Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

March 2007
Issue No. 3

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

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

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

Other DME MACs		
Jurisdiction A: NHIC, Corp	1-866-419-9458	www.medicarenhic.com
Jurisdiction B: AdminaStar Federal	1-877-299-7900	www.adminastar.com
Jurisdiction C: Palmetto GBA	1-866-270-4909	www.palmettogba.com

Other Resources		
Statistical Analysis DMERC	1-877-735-1326	www.palmettobga.com/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:

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

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 6	Supplier Signature Requirements	Word correction	2/15/07
Chapter 6	Ordering Forms	Changed package prices and corrected 1500 claim form link	2/15/07
Chapter 6	CMS Claim form Instructions	Corrected "Notice of Determination Letters" to "Education Status Letters"	2/15/07
Chapter 6	Guidelines for Filing Paper Claims	Removed statements from #'s 12 and 14 and deleted previous item #16 regarding telephone number placement	2/15/07
Chapter 6	CMS Claims Filing Policy	Word correction	2/15/07
Chapter 3	Same/Similar Equipment and ABN	Word correction	2/15/07
Chapter 5	Oxygen and Oxygen Equipment	Added HCPCS code K0738	2/6/07
Chapter 16	Level II HCPCS Codes	2007 HCPCS Changes	1/9/07
Chapter 1	What is Medicare?	Deductible amount changed from $124.00 (for 2006) to $131.00 (for 2007)	12/28/06

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

Contact Information for EDI Issues

The EDI Help desk and the Supplier Contact Center are excellent resources for questions and answers. Sometimes, however, it can be difficult to determine which area to call when issues arise regarding EDI. Listed below are common issues and contact information for the EDI Helpdesk and the Supplier Contact Center.

EDI Helpdesk
Phone Number: 1-866-224-3094
Hours: Monday through Friday, 8:00 am – 5:00 pm CT

- Set up a supplier to bill DME
- Test electronic billing software
- Assistance in submitting EMC claims into the system-prior to a claim being assigned a Correspondence Control Number

- Electronic Receipt Listings-claims that have been accepted into our system and claims that have rejected
- Electronic Remittance Notices and Medicare Remit Easy Print (MREP)
- Electronic Claim Status Inquires-enables a supplier to electronically check the status of claims (pending or completed)
- DDE beneficiary eligibility software/system
- CMN rejects- CMNs transmitted electronically that reject the front-end before processing occurs

Supplier Contact Center
Phone Number: 1-866-243-7272
Hours: Monday through Friday, 8:00 am – 5:30 pm CT

- EMC claim edits-claim edits received after the claim is assigned a CCN
- Explanation of payment determination-whether claim paid or denied
- EMC claims that are deleted from our system
- Education Status Letters
- Claim denial messages
- Information that differs on the processed claim than what was submitted
- EFT enrollment
- Administrative Simplification Compliance Act Enforcement
- Explanation of the claim appeals process
- Supplier manual updates
- Supplier outreach, materials, newsletters, list serves, etc.
- All other customer service related topics

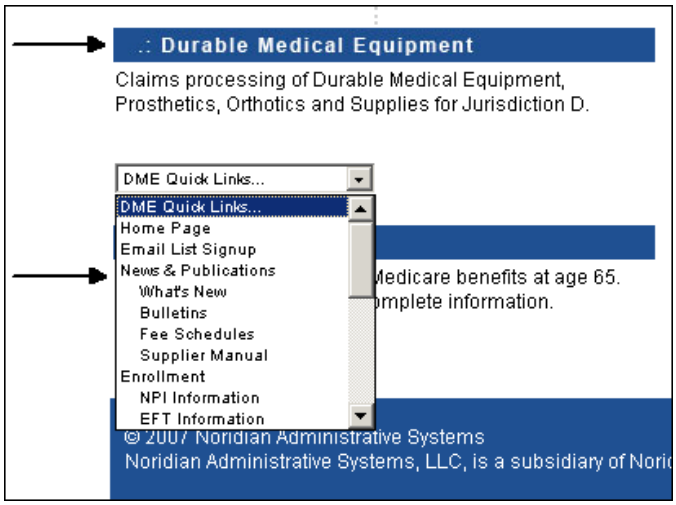
Suppliers should use the IVR, 1-877-320-0390, for claim status, eligibility, check status, CMN status and pricing. The IVR instructions are located on our website in the Contact section.

Web Site Home Page Redesign

Noridian Administrative Services has a redesigned home page of our Web site. As of February 9, 2007, visitors to the Web site see a new look to the home page:

FYI CONT'D

DME suppliers will either select "Durable Medical Equipment" or an option from the DME Quick Links drop-down menu.



When Durable Medical Equipment is selected, the DME Home Page will be displayed.

General headings available on the drop-down menu include News and Publications, Enrollment, Training, Claims, Forms, Contact and the Site Map.

Also, for quick navigation, specific headings are listed such as Bulletins, Fee Schedules, Supplier Manual, NPI Information, EFT Information, Ask the Contractor, Workshops, EDI, Fraud and Abuse, CMS 588 form, Refunds to Medicare form, Inquiries/Redeterminations form, IVR User Guide, Contact Information and the Search Engine.

Under System Status on the right side, when all Noridian systems are available, the status will state available. If Part B, for example, is down, this page will indicate that. Also, EDISS collection applies to Part A, Part B and CAP only, not DME. If the DME EDI system is down, a notice will be posted on the DME EDI website, www.cignamedicare.com/edi/dmerc.

As a reminder, the End User Agreement needs to be accepted before the selected page will be displayed.

The only change DME suppliers will see is the new home page. All DME content remains the same.

Understanding the Medicare Learning Network Fact Sheet

The *Understanding the Medicare Learning Network* **(MLN)** *Fact Sheet* is now available in downloadable and print format from the Medicare Learning Network (MLN). This Fact Sheet explains the MLN web pages within the CMS website. It provides an overview of the MLN and where to access the information and education resources which are available through the MLN. To view, download, or print, select the title of the fact sheet from www.cms.hhs.gov/MLNProducts/MPUB/list.asp on the MLN Publications web page.

Update on CMS Actions to Reverse Invalid Overpayments Generated by Managed Care Informational Unsolicited Responses-(Invalid MCIURs from the Common Working File)

MLN Matters Number: MM5507
Related Change Request (CR) #: 5507
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R262OTN
Effective Date: January 26, 2007
Implementation Date: April 26, 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 regional carriers (DMERCs), and/or DME Medicare Administrative Contractors (DME/MACs)).

Provider Action Needed

This article provides information regarding overpayment recovery actions that may be taken by your Medicare contractor and the circumstances that have caused these recovery actions. We estimate that between 150,000 – 300,000 claims may be affected by these actions. If, due to the conditions stated below, an overpayment recovery action has occurred for your claims, your Medicare contractor is in the process of correcting the payment. **You need not take any action at this time.** Because these actions will affect Medicare contractors in varying degrees, you should stay tuned to your Medicare contractor's web site for additional details.

Background

In MLN Matters article SE0681 (http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0681.pdf), the Centers for Medicare & Medicaid Services (CMS) advised providers of certain eligibility system issues related to managed care Medicare beneficiaries. In brief, article SE0681 alerted providers that, in some instances, Medicare may be recovering certain overpayments due to system updates on beneficiary eligibility. When such overpayments are identified, Medicare systems generate a managed care informational unsolicited response (MCIUR), which triggers the overpayment recovery.

During the week of December 17, 2006, Medicare systems were updated with some incorrect Managed Care enrollment data, which, in turn, caused the systems to create some incorrect MCIURs. Medicare files have now been corrected and CMS is working diligently with Medicare contractors to stop the invalid overpayment recoveries from occurring. In addition, where action to recover the overpayments has already occurred, CMS has instructed your contractor to reverse the action and reissue payment to you.

Key Points

- CR5507 states that recovery action should stop if it has been initiated and reversed if MCIURs have already effected a recovery.
- Physicians and other providers who bill Medicare

contractors need not take any action since contractors will automatically make the necessary adjustments as CR5507 is implemented.

- Your contractor will post more detailed information on their web site as CR5507 is implemented.

Additional Information

For complete details regarding this issue, please see the official instruction (CR5507) issued to your Medicare carrier, FI, A/B MAC, DME MAC, and/or DMERC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R262OTN.pdf on the CMS web site.

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."

Ask the Contractor Teleconference for Small Suppliers

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

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

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

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

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

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

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

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

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

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

Corrections to the Q&As from the December 14, 2006, Ask the Contractor Teleconference

On January 8, 2007, the questions and answers from the December 14, 2006, Ask the Contractor Teleconference were published. Since that time NAS has been informed of some incorrect responses. The answers to questions 8, 9, 22 and 25 have been revised as follows:

Q8. Can the patient be on oxygen during a sleep study and still qualify for oxygen? This patient is currently on home oxygen but hasn't been certified for oxygen by Medicare. We would like to get him qualified but his doctor does not feel it would be safe to remove the oxygen during a sleep study. In addition, if he cannot be on oxygen during the study, where in the manual does it specifically say this?

