

A25. CERT audits are completely random. It is very unlikely that you would receive a CERT documentation request on the same beneficiary for multiple months.

**Q26. We cannot seem to get our narrative information read before the claim is denied. When we call, the electronic narrative is found by the customer service representative and we are able to have the claim reopened. However, it should not have denied originally. Is there a way to get the narrative read before the claim is rejected?**

A26. NAS guidelines state that the narrative information should be reviewed when the claim suspends for claim review. It's possible that the narrative information was missed or the claim did not stop for a claim reviewer to review but was processed automatically by the system. The customer service representative can research the situation and will provide feedback to our claims processing staff if the narrative was present but not reviewed, resulting in an inappropriate claim denial.

**Q27. If we request a reopening to add a KX modifier, is the CSR able to remove a GA modifier?**

A27. If the GA modifier was submitted in error and the ABN was not obtained or was invalid, the telephone reopening representative may remove the GA modifier.

**Q28. Why doesn't the redetermination form have a place for a date requested?**

A28. All redetermination forms are date stamped upon receipt and the enveloped retained so timeliness can be calculated to ensure that redeterminations are processed within 60 days of receipt.

**Q29. If we billed the incorrect charge for a power wheelchair, would we be able to send it to reopening?**

A29. If the change will result in reduction of payment, the request should be submitted on a refund form. If the change will result in additional payment, you can submit a reopening in writing.

**Q30. When a reconsideration results in a fully favorable decision and River Trust Solutions sends the letter that a remittance advice will follow in 60 days, to whom do we appeal if the effectuation notice is still not in the contractor's system four months later and the 60 days time frame has not yet started?**

A30. The supplier needs to call into the DME Supplier Contact Center. The representative will request a copy of the favorable letter from RiverTrust in order to expedite payment.

# Ask the Contractor – DME Small Supplier – Questions and Answers April 18, 2007

Prior to taking questions, NAS provided the following updates:

NAS is pleased to report that our suspended claim inventory has dramatically decreased over the past several months and we are currently exceeding CMS' standards for claim processing timeliness. The CMS standard for claims processing timeliness (CPT) is to process 95% of clean claims, both paper and electronic, within 30 days and 98% of all claims within 90 days. As of April 13, the current CPT for all clean claims is 97.6% and CPT for all claims within 90 days is sitting at 99.88%. We have recently added CPT information to our website so check this section for the current statistics.

We also wanted to let suppliers know that we recently split the reopenings and redeterminations form into two separate forms. Please ensure that you are using the correct form to speed up processing of these requests.These new forms are located in the Forms section of our DME website.

We also want to address the new CMS-1500 paper claim form. The OMB approved CMS-1500 Form (08/05) has the identifiable 1500 in a rectangle located in the upper left corner of the form. This identifier should be in black ink and must not be covered or typed over.

When using the new CMS-1500 Form (08/05), suppliers must change the printing specifications so that the correct claim information is printed within the confines of the appropriate boxes. The specifications can be found in the Medicare Claims Processing Manual, Chapter 26 found at www.cms.hhs.gov/manuals/downloads/clm104c26.pdf. Providers cannot just switch to the new claim form without making these changes. The fields that have changed are:

**Box 17a, which has been split horizontally into 17a and 17b**

The shaded box is for the 1G qualifier for the UPIN. The unshaded box already contains the NPI indicator. The two larger boxes are for the UPIN and NPI numbers. The top, shaded box is for the UPIN. The bottom, unshaded box is for the NPI.

**Boxes 24A through 24K**

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, Medicare does use the shaded areas of 24A through 24H.**

It is important to note that box 24E on the new form was shifted slightly to the right. This will cause the diagnosis pointers to fall into the modifier boxes of 24D if providers do not change their printing specifications.

**Boxes 32a and 32b**

Box 32 was changed to accommodate the submission of both the legacy identifier/NSC number and NPI of the service facility. Box 32a is for the NPI. Box 32b is for the legacy identifier/NSC number. For box 32b, the ID qualifier 1C must be separated by one blank space from the legacy identifier/NSC number.

**Boxes 33a and 33b**

Box 33 was changed to accommodate the submission of both the legacy identifier/NSC number and the NPI. Box 33a is for the NPI. Box 33b is for the legacy identifier/NSC number. For box 33b, the ID qualifier 1C must be separated by one blank space from the legacy identifier/NSC number.

NAS will be returning claims with educational letters for claims that do not meet the printing specifications. These claims must be corrected and resubmitted. We are returning many claims based on incorrect placement of data.

Also, in regards to the NPI, the Centers for Medicare & Medicaid Services (CMS) also recently announced that it is implementing a contingency plan for covered entities who will not meet the May 23, 2007, deadline for compliance with the NPI regulations. Additional details on Medicare's specific contingency plan are forthcoming. See the What's New section of our website for additional details.

Lastly, if you hadn't heard, CMS also recently released the final rule for the DMEPOS Competitive Bidding program, slated to begin in 10 Metropolitan Statistical Areas in 2008. Jurisdiction D areas affected are Kansas City, both in the states of Missouri and Kansas, and the Riverside, San Bernardino, and Ontario areas in California. Please see the What's New section of our website for the flurry of information recently released on this topic. NAS has limited involvement with this initiative. Therefore, suppliers with questions on this topic should contact the Competitive Bidding Contractor at 1-877-577-5331.

The following questions and answers are from the April 18, 2007, small supplier Ask-the-Contractor conference call. In some cases, the original answers given during the call may have been expanded to provide further detail. These were current answers as of this event. Please check our website for updates.

**Q1. We are a small supplier concentrating on sleep apnea treatment devices. We have a patient who previously received a CPAP with a heated humidifier. Now this patient needs a bi-level machine with a heated humidifier. We submitted the claim for both portions but the humidifier portion denied based on same/similar edits. The problem is that the humidifier used with the CPAP does not work with the bi-level machine. Are we allowed to appeal the denial of the humidifier or should we just bill the patient for this item?**

A1. Based on the information provided during this call, we would suggest that you request a redetermination on the denied humidifier portion of the claim and provide information explaining why your patient required the new humidifier. The easiest way to request a redetermination is by using the redetermination request form found on our web site in the Forms section.

**Q2. Where is the Healthy Connections provider number placed when submitting a claim for payment? We have received denials because we have not placed this number in the correct place when submitting the claims.**

A2. NAS is not familiar with Healthy Connections, therefore, the caller was asked to fax her denial to NAS for research. At the time of this publication, no fax has been received, however, Healthy Connections appears to be associated with the Idaho Medicaid program. You may want to contact them for assistance.

**Q3. I am a small supplier in a rural community with a question regarding the Competitive Bidding Program. We generally provide enteral nutrition to our rural patients but there is a large supplier about 250 miles outside our area. Are we at risk?**

A3. NAS does not hold the contract for the Competitive Bidding Program. Therefore, we suggest that you contact the CBIC at 877-577-5331 for assistance with this program.

**Q4. If a patient is in a skilled nursing facility (SNF) or being seen by a home health (HH) agency, who processes the claims for manual and power wheelchairs and their repairs?**

A4. If a patient is in a SNF, there is no coverage for wheelchairs or their repairs because the nursing facility should be providing that equipment. However, if a patient is being seen by a home health agency, claims for wheelchairs and related repairs are submitted to the DME MAC for processing. These items are not included in the HH Prospective Payment System (PPS)

In addition, there is information regarding consolidated billing (CB) and the PPS in the Supplier Manual, Chapter 5, located on our web site at www.noridianmedicare.com/dme/news/manual/chapter5.html#cb. This section of Chapter 5 also provides you with links to the CMS web site regarding SNF CB and HH PPS. The master code list for SNF CB can be accessed at www.cms.hhs.gov/SNFConsolidatedBilling/75_2007_FI_Update.asp#TopOfPage and the master code list for HH PPS can be accessed at www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp#TopOfPage.

**Q5. I have a question for EDI. What is the final date that the diagnosis pointers, the NPI/legacy numbers and the NPI/UPIN numbers need to be inputted into the transmission when sending claims to EDI?**

A5. There has been no change regarding reporting diagnosis pointers. Regarding NPIs, legacy numbers, and UPINs, we are recommending that you continue reporting both NPI/legacy numbers and NPI/UPINs during the transition period along with the ID qualifiers 1C for the legacy number and 1G for the UPIN. Medicare will continue to accept both during the contingency NPI transition period. You should also contact you software vender regarding any upgrades that may be needed for the NPI.

**Follow-up question. Is there an online system where we can look for physician NPIs similar to the UPIN directory?**

At this time you will need to ask each physician for his/her NPI, as there is no NPI directory available. In addition, based on the many questions we have received regarding this issue,

we have brought this concern to CMS. They have stated a plan is being developed but no time frame for release of this plan has been given.

**Q6. My question is regarding capped rental. It is my understanding that any capped rental item with an initial rental date on/after January 1, 2006, will become the property of the patient after 13 months of rental payments have been made. If we accidentally bill for a 14th month, will Medicare deny that month on the basis that the maximum benefit has been paid? In addition, what is happening with the oxygen capped rental benefit? Does this equipment become the patient's property after 36 months of rental payments?**

A6. You are correct in that the 14th month, if billed, would be denied on the basis that the maximum benefit has been paid.

Regarding oxygen, Medicare will allow for 36 months of rental payments for services provided on/after January 1, 2006, regardless if Medicare had been paying for rental prior to January 1, 2006, or if the rental began on/after January 1, 2006.

**Q7. What specific documentation do we need if we are asked to replace a wheelchair because it has been destroyed in an accident or stolen and the wheelchair was less than five years old? Do we need to start from the beginning with a face-to-face examination etc., or do we just need a repair estimate and a police report?**

A7. The current policy accessed at www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp states that you need a new order and documentation as to why the item needs to be replaced. You do not need a face-to-face evaluation.

**Q8. Is HCPCS code A5512 (For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230° F or higher, total contact with patient's foot, including arch, base layer minimum of ¼ inch material of shore a 35 durometer or 3/16 inch material of shore at 40 durometer (or higher) prefabricated, each) valid?**

A8. Yes, this is a valid code for Medicare. In addition, the policy accessed at www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp states this code may only be used for items related to diabetic shoes (A5500, A5501). It must not be used for items related to footwear coded with codes L3215 – L3253. The policy also states in part as follows:

For claims with dates of service on or after July 1, 2006, the only products that may be billed to the DMERCs using codes A5512 or A5513 are those for which a Coding Verification Review has been made by the Statistical Analysis DME Regional Carrier (SADMERC) and subsequently published on the appropriate Product Classification List. Information concerning the documentation that must be submitted to the SADMERC for a Coding Verification Review can be found on the SADMERC web site at www.palmettogba.com/palmetto/Other.nsf/Home/Other+Medicare+Partners+SADMERC+Home?OpenDocument or by contacting the SADMERC at 1-877-735-1326. If an insert has not received a written coding verification review from the SADMERC or if it is determined that the insert does not meet the criteria for the code, it must be billed with A9270 (noncovered item).

**Q9. My software vender is having trouble with aligning the revised CMS-1500 claim form, especially item 17a where the 1G qualifier is reported before the UPIN and item 33b when the 1C qualifier is reported with a space and the legacy number. Can I manually handwrite the 1G and 1C qualifiers when needed or will the optical scanner reject those claims?**

A9. You can handwrite the ID qualifiers 1C and 1G as long as the writing is legible and stays within the confines of the box. In addition, make sure you have a space between the 1C qualifier and the legacy number in item 33b.

**Q10. I understand that if the beneficiary owns a capped rental item after 13 months but no longer needs the item and requests pick-up, I can pick that piece of equipment up but I must purchase the item from the beneficiary at fair market value. Is there a method to determine fair market value?**

A10. One guideline to follow would be to use the "used" allowance from the DMEPOS fee schedule to determine the fair market value for the item.

**Q11. I have claims denied on the basis that item 19 does not have information needed for processing. When I look at my copy of the claim, it indicates that the information was sent. Why aren't my attachments forwarded along with the claim for processing?**

A11. The caller was asked to fax examples for NAS to research; however, no examples have been received at the time of this publication.

**Q12. Are there any specific guidelines regarding how oxygen will be handled after the 36-month rental period is over and ownership of the equipment reverts to the beneficiary? I am speaking mainly about maintenance and service.**

A12. MLN Matters 5461 relating to changes in maintenance and servicing due to the Deficit Reduction Act legislation for capped rentals and oxygen equipment states as follows:

For beneficiary-owned gaseous or liquid oxygen systems, Medicare will continue to pay for the oxygen contents. In addition, Medicare will pay for reasonable and necessary repairs and servicing *(i.e., parts and labor not covered by a supplier's or manufacturer's warranty)* of beneficiary-owned equipment (including oxygen concentrators). This provision was effective January 1, 2006. For beneficiaries receiving oxygen equipment on or before December 31, 2005, the 36-month rental period begins on January 1, 2006.

- **Oxygen Equipment** – Payment may be made for M&S every 6 months, starting 6 months after the beneficiary owns the equipment. The payment for M&S will be paid in 15-minute intervals and shall not exceed 30 minutes. In addition, Medicare will cover reasonable and necessary repairs.
- Claims with the base HCPCS code for the oxygen equipment and the "MS" modifier for maintenance and servicing for oxygen equipment will be accepted for payment.
- Maintenance and servicing claims for oxygen equipment not to exceed 2 units (of E1340) every 6 months will be accepted for payment.

- The modifier "RP" will be accepted for replacement parts.
- Claims with HCPCS code E1399 and modifier "RP" if a specific replacement code is not available for billing will be accepted for payment.

The MLN Matters article can be read in its entirety at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5461.pdf

**Q13. What is the timeline regarding using the 12-90 version of the CMS-1500 claim form?**

A13. We haven't been given a final date although June 1, 2007, was tentatively set as the final date the 12-90 version could be accepted.

**Q14. It is my understanding that once a rental item becomes the beneficiary's property it cannot be replaced for five years. If that is the case, at what point are we allowed to buy the item back from the beneficiary and what happens if the patient needs that same/similar item again within that five-year period? Will Medicare purchase another item if the beneficiary sold the original item back to the supplier?**

A14. The supplier can buy the item back anytime after the beneficiary owns the item and requests pickup; however, if the beneficiary needs that same item within five years Medicare will not pay for it as the beneficiary had previously utilized his benefit for the item.

**Q15. We deal with three types of infusions pumps: E0781 (ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by the patient), B9002 (enteral nutrition pump-with alarm), and B9004 (parenteral nutrition infusion pump, portable). Am I correct that both the B-coded pumps are exempt from the new DRA capped rental rule?**

A15. Yes, you are correct. Parenteral and enteral pumps are not included in the DRA capped rental rule.

**Q16. I have a patient who used E0781 (infusion pump) for 13 months for chemotherapy purposes after which he owns the equipment. After 15 months the physician advises the patient that he is done with chemotherapy so the beneficiary asks us to pick up the pump; we pay the beneficiary the fair market value. Then six months later the physician again orders chemotherapy so the beneficiary needs the infusion pump again. Is a new capped rental period started for the second infusion pump?**

A16. No. A new capped rental period would not start for the second order. In this case the beneficiary made a poor choice when he made the decision to sell his equipment; he used his Medicare benefit for this item and it could not be used again for five years which is considered the length of time that a piece of equipment is considerable usable.

**Follow-up Question: It is my understanding that if there is a break-in-service then a new capped rental period begins. Wouldn't this scenario be considered a break-in-service?**

A break-in-service occurs when a patient is in a current capped rental period. In your scenario the patient had rented the equipment for 13 months after which he owned the equipment. Once the patient owns the equipment it can no longer be rented. The patient in your scenario was not in a current rental period therefore there was not a break-in-service. As stated above, your patient used his benefit for the infusion pump and made a poor choice when he decided to sell it back to you. He was assuming that he would never need the pump again and unfortunately he did.

**Q17. We have a patient who is currently in her 10th month of capped rental for a wheelchair. Last week the police notified us that her wheelchair was stolen so we took a new replacement chair to her. How do we go about getting paid for this replacement wheelchair? Does a new capped rental period begin?**

A17. If the item was stolen, a new capped rental period will begin; however, be sure to indicate in the narrative section of the claim that the item was either lost or stolen and that you have the documentation available to support that the item was either lost or stolen. Medicare may request this documentation.

**Q18. After the NPI deadline of May 23, 2007, do we still need to use the 1C and 1G qualifiers on the revised 08-05 CMS-1500 claim form?**

A18. If you are using the revised claim, CMS is allowing continued use of legacy numbers only on transactions, accepting transactions with NPIs only, and accepting transactions with both legacy numbers with ID qualifiers and NPIs. We would recommend that if you have your NPI number, you submit it along with your legacy number and ID qualifier to aid in building the crosswalk of the two numbers. However, legacy numbers with associated ID qualifiers will not be permitted on any inbound or outbound transactions after May 23, 2008.

For additional information on the Medicare NPI implementation contingency plan, see the MLN Matters associated with CR 5595 at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf

**Q19. Let's imagine that a beneficiary owns a piece of DME after the 13 months of rental and then decides he/she doesn't need it anymore so it's thrown away, given away, or sold at a garage sale. A few months later the beneficiary does need that item again. Will Medicare allow for a second capped rental period for this beneficiary?**

A19. In this case the beneficiary made the decision to get rid of the item. Unfortunately, if they need the same item again within five years, Medicare will not pay for it. The benefit for the particular item has been used and the beneficiary will need to pay for the item himself.

**Q20. If an item needs to be replaced after five years, do I need to provide information to show that repairs would cost more than replacement or do I just start over with a new item?**

A20. This scenario is addressed in the Internet Only Manual, Publication 100-02, Chapter 15, Section 110.2 accessed at www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf and states in part as follows:

If the item of equipment has been in continuous use by the patient on either a rental or purchase basis for the equipment's useful lifetime, the beneficiary may elect to obtain a new piece of equipment. Replacement may be

reimbursed when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item.