A8. This is a correction to the previously published questions and answers from the December 14, 2006, Ask the Contractor Teleconference. The questions and answers were placed on our Web site on January 8, 2007.

The medical policy addressing home oxygen and the qualifying criteria for home oxygen can be accessed at www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp and states in part as follows:

The qualifying blood gas study may be performed while the patient is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria.

However, the policy further states that if the patient is to qualify for a portable oxygen system the qualifying blood

gas study must be performed while at rest (awake) or during exercise. If the only qualifying blood gas study is performed during sleep, portable oxygen will be denied as not medically necessary.

Q9. If a patient is receiving oxygen during sleep and his saturation levels are under 89%, would he qualify for oxygen?

A9. This is a correction to the previously published questions and answers from the December 14, 2006, Ask the Contractor Teleconference. The questions and answers were placed on our Web site on January 8, 2007.

Based on the information provided and medical policy addressing home oxygen, the patient would not qualify for oxygen under the Group I criteria. He would, however, qualify under the Group II criteria if his oxygen saturation is 89% during sleep for at least 5 minutes and he has dependent edema suggesting congestive heart failure, or pulmonary hypertension or cor pulmonale as determined by specific medical testing, or erythrocythemia with a hematocrit greater than 56%.

Q22. In the past we billed HCPCS codes E1390 (oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate) and E0431 (portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing). E0431 then changed to K0738 (portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders, includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing). Is the K0738 changing to an E1392 (portable oxygen concentrator, rental) on January 1, 2007, and do I then bill E1390 and E1392?

A22. This is a correction to the previously published questions and answers from the December 14, 2006, Ask the Contractor Teleconference. The questions and answers were placed on our Web site on January 8, 2007.

K0738 is valid for 2007 and is not changing to E1392; K0738 describes a portable gaseous oxygen system (OPGE) only (aka "home fill unit") and E1392 describes a portable oxygen concentrator. You would bill E1390 and E1392 if the patient is renting a stationary oxygen concentrator and a portable oxygen concentrator.

Furthermore, HCPCS code E0431 (portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannulaor mask, and tubing) did not change to K0738; E0431 is valid for 2007 and can continue to be billed with E1390.

Q25. I have a patient on a CPAP machine; he purchased it prior to enrolling in Medicare. Now he is in need of a new CPAP machine. The regulations say that he needs a new sleep study; however, the patient told me that he couldn't undergo another sleep study because he cannot be without his machine for even ten minutes due to his medical condition. What documentation must I have on file showing that it would be detrimental to his health to undergo this testing?

A25. This is a correction to the previously published questions and answers from the December 14, 2006, Ask the Contractor Teleconference. The questions and answers were placed on our Web site on January 8, 2007.

A new study is not required simply because the patient is now Medicare eligible. The Local Coverage Determination accessed on the CMS Web site at www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=171&lcd_version=32&show=all simply states that the CPAP is covered if the patient has obstructive sleep apnea documented by an attended, facility-based polysomnogram and meets either of the following criteria (1 or 2):

1) The AHI is greater than or equal to 15 events per hour; or,
2) The AHI is from 5 to 14 events per hour with documented symptoms of:
    a) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
    b) Hypertension, ischemic heart disease, or history of stroke.

If, however, the patient's initial sleep study does not qualify him for a CPAP based on the above criteria, then a new sleep study would be needed or you would need medical documentation and a detailed letter from the patient's physician explaining why it would be detrimental to the patient's health to undergo a sleep study.

Q & As Resulting from the January 2007 CMS-1500 Claim Form Workshops

The following questions and answers are from the January 18 and 23, 2007, CMS-1500 Claim Form Changes WebEx workshops. In some cases, the original answers given during the workshop may have been expanded to provide further detail.

Q1. The revised 1500 (08-05) claim form is effective April 1, 2007. Is that date of service or receipt date?

A1. All claims received on/after April 1, 2007, must be on the revised (08-05) claim form regardless of the date of service.

Q2. If we continue to report data in the shaded areas of the 1500 (08-05) form after May 22, 2007, will the claims be denied or will Noridian simply ignore the data?

A2. We have not been given specific instruction from CMS regarding this question. Therefore, we would recommend that you not report any data in the shaded areas after May 22, 2007.

Q3. Where on the 08-05 claim form is the oxygen flow rate for the patient to be placed?

A3. The oxygen flow rate is placed in Item 19.

Q4. Will there be a website or other source that will give us the physicians' NPI numbers?

A4. At this time there will not be website or other source to give you the physicians' NPI numbers. You will need to contact the physicians personally for their NPI numbers.

Q5. Do we need to list our NPI in both 24J and 33a?

A5. DME POS suppliers do not need to place their NPI numbers in both items. NAS first looks at the information placed in Item 33/33a. If the information in that item is questionable, then NAS looks at Item 24J.

Q6. If I am not a DME supplier but am submitting claims to Medicare, do I still need to use the qualifiers 1G and 1C in order to map my provider number to my NPI?

A6. Yes, Medicare Part B also uses the 1G and 1C qualifiers during the transition to NPI.

Q7. Can you explain the diagnosis pointer instructions for Item 24E?

A7. The 1500 claim form instruction for Item 24E states:

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

This means that if you are listing up to four diagnosis codes in Item 21 for the DMEPOS that you are billing, you choose the one primary diagnosis for that item and enter that reference number in Item 24E. You can reference only one of the diagnoses in Item 21. Medicare is unable to process the claim if anything other than a 1 or a 2 or a 3 or a 4 is present in this item. All diagnoses in Item 21 are reviewed when the claim is processed.

Q8. Is Item 33b to contain our current supplier number during the time when the crosswalk is being built only? Is Item 33a to be used for the NPI number?

A8. Item 33a is used for your NPI number and Item 33b is used for your current NSC number along with the 1C qualifier. Item 33b will not be used after May 22, 2007.

Q9. We currently do not complete Item 32 but fill in our name and address in Item 33. What goes into Item 32?

A9. Because most DMEPOS are delivered to patients in their homes, NAS currently does not look at Item 32 for DMEPOS claims. If, however, you deliver the DMEPOS to the patient in a nursing home, you would note the name and address of the nursing home in Item 32 and the nursing home's NPI in Item 32a. All health care providers, including nursing homes, must request an NPI to share with their health care partners whether or not they bill claims to Medicare.

Q10. Are the numbers in 17b and 24J going to be the same since they are typically the ordering physician's NPI?

A10. The NPIs in Items 17b and 24J are not the same for DMEPOS claims. Item 17b contains the NPI of the referring physician and Item 24J contains the NPI of the supplier of the DMEPOS. The referring physician's NPI never goes in Item 24J for DMEPOS claims.

Q11. Will my claim be denied if I submit it electronically without using the 1G or 1C Qualifier?

A11. If you do not provide the ID Qualifier 1G or 1C when submitting your electronic claim during this transition period, the claim will reject on the EDI front end before it even reaches NAS for processing.

Q12. If I submit more than one diagnosis pointer electronically, will my claim reject?

A12. Your electronic claim will not reject when you submit more than one diagnosis pointer; however, the processing system links the first pointer noted as the primary diagnosis code.

Q13. If I already submitted my NSC number and my NPI electronically, has the crosswalk been established? This also applies to the physician's UPIN. Once I have submitted the UPIN and the NPI, must I continue to do so throughout the transition period?

A13. You are not required to submit both the NPI and the NSC or UPIN during this transition period, but CMS is strongly recommending that you do so. This directive was published in MLN Matters SE0679.

Q14. Are the changes that were addressed during the CMS-1500 claim form changes WebEx going to be the same for the other DME jurisdictions?

A14. The changes addressed during these WebEx workshops originated from CMS. You will need to ask the other jurisdictions how they are implementing these changes.

Q15. Will I need to bill with the ordering physician's NPI after May 22, 2007?

A15. Yes, the ordering physician's NPI is replacing his UPIN and will be used after May 22, 2007.

Q16. Do all physicians need to have NPI numbers?

A16. Yes, all physicians need to have NPI numbers.

Q17. Do I need an NPI number to use the revised CMS-1500 claim form?

A17. No, you do not need an NPI number to use the revised CMS-1500 claim form; however, if you do not have an NPI by May 23, 2007, you will not have the ability to bill any services to Medicare for payment.

Q18. Do DME claims need the 1G qualifier in Item 17a or is that just for physicians?

A18. Item 17a is used for the referring physician's UPIN during the transition period ending May 22, 2007. Therefore, during this time period when you are billing for DMEPOS that is ordered by a physician or other entity, you will place that referring medical professional's UPIN along with the 1G qualifier in Item 17a and his NPI in 17b.

Q19. Will the shaded portions of the revised CMS-1500 claim form be used after May 22, 2007?

A19. The shaded portions of the revised CMS-1500 claim form will not be used after May 22, 2007.

Q20. Do claims need to have the 1G qualifier in Item 17a before submission?

A20. If you are billing the referring physician's UPIN and his NPI, then the 1G qualifier must be placed in Item 17a to aid in building the crosswalk between the physician's UPIN and his NPI.

Q21. Can narrative be place in the shaded portions of the CMS-1500 claim form?

A21. No, narrative cannot be placed in the shaded portions of the CMS-1500 claim form. Any narrative needs to be placed in Item 19. Narrative placed in any other portion of the 1500 claim form will result in an unprocessable claim and an Education Status Letter.

Q22. What is the qualifier for the provider number?

A22. You use the 1G qualifier in Item 17a along with the referring physician's UPIN. The qualifier 1C is used with the supplier's NSC number in Items 24I, 32b, and/or 33b.

Q23. Will my claims be denied if they do not contain the legacy supplier number?

A23. As stated in question 13, you are not required to submit your legacy NSC number during this transition period, but CMS is strongly recommending that you do. This directive was published in MLN Matters SE0679.

Q24. I am a sole proprietor. I have an individual NPI and the business has an NPI. Which NPI do I use?

A24. MLN Matters SE0679 states the following regarding DME suppliers:

"Medicare DME suppliers are required to obtain an NPI for every location. The only exception to this requirement is the situation in which a Medicare DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI (the individual's NPI) regardless of the number of locations the DME supplier may have." Based on this directive, you should bill with your individual NPI.

In addition MLN Matter Number: SE0608 states as follows regarding enrolling as more than one type of provider: Generally, the type of service being reported on a Medicare claim determines the type of Medicare contractor who processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type (fiscal intermediary, carrier, RHHI, DMERC) of Medicare contractor.

In certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as **more than one type of provider**. For example, an ambulatory surgical center enrolls in Medicare as a Certified Supplier, and bills its services to a carrier. If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a Supplier of DME and bill the DME to a DMERC. This ambulatory surgical center would obtain a single NPI and use it to bill the carrier and the DMERC.

Medicare expects that this ambulatory surgical center would report two different taxonomies when it applies for its NPI:

- Ambulatory Health Care Facility—Clinic/Center - Ambulatory Surgical (261QA1903X); and
- Suppliers—Durable Medical Equipment & Medical Supplies (332B00000X) or the appropriate sub-specialization under the 332B00000X specialization."

Q25. If a DMEPOS is provided in a nursing home, will I need to obtain the nursing home's NPI and place it in Item 32a?

A25. Yes. During the transition period ending on May 22, 2007, you would also place the nursing home's legacy number and the 1C qualifier in Item 32b.

Q26. When submitting Medicare Secondary Payer claims to Medicare, must I retype all the information onto a new red and white CMS-1500 claim form?

A26. All paper claims submitted to Medicare must be submitted on original red and white CMS-1500 claim form.

Q27. Where can I purchase the revised CMS-1500 (80-05) claim forms?

A27. CMS-1500 claim forms can be purchased from the U.S. Printing Office, local printing companies or office supplies stores in your area, or from numerous venders found on the Internet.

Q28. How can we get a copy of the PowerPoint?

A28. The PowerPoint slides were included with the confirmation documents sent to you prior to the presentation.

Q29. How do I qualify for an ASCA exemption?

A29. Information regarding ASCA exemptions can be found on our Web site in the Claims section under the subheading Electronic Data Interchange. If you intend to apply for an ASCA exemption, it is very important that you include all documentation to support why you should qualify for the exemption.

Q30. How do I check to see if I have an ASCA exemption?

A30. If you call the Supplier Contact Center, they will be able to provide you with that information.

Q31. Does the ASCA exemption need to be renewed yearly?

A31. Medicare reviews your ASCA exemption no more often then every two years. You do not need to provide any renewal information unless requested to do so by your Medicare contractor.

Q32. I submit ostomy claims. Some beneficiaries have several stomas and a given supply (A4365, A4394, A4406, A4414, and/or A5120) is used for both stomas. If I bill the same HCPCS code on different lines with different diagnoses will the second line not deny as a duplicate?

A32. Yes, it is probable that the second line will deny as a duplicate. In that case you would need to appeal the denial with documentation supporting the need for the same supplies for the different stomas.

Q33. I make custom splints and often make the same splint for both hands. How do I submit these splints?

A33. If you are billing the same HCPCS code for both splints, bill the service on one line with the HCPCS code and the LT and RT modifiers in Item 24D and 2 units in Item 24G.

Q34. Will NAS continue to support Express Plus for submitting electronic claims?

A34. Yes, NAS will continue to support Express Plus; if there is a change regarding this, you will be notified well in advance.

Q & As Resulting from the February 2007 CMS-1500 Claim Form Workshops

The following questions and answers are from the February 1 and 8, 2007, CMS-1500 Claim Form Changes WebEx workshops. In some cases, the original answers given during the workshop may have been expanded to provide further detail.

Q1. Do facilities such as Ambulatory Surgery Centers need NPI numbers or is it only physicians?

A1. All healthcare providers need NPI numbers by May 23, 2007.

Q2. We are a corporation with one tax ID but three locations. Do I need to apply for NPIs by location?

A1. DMEPOS suppliers need one NPI number for each physical location. If you are a DME supplier and have three locations, you need three NPI numbers.

Q3. I am a DMEPOS supplier in need of the physician's NPI in order to submit claims for equipment the physician ordered. I have one physician who refuses to share her NPI, stating that is confidential information. This physician asked me to provide the regulation that says it is required that she share her NPI. Where can I find the section that says physicians must share their NPI numbers with other healthcare providers who need it to submit claims for payment?

A3. All of the CMS publications addressing NPI state that as outlined in the Federal Regulation (the Health Insurance Portability and Accountability Act of 1996) the provider must share his NPI with other providers, health plans, clearinghouses and any entity that may need it for billing purposes.

Q4. Is an NPI number required by all insurance companies on May 23, 2007?

A4. Yes, the NPI is a unique identification number for health care providers that will be used by all health plans no later than May 23, 2007.

Q5. Is there a Web site where we can locate a physician's NPI?

A5. No, there is not a Web site that contains physician's NPIs. You will need to ask each physician for his/her NPI number.

Q6. What is the exact format for placing the 1G qualifier in item 17a of the CMS-1500 (80-05) form? Is there a hyphen or other punctuation required after the UPIN?

A6. You place the 1G qualifier in the smaller box of item 17a and the UPIN in the larger box of item 17a. No punctuation is used. Remember item 17a is only used until May 22, 2007, when the crosswalk between UPINs and NPIs is complete.

Q7. Do I also place the UPIN in the shaded portion of item 24J?

A7. During the transition period ending May 22, 2007, the UPIN is only placed in item 17a. The Shaded portion of item 24J is used for your National Supplier Clearinghouse (NSC) number through the transition period.

Q8. Are both the 1C qualifier and the NSC number placed in item 32b or is the 1C qualifier placed in 32a?

A8. The 1C qualifier followed by a space and the NSC number are placed in 32b through the transition period ending May 22, 2007. The NPI number is placed in 32a.

Q9. Do I place the supplier NPI in item 33a?

A9. Yes, your supplier NPI is placed in item 33a. During the transition period ending May 22, 2007, you will also place the ID qualifier 1C followed by a space and your legacy (NSC) number in item 33b. This will aid in building a crosswalk between your NSC and your NPI numbers.

Q10. How will the new claim form affect Certificates of Medical Necessity (CMNs)?

A10. The revised CMS-1500 claim form will not affect CMNs.

Q11. Am I correct in that the CMS-1500 (12-90) form cannot be used after March 31, 2007?

A11. That is correct. The only form that can be used on/after April 1, 2007, is the revised CMS-1500 (08-05) form.

Q12. In which box do I place my tax ID number?

A12. Your tax ID number is placed in item 25.

Q13. For how long has there been the requirement that only one diagnosis pointer can be placed in item 24E of the CMS-1500 paper claim form?

A13. The CMS has been providing this instruction as far back as 1995; however, NAS didn't enforce this instruction until 2005.

Q14. I received a recent update that up to eight diagnosis codes would be accepted in the future. Will the revised CMS-1500 claim form be amended to accommodate this?

A14. You are correct that up to eight diagnosis codes can be submitted and accepted for processing, but that only affects electronically submitted claims. At this time, unless the CMS does revise the claim form again, only four diagnosis codes can be submitted on the paper claim form.

Q15. I hand printed the CMS-1500 (12-90) form. Can I do the same with the revised CMS-1500 (08-05) form?

A15. The revised form can be handwritten, however, all claims are entered into the system via an optical scanner. If your handwriting is not clear or the items are not contained within the space provided on the claim form, the scanner will not be able to read it. That will result in NAS sending you an Education Status letter advising you that your claim cannot be processed as submitted. The Education Status letter will also advise you as to what needs to be corrected on your claim before you resubmit it correctly.

Q16. Can I still use the 2005 edition of the ICD-9-CM?