**Q21. What is the difference between my legacy number and my NPI number?**

A21. Your legacy numbers are numbers assigned to you by your DMEPOS payers. You probably have many legacy/supplier numbers for billing different DMEPOS payers. The National Supplier Clearinghouse (NSC) assigned your legacy number for Medicare, called your NSC number, when you applied to become a Medicare DMEPOS supplier.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers and is a 10-position, intelligence-free numeric identifier. This means that the NPI numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. Your NPI number is replacing your NSC or legacy number for all billing transactions with Medicare. In addition, your NPI is a national number, which you will use to bill all payers (Medicare, Medicaid, private insurance companies etc.)

Also, if you are a new supplier you will not be assigned an NSC number, however, you will still need to enroll with the National Supplier Clearinghouse to become a Medicare supplier. Once you have enrolled with the NSC and have been accepted as a Medicare supplier, you will use your NPI number to bill Medicare.

**Q22. What does it mean when you say certain pumps are exempt from DRA?**

A22. DRA stands for the Deficit Reduction Act. This act changed the regulations regarding capped rental items and oxygen equipment.

Prior to January 1, 2006, all items that were considered capped rental items could be either purchased at 13 months or rented for 15 months. If the patient chose the 15 month rental option the equipment technically remained the property of the supplier and the supplier was responsible for maintaining that equipment for the life of the equipment. With the DRA there is no longer a rental option beyond the 13 months of rent; the equipment automatically becomes the property of the beneficiary after 13 months, and the beneficary is responsible for maintaining the equipment in working condition.

Oxygen equipment, under the previous regulations, was rented for the beneficiary's lifetime. Beginning January 1, 2006, that regulation changed and oxygen equipment can only be rented for 36 months after which the supplier will be reimbursed for reasonable and necessary maintenance and servicing.

When we say that enteral/parenteral pumps are not part of the DRA, we mean that the capped rental regulations do not apply to these items. These pumps can be rented for up to 15 months after which the supplier maintains that equipment.

**Q23. Medicare will allow for repair of an item if it is less costly to repair than to replace. When you look at replacement cost, are you looking at 100% of the replacement cost or is the percentage less than that?**

A23. The normal rule of thumb throughout the industry is 60% of the replacement cost. If it would cost less than 60% of the suggested retail price to repair the item, then Medicare would allow for the repair. If the repair would cost more than 60% of the suggested retail price, then Medicare would opt to replace the item.

**Q24. We are currently in the 16th month of rental for an oxygen concentrator. If this patient moves from my service area to another service area and requires a new supplier, what is my liability if another supplier will not accept the patient because they will only receive a portion of the oxygen capped rental payments? What is my liability if the situation is reversed and a beneficiary comes to me 16 months into a capped rental period with another supplier? As a non-assigned provider, can I continue to bill the patient for the additional lost months of rent beyond the 36-month cap?**

A24. You are not liable for services you cannot provide outside your service area. Unfortunately, the beneficiary is the one placed in a bad spot and will need to work to find a new supplier in his new area.

If the situation is reversed and you accept a patient 16 months into the capped rental period, you cannot bill the beneficiary for additional months beyond the 36 months to make up for lost revenue. When this patient comes to you, you will need to make your own business decision regarding whether or not you want to take on the patient with the knowledge that your revenue intake will be less.

**Q25. Could you give me information on competitive bidding and accreditation?**

A25. NAS is not the contractor for either item. Therefore, we recommend that you contact the competitive bidding implementation contractor (CBIC) at 877-577-5311 for your questions regarding competitive bidding.

Information on accreditation can be gotten from the CMS web site at www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=1925&intNumPerPage=10&checkDate=&checkKey=&srchType=&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=true&cboOrder=title.

**Follow-up Question: What is the relationship between competitive bidding and accreditation?**

Suppliers must be accredited by August 31, 2007, to be awarded a contract and must be accredited or be pending accreditation to submit a bid. In addition, even if you don't participate in the competitive bidding program you must become accredited to continue as a DMEPOS supplier. The final date by which a supplier must be accredited has not been determined.

**Q26. I have a question regarding HCPCS code E1399 for miscellaneous items. I recently had this code denied and am wondering if the code has changed?**

A26. This code has not changed and is a valid code for Medicare purposes. Without the specifics regarding the denial, it is possible that your code denied because we did not

have enough information to process the code for payment or we determined after reviewing the information provided that the item provided was not medically necessary. In addition, NAS will no longer correct code your claim if you bill a miscellaneous code when a valid code is available. Those claims will be denied as unprocessable and will need to be resubmitted with a valid code.

**Q27. Can a glucose monitor be replaced sooner than five years? I have some glucometers that have been denied because of the five-year rule.**

A27. If you need to replace a glucose monitor before five years has passed, you would need to submit the claim for payment. It the monitor denies you would need to request a redetermination with documentation to support why the particular glucose monitor needed replacement before the general five year replacement rule.

**Q28. I am new to the DMEPOS world and would like to know where I can get additional training on billing items to Medicare?**

A28. The first thing we recommend is for you to become familiar with our web site at www.noridianmedicare.com/dme/. The web site provides you with a host of information including the supplier manual, fee schedules, forms, and a path to the local coverage determinations established by the program safeguard contractor (PSC). In addition, we also provide online training courses periodically including a web site tour that is offered monthly. Watch our web site for notification of the online training courses.

**Q29. We found a web site that provided us with real time Medicare eligibility information. Is there a way that Medicare could provide a web site for DME suppliers where we could obtain same/similar information?**

A29. We have looked at the possibility of adding same/similar to the IVR but that is not a simple transaction; the IVR would need to search the entire history for all codes that could possibly be the same or similar to code you provide. In addition, even if a system could provide you with that information, an hour later a claim could be received for a similar item and your claim could still deny. We have also made CMS aware of this question as other suppliers have requested the same information, but it will not be a simple thing to offer.

**Follow-up Question: If the same/similar information cannot be gotten from the IVR, are you going to increase your customer service staff to answer these questions?**

Our call center is currently meeting the CMS standard and is averaging 48 seconds to answer supplier questions. Furthermore, the issue of same/similar is not a new issue. You should begin by speaking with the beneficiary regarding same/similar items. The beneficiary should know if they have used or owned a same or similar item in the past. If the beneficiary is not able to give you that information, then the contact center is available to you without the beneficiary being involved with the call.

**Q30. I have a patient who was given a wheelchair about three years ago. The patient has since improved and the physician has requested that he be given a walker. Will the walker deny because the patient already has a wheelchair?**

A30. If the patient now meets the medical necessity for a walker, the item should be allowed. If, however, the walker would deny, you can request a redetermination with documentation to support the need for the walker.

## COMPETITIVE BIDDING

# Pre-Bidding Activities for DMEPOS Competitive Bidding Program

**MLN Matters Number: SE0714**

**Provider Types Affected**

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

**Provider Action Needed**

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

**Background**

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

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

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

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

**Basic Instructions**

**All suppliers submitting a bid must:**

- Be in good standing and have an active National Supplier Clearinghouse number (NSC#);
- Meet any local or State licensure requirements, if any, for the item being bid;
- Be accredited or be pending accreditation. CMS cannot

accept a bid from any supplier that is not accredited or that has not applied for accreditation. The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers should apply for accreditation immediately to allow adequate time to process their applications. (For a listing of CMS-approved accrediting organizations, please visit http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf on the CMS Web site. MLN Matters article SE0713 provides additional information on accreditation and is located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf; and

- Complete initial registration in the Internet application (Individuals Authorized Access CMS computer Services, IACS) to get a USER ID and password. Suppliers need to complete this initial registration process early to avoid delays in being able to submit bids. The initial registration process requires the authorized official, as identified in Section 15 of the CMS 855S, to complete the information required in the Internet application. The authorized official's information must match the information on file at the National Supplier Clearinghouse. To complete this initial registration and obtain a USER ID and password, please go to https://applications.cms.hhs.gov/.

**All suppliers submitting a bid should:**

- Review MLN Matters article SE0717, Initial Supplier Registration for Competitive Bidding Program is Now Open, which provides important information about the registration process;
- Review the information in the Bid Application Tool Kit to facilitate a better understanding of the bidding process and rules. This information is located on the CBIC Web site at http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersBid Application Tool Kit;
- View the educational webcast to learn more about the Medicare DMEPOS Competitive Bidding Program and detailed information on the bid application process. This information is located on the CBIC Web site at http://www.dmecompetitivebid.com/cbic/cbic.nsf/(subpages)/CBICSuppliersEducational Tools; and
- CMS encourages you to register to receive updates on the Competitive Bidding Program. You may do so by going to http://www.cms.hhs.gov/apps/mailinglists/ on the Web

**Additional Information**

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

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

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

## Financial Measures for DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services (CMS) released the measures that will be used to evaluate the financial stability of suppliers that bid under the new Medicare DMEPOS Competitive Bidding Program on Friday May 25, 2007. All bids must include certain financial documentation in order for the supplier to be considered for a contract under the program. CMS and its Competitive Bidding Implementation Contractor (CBIC) will evaluate each bidder's financial documentation to determine whether the supplier will be able to participate in the program and maintain viability for the duration of the contract period.

The financial measures are standard accounting ratios commonly used to evaluate financial health. The following financial ratios will be used:

- Current ratio = current assets/current liabilities
- Collection period = (accounts receivable/sales) x 360
- Accounts payable to sales = accounts payable/net sales
- Quick ratio = (cash + accounts receivable)/current liabilities
- Current liabilities to net worth = current liabilities/net worth
- Return on sales = net sales/inventory
- Sales to Inventory
- Working capital = current assets – current liabilities
- Quality of earnings = cash flow from operations/(net income + depreciation)
- Operating cash flow to sales = cash flow from operations/(revenue – adjustment to revenue)

CMS and the CBIC will calculate each bidder's financial ratios using the financial information submitted as part of the bid. CMS and the CBIC will also be utilizing the supplier's credit history in evaluating the financial health of the supplier.

## DMEPOS Competitive Bidding Program Final Regulation and First 10 Metropolitan Areas

The Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Final Regulation is now published at the Federal Register at http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/Downloads/CMS-1270-F.pdf

CMS has also announced the first 10 metropolitan areas in which competition will occur, as well as the first items to be competitively bid. Visit the CMS website at http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/ to view the rule and for additional information.

## Webcast Available for Medicare DMEPOS Competitive Bidding Program Suppliers

An educational webcast is now available at the Competitive Bidding web site at www.dmecompetitivebid.com. The presentation is designed to help suppliers that intend to participate in the Medicare DMEPOS Competitive Bidding Program being implemented in ten metropolitan areas throughout the United States.

The webcast highlights key bidding dates, provides an overview of the Competitive Bidding Program, and guides bidders through required application forms. Suppliers may view it at any time and submit questions at the conclusion of the presentation.

The Competitive Bidding web site contains other helpful educational materials for suppliers, including a supplier tool kit, fact sheets, frequently asked questions, and more. For more information, call the Competitive Bidding Helpline at (877) 577-5331.

## Home Health Agencies Providing Durable Medical Equipment in Competitive Bidding Areas

**MLN Matters Number: MM5551**
**Related Change Request (CR) #: 5551**
**Related CR Release Date: April 20, 2007**
**Related CR Transmittal #: R1224CP**
**Effective Date: October 1, 2007**
**Implementation Date: October 1, 2007**

**Provider Types Affected**

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

**Provider Action Needed**

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

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

HHAs should read the remainder of this article for important information regarding the new competitive bidding program for DME under Medicare and take appropriate action based on the impact of this program on your DME billings.

**Background**

This article and related Change Request (CR) 5551 provides general guidelines for processing HHA claims. Beginning in 2007, in a competitive bidding area, a supplier must be awarded a contract by the Centers for Medicare & Medicaid Services (CMS) in order to bill Medicare for competitively bid DME. Therefore, HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program must either:

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

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

Important points to remember are:

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

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

**Additional Information**

For information on registering to compete for a DME contract in the competitive bidding areas, see the MLN Matters article titled "Initial Supplier Registration for Competitive Biding Program is Now Open", which is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0717.pdf on the CMS website.

For complete details regarding this Change Request (CR) please see the official instruction (CR5551) issued to your Medicare RHHI, FI, or DME MAC. This instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1224CP.pdf on the CMS website.

# Accreditation Information for Suppliers of DMEPOS

**MLN Matters Number: SE0713 Revised**

**Note:** This article was revised on April 23, 2007, to reinforce the need for suppliers to be accredited in order to be awarded a contract under this program. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

This Special Edition (SE) article, SE0713, provides the information that DME suppliers need to comply with Section 302(b)(1) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). That MMA section requires the Secretary of the Department of Health and Human Services (HHS) to establish and implement quality standards for DMEPOS suppliers. All DMEPOS suppliers wishing to bill Medicare for DMEPOS provided to Medicare patients must comply with these standards to receive Medicare Part B payments. In addition, Section 1847 (b)(2)(A)(i) of the Social Security Act requires DMEPOS suppliers meet these standards before being awarded a contract under the upcoming Medicare DMEPOS Competitive Bidding Program.

**Background**

Section 302 of the MMA required the Secretary to establish and implement quality standards for suppliers of DMEPOS. All suppliers of DMEPOS must comply with the quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. Covered items include (Section 1834 (a) (13 and (h) (4)):

- Medical supplies;
- Home dialysis supplies and equipment;
- Therapeutic shoes;
- Parenteral and enteral nutrient, equipment and supplies;
- Electromyogram devices;
- Salivation devices;
- Blood products;
- Transfusion medicine; and
- Prosthetic devices, orthotics.

The standards will be applied prospectively and are published at www.cms.hhs.gov/Medicareprovidersupenroll on the Centers for Medicare & Medicaid Services (CMS) website. Also, note that Section 1847(b)(2)(A)(i) of the Act requires DMEPOS suppliers to meet the quality standards before being awarded a contract under the Medicare DMEPOS Competitive Bidding Program.

Please note that suppliers must be accredited or be pending accreditation to submit a bid. CMS cannot accept a bid from any supplier that is not accredited or has not applied for accreditation. Additionally, suppliers will need to be accredited to be awarded a contract. **The accreditation deadline for the first round of competitive bidding is August 31, 2007. Suppliers must be accredited before this date in order to be awarded a contract.** Suppliers should apply for accreditation immediately to allow adequate time to process their applications.

The quality standards are separated into two sections and have three appendices, as follows:

- Section I includes the business standards that apply to all suppliers and focus on standards for administration, financial management, human resource management, consumer services, performance management product safety, and information management.
- Section II contains product-specific service standards, including intake, delivery and setup, training and instruction of the beneficiary and/or their caregiver, and follow-up service.
- Appendix A deals with respiratory equipment, supplies, and services.
- Appendix B deals with manual wheelchairs and power mobility devices, including complex rehabilitation and assistive technology.
- Appendix C deals with custom fabricated, custom fitted and custom made orthotics, prosthetic devices, somatic, ocular and facial prosthetics, and therapeutic shoes and inserts.

In order to participate in Medicare Part B, DMEPOS suppliers will need to be accredited and in compliance with these standards. The accreditation will be phased in and to accommodate the suppliers who wish to participate in the Medicare Competitive Bidding Program for DMEPOS, CMS will require accreditation organizations to prioritize their surveys of suppliers to accredit suppliers in the selected Metropolitan Statistical Areas (MSAs) where the Bidding Program will begin. To provide additional information on the accreditation surveys, suppliers should note that:

- All surveys are performed on site at the supplier location.
- All surveys are unannounced.
- Accreditation cannot be transferred upon merger, acquisition or sale – CMS, the National Supplier Clearinghouse (NSC) and the Accreditation organization must be notified when these events occur.
- The Accreditation organization and the NSC will be coordinating efforts so that the supplier number can be revoked when accreditation is revoked.

**Status of Accreditations**

- Almost 5,000 suppliers are already accredited (329 of those are in the 20 MSAs proposed in the NPRM for the Competitive Bidding Program).
- 1,000 surveys have been scheduled since the start of 2007.
- Ten (10) Accreditation Organizations were deemed by CMS in Nov. 2006. Those organizations are listed at www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf on the CMS website.

## ACCREDITATION CONT'D

Suppliers can contact the deemed accrediting organizations directly based on the information provided at that website.

**Additional Information**

The CMS complete listing of all DME resources is available at www.cms.hhs.gov/center/dme.asp on the CMS website.

The CMS webpage for the Competitive Bidding Program is www.cms.hhs.gov/CompetitiveAcqforDMEPOS.

## NPI

# CMS Publishes NPPES Data Dissemination Notice

On May 30, 2007, CMS published the Data Dissemination Notice in the Federal Register. The final copy of the notice is posted at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/DataDisseminationNPI.pdf on the CMS NPI Website.

**New Data Dissemination FAQs Available**

CMS has posted new FAQs related to the recently published Data Dissemination Notice. Questions include:

- Where is the National Plan and Provider Enumeration System (NPPES) data dissemination policy conveyed?
- What National Plan and Provider Enumeration System (NPPES) data will CMS disclose?
- How will CMS make the Freedom of Information Act (FOIA)-disclosable National Plan and Provider Enumeration System (NPPES) data available?
- Is there a charge to obtain the Freedom of Information Act (FOIA)-disclosable National Plan and Provider Enumeration System (NPPES) health care provider data?
- I want Freedom of Information Act (FOIA)-disclosable data for only the physicians in New York and I want the data on a CD. How do I go about having my request fulfilled?
- When will the Freedom of Information Act (FOIA)-disclosable National Plan and Provider Enumeration System (NPPES) health care provider data be available?

To view these FAQs, you should:

- Go to the CMS dedicated NPI web page at www.cms.hhs.gov/NationalProvIdentStand
- Scroll down to the section that says "Related Links Inside CMS"
- Click on NPI Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated". Look for the word "NEW" in red font to appear beside the most recent FAQs.

Important Information for Medicare Fee-For-Service (FFS) Providers

**CMS Discontinues the Unique Physician Identifier Number (UPIN) Registry**

Effective June 29, 2007, CMS will discontinue assigning UPINs to Medicare providers. For further details, visit the Change Request on this subject at http://www.cms.hhs.gov/transmittals/downloads/R207PI.pdf and the associated MLN Matters article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5584.pdf on the CMS website.

As always, more information and education on the NPI can be found at the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203.