A16. All diagnoses must be coded to highest level of specificity. By using a 2005 edition of the ICD-9-CM, you run the risk of an item denying based on a truncated or invalid diagnosis code. NAS recommends that you purchase new coding manuals every year to keep abreast of all the coding changes, both ICD-9-CM and HCPCS.

Q17. Can I use my NPI on the CMS-1500 (12-90) form?

A17. No. The CMS-1500 (12-90) was not designed to accept the ten digit NPI.

Q18. What is my legacy number?

A18. Your legacy number is the supplier number given to you by the National Supplier Clearinghouse (NSC). It is the original billing number you were given when you became a DMEPOS supplier. Your NPI number is replacing your NSC (legacy) number.

Q19. Is the legacy number also the provider identification number (PIN) used by physicians?

A19. That is correct.

Q20. In item 32 we previously noted the location where the item was received if other than home or office. Will we follow the same procedure on the revised CMS-1500 (08-05) form?

A20. Yes, that procedure remains the same on the revised form.

Q21. I was told to use the ZZ code for taxonomy, not 1C.

A21. Taxonomy codes are also called specialty codes and are the 9-digit numbers assigned under the HIPAA provisions to health care providers in order to digitally encode their specialty to facilitate electronic billing. You may need to place your taxonomy code when there is a need to report your specialty on an electronic submission, but when billing your legacy number you use the 1C qualifier.

You should contact EDI customer service at 1-866-224-3094 for clarification on placement of your taxonomy code for electronic transmission.

Q22. We heard that Noridian does not read item 19, but the previous contractor instructed us to place descriptions of unspecified codes in that box. Where should I place the narrative for Noridian?

A22. Continue to place narrative in item 19. Noridian has always instructed its providers to place descriptions or any needed narrative in item 19.

Q23. If we choose not to use the new form until May 23, 2007, and only use the NPI after that, will my claims process without having the crosswalk first?

A23. Your claims will process after May 23, 2007, without you submitting your NPI prior to that date. However, remember the revised form must be used on/after April 1, 2007. So if you submit any claims between then and May 22, 2007, it would be wise to bill your NPI along with your legacy number during that time to aid in building the crosswalk.

Q24. Are the ID qualifiers the same for Part B and DME?

A24. Yes, the ID qualifiers are the same for Part B and DME.

Q25. Will other insurance companies accept the revised CMS-1500 claim form?

A25. Noridian cannot answer for other insurance companies, but we assume they will.

Q26. Will the shaded portion of the revised form be removed after the crossover period?

A26. We have not been notified that the shaded portion will be removed.

Q27. I bill electronically. Should I contact EDI regarding how to include both the NPI and the NSC when submitting my electronic claims?

A27. Noridian has a document on its Web site at www.noridianmedicare.com/dme/ in the Claims section that will assist you with the placement of the NPI and NSC numbers when submitting claims electronically. If you need additional assistance beyond what you find in the document, then you should contact the EDI contractor at 1-866-224-3094 for assistance.

Q28. Following the transition period to NPI ending May 22, 2007, will any other supplier numbers or UPINs be needed to bill either Medicare or other insurances?

A28. No, the only number you will use for billing Medicare or other insurances is your NPI number.

Q29. Do I need the referring physician's NPI to bill Medicare and if so, where do I get it?

A29. Yes, you need the referring physician's NPI to bill Medicare. It is replacing the physician's UPIN. You will need to contact the physician and ask for his NPI number.

Q30. Where can I order the revised CMS-1500 claim forms or does Medicare provide them for the suppliers?

A30. Medicare does not provide suppliers with paper claim forms. You can order them from the U.S. Printing office by calling 202-512-1800 or from a number of vendors on the Internet. They can also be purchased from you local office supply store or print shop.

Q31. Where on the revised form do I place the UPIN?

A31. During the transition period ending May 22, 2007, the ID qualifier 1G and the UPIN are placed in item 17a. The referring physician's NPI is placed in item 17b. You will not use a UPIN or item 17a after May 22, 2007.

Q32. What is the difference between NPI type 1 and NPI type 2?

A32. An NPI type 1 is an individual that renders health care services (pharmacist, physician). An NPI type 2 is an organization that renders health care services (hospital, nursing facility).

Q33. Does item 24J need to be completed for each line item or just for the first line item for DME claims?

A33. DME suppliers have the option of completing item 24J. If you choose to complete item 24J, then the NPI must be placed on each line item.

EDUCATIONAL CONT'D

Q34. Our company has multiple supplier sites with each site having its own NSC number. Do I need one NPI for all sites or one NPI for each site?

A34. Suppliers, unless the supplier is a sole proprietorship, are required to obtain an NPI for every location. This is addressed in MLN Matters SE0679 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0608.pdf

Q35. Modifiers are placed in item 24D. With space for four modifiers, can I now place the RT and LT modifiers on the same line when billing the same HCPCS code?

A35. Yes, you can place both modifiers on the same line when billing the same HCPCS code, but when doing this remember to also place a two in item 24G to indicate the number of units dispensed.

Q36. Are military doctors required to get NPIs as well?

A36. All health care providers who are HIPAA-covered entities, whether they 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, HMOs, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI to identify themselves in HIPAA standard transactions.

BILLING

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 2, 2007, to correct the Web address on page 2 for accessing CR4309. All other information remains the same.

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:
    - o 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 electronically submitted 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 http://www.cms.hhs.gov/Transmittals/downloads/R1187CP.pdf on the CMS website.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

MLN Matters Number: MM5456
Related Change Request (CR) #: 5456
Related CR Release Date: January 26, 2007
Related CR Transmittal #: R1163CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

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

Provider Action Needed

CR 5456, from which this article is taken, announces the latest update of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 and 837 Health Care Claim Adjustment Reason Codes, effective April 2, 2007. Be sure billing staff are aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The RARC list is maintained by the Centers for Medicare & Medicaid Service (CMS), and used by all payers; and additions, deactivations, and modifications to it may be initiated by both Medicare and non-Medicare entities. The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes.

Both code lists are updated three times a year, and are posted at http://wpc-edi.com/codes. **The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5456, effective on and after April 1, 2007.**

CMS has also developed a new tool to help you search for a specific category of code and that tool is at http://www.cmsremarkcodes.info. Note that this website does not replace the WPC site and, should there be any discrepancies between this site and the WPC site, consider the WPC site to be correct.

Additional Information

You can see the official instruction issued to your FI/carrier/DMERC/RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5456, located at http://www.cms.hhs.gov/Transmittals/downloads/R1163CP.pdf on the CMS website.

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

X12N 835 Remittance Advice Remark Code Changes

New Codes

Code	Current Narrative	Medicare Initiated
N373	It has been determined that another payer paid the services as primary when they were not the primary payer. Therefore, we are refunding to the payer that paid as primary on your behalf. **Note: (New Code 12/1/06)**	No
N374	Primary Medicare Part A insurance has been exhausted and a Part B Remittance Advice is required. **Note: (New Code 12/1/06)**	No
N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility. **Note: (New Code 12/1/06)**	No
N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE. **Note: (New Code 12/1/06)**	No
N377	Payment adjusted based on a processed replacement claim. **Note: (New Code 12/1/06)**	No
N378	Missing/incomplete/invalid prescription quantity. **Note: (New Code 12/1/06)**	No
N379	Claim level information does not match line level information. **Note: (New Code 12/1/06)**	No

Modified Codes

Code	Current Narrative	Modification Date
M143	The provider must update license information with the payer. **Note: (Modified 12/1/06)**	12/01/06

N181	Additional information is required from another provider involved in this service. **Note: (New Code 2/28/03. Modified 12/1/06)**	12/01/06
N361	Payment adjusted based on multiple diagnostic imaging procedure rules **Note: (New Code 11/18/05. Modified 12/1/06)**	12/01/06
There are NO deactivated codes		

NOTE II: Some remark codes may provide information that may not necessarily supplement the explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Newly created informational codes will have "Alert" in the text to identify them as informational rather than explanatory codes. An example of an informational code:

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

The above information is sent per state regulation, but does not explain any adjustment. These informational codes should be used only if specific information needs to be communicated but not as default codes.