# The NPI Compliance Deadline is Here!

At this point, any covered entity that is noncompliant, and has not implemented a contingency plan, is at risk for enforcement action. Please review the April 2, 2007, CMS "*Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule."* As this guidance pertains to claims transactions, it means that:

1. Providers must have and use their NPI;
2. Clearinghouses must accept and use NPIs; and
3. Health plans must accept and send NPIs in claims transactions.

Providers should be:

1. Aware of contingency plans for any health plans they bill. Contingency plans may differ by health plan.
2. Aware that health plans may lift their contingency plans (and require an NPI on claims or other HIPAA transactions) any time before May 23, 2008.
3. Working with vendors and clearinghouses with whom they contract, to make sure the NPI is being passed to health plans.
4. Paying close attention to how and when health plans will be testing implementation of the NPI.
5. Aware that, for those health plans that did not establish a contingency plan, providers are required to use their NPIs now. This means that if you are not using your NPI, your claim may be rejected or denied.

**New Tip Sheet Available**

A Tip sheet entitled *What the "Guidance on Compliance with the HIPAA National Provider Identifier (NPI) Rule" Means for Health Care Providers* is now available at www.cms.hhs.gov/NationalProvIdentStand/Downloads/ContingencyTipSheet.pdf.

This product provides helpful steps for providers based on the contingency guidance released on April 2, 2007. This guidance does not mean that providers have an extra year to get an NPI, so please view the Tip Sheet for additional information.

***Reminder*** **– Sharing NPIs**

Once providers have received their NPIs, they should share them with other providers with whom they do business and

with health plans that request them. In fact, as outlined in current regulation, providers who are covered entities under HIPAA must share their NPIs with any entities that request them for use in standard transactions -- including those who need to identify ordering or referring physicians/providers. Providers should also consider letting health plans, or institutions for whom they work (e.g. a large hospital system), share their NPIs for them.

**When to Contact the NPI Enumerator for Assistance**

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

- Status of an NPI application, update, or deactivation
- Forgotten/lost NPI
- Lost NPI notification letter
- 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.

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

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

**Important Information for Medicare Fee-For-Service (FFS) Providers**

**Testing Medicare Claims**

To date, Medicare has encouraged providers to submit both an NPI and a legacy identifier on claims. Medicare is now asking that submitters send a small number of claims using only the NPI. If no claims are rejected, the submitter can gradually increase the volume. If any claim is rejected, the NPI should be verified to make sure it was entered correctly. If the NPI is correct, then data in either NPPES or Medicare provider files should be corrected. The following fields in your NPPES and/or 855 provider enrollment record should be validated:

- EIN (for organization providers)
- Other Provider Identification Numbers. This is where providers, when they apply for their NPIs, list the Medicare legacy identifier(s) that needs to be linked to the NPI.
- Practice Location Address
- Master Address (from provider enrollment records)
- Other Address (from provider enrollment records)
- Legal Name or Legal Business Name

Once this has been done, test again with a small number of claims. This process will help establish confidence that your claims will be paid. It is critical that you start testing with your NPI now.

While Medicare FFS has announced its contingency plan, it is committed to ending the contingency plan as soon as possible.

***Reminder*** **- Medicare FFS Contingency Plan Announced on April 24th**

View the associated Change Request at www.cms.hhs.gov/transmittals/downloads/R1227CP.pdf, as well as the related MLN Matters article at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website. These materials were recently revised; please be sure to visit the links above for the latest information.

***Reminder*** **- NPI MLN Matters Articles**

There are many MLN Matters articles dealing with various topics of NPI relative to the Medicare program. These MLN articles are available at

www.cms.hhs.gov/NationalProvIdentStand/Downloads/MMArticles_npi.pdf

**Additional Information**

As always, more information and education on the NPI can be found at the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203.

## Medicare Fee-For-Service NPI Implementation Contingency Plan

**MLN Matters Number: MM5595 Revised**
**Related Change Request (CR) #: 5595**
**Related CR Release Date: April 24, 2007**
**Related CR Transmittal #: R1227CP**
**Effective Date: May 23, 2007**
**Implementation Date: May 23, 2007**

**Note:** This article was revised on April 24, 2007, to reflect changes made to CR5595, which CMS re-issued on April 24. The article was changed to reflect in bold print on page 2 that "As long as covered entities, including health plans and covered health providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs, they may establish contingency plans to facilitate the compliance of their trading partners". The article also has a revised transmittal number, release date, and Web address for accessing CR5595. All other information remains the same.

**Provider Types Affected**

Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries, with Medicare contractors (carriers, Fiscal Intermediaries, (FIs), including Regional Home Health Intermediaries (RHHIs), Medicare Administrative Contractors (MACs), Durable Medical Equipment Regional Carriers (DMERCs), and DME Medicare Administrative Contractors (DME MACs))

## NPI CONT'D

**Provider Action Needed**

As early as July 1, 2007, Medicare fee for service (FFS) contractors may begin rejecting claims that do not contain an NPI for the primary providers.

CR 5595, from which this article is taken, announces that (effective May 23, 2007) Medicare fee for service (FFS) is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007.

If you have not yet done so, you should obtain your NPI now. You can apply on line at https://nppes.cms.hhs.gov/ on the CMS website. You should also make sure that your billing staffs begin to include your NPI on your claims as soon as possible.

**Background**

The 1996 Health Insurance Portability and Accountability Act (HIPAA) required that each physician, supplier, and other health care provider conducting HIPAA standard electronic transactions, be issued a unique national provider identifier (NPI). CMS began to issue NPIs on May 23, 2005; and to date, has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers, including:

- NPI only,
- Medicare legacy only, or
- An NPI and legacy combination.

On April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance to covered entities regarding contingency planning for NPI implementation. **As long as covered entities, including health plans and covered health providers, continue to act in good faith to come into compliance, meaning they are working towards being able to accept and send NPIs, they may establish contingency plans to facilitate the compliance of their trading partners.** (You can find this guidance on the CMS website at: http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Contingency.pdf.)

In CR 5595, from which this article is taken, Medicare fee for service (FFS) announces that it is establishing a contingency plan that follows this DHHS guidance. For some period after May 23, 2007, Medicare FFS will:

- Allow continued use of legacy numbers on transactions;
- Accept transactions with only NPIs; and
- Accept transactions with both legacy numbers and NPIs.

**After May 23, 2008, legacy numbers will NOT be permitted on ANY inbound or outbound transactions.**

As part of this plan, Medicare FFS has been assessing health care provider submission of NPIs on claims. As soon as the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is determined sufficient (and following appropriate notice to providers), Medicare will begin rejecting claims that do not contain an NPI for primary providers following appropriate notification. (*See Important Information* below.)

In May 2007, Medicare FFS will evaluate the number of submitted claims containing a NPI. If this analysis demonstrates a sufficient number of submitted claims contain a NPI, Medicare will begin to reject claims without NPIs on July 1, 2007. If, however, there are not sufficient claims containing NPIs in the May analysis, Medicare FFS will assess compliance in June 2007 and determine whether to begin rejecting claims in August 2007.

CMS also recognizes that the National Council of Prescription Drug Programs (NCPDP) format only allows for reporting of one identifier. Thus, NCPDP claims can contain either the NPI or the legacy number, but not both, until May 23, 2008.

In addition, in regards to the 835 remittance advice transactions and 837 Coordination of Benefits (COB) transactions, Medicare FFS will do the following until May 23, 2008:

- If a claim is submitted with an NPI, the NPI will be sent on the associated 835 remittance advice; otherwise, the legacy number will be sent on the associated 835.
- If a claim is submitted with an NPI, the associated 837 COB transaction will be sent with both the NPI and the legacy number; otherwise, only the legacy number will be sent.

By May 23, 2008, the X12 270/271 eligibility inquiry/response supported by CMS via the Extranet and Internet must contain the NPI.

**Important Information**

CR 5595 also provides specific important information that you should be aware of:

- Once a decision is made to require NPIs on claims, Medicare FFS will notify (in advance) providers and Medicare contractors about the date that claims without NPIs for primary providers will begin to be rejected. **That date will supersede all dates announced in previous CRs and MLN Matters articles.**
- In editing NPIs, Medicare considers billing, pay-to and rendering providers to be primary providers who must be identified by NPIs, or the claims will be rejected once the decision is made to reject.
- All other providers (including referring, ordering, supervising, facility, care plan oversight, purchase service, attending, operating and "other" providers) are considered to be secondary providers. Legacy numbers are acceptable for secondary providers until May 23, 2008. If a secondary provider's NPI is present, it will only be edited to assure it is a valid NPI.

**Additional Information**

You can read CR 5595 by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1227CP.pdf on the CMS website. You can also learn more about the NPI at http://cms.hhs.gov/NationalProvIdentStand/ on the CMS website.

# Provider Authentication Requirements for Telephone and Written Inquires during the Medicare FFS NPI Contingency Plan

**MLN Matters Number: SE0721**

**Provider Types Affected**

All physicians, suppliers, and providers who call or write their Medicare Fee-for-Service (FFS) contractors (Fiscal intermediaries (FIs), Carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative contractors (DME/MACs), DME Regional Carriers (DMERCs) and/or Regional Home Health Intermediaries (RHHIs) with general inquiries.

**Provider Action Needed**

Due to the Medicare FFS NPI contingency plan, the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare Fee-for-Service provider contact centers (PCCs), will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and the written inquiries units.

**What You Need to Know**

**Medicare FFS will give sufficient notice to providers of the contingency plan end date. Until the date, you will need to provide the following:**

- **For Inquiries to the IVR:**
  - **PTAN / Legacy Number, depending upon the contractor**
- **For Inquiries to a CSR and Written Inquiries:**
  - **PTAN / Legacy Number, depending upon the contractor, and**
  - **Provider Name.**

Remember, if you make inquiries to more than one contractor, you may hear the provider identification number referred to as either the legacy number or PTAN. On the date that the NPI is required to be on all claim transactions, the provider authentication elements required by all contractors will be both the NPI and PTAN.

**What You Need to Do**

If you have not yet done so, **you should obtain your NPI now**. You can apply on line at https://nppes.cms.hhs.gov/ on the CMS website. Once CMS ends the contingency plans, your claims and inquiries will not be processed without NPIs.

**Background**

In order to give providers and other trading partners more time to obtain and use the NPI, Medicare FFS invoked a contingency plan that allows continued use of legacy numbers beyond the May 23, 2007, implementation for the NPI. As reported in *MLN Matters* article MM5595, for some period after May 23, 2007, Medicare FFS will:

- Allow continued use of legacy numbers on transactions;
- Accept transactions with only NPIs; and
- Accept transactions with both legacy numbers and NPIs.

**After May 23, 2008, legacy numbers will NOT be permitted on ANY inbound or outbound transactions.**

As part of this plan, Medicare FFS is assessing health care provider submission of NPIs on claims. As soon as the number of claims submitted with an NPI for primary providers (billing, pay-to and rendering providers) is determined to be sufficient (and following appropriate notice to providers), Medicare will begin rejecting claims that do not contain an NPI for primary providers. Beginning May 23, 2007, Medicare FFS contractors will require that providers provide their PTAN as a required authentication element for all general telephone or written inquiries.

In this contingency environment, the PTAN is the provider legacy number. Some contractors may continue to use the provider legacy number as the required authentication element. Other contractors will begin to refer to the legacy number as the PTAN.

Provider enrollment letters may also continue to refer to the provider legacy number. Newly enrolled or re-enrolled providers will receive either a legacy number or PTAN in their provider enrollment letters depending on which is used for authentication.

**Remember: CMS may end the contingency plan once it appears that the level of claims containing NPIs is sufficient to do so. CMS encourages you to get and use your NPI now. Also, remember to ready your other processes to use the NPI as soon as possible to avoid a situation where your claims are not processed when the contingency ends.**

**Additional Information**

The CMS complete listing of all NPI resources is available at http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS website.

More details regarding the CMS NPI contingency plan are in the *MLN Matters* article MM5595 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

## Provider Education for Handling Issues Related to Deceased Providers

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

**Note:** This article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

**Provider Types Affected**

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

**Background**

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

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

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

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

**Key Points of CR5508**

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

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

**Additional Information**

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

## Provider Identifiers Reported on Remittance Advice Transactions

***MLN Matters*** **Article #MM5081** discusses what provider identifiers Medicare will report on remittance advice transactions under Stage 2 of Medicare's NPI implementation. This is to let you know that the article has recently been revised to note that the processes will change as Medicare moves to Stage 3 implementation of the NPI and to emphasize that providers need to review and understand the impact of Stage 3 on remittances as discussed in the ***MLN Matters*** **Article #MM5452**, which can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf on the CMS Website. The revised version of **MM5081** can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5081.pdf.

# Stage 3 NPI Changes for Transaction 835 and Standard Paper Remittance Advice

**MLN Matters Number: MM5452**
**Related Change Request (CR) #: 5452**
**Related CR Release Date: May 18, 2007**
**Related CR Transmittal #: R1241CP**
**Effective Date: July 2, 2007**
**Implementation Date for DME suppliers: July 2, 2007**
**Implementation Date for other providers: October 1, 2007**

**Provider Types Affected**

Physicians, providers, and suppliers who conduct Health Insurance Portability and Accountability Act (HIPAA) standard transactions, such as claims and eligibility inquiries, with Medicare.

**Provider Action Needed**

Be aware that Stage 3 of the NPI implementation is nearing. This article discusses impact of the NPI Stage 3 implementation on remittance advice transactions.

Make sure you have your NPI, know how to use it, and are prepared to receive it back in your remittance advice processes.

Read the remainder of this article and be sure your staff are aware of how the NPI implementation impacts the remittance advice transactions you receive.

**Background**

**This article discusses Stage 3 of Medicare's fee-for-service (FFS) processes for the NPI and reflects Medicare processing of claims submitted with NPIs**. Submitted NPIs will be crosswalked to the Medicare legacy number(s) for processing. Medicare's internal provider files will continue to be based upon records established in relation to the legacy identifiers. The crosswalk may result in:

| | | | |
|---|---|---|---|
| **Scenario I** | Single NPI | Cross walked to | Single Medicare legacy number |
| **Scenario II** | Multiple NPIs | Cross walked to | Single Medicare legacy number |
| **Scenario III** | Single NPI | Cross walked to | Multiple Medicare legacy numbers |

CMS will adjudicate Medicare FFS claims based upon a unique NPI/Legacy combination for Scenarios II and III, but the remittance advice, both electronic and paper, and any output using PC Print or Medicare Remit Easy Print (MREP) will have only NPI as the primary provider identification. The TIN will be used as the secondary identifier for the Payee. The NPI regulation permits continued use of Taxpayer Identification Number (TIN) for tax purposes if the implementation guide allows it.

The Companion Documents and Flat Files for both Part A and B will be updated to reflect these changes and the updated documents will be posted at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp - TopOfPage on the CMS website.

The following three scenarios refer to Medicare reporting of NPIs in remittance advice processes.

**Note that current requirements concerning the reporting of provider names and addresses still apply.**

**Scenario I – Single NPI cross walked to single legacy number:**

- **Electronic Remittance Advice (ERA)** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (Employer Identification Number (EIN) Social Security Number (SSN) (EIN/SSN)) in the REF segment as Payee Additional ID. Medicare will report any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will also report relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, there will be one remittance advice, and one check/Electronic Funds Transfer (EFT) per NPI.
- **Standard Paper Remittance (SPR)** - Medicare will insert the appropriate Payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** - Medicare will show the Payee NPI at the header level and add the relevant Rendering Provider NPI at the claim level if different from the Payee NPI.
- **MREP Software** - Medicare will show the Payee NPI at the header level and add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI, and any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI.

**Scenario II: Multiple NPIs cross walked to Single Medicare legacy number:**

- **ERA** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN)

in the REF segment as Payee Additional ID. Then add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.

- **SPR** - Medicare will insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** - Same as Scenario I.
- **MREP Software** - Same as Scenario I.

**Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:**

- **ERA** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then, Medicare will add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will add relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
- **SPR** - Insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional notes.
- **PC Print Software** - Same as Scenario I.
- **MREP Software** - Same as Scenario I.

**Implementation**

While these changes are effective for dates of service on or after July 2, 2007, the changes will be implemented as follows:

- For claims submitted to DMERcs and/or DME MACs, the changes will be implemented on July 1, 2007.
- For claims submitted to other Medicare contractors, the implementation will occur on October 2, 2007.

**Additional Information**

For complete details regarding this Change Request (CR) please see the official instruction (CR5452) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf on the CMS web site. The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* are attached to CR5452.

# Stage 2 NPI Changes for Transaction 835 and Standard Paper Remittance Advice and Changes in Medicare Claims Processing Manual, Chapter 22 – Remittance Advice

**MLN Matters Number: MM5081 Revised**
**Related Change Request (CR) #: 5081**
**Related CR Release Date: June 30, 2006**
**Related CR Transmittal #: R996CP**
**Effective Date: October 1, 2006**
**Implementation Date: October 2, 2006**

**Special note regarding remittance advice transactions:** Just as it is important to understand when and where to report NPIs in claim transactions, it is crucial that providers understand and be ready to accept the provider identifiers as reported on remittance advice transactions. This article discusses what provider identifiers Medicare will report on remittances under Stage 2 of Medicare's NPI implementation. However, the processes will change as Medicare moves to Stage 3 implementation of the NPI. A key difference is that NPIs will be returned in many remittance transactions as the payee and the TIN as the additional payee identifier rather than the current practice of reporting TIN and legacy number respectively, even though the provider may have included the legacy number and the NPI on their claim. Providers need to review, and understand the impact of, Stage 3 on remittances as discussed in the *MLN Matters* article MM5452, which is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf on the CMS site.

Also, note that this article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

**Provider Types Affected**

All Medicare physicians, providers, suppliers, and billing staff who submit claims for services to Medicare contractors (fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) and durable medical equipment administrative contractors (DME MACs))

**Background**

This article instructs the Shared System Maintainers and FIs, RHHIs, carriers, and DMERCs/DME MACs how to report Medicare legacy numbers and NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advice (ERA) – transaction 835, and Standard Paper Remittance (SPR) advice, any output using PC Print or Medicare Remit Easy Print (MREP) between October 2, 2006, and May 22, 2007.

The Centers for Medicare & Medicaid Services (CMS) has defined legacy provider identifiers to include OSCAR,

National Supplier Clearinghouse (NSC), Provider Identification Numbers (PIN), National Council of Prescription Drug Plans (NCPDP) pharmacy identifiers, and Unique Physician Identification Numbers (UPINs). CMS's definition of legacy numbers does not include taxpayer identifier numbers (TIN) such as Employer Identification Numbers (EINs) or Social Security Numbers (SSNs).

Medicare has published CR4320 (http://www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf) instructing its contractors how to properly use and edit NPIs received in electronic data interchange transactions, via Direct Data Entry screens, or on paper claim forms.

Providers need to be aware that these instructions that impact contractors will also impact the content of their SPR, ERA, and their PC print and MREP software.

The following dates outline the regulations from January 2006 forward and are as follows:

- **January 3, 2006 – October 1, 2006**: Medicare rejects claims with only NPIs and no legacy number.
- **October 2, 2006 – May 22, 2007**: Medicare will accept claims with a legacy number and/or an NPI, and will be capable of sending NPIs in outbound transaction e.g., ERA
- **May 23, 2007 – Forward**: Medicare will only accept claims with NPIs. Small health plans have an additional year to be NPI compliant.

Medicare providers may want to be aware of the following Stage 2 scenarios so that they are compliant with claims regulations and receive payments in a timely manner.

**Key Points**

**During Stage 2,** if an NPI is received on the claim, it will be cross walked to the Medicare legacy number(s) for processing. The crosswalk may result in:

| | | | |
|---|---|---|---|
| **Scenario I:** | Single NPI | cross walked to | Single legacy number |
| **Scenario II:** | Multiple NPIs | cross walked to | Single Medicare legacy number |
| **Scenario III:** | Single NPI | cross walked to | Multiple Medicare legacy numbers |

**Note:** The Standard Paper Remittance for institutional providers would include NPI information at the claim level. NPI information for professional providers and suppliers would be sent at the service level.

CMS will adjudicate claims based upon Medicare legacy number(s) even when NPIs are received and validated. The Remittance Advice (RA) may be generated for claims with the same legacy numbers but different NPIs. These claims with different NPIs will be rolled up and reported in a single RA accompanied by one check or electronic funds transfer (EFT).

During Stage 2, Medicare will report both the legacy number(s) and NPI(s) to providers enabling them to track payments and adjustments by both identifiers. The Companion Documents will be updated to reflect these changes and the updated documents will be posted at http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp - TopOfPage on the CMS web site.

**Important Note:** The following scenarios will change under Stage 3 of Medicare's NPI implementation. To see the changes, see MLN Matters article MM5452, which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf on the CMS website.

**Scenario I – Single NPI cross walked to single legacy number:**

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed.
2. SPR: Insert the legacy number at the header level and the NPI at the claim and/or at the service level. If needed.
3. PC Print Software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

**Scenario II: Multiple NPIs cross walked to Single Medicare legacy number:**

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the legacy number in the REF segment as Payee Additional ID. Then add the specific NPIs at the claim and/or at the service level, if needed. The specific NPI associate with the claim(s)/service lines included in the ERA will need to be identified using additional information provided on the claim.
2. SPR: Insert the legacy number at the header level. Add the specific NPIs at the claim and/or at the service level, if needed.
3. PC Print Software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the legacy number at the header level and the specific NPI at the claim and/or at the service level, if needed.

**Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:**

1. ERA: Under this scenario, use the TIN (EIN/SSN) at the Payee level as the Payee ID, and the appropriate legacy number in the REF segment as Payee Additional ID. Then add the NPI at the claim and/or at the service level, if needed. (Under this scenario, if there are 50 claims with the same NPI and that NPI crosswalks to 5 legacy numbers, we will issue 5 separate RAs and 5 separate checks/EFTs per each legacy number.
2. SPR: Insert the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
3. PC Print Software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.
4. MREP software: Show the appropriate legacy number at the header level and the NPI at the claim and/or at the service level, if needed.

**Additional Information**

The official instructions issued to your Medicare FI, Carrier, RHHI, DMERC, or DME MAC regarding this change can be found at http://www.cms.hhs.gov/transmittals/downloads/R996CP.pdf on the CMS web site. The revised sections of Chapter 22—Remittance Advice of the Medicare Claims Processing Manual is attached to CR5081

The MLN Matters article that provides additional information about Stage 1 Use of NPI is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf on the CMS website.

## NPI: Get It. Share It. Use It.

Over 2 million providers have their NPIs – do you have your NPI yet? Covered entities (including health plans, covered health care providers and clearinghouses) across the country are making decisions regarding their need for contingency plans for NPI implementation. It is more important than ever to obtain an NPI as soon as possible and begin testing it on claims, as directed by your health plan.

Medicare providers should pay special attention to the Medicare information section below for important news on the Medicare FFS Contingency Plan.

**New Compliance Contingency Guidance FAQs**

CMS has posted new FAQs related to the previously posted NPI Compliance Contingency Guidance. Questions include:

- What are the exact dates for the National Provider Identifier (NPI) contingency plan?
- If a complaint is filed against me for not being in compliance with the National Provider Identifier (NPI) after May 23, 2007, what will happen?
- What happens if a complaint for not being in compliance with the National Provider Identifier (NPI) is filed against me after May 23, 2008?
- Is it acceptable for a health plan to announce their National Provider Identifier (NPI) contingency now?
- Is the National Provider Identifier (NPI) contingency plan voluntary?
- Am I allowed to give my National Provider Identifier (NPI) to other providers as well as to the health plans with whom I exchange transactions?

To view these FAQs, you should:

1. Go to the CMS dedicated NPI web page at www.cms.hhs.gov/NationalProvIdentStand
2. Scroll down to the section that says "Related Links Inside CMS"
3. Click on NPI Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated". Look for the word "NEW" in red font to appear beside the most recent FAQs.

**Obtain Information on Contingency Plans**

CMS strongly urges providers to pay attention to information from the health plans they bill so that they are aware if, and when, a specific health plan announces its own contingency plan.

**Reminder – 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, providers who are covered entities under HIPAA must share their NPIs with any entities that need them for billing purposes -- including those who need them for designation of ordering or referring physician. Providers should also consider letting health plans or institutions for whom they work share their NPIs for them.

**Reminder – Enumerating a Group Practice**

A group practice that conducts any of the HIPAA standard transactions is a covered healthcare provider (a covered entity under HIPAA) and, as such, must obtain an NPI. The physicians employed by the group practice, on the other hand, are furnishing services at the group office(s) but they are not conducting any of the HIPAA standard transactions (such as submitting claims, checking eligibility and claim status). As such, the physicians would not be covered health care providers and are not required by the NPI Final Rule to obtain NPIs. However, as the employer, the group could require these physicians to obtain NPIs and use the NPIs to identify them as the rendering providers in the claims that the group submits. If these physicians prescribe medication, the pharmacies may require their NPIs in the claims that the pharmacies submit to health plans. Additionally, health plans can require enrolled physicians to obtain NPIs in order to participate in that plan. Medicare is an example of a health plan with this requirement.

**Reminder – Applying for an NPI Does Not Enroll a Health Care Provider in a Health Plan**

Applying for an NPI and enrolling in a health plan are two completely separate activities. Having an NPI does not guarantee payment by any health plan.

## NPI CONT'D

**When to Contact the NPI Enumerator for Assistance**

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.

**Important Information for Medicare Providers**

**Medicare Fee-For-Service (FFS) Contingency Plan Announced!**

FFS Medicare has announced its contingency plan. View the associated Change Request at www.cms.hhs.gov/transmittals/downloads/R1227CP.pdf, as well as the related MLN Matters article at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website. Please note that these materials were recently revised; please be sure to visit the links above for the latest information. This information will also be available shortly on CMS' dedicated NPI web page.

**Reporting a Group Practice NPI on Claims**

Medicare has identified instances where the Multi-Carrier System (MCS) is correcting billing or pay-to provider data on Part B claims submitted by group practices. As of May 18, 2007, the MCS Part B claims processing systems will no longer correct claims submitted by group practices that are reporting the individual rendering Provider Identification Number (PIN) or individual rendering NPI in either the billing or pay-to provider identifier fields. Groups should enter either their group NPI or group NPI and legacy PIN number pair in either of these fields.

**Still Confused?**

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found at the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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

# Important Guidance Regarding National Provider Identifier Usage in Medicare Claims

**MLN Matters Number: SE0659 Revised**

This article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595 at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

**Provider Types Affected**

Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries

**Provider Action Needed**

You must report your NPI correctly on all electronic data interchange (EDI) transactions that you submit, as well as on paper claims you send to Medicare and telephone Interactive Voice Response (IVR) queries by no later than May 23, 2007, or your transactions will be rejected.

Carriers have reported errors on claims (see Background, below) that will impact your payment when you begin to submit NPIs. Although not mandated until May 23, 2007, providers are currently allowed to submit NPIs in Medicare transactions other than paper claims. NPI will be accepted on the revised paper claim CMS-1500 (0805) and UB-04 forms early in 2007.

Make sure that your billing staffs are using your NPI correctly when they submit your claims for services provided to Medicare beneficiaries or submit electronic beneficiary or claim status queries to Medicare.

**Background**

All HIPAA covered healthcare providers who would either bill Medicare; render care to Medicare beneficiaries; order durable medical equipment, supplies, or services for beneficiaries; refer beneficiaries for other health care services; act as an attending physician when a beneficiary is hospitalized; prescribe covered retail prescription drugs for beneficiaries; operate on beneficiaries; or could otherwise be identified on a claim submitted to Medicare for payment must obtain an NPI. This applies whether providers are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, managed care organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions.

Although the NPI requirement applies by law to covered entities such as healthcare providers, healthcare clearinghouses, and health plans in the U.S. when exchanging electronic transactions for which a national standard has been adopted under HIPAA, HIPAA permits healthcare plans to

elect to require reporting of NPIs in paper claims and for non-HIPAA transaction purposes. Medicare will also require NPIs for identification of all providers listed on the UB-04 institutional paper claim form and of physicians and suppliers listed on the revised CMS-1500 (08-05) professional paper claim form by May 23, 2007.

Medicare will reject paper claims received after May 22, 2007, that do not identify each provider, physician or supplier listed on a paper or electronic claim with an NPI. Medicare will also begin to require an NPI in Interactive Voice Response (IVR) queries effective May 23, 2007.

Retail pharmacies are required to use the NCPDP format adopted as a HIPAA standard for submission of prescription drug claims to Medicare. Since that format permits entry of only one provider identifier each for a pharmacy and the physician who prescribed the medication, retail pharmacies that use the NCPDP HIPAA format can use either their National Supplier Clearinghouse (NSC) number or their NPI to identify themselves, and either the Unique Provider Identification Number (UPIN) or the NPI to identify the prescribing physician prior to May 23, 2007.

May 23, 2007, and later, only an NPI may be reported for identification of pharmacies and prescribing physicians. NCPDP claims received by Medicare after May 22, 2007, that lack an NPI for either the pharmacy or the prescribing physician will be rejected.

This being said, Medicare carriers and fiscal intermediaries (FIs) have reported receiving X12 837-P (professional) and X12-837–I (institutional) claims containing errors that will result in claim rejection, and/or processing delays, if they continue to occur once NPI reporting begins.

**Incorrect information in the 2010A/A Billing Provider Loop in X12 837-P Claims**

Prior to May 23, 2007, carriers will reject claims when the NPI in a loop does not belong to the owner of the Provider Identification Number (PIN) or UPIN that should also be reported in REF02 of the same loop, or if the name and address of the provider in that loop do not correlate with either the NPI, PIN or UPIN in the same loop. The same edits will also be applied to NPIs when received on paper claims prior to May 23, 2007.

Carriers have also detected claims where the rendering physician's or supplier's NPI is reported in the 2010A/A NM1 segment when the claim was submitted by a group to which the physician belongs or the home office of a chain to which a supplier belongs. The 2010A/A loop of an 837-P claim must contain the identifier that applies to the groups/chains (NPI entity 2) that submitted the claims. This rule also applies to identification of the billing provider on a paper claim. Information concerning a billing agent or a healthcare clearinghouse may never be reported in the billing provider loop for a Medicare claim.

To prevent this error, you must report the rendering physician's or supplier's NPI in the NM109 data element in the rendering provider claim level loop (2310B), unless multiple services were furnished by different members of the group/chain. If multiple rendering providers were involved, the information for each must be reported in the service level 2420A loop along with the service(s) each of them rendered.

To facilitate claim processing prior to May 23, 2007, you should also report the rendering provider(s) PIN(s) as the REF02 data element with 1C in REF01 in that same rendering provider loop (2310B for the claim or 2420A for individual services, as applicable).

**Reporting of the Pay-to Address in the Billing Provider (2010A/A) Loop**

Once NPI reporting begins, carriers will reject claims when the pay-to-address, if different than the actual practice location address, is in the 2010A/A (billing provider) loop, rather than in the 2010A/B (pay-to-provider) loop.

***When groups or organizations submit claims, and the billing and the pay-to providers are different individuals or entities, the pay-to information must always be reported in the 2010A/B loop and the billing provider information in the 2010A/A loop.***

**Reporting of the Name and Address of a Billing Provider in the 2010A/A Loop of an X12 837-I (Institutional) Electronic Claim**

FIs will reject claims in which the billing provider and the rendering provider are different entities, and you report the billing provider's name and address in the 2010A/A loop of an X12 837-I (institutional) electronic claim, and the OSCAR number of the rendering provider in that same loop.

If the home office of a chain has obtained one NPI for all facilities it owns, or one of a chain's facilities bills for all (or other) facilities owned by that chain, or a hospital bills for its special units, the home office, hospital or other facility submitting those claims is considered a form of billing agent for Medicare purposes.

In this instance, you must identify the specific provider, for whom the claim is being submitted, as the billing provider for that claim. If a provider that furnished the care had a separate OSCAR number than the entity submitting its claims, the provider that furnished the care must be identified in the billing provider loop. You must also report the name of the facility for whom the claim is being submitted, that facility's address, and should report applicable NPI (when obtained prior to May 23, 2007), as well as the Medicare OSCAR number assigned to that provider in the 2010A/A (billing provider) loop of the claim.

If the home office, hospital or other entity that prepared the claim is to be sent payment for the claim, you must report the name and address, and should report the NPI if issued, and the applicable OSCAR number associated with that entity in the 2010A/B (pay-to-provider) loop prior to May 23, 2007.

However, you should note that Medicare will not issue payment to a third party for a provider solely as result of completion of the 2010A/B loop of an electronic claim. The facility that furnished the care, or the established owner of that facility, must have indicated on their 855 provider enrollment form filed when that facility enrolled in Medicare (or via a subsequent 855 used to update enrollment information) that payments for that facility are to be issued to that home office, hospital, other facility or an alternate third party.

**Additional Information**

For those providers still permitted to submit any paper claims under the restrictions imposed by the Administrative Simplification Compliance Act, Medicare plans to begin accepting paper claims on the revised CMS-1500 (08-05 version) beginning January 2, 2007 (allowing you to report a provider's NPI as well as the applicable PIN or UPIN); and on the revised UB-04 (CMS-1450) form beginning March 1, 2007 (allowing you to report a provider's NPI as well as the applicable OSCAR or UPIN). Medicare carriers plan to reject "old" CMS-1500 forms received after March 31, 2007, and FIs plan to reject UB-92 forms received after April 30, 2007. **Note:** Medicare does not accept NPIs on the "old" versions of the CMS-1500 or UB-92 forms. There are no fields on those forms designed for NPI reporting.

CMS highly recommends that for electronic or paper Medicare claims that you submit during the transition period to full NPI implementation on May 23, 2007, you include both the NPI and the Medicare legacy identifier of each provider for whom you report information.

- When you report an NPI on a claim sent to a carrier for a referring, ordering, purchased service or supervising physician, or for a provider listed in the service facility locator loop, use a UPIN as the Medicare legacy identifier. Furthermore, if any of those physicians are not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007, you should report OTH000 as the UPIN.
- When you report an NPI on a claim sent to an FI for an attending, operating or other physician, or in the service facility locator loop (when those loops apply), you should also report the provider's UPIN. And as above, you may report OTH000 as the surrogate UPIN if any of those providers is not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007.
- Finally, when you report an NPI for a billing, pay-to, or rendering provider identified on a claim sent to a carrier, you should also report the valid Medicare PIN that applies to that physician or supplier. Additionally, you should always report an OSCAR number for each billing, pay-to, or possibly a service facility locator loop provider identified on a claim sent to an FI, as well as the NPI if issued to each of those providers, prior to May 23, 2007.

Remember that failure to report information as described here may result in delayed processing or rejection of your claims.

You can find more information about the National Provider Identifier (NPI) by going to the NPI page at http://www.cms.hhs.gov/apps/npi/01_overview.asp on the CMS Website.

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

**MLN Matters Number: MM5378 – Revised**
**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**

**NOTE:** This article was revised on May 4, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

**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.***

## NPI CONT'D

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.

# Modification of National Provider Identifier Editing Requirements in CR4023 and an Attachment to CR4320

**MLN Matters Number: MM5229 Revised**
**Related Change Request (CR) #: 5229**
**Related CR Release Date: August 18, 2006**
**Related CR Transmittal #: R234OTN**
**Effective Date: October 1, 2006**
**Implementation Date: October 2, 2006**

**Note:** This article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

**Provider Types Affected**

Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Medicare carriers including durable medical equipment regional carriers (DMERCs) (or durable medical equipment Medicare administrative contractors (DME MACs) if appropriate)

**Provider Action Needed**

This article is based on CR5229, which corrects certain business requirements from CR4023 that relate to edits for National Provider Identifiers (NPIs) and provider legacy identifiers when reported on claims, particularly for referring/ordering or other secondary providers, effective October 1, 2006 and later. Additionally, CR5229 revises Attachment 1 to CR4320.

Some of those business requirements erroneously assumed that any provider for whom information is reported in a claim, including a referring/ordering or other secondary provider, would need to be enrolled in Medicare and therefore listed in the Medicare Provider Identifier Crosswalk. This is not always the case. CR5229 modifies those business requirements.