X12 N 835 Health Care Claim Adjustment Reason Codes

New Codes

Code	Current Narrative	Notes
197	Payment denied/reduced for absence of precertification/authorization **Note: New as of 10/06**	New as of 10/06
198	Payment denied/reduced for exceeded, precertification/authorization **Note: New as of 10/06**	New as of 10/06
199	Revenue code and Procedure code do not match. **Note: New as of 10/06**	New as of 10/06
200	Expenses incurred during lapse in coverage **Note: New as of 10/06**	New as of 10/06
201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC "Medicare set aside arrangement" or other agreement. (Use group code PR). **Note: New as of 10/06**	New as of 10/06

Modified Codes

Code	Current Narrative	Notes
42	Charges exceed our fee schedule or maximum allowable amount. **Note: Changed as of 10/06. This code will be deactivated on 6/1/2007.**	Modified as of 10/06 Effective 6/1/2007
45	Charges exceed your contracted/legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability). **Note: Changed as of 10/06**	Modified as of 10/06 Effective 6/1/2007 **Note: This code replaces code 42 (above) on June 1, 2007.**
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization. **Note: Changed as of 2/01 and 10/06. This code will be deactivated on 4/1/2007.**	Modified as of 10/06
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated **Note: Changed as of 2/99 and 10/06.**	Modified as of 10/06
107	Claim/service adjusted because the related or qualifying claim/service was not identified on this claim. **Note: Changed as of 6/03 and 10/06.**	Modified as of 10/06
136	Claim adjusted based on failure to follow prior payer's coverage rules. (Use Group Code OA). **Note: Changed as of 6/00 and 10/06.**	Modified as of 10/06
196	Claim/service denied based on prior payer's coverage determination. **Note: New as of 6/06. Changed 10/06. This code will be deactivated on 2/1/2007, beginning on that date, value 136 will be used.**	Modified as of 10/06
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). **Note: Changed as of 10/06**	Modified as of 10/06
B15	Payment adjusted because this service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. **Note: Changed as of 2/01 and 10/06.**	Modified as of 10/06
D17	Claim/Service has invalid non-covered days. *Note: This code will be deactivated on 2/1/2007 and code 16 will then be used with appropriate claim payment remark code [M32, M33].*	Modified as of 10/06

D18	Claim/Service has missing diagnosis information. **Note: This code will be deactivated on 2/1/2007 and then code 16 will be used with appropriate claim payment remark code [MA63, MA65].**	Modified as of 10/06
D19	Claim/Service lacks Physician/ Operative or other supporting documentation **Note: This code will be deactivated on 2/1/2007 and code 16 will be used with appropriate claim payment remark code [M29, M30, M35, M66].**	Modified as of 10/06
D20	Claim/Service missing service/ product information. **Note: This code will be deactivated on 2/1/2007 and code 16 will be used with appropriate claim payment remark code [M20, M67, M19, MA67].**	Modified as of 10/06
D21	This (these) diagnosis(es) is (are) missing or are invalid **Note: New as of 6/05. This code will be deactivated on 2/1/2007.**	Modified as of 10/06

Differentiating Mass Adjustments from Other Types of Adjustments and Claims for Crossover Purposes and Revising the Detailed Error Report Special Provider Notification Letters

MLN Matters Number: MM5472
Related Change Request (CR) #: 5472
Related CR Release Date: February 28, 2007
Related CR Transmittal #: R1189CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Note: This article was revised on March 1, 2007, to reflect changes made to CR5472, which CMS revised on February 28, 2007. The CR transmittal number, release date, and Web address for accessing CR5472 have been revised. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5472 which implements changes to Medicare contractor systems so that their claim transmissions to the Coordination of Benefits Contractor (COBC) for mass adjustments and other kinds of adjustments may be differentiated from all other types of claims sent for crossover.

This will be accomplished through modifications to the 837 COB flat files and National Council for Prescription Drug Programs (NCPDP) Part B drug claim files, all of which are transmitted to the COBC on a daily basis.

Through CR5472, Medicare contractors' systems will be modified so that the COBC Detailed Error Report information that is printed on the outgoing special provider notification letters/report that you receive when claims will not be crossed over due to claim data errors will be modified to also include the error/trading partner rejection code and accompanying description. These changes to the special provider letters should enable your billing service to determine why claims that were previously selected by Medicare for crossover were not actually crossed over.

Without these changes, CMS would be unable to isolate mass adjustment claims as part of the national COBA crossover process. This change corrects a problem that the Centers for Medicare & Medicaid Services (CMS) encountered as part of its implementation of the Deficit Reduction Act (DRA). Also, providers would continue to be unaware of the specific reasons as to why their patients' claims were not crossed over.

Background

All Medicare contractors currently send processed claims, for which Medicare systems show the beneficiary has other insurance to the COBC for crossover under the national Coordination of Benefits Agreement (COBA) program.

The Centers for Medicare & Medicaid Services (CMS) requires a method whereby its Coordination of Benefits Contractor (COBC) can differentiate among the various categories of adjustment crossover claims including:

- Mass adjustments - Medicare physician fee schedule (MPFS),
- Mass adjustments - other, and
- All other adjustments.

Having the ability to differentiate among the various categories of adjustment crossover claims will enable CMS (and the COBC) to better address the kinds of contingencies that arise with the passage of legislation such as the Deficit Reduction Act, which mandate changes for Medicare that can affect claims already processed.

CR5472 instructs that the COBC Detailed Error Report process be modified to ensure that the contractor-generated special provider letters which are created and sent in accordance with CR 3709 contain the specific Claredi rejection code returned for the claim along with its description. (See the MLN Matters article at http://www.cms.hhs.gov/mlnMattersArticles/downloads/MM3709.pdf for information on CR3709.)

Providers may wish to contact their billing agent/vendor to obtain a better understanding of these error codes and

accompanying descriptions, which, in turn, explains why their patients' claims were not crossed over successfully. In addition, providers should notify their billing agent/vendor when they receive special provider letters or reports stating why their patients' claims were not crossed over.

Additional Information

The official instruction, CR5472, issued to your carrier, FI, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1189CP.pdf on the CMS website. Attached to CR5472, you will find the new chapter of the *Medicare Claims Processing Manual* explaining in detail the new special mass adjustment process for COB. In addition, you will also find revised chapters for other portions of that manual, which discuss the COB process.

Part C Plan Type Description Display on Medicare's Common Working File

MLN Matters Number: MM5349 Revised
Related Change Request (CR) #: 5349
Related CR Release Date: February 2, 2007
Related CR Transmittal #: R1175CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected

Physicians, providers, and suppliers who access Medicare beneficiary eligibility data through CWF eligibility screens (e.g. HUQA, HIQA, HIQH, ELGA, ELGB, ELGH).

Provider Action Needed

Be aware of the expanded list of MA Plan Type Descriptions that are being displayed by Medicare's CWF system. Being aware of the MA plan type is crucial, especially for those beneficiaries who are enrolled in Private Fee-For-Service (PFFS) plans.

A plan directory, which will be quite descriptive, will soon be published that contains the list of all active Medicare contracts and their corresponding plan type. The directory will be in a table format and will be posted at the following URL in mid-March of 2007: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage

Background

When you query Medicare regarding a beneficiary's entitlement and eligibility, Medicare's CWF system responds with information on the Medicare managed care contract number in which a beneficiary is enrolled, including the plan type description associated with the contract. Currently, CWF largely displays the label "HMO" for these contracts. In many cases, the "HMO" label is incorrect since the list of possible plan type values has grown far larger since the creation of the Medicare Advantage program.

For example, under the MA Part C program, Medicare beneficiaries can enroll in Private Fee-for-Service (PFFS) plans. PFFS plans are very different from the more traditional MA HMO type plan.

PFFS PLANS

PFFS plans generally have no plan specific provider network. Enrollees in a PFFS plan can obtain plan covered health care services from any Medicare FFS enrolled provider in the U.S. who is willing to furnish services to a PFFS plan beneficiary. It is important to note that a provider is not required to furnish health care services to enrollees of a PFFS plan.

In most cases, a PFFS enrollee will inform a provider before obtaining a service that they are enrolled in a PFFS plan. In addition, the PFFS enrollee will have an enrollment card provided by the PFFS plan identifying them as enrollees in a PFFS plan. The card will specify a phone number and/or a web address where the provider can obtain the PFFS plan's terms and conditions of participation.

At a minimum, the terms and conditions will specify:

- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures, including
    - The amount the provider is permitted to collect from the enrollee; and
    - Whether the provider must obtain advance authorization from the PFFS organization before furnishing a particular service.

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers in the U.S. from whom its enrollees seek health care services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a web site and also make them available upon written or phoned request.

To be paid by a PFFS organization, the provider must send their bill to the address (or electronic address) provided in the PFFS plan's terms and conditions of participation.

For more detailed information on PFFS plans as they relate to providers, see the "Provider Q&A" Downloadable document on http://www.cms.hhs.gov/PrivateFeeforServicePlans/.

Additional Information

If you have questions regarding the plan of a specific Medicare MA enrolled patient, you may wish to contact that plan.

To view the official instruction (CR5349) issued to your Medicare FI, carrier, MAC, DMERC or RHHI, visit http://www.cms.hhs.gov/Transmittals/downloads/R1175CP.pdf on the CMS website.

To review a related article that explains Medicare's Common Working File (CWF) Part C (Medicare Advantage Managed Care) Data Exchange and Data Display Changes go to http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5118.pdf on the CMS website.

ENROLLMENT

Provider Enrollment in the Medicare Program

Related Change Request (CR) #: SE0612

Note: This article was revised to contain web addresses that conform to the new CMS web site and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

All Medicare physicians, providers, and suppliers

What You Need To Know

- You must enroll in the Medicare program in order to receive Medicare payment for covered services that you provide to Medicare beneficiaries.
- The Medicare enrollment application and process are used to collect information about you and to secure the necessary documentation to ensure you are qualified and eligible to enroll in the Medicare program.
- This Special Edition article (SE 0612) contains helpful information about the Medicare enrollment process.