These modifications will enable correct processing of affected claims in October 2006 and later, and will avoid the unnecessary rejection of many claims that involve a referring/ordering or other secondary provider. Please refer to the Background section of this article and to CR5229 for additional important information regarding these modifications.

**Background**

The Medicare Learning Network (MLN) articles, MM4023 and MM4320 which are based on CR4023 and CR4320 respectively, contain important information about the stages of the NPI implementation process. Some of this information is updated in the current article. The links to these articles are located in the Additional Information section of this article. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414). To comply with this requirement, The Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs on May 23, 2005. Applications can be made by mail and online at https://nppes.cms.hhs.gov.

During Stage 2 of the NPI implementation process (October 2, 2006 - May 22, 2007), Medicare will utilize a Medicare Provider Identifier Crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions.

**Primary and Secondary Providers**

Providers, for NPI provider identifier editing purposes, are categorized as either "primary" or "secondary" providers. Primary providers include billing, pay-to, and rendering providers. Primary providers are required to be enrolled in Medicare for the claim to qualify for payment.

Secondary providers are all other providers for which data could be reported on an institutional (837-I) or professional (837-P), free billing software or direct data entry (DDE) claim, or on a revised CMS-1500 or a UB-04 (once those paper claims are accepted by Medicare). Since the UB-92, the currently used CMS-1500, and the HIPAA NCPDP format do not allow reporting of both NPIs and legacy identifiers, information on secondary providers in those claims is not included in the following requirements. **Secondary providers may be enrolled, but are not required to be enrolled in Medicare** (unless they plan to bill or be paid by Medicare for care rendered to Medicare beneficiaries).

**Secondary Provider Claims**

**Claims Submitted with NPI and Medicare Legacy Identifier:**

During Stage 2, claim submitters should submit a provider's Medicare legacy identifier whenever reporting an NPI for a provider. Failure to report a Medicare legacy number for a provider enrolled in Medicare could result in a delay in processing of the claim. When an NPI and a legacy identifier are reported for a provider, Medicare contractors will apply the same edits to those numbers that would have been applied if that provider was a primary provider. (See MM4023.)

There are two exceptions:

1. A Medicare contractor cannot edit a surrogate Unique Provider Identification Number (sometimes called a dummy UPIN, such as OTN000). Despite its name, a surrogate is not actually unique for a specific provider.
2. Only a National Supplier Clearinghouse (NSC) identification number or a UPIN should ever be reported as the legacy numbers on a claim sent to a DMERC/DME MAC. If a carrier Provider Identification Number (PIN) is reported as a legacy identifier with an NPI, DMERCs/DME MACs will edit as if the NPI was the only provider identifier reported for that provider.

**Claims Submitted with NPI Only:**
The NPI is edited to determine if it meets with the physical requirements of the NPI (10 digits, begins with a 1, 2, 3, or 4, and the check digit in the 10th position is correct), and whether there is a Medicare Provider Identifier Crosswalk entry for that NPI.

If the NPI is located in the Crosswalk:

- The Taxpayer Identification Number (TIN) (Employer Identification Number (EIN) or Social Security Number (SSN) and legacy identifier will be sent to the trading partner in addition to the NPI if coordination of benefits (COB) applies.
- However, only the TIN will be forwarded to the COB payer if there is more than one legacy identifier associated with the same NPI in the Medicare Provider Identifier Crosswalk because it may be difficult to know which Medicare legacy identifier applies to that claim.

If the NPI is not located in the Crosswalk:

- No supplemental identifier can be reported to a COB payer.
- However, the claim will not be rejected if the NPI for a referring/ordering provider or another secondary provider cannot be located in the Medicare Provider Identifier Crosswalk, with one exception. Reporting of a Medicare legacy identifier other than a surrogate UPIN signifies a provider is enrolled in Medicare. If a Medicare legacy identifier is reported and cannot be located in the Crosswalk, the claim will be rejected, regardless of whether an NPI was reported for that provider.

**Claims (including UB-92 or the current CMS-1500 paper claims) submitted with Medicare Legacy Identifier Only**

- A Medicare contractor may, but is not required to check a legacy number against the Medicare Provider Identifier Crosswalk.
- As at present, claims will be rejected if any Medicare legacy identifier reported on a claim does not meet the physical requirements (length, if numeric or alphanumeric as applicable) for that type of Medicare provider identifier.

**COB and Medigap Trading Partners**
Legacy identifiers will not be reported to these trading partners for secondary providers if they are not submitted on the claim sent to Medicare, are surrogate UPINs or if the provider is not enrolled in Medicare. If not enrolled, a legacy identifier or a TIN cannot be sent for a "secondary" provider because Medicare would not have issued a legacy identifier to or collected a TIN from that provider.

**837-I or 837-P version 4010A1 Claims**
Attachment 1 to CR4320 which is being revised as part of CR5229 addresses (among other issues), the identification of secondary providers for which the 837-I or 837-P version 4010A1 implementation guides only require reporting of an NPI or other identifier "if known." Unless there is a pre-existing Medicare instruction that mandates the reporting of a specific identifier for those "if known" types of providers, there is no requirement for entry of any identifier for those entities/individuals. If there is no such requirement, claims received that lack an identifier for those types of providers will not be denied.

**Note** that "secondary" providers such as a referring/ordering physician are not required to be enrolled in Medicare as a condition for payment of the services or supplies they order, furnish, supervise delivery of, etc. for beneficiaries when those services are billed, paid-to or rendered by "primary" providers. For example, Medicare could pay:

- A hospital for services ordered for a patient for inpatient hospital care when the admitting or attending physician is not enrolled in Medicare;
- Hospital surgery costs when the surgeon is not enrolled in Medicare; or
- A hospital when services are purchased from another provider "under arrangements" even if that other provider is not enrolled in Medicare.

**Additional Information**

CR4320, issued February 1, 2006, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms" is located at www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf on the CMS web site.

The associated MLN article (with the same title) MM4320, can be found at www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf on the CMS web site.

CR4023, dated November 3, 2005, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms" is located at www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf on the CMS web site. MM4023, the associated MLN article, is located at www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf on the CMS web site.

CR5229 is the official instruction issued to your Medicare carrier/DMERC (DME MAC if appropriate), FI/RHHI regarding changes mentioned in this article. CR5229 may be found at www.cms.hhs.gov/Transmittals/downloads/R234OTN.pdf on the CMS web site.

# Stage 2 Requirements for Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms

**MLN Matters Number: MM4023 Revised**
**Related Change Request (CR) #: 4023**
**Related CR Release Date: November 3, 2005**
**Related CR Transmittal #: 190**
**Effective Date: April 1, 2006**
**Implementation Date: April 3, 2006**

**Note:** This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR5060, which is available at www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf. Also, this article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

**Provider Types Affected**

Physicians, providers, and suppliers who submit claims for services to Medicare carriers, including durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), to include regional home health intermediaries (RHHIs)

**Provider Action Needed**

The requirements for Stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are not based on the date of receipt of a transaction, unless otherwise stated in a business requirement.

Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the NPI in Stage 2 is October 1, 2006.

**Background**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414).

To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005. Applications can be made by mail and also online at https://nppes.cms.hhs.gov/NPPES/Welcome.do.

**NPI and Legacy Identifiers**

The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

**Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers.**

**Legacy provider identifiers include:**

- Online Survey Certification and Reporting (OSCAR) system numbers;
- National Supplier Clearinghouse (NSC) numbers;
- Provider Identification Numbers (PINs); and
- Unique Physician Identification Numbers (UPINs) used by Medicare.

They **do not** include taxpayer identifier numbers (TINs) such as:

- Employer Identification Numbers (EINs); or
- Social Security Numbers (SSNs).

**Primary and Secondary Providers**

Providers are categorized as either "primary" or "secondary" providers:

- Primary providers include billing, pay-to, rendering, or performing providers. In the DMERCs, primary providers include ordering providers.
- Secondary providers include supervising physicians, operating physicians, referring providers, and so on.

**Crosswalk**

During Stage 2, Medicare will utilize a Crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. Key elements of this Crosswalk include the following:

- Each primary provider's NPI reported on an inbound claim or claim status query will be cross-walked to the Medicare legacy identifier that applies to the owner of that NPI.
- The Crosswalk will be able to do a two-directional search, from a Medicare legacy identifier to NPI, and from NPI to a legacy identifier.
- The Medicare Crosswalk will be updated daily to reflect new provider registrations.

**NPI Transition Plans for Medicare FFS Providers**

Medicare's implementation involving acceptance and processing of transactions with the NPI will occur in separate stages, as shown in the table below:

| Stage | Medicare Implementation |
|---|---|
| **May 23, 2005 - January 2, 2006:** | Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase. |
| **January 3, 2006 - October 1, 2006:** | Medicare systems will accept claims with an NPI, but an existing legacy Medicare number **must also be on the claim.** Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, **and** eligibility benefit response electronic transactions. |
| **October 2, 2006 - May 22, 2007:**<br>**(This is stage 2, the subject of CR4023)** | CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim.<br>*Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.*<br>Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions. |
| **May 23, 2007 – Forward:** | CMS systems will only accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007. |

**Claim Rejection**

Claims will be rejected if:

- The NPI included in a claim or claim status request does not meet the content criteria requirements for a valid NPI; this affects:
- X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only);
- National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only);
- Claims submitted using Medicare's free billing software;
- Electronic claim status request received via X12 276 or DDE screen; and
- Non-X12 electronic claim status queries;
- An NPI reported cannot be located in Medicare files;
- The NPI is located, but a legacy identifier reported for the same provider in the transaction does not match the legacy identifier in the Medicare file for that NPI;
- Claims include the NPI but do not have a taxpayer identification number (TIN) reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare's free billing software.

**Note:** If only provider legacy identifiers are reported on an inbound transaction prior to May 23, 2007, pre-NPI provider legacy number edit rules will be applied to those legacy identifiers.

**Additional Information**

X12 837 Incoming Claims and COB

During Stage 2, an X12 837 claim may technically be submitted with only an NPI for a provider, but you are strongly encouraged to also submit the corresponding Medicare legacy identifier for each NPI in X12 837 Medicare claims.

Use of both numbers could facilitate investigation of errors if one identifier or the other cannot be located in the Medicare validation file. When an NPI is reported in a claim for a billing or pay-to provider, a TIN must also be submitted in addition to the provider's legacy identifier as required by the claim implementation guide.

**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 not more than one identifier for the same retail pharmacy or prescribing physician. The NCPDP did provide qualifiers, including one for NPIs, to be used to identify the type of provider identifier being reported.

- For Stage 1, retail pharmacies were directed to continue filing their NCPDP claims with their individual NSC number and to report the UPIN of the prescribing physician.
- During Stage 2, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have the prescribing physician's NPI) in their claims.

When an NPI is submitted in an NCPDP claim, it will be edited in the same way as an NPI submitted in an X12 837 version 4010A1 claim. The retail pharmacy will be considered the primary provider and the prescribing physician as the secondary provider for NPI editing purposes.

**Paper Claim Forms**

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006, and end February

1, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

Pending the start of submission of the revised CMS-1500 and the UB-04, providers must continue to report legacy identifiers, and not NPIs, when submitting claims on the non-revised CMS-1500 and the UB-92 paper claim forms.

Provider identifiers reported on those claim forms are presumed to be legacy identifiers and will be edited accordingly. "Old" form paper claims, received through the end of the transition period that applies to each form, may be rejected if submitted with an NPI.

Or, if they are not rejected—since some legacy identifiers were also 10-digits in length—could be incorrectly processed, preventing payment to the provider that submitted that paper claim.

**Standard Paper Remits (SPRs)**

The SPR FI and carrier/DMERC formats are being revised to allow reporting of both a provider's NPI and legacy identifier when both are available in Medicare's files. If a provider's NPI is available in the data center provider file, it will be reported on the SPR, even if the NPI was not reported for the billing/pay-to, or rendering provider on each of the claims included in that SPR. The revised FI and carrier/DMERC SPR formats are attached to CR4023:

- CR 4023 Attachment 1: FI Standard Paper Remit (SPR) Amended Format for Stage 2; and
- CR 4023 Attachment 2: Carrier/DMERC SPR Amended Stage 2 Format.

Remit Print Software

The 835 PC-Print and Medicare Remit Easy Print software will be modified by October 2, 2006, to enable either the NPI or a Medicare legacy number, or both, if included in the 835, to be printed during Stage 2.

**Free Billing Software**

Medicare will ensure that this software is changed as needed by October 2, 2006, to enable reporting of both an NPI and a Medicare legacy identifier for each provider for which data is furnished in a claim, and to identify whether an entered identifier is an NPI or a legacy identifier.

**In-Depth Information**

Please refer to CR4023 for additional detailed NPI-related claim information about the following topics:

- Crosswalk
- X12 837 Incoming Claims and COB
- Non-HIPAA COB Claims
- NCPDP Claims
- DDE Screens
- Paper Claim Forms
- Free Billing Software
- X12 276/277 Claim Status Inquiry and Response Transactions
- 270/271 Eligibility Inquiry and Response Transactions
- 835 Payment and Remittance Advice Transactions
- Electronic Funds Transfer (EFT)
- Standard Paper Remits (SPRs)
- Remit Print Software
- Claims History
- Proprietary Error Reports
- Carrier, DMERC, and FI Local Provider Files, including EDI System Access Security Files
- Med A and Med B Translators
- Other Translators
- Stages 3 and 4

CR4023, the official instruction issued to your FI/ regional home health intermediary (RHHI) or carrier/durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf on the CMS web site.

You may also wish to review MLN Matters article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities," which is available at www.cms.hhs.gov/MLNMattersArticles/downloads/se0555.pdf on the CMS web site. This article contains further details on the NPI and how to obtain one.

## CMS Announces NPI Enumerator Contractor and Information on Obtaining NPIs

**MLN Matters Number: SE0528 Revised**

This article was revised on May 7, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595 at *www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf* on the CMS website.

**Provider Types Affected**

All health care providers - Medicare and non-Medicare

**Provider Action Needed**

Learn about the NPI and how and when to apply for one.

**Background**

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a new health care identifier for use in the HIPAA standard transactions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary

published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.

The NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). The NPI will identify health care providers in the electronic transactions for which the Secretary has adopted standards (the standard transactions) after the compliance dates. These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace health care provider identifiers that are in use today in standard transactions. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting HIPAA standard transactions with multiple health plans.

All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.

**Important Note:** While you are urged to apply for an NPI beginning May 23, 2005, the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006.

**NPI Enumerator Contract Awarded**

Recently, the CMS announced the selection of Fox Systems, Inc. as the contractor, to be called the Enumerator, to perform the support operations for the NPI project.

Fox Systems, Inc. will process NPI applications from health care providers and operate a help desk to assist health care providers in obtaining their NPIs.

**Who may apply for the NPI?**

All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices are eligible to apply for and receive an NPI. **Note**: All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required by the NPI Final Rule to obtain NPIs. This is true even if they use business associates such as billing agencies to prepare the transactions.

**The NPI Application Process**

Health care providers may begin applying for an NPI on May 23, 2005. Once the process begins, **it will be important to apply for your NPI** before the compliance date of May 2007 because health plans could require you to use your NPI before that date.

You will be able to apply for your NPI in one of three ways:

1. You may apply through an easy-to-use Web-based application process, beginning May 23, 2005. The web address will be https://nppes.cms.hhs.gov/NPPES/Welcome.do, but please note -- the web site is not available until May 23, 2005.
2. Beginning July 1, 2005, you may complete a paper application and send it to the Enumerator. A copy of the application, including the Enumerator's mailing address (where you will send it) will be available on https://nppes.cms.hhs.gov/NPPES/Welcome.do or you can call the Enumerator to receive a copy. The phone number is 1-800-465-3203 or TTY 1-800-692-2326. But remember, paper applications may not be submitted until July 1, 2005.
3. With your permission, an organization may submit your application in an electronic file. This could mean that a professional association, or perhaps a health care provider who is your employer, could submit an electronic file containing your information and the information of other health care providers. This process will be available in the fall of 2005.

You may apply for an NPI using only one of these methods. When gathering information for your application, be sure that all of your information, such as your social security number and the Federal Employer Identification Number, are correct. Once you receive your NPI, safeguard its use.

If all information is complete and accurate, the Web-based process could result in you being issued a number within minutes. If there are problems with the information received, it could take longer. The paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

The transition from existing health care provider identifiers to NPIs will occur over the next couple of years. Each health plan with which you conduct business, including Medicare, will notify you when it will be ready to accept NPIs in standard transactions like claims. You can expect to hear about the importance of applying for an NPI from a variety of sources. Be clear that you only have to apply for, and acquire, one NPI. Your unique NPI will be used for all standard transactions, Medicare and non-Medicare.

Please be particularly aware that applying for an NPI does not replace any enrollment or credentialing processes with any health plans, including Medicare.

**Additional Information**

For additional information on NPIs:

- Visit http://www.cms.hhs.gov/NationalProvIdentStand/06_implementation.asp on the CMS web site.
- Beginning May 23, 2005, visit https://nppes.cms.hhs.gov/NPPES/Welcome.do or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- For HIPAA information, you may call the HIPAA Hotline: 1-866-282-0659, or write to AskHIPAA@cms.hhs.gov on the web.

# New Deadline for Required Submission of Form CMS-1500 (08-05)

**MLN Matters Number: MM5616**
**Related Change Request (CR) #: 5616**
**Related CR Release Date: May 25, 2007**
**Related CR Transmittal #: R1247CP**
**Effective Date: July 1, 2007**
**Implementation Date: July 2, 2007**

**Provider Types Affected**

Physicians and suppliers who qualify for an exemption from the mandatory electronic claims submission requirements, and who submit Medicare claims to carriers, Medicare Administrative Contractors (MACs), and durable Medical Equipment Medicare Administrative Contractors (DME MACs) using the paper claim Form CMS-1500.

**Provider Action Needed**

CR 5616, from which this article is taken announces that, beginning July 2, 2007, you must use the Form CMS-1500, version (08-05) for paper claims submission to Medicare. Claims received on or after July 2, 2007 using Form CMS-1500, version (12-90) will be rejected.