Background

Physicians, providers, and suppliers must enroll in the Medicare program in order to receive Medicare payment for services provided to its beneficiaries.

You can accomplish this enrollment by completing the Medicare enrollment application, in which you provide the information and supporting documentation needed to ascertain your qualifications for, and your eligibility to enroll in, the Medicare program.

When submitted, a designated Medicare fee-for-service contractor (known as a carrier or fiscal intermediary [FI]) will process your application and verify the information that you have provided.

To obtain a list of specific supporting documentation that you must submit with your enrollment application, call or visit the Medicare fee-for-service contractor serving your area (see *Additional Information* section below.)

Be aware that, at any time during the enrollment process, your carrier or FI may request documentation to support or validate information that you have reported on your application.

Applicants are responsible for providing this documentation in a timely manner. Failure to provide documentation in a timely manner may delay your enrollment into the Medicare program.

Additional Information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit http://www.cms.hhs.gov/MedicareProviderSupEnroll on the CMS web site.

Announcing the Release of the Revised CMS-855 Medicare Enrollment Applications

MLN Matters Number: SE0632

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

On **May 1, 2006**, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately.** Initially, these applications will be available only from the CMS provider enrollment web site. The link for that CMS web site is listed in the *Additional Information* section of this article.

Over the last year, CMS has received numerous comments and suggestions regarding the proposed revisions to the Medicare enrollment applications. CMS reviewed the comments and adopted many of the suggested revisions. Also, CMS incorporated a number of enhancements and changes (see *Key Points* below) to clarify the enrollment process and to reduce the burden imposed on the provider and supplier communities.

Key Points

This Special Edition outlines the significant revisions to the Medicare enrollment applications and they are as follows:

Enhancements

- Improved the application's aesthetics via a more visually appealing format, larger font, clarified headings, and the use of plain language;
- Revised cover page to include instructions that help applicants submit the correct enrollment application, inform applicants where to mail the application, and provide information on the documents that must be furnished with the enrollment application;
- Added tips on how to avoid delays in the enrollment process; and
- Redesigned Section 17 (Supporting Documentation) to make it easier for providers and suppliers to know which documents must be submitted with an enrollment application.

Significant Changes

- Require the submission of the National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application;
- Require that providers and suppliers complete the Authorization Agreement for Electronic Funds Transfer (CMS-588) when initially enrolling or – if they are currently not receiving payments via EFT - making a change to their enrollment information; and,
- Removed Sections 9 (Electronic Claims Submission Information), 10 (Staffing Companies), and 11 (Surety

Bonds) from the application. In addition, information regarding overpayments no longer must be submitted.

Application-Specific Changes for Physicians and Non-Physician Practitioners (CMS-855I)

- A sole proprietor who incorporates (and who is the sole owner of that business) only needs to complete the CMS 855I form. In the past, such suppliers had to complete the CMS 855B, CMS 855I and CMS 855R. However, the person will still need to report information about the practice, such as the legal business name and adverse legal history.

Application-Specific Changes for Clinics/Group Practices and Certain Other Suppliers (CMS-855B)

- Removed the requirement to collect crew member and certain vehicle information from ambulance companies **in Attachment 1 of the application.**
- Revised the Independent Diagnostic Testing Facility information contained in Attachment 2 of the application.

Application-Specific Changes for Institutional Providers (CMS-855A)

- Eliminated questions dealing with fiscal intermediary preferences. This change implements section 911(d)(2)(B) of the Medicare Modernization Act. See MLN Matters article SE0582 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0582.pdf for further information.

Additional Information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit http://www.cms.hhs.gov/MedicareProviderSupEnroll on the CMS web site.

Special Edition article SE0612 contains helpful information about the Medicare enrollment process. You may review the article on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf on the CMS site.

Facilitating Your Medicare Enrollment

MLN Matters Number: SE0634

Provider Types Affected

All Medicare physicians, providers, and suppliers

Background

On May 1, 2006, the Centers for Medicare & Medicaid Services (CMS) issued the revised CMS-855 Medicare enrollment applications. **Providers and suppliers should begin to use the new Medicare enrollment applications immediately**. Initially, these applications will be available only from the CMS provider enrollment web site. The link for that CMS web site is listed in the *Additional Information* section of this article.

Key Points

This Special Edition provides additional information regarding the submission of a Medicare enrollment application.

All Provider Enrollment Applications

To ensure timely processing of your application, make certain to completely fill out the application and provide all required supporting documentation at the time of filing.

Section 17 of the Medicare enrollment application lists the types of supporting documentation that you will need to submit with your enrollment application. In addition to providing the documentation previously required, all applicants are required to:

- Submit their National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System with each enrollment application; and
- Complete the Authorization Agreement for Electronic Funds Transfer (CMS588) when initially enrolling or – if they are currently not receiving payments via EFT - making a change to their enrollment information.

To obtain a list of specific supporting documentation that you must submit with your enrollment application, contact the designated Medicare fee-for-service contractor serving your area before submitting your application.

Contractor Request for Additional Information

At any time during the enrollment process, your carrier or FI may request documentation to support or validate information that you have reported on your application. Applicants are responsible for providing this documentation in a timely manner. Failure to provide documentation in a timely manner may delay your enrollment into the Medicare program.

Applications Received Through June 2, 2006

Medicare contractors will continue to accept the 11/2001 version of the Medicare enrollment applications through June 2, 2006, as long as the application is complete and contains the NPI notification from NPPES. In addition, providers and suppliers who choose to use the 11/2001 version of the 855 will be required to complete and submit Section 1 or Section 4 (completed by the provider) of the 04/06 version of the CMS-855. Providing this information will ensure that Medicare is able to link existing Medicare identification number(s) to the NPI that the provider or suppliers plan to use for billing purposes.

Specifically, Section 1 must be completed by Physician Assistants and providers reassigning all of their benefits, as this is where NPI data is reported. All other providers must furnish the NPI and Medicare Identification Number in Section 4 of the CMS-855; this is the only data that must be reported in Section 4.

Applications Received On or After June 5, 2006

All applications received on or after June 5, 2006, must be filed using the 04/06 version of the CMS-855 and contain all supporting documentation, including the NPI notification and the CMS-588.

ENROLLMENT CONT'D

Additional Information

For additional information regarding the Medicare enrollment process, including the mailing address and telephone number for the carrier or FI serving your area, visit http://www.cms.hhs.gov/MedicareProviderSupEnroll on the CMS web site.

Special Edition article SE0612 and SE0632 contain helpful information about the Medicare enrollment process. You may review the article on the CMS web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0612.pdf, and http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0632.pdf, respectively, on the CMS site.

CERT

CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

MSP

Medicare Secondary Payer

"Medicare Secondary Payer" is the term used by Medicare when it is not responsible for paying a claim first. Medicare would be considered a secondary payer if a beneficiary is covered under any of the following insurance plans:

- Group Health Insurance (www.cms.hhs.gov/ProviderServices/06_grouphealthinsurance.asp) is provided by an employer to a policyholder who is actively working. There are three types of group health plans (GHPs) including:
  - Employer Group Health Plan (EGHP) (type 12) made available to working Medicare beneficiaries age **65 or older** or Medicare beneficiaries of any age with a spouse who is working and covered by a GHP;
  - Large Group Health Plans (LGHPs) (type 43) made available to disabled Medicare beneficiaries **under the age of 65** through their current employment or the current employment of a family member; or
  - GHPs (type 13) made available to persons with end-stage renal disease (ESRD)/permanent kidney failure.
- Automobile or Liability Insurance (www.cms.hhs.gov/ProviderServices/08_nofaultandliabilityinsurance.asp) (type 14) is applicable in cases where an accident has occurred, whether it is a car accident, a fall or medical malpractice.
- Workmen's Compensation (www.cms.hhs.gov/WorkersCompAgencyServices/01_overview.asp) (type 15) covers injuries on the job. Claims for job related injuries must be submitted to the employer's Workmen's Compensation carrier before they can be sent to Medicare for payment
- Black Lung (type 41) is covered under the Federal Black Lung Program. Medicare cannot pay claims submitted with a Black Lung Diagnosis code unless a copy of the Explanation of Benefits from the Black Lung Program is submitted showing that no payment was made.
- Veterans Administration (www.va.gov/) (type 42) claims are not paid by Medicare as secondary. If a claim isn't filed with the VA, then Medicare will pay.

MSP CONT'D

Supplemental insurance, also known as Medigap, is considered a Secondary Payer to Medicare. That means you submit your claim to Medicare first. After Medicare makes their payment the supplemental insurance will usually pay the 20% coinsurance amount that Medicare doesn't pay.

Medicare Part D is similar to Medicare Parts A and B in that it provides prescription drug coverage to beneficiaries who elect this type of coverage as a Medicare benefit. Medicare Part D is not primary to Medicare Parts A and B nor is it a supplemental insurance plan. If, on your submitted Medicare DMEPOS claim, you note that Part D or a supplemental insurance plan is primary to Medicare, you risk delaying the processing of that claim.

Additional Information:

CMS Medicare Secondary Payer and You www.cms.hhs.gov/MedicareSecondPayerandYou/

Fact Sheet for Provider Billing Staff – When Medicare is the Primary Payer www.cms.hhs.gov/MLNProducts/downloads/MSP_4a.pdf

Fact Sheet for Physicians and Provider Administrators – Complying with Medicare Secondary Payer Requirements www.cms.hhs.gov/MLNProducts/downloads/MSP_2a.pdf

Fact Sheet for Physician and Provider Billing Staff – Collecting, Submitting, and Updating Beneficiary Insurance Information to Medicare www.cms.hhs.gov/MLNProducts/downloads/MSP_3a.pdf

NPI

Get It. Share It. Use It.

There are less than 90 days left between today and the NPI compliance date of May 23, 2007. It is estimated that it may take at least this much time to implement the NPI into your business practices. Failure to prepare could result in a disruption in cash flow. Will you be ready to use your NPI? Time is running out!

Updating National Plan and Provider Enumeration System (NPPES) Information

All health care providers, including Medicare providers, should include their legacy identifiers, as well as associated provider identifier type(s), on their NPI applications. If a provider has already completed an application and did not submit a legacy identifier, this provider should go back and update its information in NPPES. A provider can easily do so by using the web (nppes.cms.hhs.gov). While doing so, providers should also validate other data in NPPES, such as address, contact person information, etc. and update anything that has changed.

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 must share their NPI with any entity that may need it for billing purposes — including those who need it 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.

New Frequently Asked Questions (FAQs) Posted

CMS has posted new NPI FAQs on its website.

Questions include:

- For Medicare provider enrollment purposes, will group practices need to submit new CMS-855R's for every member of the group practice in order to let Medicare know their NPIs?
- Will health plans link the National Provider Identifiers (NPIs) of group practices to the NPIs of the health care providers who are members of the group practices?
- Who needs an NPI – who is not eligible to apply for an NPI - what if I have a Drug Enforcement Administration (DEA) number – what if I only bill on paper – what if I do not submit claims to Medicare?
- Can my office Employer Identification Number (EIN) be used instead of a National Provider Identifier (NPI)?
- When do I need to use my National Provider Identifier (NPI)?
- Is a corporation that owns pharmacies that have National Provider Identifiers (NPIs) required to have an NPI in order to receive payments on behalf of the owned pharmacies?

To view these FAQs, please go to the CMS dedicated NPI webpage at www.cms.hhs.gov/NationalProvIdentStand and click on Educational Resources. Scroll down to the section that says "Related Links Inside CMS" and click on Frequently Asked Questions. To find the latest FAQs, click on the arrows next to "Date Updated".

Upcoming WEDI Events

WEDI has several NPI events scheduled in the upcoming month. Visit www.wedi.org/npioi/index.shtml to learn more about these events. Please note that there is a charge to participate in WEDI events.

Important Information for Medicare Providers

Sharing NPIs with Medicare

In addition to updating critical data and legacy identifiers in the NPPES, Medicare providers should include both their NPIs and their Medicare legacy numbers in their Medicare claims. This will help Medicare build its NPI crosswalk by enabling Medicare to link providers' NPIs to their Medicare legacy identifiers. Also, when Medicare providers make changes to their Medicare enrollment information, they are now required to furnish their NPIs when making those changes. Providers applying for Medicare enrollment must furnish their NPIs on their enrollment applications. These actions inform Medicare of providers' NPIs.

There are no additional actions that Medicare providers need to take to inform Medicare of their NPIs.

NPI CONT'D

Still Confused?

Not sure what an NPI is and how you can get it, share it and use it? As always, more information and education on the NPI can be found at the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at 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.

WHEELCHAIR/ POWER MOBILITY DEVICE

Power Mobility Devices – Basic Equipment Package

The Power Mobility Devices Policy Article defines a Basic Equipment Package for power wheelchairs and power operated vehicles. Changes are being made to the Basic Equipment Package for power wheelchairs. These changes are effective for claims with dates of service on or after January 1, 2007.

For Group 3, 4, and 5 power wheelchairs (PWCs), angle adjustable footplates will be separately billable. For Group 3 and 4 PWCs (other than Extra Heavy Duty) with a sling/solid seat/back, non-standard seat widths and/or depths will be separately billable. The following list includes these changes and other clarifications.

PWC Basic Equipment Package - Each power wheelchair code is required to include all these items on initial issue (i.e., no separate billing/payment at the time of initial issue, unless otherwise noted). The statement that an item may be separately billed does not necessarily indicate coverage.

- Lap belt or safety belt. Shoulder harness/straps or chest straps/vest may be billed separately.
- Battery charger, single mode.
- Complete set of tires and casters, any type.
- Legrests. There is no separate billing/payment if fixed, swingaway, or detachable non-elevating legrests with or without calf pad are provided. Elevating legrests may be billed separately.
- Footrests/foot platform. There is no separate billing/payment if fixed, swingaway, or detachable footrests or a foot platform without angle adjustment are provided.
- There is no separate billing for angle adjustable footplates with Group 1 or 2 PWCs. Angle adjustable footplates may be billed separately with Group 3, 4 and 5 PWCs.
- Armrests. There is no separate billing/payment if fixed, swingaway, or detachable non-adjustable height armrests with arm pad are provided. Adjustable height armrests may be billed separately.
- Any weight specific components (braces, bars, upholstery, brackets, motors, gears, etc.) as required by patient weight capacity.
- Any seat width and depth. Exception: For Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately:
  - For Standard Duty, seat width and/or depth greater than 20 inches;
  - For Heavy Duty, seat width and/or depth greater than 22 inches;
  - For Very Heavy Duty, seat width and/or depth greater than 24 inches;
  - For Extra Heavy Duty, no separate billing.
- Any back width. Exception: For Group 3 and 4 PWCs with a sling/solid seat/back, the following may be billed separately:
  - For Standard Duty, back width greater than 20 inches;
  - For Heavy Duty, back width greater than 22 inches;
  - For Very Heavy Duty, back width greater than 24 inches;
  - For Extra Heavy Duty, no separate billing.
- Controller and Input Device. There is no separate billing/payment if a nonexpendable controller and a standard proportional joystick (integrated or remote) is provided. An expandable controller, a nonstandard joystick (i.e., nonproportional or mini, compact or short throw proportional), or other alternative control device may be billed separately.

Nonstandard seat dimensions and nonstandard back dimensions should be billed with code K0108.

For information about which specific HCPCS codes are included in the allowance for the power wheelchair base code, refer to the bundling table in the Wheelchair Options and Accessories Policy Article.

These changes will be incorporated in a future revision of the Power Mobility Devices and Wheelchair Options and Accessories Policy Articles.

For specific coding questions contact the SADMERC at: http://www.palmettogba.com/SADMERC or call 1-877-735-1326.

COVERAGE

Changes in Maintenance and Servicing Due to Deficit Reduction Act Legislation for Capped Rentals and Oxygen Equipment

MLN Matters Number: MM5461
Related Change Request (CR) #: 5461
Related CR Release Date: February 2, 2007
Related CR Transmittal #: R1177CP
Effective Date: January 1, 2006
Implementation Date: July 2, 2007

COVERAGE CONT'D

Provider Types Affected

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

Provider Action Needed

Suppliers of oxygen equipment and services need to be aware of changes in Medicare processes impacting maintenance and servicing of oxygen equipment for Medicare beneficiaries as described in this article.

Background

This article is based on Change Request (CR) 5461 and the purpose is to identify the Medicare payment method used for maintenance and servicing (M&S) for both capped rental items generally and for oxygen equipment in particular. Sections 5101(a) and 5101(b) of the DRA of 2005 mandate changes in the way Medicare makes payment for certain items of DME.

Section 5101(a) revises the payment rules for capped rental DME. After 13 months, the beneficiary owns the capped rental DME item and, after that time, Medicare pays for reasonable and necessary repairs and servicing (i.e., parts and labor not covered by a supplier's or manufacturer's warranty) of the item. The provision applies to beneficiaries renting an item for which the first rental month occurs on or after January 1, 2006.

For rentals prior to January 1, 2006, Section 5101(b) limits the total number of continuous rental months for which Medicare will pay for oxygen equipment to 36 months. After the 36th month, the beneficiary will own the oxygen equipment. 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.

CR5370 and the resulting MLN article preceded CR5461 and provides background explanations that detail the impact of the DRA. The web address for CR5370 is listed in the Additional Information section of this article.