Make sure that your billing staffs use Form CMS-1500 (08-05) for your claims, beginning July 2, 2007.

**Background**

The Form CMS-1500 is the paper claim form that physicians and suppliers, who qualify for an exemption from the mandatory electronic claims submission requirements (as set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32), use to submit claims.

CR 5568, released March 19, 2007, instructed Medicare contractors to continue to accept the earlier (12-90) version of Form CMS-1500 (tentatively until June 1, 2007), because of reports that some vendors had printed the newer (08-05) version of the form incorrectly. After analysis, however, the problem does not appear to be as widespread as previously suspected.

Therefore, CR 5616, from which this article is taken, announces, based on the information at hand, that beginning July 2, 2007, you will need to submit claims using the Form CMS-1500 (08-05).

**Note: CR5616 addresses submission of the revised Form CMS-1500 paper claim form only, and has no bearing on the implementation of the National Provider Identifier (NPI), nor does CR5616 mandate the submission of the NPI by July 1, 2007.**

**Additional Information**

You can find more information about the official instruction issued to your Medicare contractor on this issue (CR5616) at http://www.cms.hhs.gov/Transmittals/downloads/R1247CP.pdf on the CMS website.

# Revisions to Incomplete or Invalid Claims Instructions Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (Version 8/05)

**MLN Matters Number: MM5391 Revised**
**Related Change Request (CR) #: 5391**
**Related CR Release Date: February 23, 2007**
**Related CR Transmittal #: R1187CP**
**Effective Date: May 23, 2007**
**Implementation Date: May 23, 2007**

**Note:** This article was revised on March 20, 2007, to eliminate the words "electronically submitted" from the bullet point at the top of page 3. All other information remains the same. This article was revised on May 8, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 5391 which revises the Medicare Claims Processing Manual (Publication 100-04; Chapter 1, Section 80.3.2) relating to the handling of incomplete and invalid claims to reflect the changes in reporting items for the National Provider Identifier (NPI) on the revised Form CMS-1500 version 08/05 and updates the references to remark codes in the instructions and revises the instructions to indicate what is consistent with Health Insurance Portability and Accountability Act (HIPAA) guidelines. Affected providers should assure their billing staff are aware of NPI reporting requirements. These changes apply to claims received on or after May 23, 2007.

**Background**

The Centers for Medicare & Medicaid Services Form 1500 (CMS-1500; Health Insurance Claim Form) has been revised to accommodate the reporting of the National Provider Identifier (NPI). The revised form is designated as Form CMS-1500 (8/05). The revisions to CMS-1500 include additional items for the reporting of the NPI. The manual revisions also include items that have already been implemented through the Competitive Acquisition of Part B Drugs and Biologicals (CAP) through the following Change Requests (CRs):

- CR4064 at http://www.cms.hhs.gov/Transmittals/Downloads/R777CP.pdf, and MLN Matters article MM4064 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4064.pdf;
- CR4306 at http://www.cms.hhs.gov/transmittals/downloads/R841CP.pdf;
- CR4309 at http://www.cms.hhs.gov/transmittals/downloads/R866CP.pdf; and MLN Matters article MM4309 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4309.pdf;
- CR5079 at http://www.cms.hhs.gov/transmittals/downloads/R1055CP.pdf; and
- CR5259 at http://www.cms.hhs.gov/transmittals/downloads/R1034CP.pdf.

As a result of the revisions included in the Form CMS-1500 (8/05), the incomplete and invalid claims instructions are being updated to reflect the appropriate items in which the NPI will be reported.

CR 5391 instructs Medicare contractors (carriers, DMERCs, DME MACs, and A/B MACs):

- To make all necessary changes to their internal business processes to enable the return of claims as unprocessable that do not report an NPI when required in a provider name segment or another provider identification segment in an electronic or a CMS-1500 (08/05) paper claim. See the Medicare Claims Processing Manual (Pub. 100-04), Chapter One (Sections 80.3.2.1.1 through 80.3.2.1.3) included as an attachment to CR5391, and the Health Care Claim Professional 837 Implementation Guide (http://www.wpc-edi.com/) for further information.
- To use the appropriate remittance advice remark codes provided in the Medicare Claims Processing Manual, Chapter One, (Pub. 100-04), Chapter One, Sections 80.3.2.1.1 through 80.3.2.1.3, when returning claims as unprocessable.
- To not search their internal files:
- To correct a missing or inaccurate NPI on a Form CMS-1500 (8/05) or on an electronic claim.
- To correct missing or inaccurate information required for HIPAA compliance for claims governed by HIPAA.

**Additional Information**

For complete details, please see the official instruction issued to your Medicare contractor (carrier, DMERC, A/B MAC, or DME MAC) regarding this change. That instruction may be viewed at www.cms.hhs.gov/Transmittals/downloads/R1187CP.pdf on the CMS website.

## Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500

**MLN Matters Number: MM5060 Revised**
**Related Change Request (CR) #: 5060**
**Related CR Release Date: September 15, 2006**
**Related CR Transmittal #: R1058CP**
**Effective Date: January 1, 2007**
**Implementation Date: January 2, 2007**

**Note:** This article was revised on May 8, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007, implementation of the NPI. For some period after May 23, 2007, Medicare FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the *MLN Matters* article, MM5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS website.

**Provider Types Affected**

Physicians and suppliers who bill Medicare carriers including durable medical equipment regional carriers (DMERCs) for their services using the Form CMS-1500.

**Key Points**

- The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the National Provider Identifier (NPI).
- The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until April 2, 2007.
- During this transition time there will be a dual acceptability period of the current and the revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the split provider identifier fields.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.

- There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

| | |
|---|---|
| **January 2, 2007 – March 30, 2007** | Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version. **Note**: Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08-05) by January 2, 2007. |
| **April 2, 2007** | The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used. **Note**: All **rebilling** of claims should use the **revised** Form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12-90). |

**Background**

Form CMS-1500 is one of the basic forms prescribed by CMS for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The CMS-1500 form is being revised to accommodate the reporting of the National Provider Identifier (NPI).

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Thus, small plans may need to receive legacy provider numbers on coordination of benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

In a related Change Request, CR4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report Provider Identification Numbers (PINs) and Unique Physician Identification Numbers (UPINs) as applicable.

There were no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. Change Request 4293 provided guidance for implementing the revised Form CMS-1500 (08-05). This article, based on CR 5060, provides additional Form CMS-1500 (08-05) information for Medicare carriers and DMERCs, related to validation edits and requirements.

**Billing Guidelines**

- When the NPI number is effective and required (May 23, 2007, although it can be reported starting January 1, 2007), claims will be **rejected** (in most cases with reason code 16 – "claim/service lacks information that is needed for adjudication") in tandem with the appropriate remark code that specifies the missing information,

  **if**

- The appropriate **NPI is not entered** on Form CMS-1500 (08-05) in items:
  - **24J** (replacing item 24K, Form CMS-1500 (12-90));
  - **17B** (replacing item 17 or 17A, Form CMS-1500 (12-90));
  - **32a** (replacing item 32, Form CMS-1500 (12-90)); and
  - **33a** (replacing item 33, Form CMS-1500 (12-90)).

**Additional Information**

**When the NPI Number is Effective and Required (May 23, 2007)**

To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.

Legacy identifiers are pre-NPI provider identifiers such as:

- PINs (Provider Identification Numbers)
- UPINs (Unique Physician Identification Numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSCs (National Supplier Clearinghouse numbers) for DMERC claims.

**Additional NPI-Related Information**

Additional NPI-related information can be found at www.cms.hhs.gov/NationalProvIdentStand/ on the CMS web site.

The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Web site at www.nucc.org/images/stories/PDF/change_log.pdf.

MLN Matters article MM4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms," can be found at www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf on the CMS web site.

CR4293, Transmittal Number 899, "Revised Health Insurance Claim Form CMS-1500," provides contractor guidance for implementing the revised Form CMS-1500 (08-05). It can be found at www.cms.hhs.gov/transmittals/downloads/R899CP.pdf on the CMS web site.

MLN Matters article MM4023, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms," can be found at www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf on the CMS web site.

CR5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going to www.cms.hhs.gov/Transmittals/downloads/R1058CP.pdf on the CMS web site.

## Item 11 Submission for Paper Claims

Item 11 on the CMS-1500 paper claim form **is a required field** and **must be completed** on all claims submitted to Medicare. By completing this item, the supplier acknowledges having made a good faith effort to determine whether Medicare is the primary or secondary payer for the services being submitted for payment.

There are only two possible responses for item 11:

1. **None**
   Reporting **None** informs Medicare that the beneficiary has no insurance primary to Medicare for this claim. There is **no** Explanation of Benefits/Remittance Advice attached to the claim when **None** is reported in item 11.
2. **Insurance Policy Number**
   By placing an insurance policy number in Item 11, the supplier is notifying Medicare that there is another insurance primary to Medicare for this claim. The supplier **must attach** an Explanation of Benefits/Remittance Advice to the claim when a policy number is reported in item 11.

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

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

For more information on how to correctly submit a CMS-1500 (08-05) claim form, refer to the CMS-1500 Claim Form (08-05) interactive tutorial located on the Noridian Administrative Services (NAS) website at: www.noridianmedicare.com. To access the tutorial, select the "Claims" tab from the drop down box beneath DME on the NAS homepage. The tutorial is listed beneath the "Claims Filing Information" subtitle in the left hand column.

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



# BILLING

## Capped Rental Month Modifiers - KH, KI, KJ

**If the wrong rental month modifier is applied to capped rental items, effective June 4, 2007 the claim will be denied as unprocessable and must be corrected and resubmitted.**

To prevent delays in payment and assure accurate processing of capped rental items, it is important to use the modifier that indicates the correct rental month. The first three months of a capped rental item is calculated to limit the monthly rental to 10% of the allowed purchase price. Therefore, the KH modifier must be used on the first month and KI on the second and third months.

For each additional month, the allowance is reduced to 7.5% of the allowed purchase price. Therefore, the KJ modifier must be used for months four through thirteen.

## PO Box vs. Street Address

It recently came to our attention that many suppliers are mailing claims and correspondence to the NAS street address rather than to the appropriate PO box. This delays the processing of claims and correspondence.

Therefore, to expedite processing, we encourage suppliers to send DME claims or correspondence to the following DME PO boxes:

| Type of Mail | Address |
|---|---|
| Claims<br>Redetermination Requests<br>General Correspondence | Noridian Administrative Services<br>PO Box 6727<br>Fargo ND 58108-6727 |
| Electronic Funds Transfer Forms | Noridian Administrative Services<br>PO Box 6728<br>Fargo ND 58108-6728 |
| Benefit Protection | Noridian Administrative Services<br>PO Box 6736<br>Fargo ND 58108-6736 |
| Administrative Simplification Compliance Act (ASCA) | Noridian Administrative Services<br>PO Box 6737<br>Fargo ND 58108-6737 |

The street address should **only** be used in the rare circumstance where correspondence needs to be sent via a courier service.

In addition, if you are a supplier/provider who also submits claims/correspondence to Part B, those items need to be mailed to the appropriate Part B PO box. A complete listing of the Part B PO boxes can be found at www.noridianmedicare.com in the Contact section under Phone and Mail Contact Information.

We would also like to remind suppliers that NAS does **not** need notification of your NPI number via a letter. The NPI is reported to us each time you submit a claim with the NPI number. Remember to include your legacy number on all claims during the conversion to NPI or until advised by CMS to do differently.

## DME Upgrades, ABNs and Claims Modifiers

GK and GL modifiers are used on claims for upgraded DMEPOS items. An upgrade is defined as an item that goes beyond what is medically necessary under Medicare's coverage requirements. An item can be considered an upgrade even if the physician has signed an order for it.

Use of the GK and GL modifiers allows the DME MAC to automate the downcoding at the time of the initial determination. The advantage to suppliers is that they will not receive a total denial at the time of initial determination. Therefore the claim will not have to be sent through the appeals process in order to be paid comparable to the least costly alternative. Some examples (not all-inclusive) of situations in which this would be used are downcoding between different types of power wheelchairs, different types of hospital beds, different type of prosthetic components, or from a bi-level positive airway pressure device to a CPAP.

The GK and GL modifiers are used and the following instructions apply only when suppliers provide an upgrade – i.e., an item that goes beyond what is covered by Medicare.

The descriptions of the modifiers are:

**GK** - Reasonable and necessary item/service associated with a GA or GZ modifier

**GL** - Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN

If the beneficiary does not meet the coverage criteria specified in the medical policy for the item that is provided, but does meet the criteria for a different type device, the GK or GL modifier must be used. Suppliers decide which modifier to use depending on whether or not they want to collect the difference between the submitted charge for the upgraded item and the submitted charge for the item that meets coverage criteria from the beneficiary.

**Supplier Collects Additional Charge for Upgrade – GK/GA Modifiers**

If a supplier wants to collect the difference from the beneficiary, a properly completed ABN must be obtained. If an ABN is obtained, the supplier bills the HCPCS code for the item that is provided (but that does not meet coverage criteria) with a GA modifier on one claim line and the HCPCS code for the item that meets coverage criteria with a GK modifier on the next claim line. (Note: The codes must be billed in this specific order on the claim.) In this situation, the claim line with the GA modifier will be denied as not medically necessary with a "patient responsibility" (PR) message and the claim line with the GK modifier will continue through the usual claims processing.

**Supplier Provides Upgrade without Additional Charge – GL Modifier or GK/GZ Modifiers**

If a supplier wants to provide the upgrade without any additional charge to the beneficiary, then no ABN is obtained. In this situation, there are two options for claim submission:

1. If the physician has ordered the upgrade or if the upgrade is provided without additional charge for supplier convenience, the supplier only bills the HCPCS code for the item that meets coverage criteria with a GL modifier. The HCPCS code for the item that is provided is not billed. The code with the GL modifier will continue through the usual claims processing.
2. If the physician has not ordered the upgrade but it is provided at the request of the beneficiary, the supplier bills the HCPCS code for the item that is provided (but that does not meet coverage criteria) with a GZ modifier on one claim line and the HCPCS code for the item that meets coverage criteria with a GK modifier on the next claim line. (Note: The codes must be billed in this specific order on the claim.) In this situation, the claim line with the GZ modifier will be denied as not medically necessary with a "contractual obligation" (CO) message and the claim line with the GK modifier will continue through the usual claims processing.

**KX Modifier**

If there is a requirement in a specific policy to use a KX modifier to indicate that an item meets coverage criteria, then it is used in addition to the GK or GL modifier. For example:

- If a power wheelchair that does not meet coverage criteria specified in the policy is provided and an ABN is obtained, the supplier bills the HCPCS code for the PWC that is provided with a GA modifier and no KX modifier on one claim line and the HCPCS code for the PWC that meets coverage criteria with a GK modifier and a KX modifier on the next claim line.
- If a supplier does not obtain an ABN and therefore provides an upgrade without any additional charge to the beneficiary, the supplier either
    1) Bills the HCPCS code for the item that meets coverage criteria with the GL modifier and a KX modifier or
    2) Bills the HCPCS code for the PWC that is provided with a GZ modifier and no KX modifier on one claim line and the HCPCS code for the PWC that meets coverage criteria with a GK modifier and a KX modifier on the next claim line. The specific situations in which the GZ/GK combination is used instead of the GL are discussed above.

**Orders and the EY Modifier**

In order to use the GK or GL modifier, the supplier must have a physician order for one of the items. An order for either the covered or upgraded item is acceptable.

If the GK or GL modifier is used as specified in these instructions, the EY should not be used – i.e., it is not used on the GA, GK, or GL claim line. This is an exception to the general instruction that an EY modifier is added to a code if there is no physician order for the item that is billed.

The supplier may not use the GK or GL modifiers if there is no physician order for either the upgraded item or the item that otherwise meets coverage criteria. In this situation, the HCPCS code for the item that is provided must be billed with an EY modifier and the claim line will be denied.

The supplier may not use the GK or GL modifiers if there is a physician order for the upgraded item but the supplier provides an item that meets coverage criteria. In this situation, the HCPCS code for the item that is provided is billed but the EY modifier should not be used. This is another exception to the general instruction that an EY modifier is added to a code if there is no physician order for the item that is billed.

**Other Requirements/Instructions**

In order to use the GK or GL modifiers, the upgraded item must be within the range of items that are medically appropriate for the beneficiary's medical condition and the purpose of the physician's order. For example, there could be an upgrade between two different types of wheelchairs but the upgrade modifiers would not be used if a walker met a patient's mobility needs but the beneficiary chose to obtain a wheelchair.

When using the GK or GL modifier, the supplier must specify the manufacturer and model name/number of the item that is actually furnished – i.e., the upgraded item – and describe why this item is an upgrade. This information must be included in the narrative field of the electronic claim (item 19 of the CMS-1500 claim form).

Codes with a GK or GL modifier will continue through the usual claims processing. Other edits may cause the GK/GL claim line to be paid at a less costly alternative or to be denied. However, if no other edits are involved, payment would be made for the code with the GK or GL modifier.

An upgrade may be from one HCPCS code to another code or it may be from one item to another item within a single HCPCS code. When an upgrade is within a single code, the upgraded item must include features that exceed the official code descriptor for that item.

Refer to the CMS Internet-Only Claims Processing Manual, Publication 100-04, Chapter 20, Sections 120 and 120.1 for additional billing information.

These instructions are effective for claims with dates of service on or after April 1, 2007.

Please see the table below for examples of how to use these modifiers.

**DME Upgrades and ABN and Claim Modifiers**

An upgrade is defined as an item that goes beyond what is medically necessary under the Medicare coverage requirements.

| | ABN Required | Required Modifier(s) | DMAC Payment | Beneficiary Pays for Upgrade |
|---|---|---|---|---|
| **1. Physician orders upgrade:** | | | | |
| a. Supplier provides upgrade free of charge | No | GL | R&N item only (GL line) | No |
| b. Supplier bills beneficiary for upgrade | Yes | GA/GK | R&N item only (GK line) | Yes |
| **2. Patient requests upgrade:** | | | | |
| a. Supplier provides upgrade free of charge to beneficiary | No | GZ/GK | R&N item only (GK line) | No |
| b. Supplier bills beneficiary for upgrade | Yes | GA/GK | R&N item only (GK line) | Yes |
| **3. Supplier provides upgrade for supplier convenience:** | | | | |
| a. Supplier provides upgrade free of charge to beneficiary | No | GL | R&N item only (GL line) | No |

GK or GL is added to the HCPCS code for the item that meets Medicare coverage requirements.

When GK is used, GA or GZ is added to the HCPCS code for the item that is provided.

R&N = Reasonable and necessary

## Changes in Maintenance and Servicing

NAS is receiving claims incorrectly billed for maintenance and servicing. Under the Deficit Reduction Act of 2005, payment methods for maintenance and servicing for both capped rental items and oxygen equipment have changed.

The title for equipment under the capped rental category will transfer to the patient after 13 months when the first rental month occurs on or after January 1, 2006. Payment will no longer be made every six months for maintenance and servicing. Once the patient owns the equipment, however, Medicare will cover reasonable and necessary repairs and servicing.

Effective January 1, 2006, Medicare will pay for oxygen equipment for 36 months. After the 36th month, the beneficiary will own the equipment. For beneficiaries receiving oxygen equipment on or before December 31, 2006, the 36-month rental period begins on January 1, 2006. Payment may be made for maintenance and servicing of oxygen equipment every six months, beginning six months after the beneficiary owns the equipment.

Suppliers should check their automated billing systems to ensure that maintenance and servicing charges are not being billed incorrectly. Complete information on this change can be found in MLN Matters 5461.

## Reminder for Submitting Narratives

When narratives are submitted on electronic claims to provide additional information related to the service line, they should be entered at the line level, 2400 loop in the NTE segment. This is a free form text field with a limit of 80 characters. If all of the information does not fit, include the word "cont" in the narrative in the 2400 NTE segment and continue the narrative in the claim level 2300 NTE segment. This will allow for an additional 80 characters.

Instructions for adding narratives in the Express Plus software are in Section 2, Claim Entry, of the Express Plus User Manual available at www.cignamedicare.com/edi/dmerc/pdf/Express_Plus_Manual.pdf. Suppliers may also call the EDI helpdesk at 1-866-224-3094 for assistance.

## Narrative for Temporary Replacement Codes

When billing temporary replacement codes, the narrative needs to contain a brief explanation of why it is being billed. For example, K0462 (Temporary replacement for patient owned equipment being repaired, any type) could be billed with the narrative "loaner while K0011 is repaired." If a supplier chooses to include additional information in the narrative, the explanation of the reason for the temporary equipment should be reported first, followed by any other additional information.

As a reminder, place the narrative for specific codes at the line level, NTE segment, 2400 loop for electronic claims and in Item 19 for CMS-1500 paper claim forms.

## Announcement Regarding Part B Paid Claims That Overlap Non-pay SNF Claims

As was discussed at the March 28, 2007, Skilled Nursing Facility-Long Term Care Open Door Forum, Part B paid claims that overlap non-pay SNF claims are rejecting in error. On April 27, 2007, CMS released a change request that addresses the situation: Change Request Number 5587, Transmittal Number R274OTN, "Invalid Skilled Nursing Facility (SNF) Information Unsolicited Responses (IURs) from CWF." This CR can be found at the CMS website 2007 Transmittals page:

www.cms.hhs.gov/Transmittals/2007Trans/list.asp?sortByDID=2a&filterType=none&filterByDID=-99&sortOrder=ascending&intNumPerPage=10&submit.x=7&submit.y=14.

CMS has commissioned the CWF maintainer to create a program that will automatically identify the Part B claims that were erroneously rejected for the FIs, Part A MACs, MCS carriers, and DME MACs. The FISS maintainer has created an additional utility that will automatically adjust the Part B claims and reinstate the payment that was erroneously recouped. The FIs will be utilizing this program during the weekend of May 26th and 27th. The applicable providers will be able to view the corrected claims during the week of May 28th through June 1st and should expect payment shortly thereafter.

Regarding the Part B MCS carriers and DME MACs, these contractors will be manually adjusting these claims now that CR 5587 has been released. The applicable providers will begin seeing these claims online and should expect to receive payment immediately thereafter. Part B providers are encouraged to allow the Medicare contractors to reprocess these claims and to not resubmit or adjust them in the meantime. If there are any questions or concerns relating to the timeframes in which these claims will be reprocessed, please contact the appropriate FI, carrier, or DME MAC.

## Discontinuance of UPIN Registry

**MLN Matters Number: MM5584**
**Related Change Request (CR) #: 5584**
**Related CR Release Date: May 31, 2007**
**Related CR Transmittal #: R207PI**
**Effective Date: May 29, 2007**
**Implementation Date: June 29, 2007**

**Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment 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) 5584 which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning Unique Physician Identification Numbers (UPINs) on June 29, 2007.

The National Provider Identifier (NPI) is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.) Information on that contingency plan is at http://www.cms.hhs.gov/NationalProvIdentStand/downloads/NPI_Contingency.pdf on the CMS site.)

If you do not have an NPI, you should obtain one as soon as possible. Applying for an NPI is fast, easy and free by going to the National Plan and Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov/. See the Background and Additional Information Sections of this article for further details.

**Background**

The Centers for Medicare & Medicaid Services (CMS) was required by law to establish an identifier that could be used in Medicare claims to uniquely identify providers/suppliers who order services for Medicare patients or who refer Medicare patients to physicians and certain other suppliers. The UPIN was established to meet this requirement. CMS assigns UPINs to those physicians and eligible suppliers who are permitted by Medicare to order or refer in the Medicare program. Medicare claims for services that were ordered or for services that resulted from referrals must include UPINs to identify the providers/suppliers who ordered the services or made the referral.

On January 23, 2004, the Secretary of Health and Human Services published a Final Rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the National Provider Identifier (NPI). The NPI will replace all legacy provider identifiers that are used

in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007 (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007, but see the note in the following box regarding the May 23, 2007 implementation by Medicare.

Important Note: Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007. For more information on this contingency plan, please visit the NPI dedicated website at http://www.cms.hhs.gov/NationalProvIdentStand/. This contingency plan does not affect CMS plans to discontinue assigning UPINs on June 29, 2007 or to disable the UPIN "look-up" functionality as of September 30, 2007.

The CMS will discontinue assigning on June 29, 2007, but CMS will maintain its UPIN public "look-up" functionality and Registry website (http://www.upinregistry.com/) through September 30, 2007.

**Additional Inf.ormation**

For additional information regarding NPI requirements and use, please see MLN Matters articles, MM4023 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf) titled Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms, and MM4293 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4293.pdf ) titled Revised CMS-1500 Claim Form, which describes the revision of claim form CMS-1500 (12-90) to accommodate the reporting of the National Provider Identifier (NPI) and renamed CMS-1500 (08-05).

The official instruction, CR5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R207PI.pdf on the CMS website.

## Invalid SNF Informational Unsolicited Responses from Medicare's Common Working File System

**MLN Matters Number: MM5587**
**Related Change Request (CR) #: 5587**
**Related CR Release Date: April 27, 2007**
**Related CR Transmittal #: R2740TN**
**Effective Date: April 27, 2007**
**Implementation Date: July 2, 2007**

**Provider Types Affected**

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

**Provider Action Needed**

Medicare systems may have inadvertently rejected outpatient, Part B, and DME claims that overlapped periods of a SNF stay by a beneficiary, whose Medicare SNF benefits were exhausted and for whom a non-pay SNF claim was submitted to Medicare.

This problem may have affected some of your claims processed by Medicare from October 2, 2006 until January 29, 2007, when Medicare systems were fixed.

You need not take any action as your Medicare contractor will take steps to adjust any claims affected and to reverse or stop any payment recovery actions. See the Background section for more details.

**Background**

Providers need to be aware that the Centers for Medicare & Medicaid Services (CMS) has identified an issue with processing outpatient, Part B, and DME claims for beneficiaries who are in a SNF, but whose Medicare coverage for the SNF stay has ended. In October of 2006 Change Request (CR) 4292 (Benefits Exhaust and No-Payment for Medicare FIs and SNFs) was implemented. CR4292 (see *Additional Information* section for the CMS website address of CR4292) mandated that providers submit ALL SNF non-pay claims after benefits were exhausted to allow CMS to track the beneficiary's benefit period.

Medicare system changes relating to CR4292 caused outpatient, Part B, and DME paid claims that overlap non-pay SNF claims to be rejected. **This is an error and your Medicare contractor will adjust claims or payment recovery actions resulting from this problem.** The CWF coding change to fix this problem was effective and in production on January 29, 2007 and CWF will provide a list of claims to the applicable contractors to allow for corrections and payment to be made to providers.

**Key Points**

CMS has directed Medicare contractors to correct any claims that were adjusted as a result of the problem with implementation of CR4292.

- Any providers whose claims were impacted will be paid any payment recovered to include any interest charged.
- Where the payment recovery has not occurred, the Medicare contractor will stop such action.

**Additional Information**

For complete details regarding this CR please see the official instruction (CR5587) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R274OTN.pdf on the CMS website.

The *MLN Matters* article for CR4292, *Benefits Exhaust and No-Payment for Medicare FIs and SNFs*, can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4292.pdf on the CMS website.

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

**MLN Matters Number: MM5603**
**Related Change Request (CR) #: 5603**
**Related CR Release Date: May 25, 2007**
**Related CR Transmittal #: R1253CP**
**Effective Date: July 1, 2007**
**Implementation Date: July 2, 2007**

**Provider Types Affected**

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

**Background**

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

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

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

- An appeal process will not be allowed for RTP'ed claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the National Correct Coding Contractor.
- Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability"), and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

**Additional Information**

To see the official instruction (CR5603) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1253CP.pdf on the CMS website.

## Transitioning the Mandatory Medigap ("Claim-Based") Crossover Process to Coordination of Benefits Contractor

**MLN Matters Number: MM5601**
**Related Change Request (CR) #: 5601**
**Related CR Release Date: May 18, 2007**
**Related CR Transmittal #: R1242CP**
**Effective Date: October 1, 2007**
**Implementation Date: October 1, 2007**

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 5601, which outlines the Centers for Medicare & Medicaid Services (CMS) systematic requirements for the transitioning of its mandatory Medigap ("claim-based") crossover process from its Part B contractors to the COBC. During the period from June through September 2007, CMS' Coordination of Benefits Contractor (COBC) will sign national crossover agreements with Medigap claim-based crossover insurers and will assign new 5-digit Coordination of Benefits (COBA) Medigap claim-based crossover identifiers to these entities for inclusion on incoming Medicare claims. CMS is also preparing a separate change request (CR 5662) that includes the website where provider billing staffs may go to obtain the listing of new COBA Medigap claim-based identifiers for purposes of initiating Medigap claim-based crossovers. Within the next few weeks, following the issuance of CR 5662, providers will also receive more detailed information regarding this change via their Medicare contractors' provider newsletters/bulletins and websites.

**October 1, 2007 is the effective date for completing the transition of the Medigap crossover process to the COBC.** At that time, CMS will then only support the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X-12N 837 professional COB (version 4010-A1) claim format **and National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claim format for such crossovers.** As CMS' COBC assigns the new COBA Medigap claim-based ID to the Medigap insurers, it will populate this information on its COB website so that provider billing staffs may access it for purposes of including

the new identifiers on incoming Medicare Part B claims, claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and NCPDP Part B drug claims. By October 1, 2007, providers will exclusively be including the new identifiers on incoming claims to initiate Medigap claim-based crossovers.

During June through September, 2007, CMS will gradually be moving Medigap insurers to the new process. Be certain that your billing staffs are aware of these changes and that claims are sent to Medicare contractors in a timely and correct manner.

**Background**

Currently, in accordance with §1842(h)(3)(B) of the Social Security Act and §4081(a)(B) of Public Law 100-203 (the Omnibus Budget Reconciliation Act of 1987), Part B contractors, including carriers and Medicare Administrative Contractors (MACs), and Durable Medical Equipment Regional Carriers (DMERCs)/DME Medicare Administrative Contractors (DMACs) transfer participating provider claims to Medigap insurers if the beneficiary has assigned rights to payment to the provider and if other claims filing requirements are met. This form of claims transfer is commonly termed "Medigap claims-based crossover." One of the "other" claims filing requirements for Medigap claim-based crossover is that the participating provider must include an Other Carrier Name and Address (OCNA) or N-key identification number on the incoming electronic claim to trigger the crossing over of the claim.

**Key Points of CR5601**

- Be aware that during the transition period from June through September 2007 the COBC will assign new 5-byte claim-based Coordination of Benefits Agreement (COBA) IDs to the Medigap insurers on a graduated basis throughout the three month period prior to the actual transition. Until CMS' COBC assigns a new 5-digit COBA Medigap claim-based ID to a Medigap insurer, Medicare will continue to accept the older contractor-assigned OCNA or N-key identifiers for purposes of initiating Medigap claim-based crossovers. During June through September 2007, the affected contractors will also continue to cross claims over as normal to their Medigap claim-based crossover recipients. CMS will be regularly apprising the affected Medicare contractors when -the COBC has assigned new COBA Medigap claim-based IDs to the Medigap insurers and will post this information on its COB website so that contractors may direct providers to that link for purposes of obtaining regular updates.
- Effective with claims filed to Medicare on October 1, 2007:
    - All participating providers that have been granted a billing exception under the Administrative Simplification Compliance Act (ASCA) should enter CMS' newly assigned COBA Medigap claim-based identifier (ID) within block 9-D of the incoming CMS-1500 claim for purposes of triggering Medigap claim-based crossovers.
    - All other participating providers shall enter the newly assigned COBA Medigap claim-based ID, left-justified and followed by spaces, within the NM109 portion of the 2330B loop of the incoming HIPAA ANSI X12-N 837 professional claim and within field 301-C1 of the T04 segment on incoming National Council for Prescription Drug Programs (NCPDP) claims for purposes of triggering Medigap claim-based crossovers.
- Providers will need to make certain that claims are submitted with the appropriate identifier that begins with a "5" and contains "5" numeric digits.
- Be mindful that claims for Medigap claim-based crossovers shall feature a syntactic editing of the incoming COBA claim-based Medigap ID to ensure that the identifier begins with a "5" and contains 5 numeric digits. If your claim does not follow the appropriate format, Medicare will continue to adjudicate your claim as normal but will notify you via the Electronic Remittance Advice (ERA) and the beneficiary via the Medicare Summary Notice (MSN) that the information reported was insufficient to cause the claim to be crossed over.
- Your Medicare contractor's screening process will also continue to verify that you participate with Medicare and that the beneficiary has assigned benefits to you as the provider.
- If the claim submitted to the Medicare contractor indicates that (1) the claim contained an invalid claim-based Medigap crossover ID, **the Medicare contractor** will send the following standard message to you, the provider.
- "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning the insurer. **Please verify your information and submit your secondary claim directly to that insurer."**
- In addition, in these cases, if CMS' Common Working File (CWF) system determines that the beneficiary was identified for crossover on a Medigap insurer's eligibility file, the CWF system will suppress crossover to the Medigap insurer whose information was entered on the incoming claim.
- Also, the Medicare contractor will include the following message on the beneficiary's MSN in association with the claim: (MSN #35.3):
    - "A copy of this notice will not be forwarded to your Medigap insurer because the Medigap information submitted on the claim was incomplete or invalid. Please submit a copy of this notice to your Medigap insurer."
- **REMEMBER:** As CMS's COBC assigns new 5-digit COBA Medigap claim-based identifiers to Medigap insurers, participating providers will be expected to include the new 5 digit identifier on incoming crossover claims for purposes of triggering claim-based Medigap crossovers. Additionally, effective with **October 1, 2007, Medigap claim-based crossovers will occur exclusively through the COBC in the HIPAA ANSI X12-N 837 professional claim format (version 4010A1 or more current standard) and NCPDP claim format.**

## BILLING CONT'D

**Additional Information**

For complete details regarding this Change Request (CR) please see the official instruction (CR5601) issued to your Medicare carrier, A/B MAC, DME MAC, or DMERC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1242CP.pdf on the CMS website.

## 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.

## APPEALS

# Telephone Reopenings

Effective immediately, telephone reopenings should be initiated by calling the telephone reopening line at 1-888-826-5708. Representatives are available Monday through Friday from 10 am to 4 pm CT. If requests for reopenings are made through the Supplier Contact Center, callers will be redirected to call the telephone reopenings line.

Reopenings can be done for diagnosis changes/additions, date of service changes, clerical errors and much more. For a complete listing, see Telephone Reopenings.

# Telephone Reopening Changes

Effective Monday, June 11, 2007, all categories of DMEPOS claim corrections for clerical errors or omissions will be allowed as a phone reopening.

Also, effective on this date, the following issues will not be taken as a phone reopening request. The following situations must be submitted in writing, along with supporting documentation, as a redetermination. In addition, MSP issues must be submitted in writing and mailed with an attention line of MSP.

- Codes requiring review by our medical staff
- Timely denials
- Late files
- Requests that require documentation
- ABN issues
- Adding GA or GY modifiers (changing liability)
- Medicare Secondary Payer (MSP)

**Effective Monday, July 2, 2007, suppliers will be limited to five reopenings per call.**

# Modification to the Model MRN (for partly or fully unfavorable redeterminations) and ALJ Filing Locations Where the Place of Service Was in Delaware, Kentucky, Puerto Rico, Virginia, &/or the US Virgin Islands

**MLN Matters Number: MM5554**
**Related Change Request (CR) #: 5554**
**Related CR Release Date: April 27, 2007**
**Related CR Transmittal #: R1229CP**
**Effective Date: July 2, 2007**
**Implementation Date: July 2, 2007**

**Provider Types Affected**

Physicians, suppliers, and providers who submit claims to Medicare contractors (Fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs),

DME Medicare Administrative contractors (DME/MACs), durable medical equipment regional carriers (DMERCs), and/or regional home health intermediaries (RHHIs)).

**Provider Action Needed**

The Centers for Medicaid & Medicare Services (CMS) issued change request (CR) 5554 in order to modify the Reconsideration Request Form and to amend the ALJ filing locations.

Providers and suppliers do not need to resubmit documentation when requesting a Qualified Independent Contractor (QIC) reconsideration if the documentation was previously submitted as part of the redetermination process. This documentation is forwarded to the QIC as part of the case file utilized in the reconsideration process. Make certain that any additional evidence is submitted prior to the reconsideration decision. If all additional evidence is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence to the ALJ or further appeal unless you can demonstrate good cause for withholding the evidence from the QIC.

Be aware that when the service was rendered in **Delaware, Kentucky, Virginia, Puerto Rico, and/or the US Virgin Islands,** the filing locations for ALJ requests are modified to identify the appropriate Office of Medicare Hearings and Appeals (OMHA) field office. All other jurisdictions remain unchanged.

**Background**

CR5554 is the official document that announces these changes in Medicare processes. Attached to this CR are three documents that assist with the appeals process:

- A sample form letter titled: Medicare Appeal Decision,
- A paper outlining Important Information About Your Appeal Rights, and
- A modified Reconsideration Request Form containing revised introductory instructions, as follows: "At a minimum, you must complete/include information for items 1, 2a, 6, and 7 but to help us serve you better, please include a copy of the redetermination notice you received with your reconsideration request."

The revised filing locations for sending documentation for requesting ALJ hearings are as follows:

- **Cleveland, Ohio** is the filing location for services rendered in **Delaware and Kentucky,**
- **Arlington, Virginia** for services in **Virginia, and**
- **Miami, Florida** for services in **Puerto Rico and the US Virgin Islands.**

The following table lists the addresses of all filing locations along with the place of service.

| HHS OHMA Field Office & Mailing Address | Jurisdiction (Based on the place of service) | | | |
|---|---|---|---|---|
| Cleveland, OH<br>BP Tower & Garage<br>200 Public Square, Suite 1300<br>Cleveland, OH 44114-2316 | Connecticut<br>Maine<br>Massachusetts<br>New Hampshire<br>Rhode Island<br>Vermont | New York<br>New Jersey<br>Puerto Rico<br>Virgin Islands | Pennsylvania<br>Delaware<br>West Virginia<br>Kentucky | Illinois<br>Indiana<br>Ohio<br>Michigan<br>Minnesota<br>Wisconsin |
| Miami, FL<br>100 SE 2nd Street, Suite 1700<br>Miami, FL 33131-2100 | Alabama<br>Florida<br>Georgia<br>Mississippi<br>North Carolina<br>South Carolina<br>Tennessee<br>Arkansas | Louisiana<br>New Mexico<br>Oklahoma<br>Texas<br>Puerto Rico<br>US Virgin<br>Islands | | |

| | | | | |
|---|---|---|---|---|
| Irvine, CA<br>27 Technology Drive, Suite 100<br>Irvine, CA 92618-2364 | Iowa<br>Kansas<br>Missouri<br>Nebraska | Colorado<br>Montana<br>North Dakota<br>South Dakota<br>Utah<br>Wyoming | Arizona<br>California<br>Hawaii<br>Nevada<br>Guam<br>Trust Territory of the Pacific Islands<br>American Samoa | Alaska<br>Idaho<br>Oregon<br>Washington |
| Arlington, VA<br>1700 N. Moore St., Suite 1600<br>Arlington, VA 22209 | Virginia<br>Maryland<br>District of Columbia | | | |

**Additional Information**

For complete details regarding this Change Request (CR) please see the official instruction (CR5554) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1229CP.pdf on the CMS website.

## EDI

# Medicare Remit Easy Print New Version Available

Medicare Remit Easy Print (MREP) Version 2.1 is available for download!

Version 2.1 includes the latest version of the Claim Adjustment Reason Codes and the Remittance Advice Remark Codes as outlined in MLN Matters 5456. These code changes were effective as of April 2, 2007.

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

## CMN/DIF

# New DMEPOS CMNs and DIFs for Claims Processing

**MLN Matters Number: MM5571 - Revised**
**Related Change Request (CR) #: 5571**
**Related CR Release Date: April 13, 2007**
**Related CR Transmittal #: R198PI**
**Effective Date: October 1, 2006**
**Implementation Date: July 2, 2007**

**Note:** This article was revised on May 8, 2007, to show that the effective dates refer to the dates the claims/forms are processed, as opposed to date of service. All other information remains the same.

**Provider Types Affected**

Physicians (when ordering DMEPOS) and suppliers using CMNs and DIFs when billing to Medicare durable medical equipment regional carriers (DMERCs) or DME Medicare Administrative Contractors (DME/MACs).

**Provider Action Needed**

The Centers for Medicaid & Medicare Services (CMS) has developed improved CMNs and DIFs that are consistent with current medical practices and conform to Medicare guidelines. Through this process, CMS revised several CMNs and replaced three CMNs with two DIFs. **This information was previously communicated in *MLN Matters* article MM4296** (http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4296.pdf).

The transition period has been extended for claims processed from October 1, 2006, through June 30, 2007. During this transition period claims for items requiring a CMN or DIF will be accepted with either the old or the new form. **For CMN/DIF forms processed on or after July 1, 2007, the old CMN/DIF forms will no longer be accepted.**

**Background**

CMNs provide a mechanism for suppliers of durable medical equipment, defined in 42 United States Code (U.S.C.) §1395x(n) and medical equipment and supplies defined in 42 U.S.C. §1395j(5), to demonstrate that the item they provide meets the minimal criteria for Medicare coverage.

CMNs contain section A through D. Sections **A and C are completed by the supplier** and Sections **B and D are completed by the physician.** A DME DIF is completed and signed by the supplier. It does not require a narrative description of equipment and cost or a physician signature. Contractors review the documentation provided on the CMNs and DIF.

**Recap of MM4296 Information**

As previously reported in *MLN Matters* article MM4296, the changes to the CMN forms have resulted in the following:

- *Medicare Program Integrity Manual*, Chapter 5, Items and Services Having Special DME Review Considerations, has been revised.
- The improved forms permit the use of a signature and date stamp that has resulted in revision of the *Medicare Program Integrity Manual*, Chapter 3, Section 3.4.1.1, Documentation Specifications for Areas Selected for Prepayment or Post Payment Medical Review.
- These new forms were approved by the Office of Management and Budget (OMB).
- For the CMS-484 form, the OMB # is 0938-0534.
- For the CMS forms 846, 847, 848, 849, 854, 10125 and 10126, the OMB # is 0938-0679.

**Claims Accepted During Transition Period**

The following table identifies the old versions of the CMNs, which are acceptable for claims for services provided during the transition period from October 1, 2006, through June 30, 2007. (For CMN/DIF forms processed on or after July 1, 2007, the old forms will no longer be accepted.)

| DMERC 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 |

**Newly Revised CMNs Accepted During Transition Period**

The following table identifies the newly revised CMNs that will be accepted for services provided during the transition period for claims from October 1, 2006, through June 30, 2007. (These forms are available at http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp - TopOfPage.) For forms processed on or after July 1, 2007, these forms will become effective for claims for items requiring a CMN.

Noteworthy changes include changing the title of CMS-484 from Home Oxygen Therapy to Oxygen. In addition, the title of CMS-846 was changed from Lymphedema Pumps to Pneumatic Compression Devices.

| 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 Stimulators (TENS) |

| | | |
|---|---|---|
| 07.03A | 849 | Seat Lift Mechanisms |
| 11.02 | 854 | Section C Continuation Form |

**New DIFs Accepted During Transition Period**

The following table identifies the new DIFs that will also be accepted during the transition period for claims for services provided from October 1, 2006, through June 30, 2007. (These forms are available at http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp - TopOfPage.) For forms processed on or after July 1, 2007, the new forms will become effective for claims for items requiring a DIF.

Noteworthy changes include changing CMS-851 for Infusion Pumps to a CMS-10125, External Infusion Pump DIF.

In addition, CMS-852 for Parenteral Nutrition and CMS-853 for Enteral Nutrition were combined into a CMS-10126 Enteral and Parenteral Nutrition DIF.

| DME MAC FORM | CMS FORM | ITEMS ADDRESSED |
|---|---|---|
| 09.03 | 10125 | External Infusion Pumps |
| 10.03 | 10126 | Enteral and Parenteral Nutrition |

The use of the CMNs for hospital beds (CMS-841) and support surfaces (CMS-842) will be eliminated for claims with dates of service on or October 1, 2006.

**CMNs Eliminated**

The following table identifies the CMNs that will be eliminated for claims 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 |

**Additional Information**

For complete details regarding this Change Request (CR) please see the official instruction (CR5571) issued to your Medicare DME MAC, or DMERC. This instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R198PI.pdf on the CMS website.

For additional information about the new CMNs and DIFs, see the MLN Matters article MM4296, titled "New Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Medicare Administrative Contractor (MAC) Information Forms (DIFS) for Claims Processing" at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4296.pdf on the CMS website.

## CODING

# Payment and Coding for Drugs and Biologicals

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

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

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

codes. Examples of how we are operationalizing this approach using unique HCPCS codes include: (1) the Q codes for Euflexxa™, Orthovisc®, and Synvisc® effective January 1, 2007, and (2) the series of Q codes for immune globulin and the new Q code for Reclast® effective July 1, 2007.

Section 1847A requires single source drugs or biologicals that were within the same billing and payment code as of October 1, 2003, be treated as multiple source drugs, so the payment under Section 1847A for these drugs and biologicals is based on the volume weighted average of the pricing information for all of the products within the billing and payment code. We are working to ensure that payments accurately reflect this "grandfathering" provision. Examples of how we are operationalizing this provision include: (1) Q4083 for Hyalgan and Supartz effective January 1, 2007, and (2) Q4094 for albuterol and levalbuterol and Q4093 for concentrated forms of albuterol and levalbuterol effective July 1, 2007.

In addition, appropriate modifications of the NDC to HCPCS crosswalk used to calculate the payment limits for purposes of Section 1847A will be made to ensure that payment will be based on the pricing information for all products produced or distributed under an FDA approval for the drug or biological. One result is the same payment limit for J0885 (injection, epoetin alfa, (for non-ESRD use)) and J0886 (injection, epoetin alfa, (for ESRD on dialysis)).

We will continue to work to identify and implement payment and coding changes as necessary to ensure more accurate payments under Section 1847A. So that we can implement any further necessary changes during 2007, we will continue to use our internal process for modifying the HCPCS code set and for adjusting the NDC to HCPCS crosswalk.

A full list of the July 2007 quarterly updates to the HCPCS is available at www.cms.hhs.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp#TopOfPage

Pricing information for Part B drugs and biologicals for the third quarter of 2007 (July 1 – September 30) will be posted on or after June 15th at www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/01a_2007aspfiles.asp#TopOfPage

The announcement for the Q codes for Euflexxa™, Orthovisc®, and Synvisc® effective January 1, 2007 and Q4083 for Hyalgan and Supartz also effective January 1, 2007, was posted on December 22, 2006 and is available at www.cms.hhs.gov/Transmittals/downloads/R1152CP.pdf

## COVERAGE

# Requirement for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents

**MLN Matters Number: MM5480 Revised**
**Related Change Request (CR) #: 5480**
**Related CR Release Date: March 30, 2007**
**Related CR Transmittal #: R1212CP**
**Effective Date: January 1, 2007**
**Implementation Date: June 29, 2007**

**Note:** This article was revised on April 30, 2007, to replace one of the HCPCS codes on page 2 (Q4055) with J0886. All other information is the same.

**Provider Types Affected**

Physicians, providers, and suppliers who bill Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Medicare administrative contractors (MACs)) for providing ESA administration services to Medicare end stage renal disease (ESRD) beneficiaries.

**What You Need to Know**

CR 5480, from which this article is taken, instructs all providers and suppliers on the voluntary reporting of route of administration modifiers on claims for Erythropoiesis Stimulating Agents (ESAs) for ESRD beneficiaries. Route of administration modifiers were published and effective January 1, 2007, for reporting on Medicare claims submitted on or after February 1, 2007, for dates of service on or after January 1, 2007. Please see the background section for details.

**Background**

Current claims processing requirements do not allow you to report the method of administering Erythropoiesis Stimulating Agents (ESA) – such as epoetin alfa (EPO) and darbepoetin alfa (Aranesp) – to treat your end stage renal disease (ESRD) patients who are anemic. However, in order to study the efficacy of both intravenous administration and subcutaneous administration methods of ESA administration, the Centers for Medicare and Medicaid Services (CMS) will begin requesting you to voluntarily report modifiers, which will indicate the method of ESA administration.

Specifically, CR 5480, from which this article is taken, announces that, effective for claims submitted on or after February 1, 2007 (with dates of services on or after January 1, 2007), all providers and suppliers who bill for administering ESA to ESRD beneficiaries (Healthcare Common Procedure Coding System (HCPCS) codes Q4081, J0882, or J0886) are encouraged to include:

- Modifier JA on the claim to indicate an intravenous administration or
- Modifier JB to indicate a subcutaneous administration.

**You should be aware that in the future, this reporting of the route of ESA administration will be a requirement, and additional instructions will be issued at that time.** But until then, a claim for an ESA that does not report the route of administration will not be returned to the provider, and will be paid the same as a claim that does report the route of administration. Also, be aware that renal dialysis facilities whose claims include charges for ESA administration by both methods should report them in separate lines in order to identify the number of administrations provided by each method.

**Additional Information**

You can find more information about route of administration codes for Erythropoiesis Stimulating Agents (ESAs) by going to CR 5480, located at http://www.cms.hhs.gov/Transmittals/

## COVERAGE CONT'D

downloads/R1212CP.pdf on the CMS website. As attachments to this CR, you will find updated Medicare Claims Processing Manual, Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims), Section 60.2.3.1 (Requirement for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents (ESAs)); and Chapter 17 (Drugs and Biologicals), Section 80.11(Requirements for Providing Route of Administration Codes for Erythropoiesis Stimulating Agents (ESAs)).

## REIMBURSEMENT

# Jurisdiction D DME MAC Revised Fee Schedule Amounts for New and Used PMDs for Dates of Service on/after January 1, 2007

The allowances are for all states included in Jurisdiction D. Inclusion of a fee schedule amount for an item does not necessarily indicate coverage.

| | |
|---|---|
| K0822RR | $ 399.75 |
| K0822NU | $3,997.50 |
| K0822UE | $2,998.13 |
| K0825RR | $ 443.32 |
| K0825NU | $4,433.20 |
| K0825UE | $3,324.90 |
| K0835RR | $ 405.74 |
| K0835NU | $4,057.40 |
| K0835UE | $3,043.05 |
| K0838RR | $ 433.22 |
| K0838NU | $4,332.20 |
| K0838UE | $3,249.15 |
| K0848RR | $ 528.44 |
| K0848NU | $5,284.40 |
| K0848UE | $3,963.30 |
| K0850RR | $ 612.98 |
| K0850NU | $6,129.80 |
| K0850UE | $4,597.35 |
| K0851RR | $ 589.37 |
| K0851NU | $5,893.70 |
| K0851UE | $4,420.28 |
| K0859RR | $ 671.17 |
| K0859NU | $6,711.70 |
| K0859UE | $5,033.78 |
| K0864RR | $ 1196.45 |
| K0864NU | $11,964.50 |
| K0864UE | $ 8,973.38 |

## DRUG/BIOLOGICALS

# Revisions to Medicare Claims Processing Manual, Chapter 17, Sections 40 and 100, Regarding Discarded Drugs and Biologicals and Submission of Claims With Modifier JW, "Drug Amount Discarded/Not Administered to Any Patient"

**MLN Matters Number: MM5520**
**Related Change Request (CR) #: 5520**
**Related CR Release Date: May 25, 2007**
**Related CR Transmittal #: R1248CP**
**Effective Date: July 1, 2007**
**Implementation Date: July 2, 2007**

**Provider Types Affected**

Physicians, hospitals, other providers, and suppliers who bill Medicare contractors (carriers, fiscal intermediaries (FI), regional home health intermediaries (RHHI), Part A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs)) for administering or supplying drugs and biologicals.

**What You Need to Know**

CR 5520, from which this article is taken, revises the Medicare Claims Processing Manual, Chapter 17, Sections 40 and 100.2.9 to include language that references payment for administering (and discarding) both single use vials and single use packages. Specifically, the change is to clarify that Medicare will cover the amount of a single use vial or single use package of a drug or biological that was discarded along with the amount of that single use vial/package that was administered to the Medicare patient.

**Background**

CR 5520, from which this article is taken revises the Medicare Claims Processing Manual, Chapter 17 (Drugs and Biologicals), Sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) to ensure the proper billing of discarded drugs and biologicals in both single use vials and single use packages.

These revisions are summarized as follows:

- Centers for Medicare & Medicaid Services (CMS) encourages physicians, hospitals and other providers to schedule patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner.
- Section 40 of Chapter 17 is amended to address single use vials/packages of drugs and boilogicals. If after administering a dose/quantity of the drug or biological to a Medicare patient, a physician, hospital or other provider must discard the remainder of a single use vial or other single use package, the program provides payment for the amount of drug or biological administered and the amount discarded, up to the total amount of the drug or biological as indicated on the vial or package label.

- Section 100.2.9 is amended to show that CMS will reimburse physicians, providers and suppliers for the amount of a drug or biological administered (and for the amount discarded) when:
- The participating competitive acquisition program (CAP) physician has made a good faith effort to minimize the unused portion of the CAP drug or biological in scheduling patients and in ordering, accepting, storing, and using the drug or biological;
- In its process of supplying the drug or biological to the participating CAP physician, the approved CAP vendor has made a good faith effort to minimize the unused portion of the drug or biological.

**NOTE: Multi-use vials are not subject to payment for discarded amounts of drug or biological.**

**Additional Information**

You can view CR 5520, the official instruction issued to your Medicare contractor, by visiting http://www.cms.hhs.gov/Transmittals/downloads/R1248CP.pdf on the CMS website. You will find the revised Medicare Claims Processing Manual, Chapter 17 (Drugs and Biologicals), Sections 40 (Discarded Drugs and Biologicals) and 100.2.9 (Discarded Drugs and Biologicals) as an attachment to that CR.

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