Key Points

- **Capped Rental Items** – Payment will no longer be made every 6 months for Maintenance and Servicing (M&S) for capped rental items (with the exception of oxygen equipment as discussed in the next bullet point). However, once the beneficiary owns the capped rental item, Medicare will cover reasonable and necessary repairs and servicing.
- **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 following Medicare Summary Notice (MSN) messages for capped rental items where the title has been transferred to the beneficiary will be sent to beneficiaries:
  - Monthly rental payments can be made for up to 13 months from the first paid rental month or until the equipment is no longer needed, whichever comes first. After the 13 month of rental is paid, your supplier must transfer title of this equipment to you.
  - Medicare will pay for medically necessary maintenance and/or servicing as needed after the end of the 13th paid rental month.
- The following MSN messages for oxygen equipment where the title has been transferred to the beneficiary will be sent to beneficiaries, as appropriate:
  - "Medicare will pay for you to rent oxygen for up to 36 months (or until you no longer need the equipment). After Medicare makes 36 payments, your supplier must transfer title of this equipment to you, and you will own the equipment."
  - "Medicare will pay to maintain and service your oxygen equipment. This will start 6 months after the supplier transfers the title of the equipment to you."
  - "Billing exceeds the rental months covered/approved by the payer."
  - "Title of this equipment must be transferred to the patient."

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5461) issued to your Medicare DME MAC or DMERC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1177CP.pdf on the CMS website.

MLN article MM5370, which relates to CR5370, contains additional information regarding oxygen caps and is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5370.pdf on the CMS website.

Infrared Therapy Devices

MLN Matters Number: MM5421
Related Change Request (CR) #: 5421
Related CR Release Date: February 9, 2007
Related CR Transmittal #: R1183CP and R62NCD
Effective Date: October 24, 2006
Implementation Date: January 16, 2007

Note: This article was revised on February 9, 2007, to correct the range of ICD-9 codes shown in bold print on page 2. The range is 880.00-887.7. Originally, CR5421 and the related article incorrectly showed 880.00-887.79 for that range. The CR transmittal number, release date, and Web address for accessing CR5421 are also revised, but all other information remains the same.

Provider Types Affected

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

Impact on Providers

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

Background

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

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

- **Effective for services performed on or after October 24, 2006**, infrared therapy devices, HCPCS codes E0221 (infrared heating pad system) and A4639 (infrared heating pad replacement) are **non-covered** as DME or PT/OT services when used for the treatment of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds, and/or ulcers of the skin and/or subcutaneous tissues.
- Claims will be denied with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if they are accompanied by the following ICD-9 codes:
  - 250.60-250.63,
  - 354.4, 354.5, 354.9,
  - 355.1-355.4,
  - 355.6-355.9,
  - 356.0, 356.2-356.4, 356.8-356.9,
  - 357.0-357.7,
  - 674.10, 674.12, 674.14, 674.20, 674.22, 674.24,
  - 707.00-707.07, 707.09-707.15, 707.19,
  - 870.0-879.9,
  - **880.00-887.7,**
  - 890.0-897.7, or
  - 998.31-998.32.
- Note that denial of infrared therapy claims for the indications listed above applies to all settings, and affects Types of bills (TOBs) 12X, 13X, 22X, 23X, 34X, 74X, 75X and 85X.
- If you submit a claim for one of the non-covered services, your patient will receive the Medicare Summary Notice (MSN) message stating "This service was not covered by Medicare at the time you received it". The Spanish translation is: "Este servicio no estaba cubierto por Medicare cuando usted lo recibió."
- If you submit a claim for one of the non-covered services you will receive a remittance advice notice that reads: Claim Adjustment Reason Code 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer."
- Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospital outpatient departments should note that **you are liable** if the service is performed, unless the beneficiary signs an Advanced Beneficiary Notice (ABN).
- DME suppliers and HHA be aware that **you are liable** for the devices when they are supplied, unless the beneficiary signs an ABN.

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5421) issued to your Medicare A/B MAC, FI, DME MAC, RHHI, or carrier. There are actually two transmittals associated with CR5421. The first is the national coverage determination transmittal, located at http://www.cms.hhs.gov/Transmittals/downloads/R62NCD.pdf on the CMS website. In addition, there is a transmittal related to the Medicare Claims Processing Manual revision, which is at http://www.cms.hhs.gov/Transmittals/downloads/R1183CP.pdf on the CMS site.

Durable Medical Equipment Coding System Overview

View and use DMECS on the SADMERC pages of the Palmetto GBA web site. From www.palmettoGBA.com select SADMERC from the Quick Links section. Select the link to DMECS in the Topics section.

DMECS provides HCPCS (Healthcare Common Procedure Coding System) coding assistance and national pricing information via searches for HCPCS Level II codes and modifiers, DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies) products, and CMS national fee schedules. As the SADMERC, Palmetto GBA provides coding assistance to the public that is reflective of DMERC/MAC policies and guidelines. Therefore, DMECS is designed to assist the public with the coding of DMEPOS products for submission to the DMERC/MAC. DMECS contains HCPCS codes beginning with the letter G related to DMERC/MAC billing and all HCPCS codes beginning with the letters A, B, E, J, K, L, Q, and V. Not all of the HCPCS starting with these letters are valid for submission to the DMERC/MAC, such as codes for ambulance services. Invalid HCPCS are included for convenience to our customers. Please note the tracking of coding history and crosswalk information may be incomplete for codes invalid for DMERC/MAC submission.

DMECS currently has four interactive components that work together to provide HCPCS coding information.

I. Search by HCPCS Information

II. Search for Modifier

III. Search for Fee Schedule

IV. Search DMEPOS Product Classification List

Following are brief summaries of each component.

I. Search by HCPCS Information

All searches are wild card searches against the HCPCS short and long descriptions as well as additional search terminology added to help the public find codes using industry jargon not found in the descriptions. You may search by a whole word or code or part of the word or code.

You have two options for the set of codes you are searching. The options are listed at the top of the Search by HCPCS Information section of the screen. Click on your option of choice.

The default option selected is Active HCPCS Codes. Using this option, you search the HCPCS codes currently active, including active codes invalid for DMERC/MAC submission. This feature combined with the display of the dates of service valid for DMERC/MAC submission may help you determine if your product is billable to a Medicare Part B local carrier rather than the DMERC/MAC.

The second option is to search All HCPCS Codes. This option searches active and terminated HCPCS codes. DMECS contains HCPCS codes listed on the 2005 and 2006 CMS HCPCS files and subsequent updates. In addition, the SADMERC has added codes relevant to DMERC billing since 1993. The purpose of the additions is to provide as complete a crosswalk history as possible.

HCPCS Results Screen

The results of your search are displayed in the HCPCS Search Results screen. The columns that may need explaining are Dates of Service Valid for DMERC and Previous Dates of Service Valid for DMERC.

- Dates of Service Valid for DMERC – From and To: This column gives the most recent set of dates for which the code is/was valid for submission to the DMERC/MAC. If the From and To columns are blank, the code is and has never been valid for DMERC/MAC submission. (The code may be billable to the local Medicare Part B carrier. Please check with your local carrier.) If the To column contains the word 'present', the code is currently valid for submission.
- Previous Dates of Service Valid for DMERC – From and To: This column gives prior sets of dates for which the code was valid for submission to the DMERC/MAC. Some codes have changed billing status multiple times.

The information in the HCPCS Search Results table is limited so we encourage users to make a habit of always selecting a code of interest to link to the HCPCS Detail Screen.

HCPCS Detail Screen

While much of the information on this screen is self-explanatory, you may find the following explanations for selected items helpful.

Additional Search Terminology: Industry jargon added by the SADMERC to facilitate searches for the public using appropriate terms not found in the short and long descriptions of HCPCS codes. For example, the industry often refers to power operated vehicles as "scooters". If you enter the term "scooter" in the keyword field the search will show the same results as if power operated vehicle were entered.

Medicare Statute: Statutes associated with codes by CMS on the CMS HCPCS Tape are listed.

Code History table: This table contains the history of 'actions' for the code and the associated effective date and notes. The most recent action is at the top of the table. To see the actions in chronological order, read the table from bottom to top. Following are action types found in DMECS.

- Added to HCPCS Code Set – the date CMS added the HCPCS code to the Level II code set.
- Valid for DMERC Submission – the date the code became valid for submission to the DMERC/MAC.
- Invalid for DMERC Submission – the date the code was no longer valid for DMERC/MAC submission.
- Long Description Change – effective date of a change in the description of the code. The notes section will contain the old long description for comparison.
- Terminated Date – the date CMS terminated the HCPCS code from the Level II code set. Codes that have been terminated from the code set for five years can be reactivated. Reactivated codes may or may not represent the same HCPCS category as before. Please be sure to

look for differences using information in the Detail screen.

- Important Note – the date a special condition or information on the use of the code was effective.

Crosswalk History table: This table contains the immediate predecessor and successor crosswalk history for a code. You can think of this as the code's parents (predecessors) and children (successors). The most recent crosswalk information (the successors of the code) is at the top of the table. To see the actions in chronological order (predecessors to successors or parents to children of the code), read the table from bottom to top.

- Crosswalk Effective Date – the date the crosswalk is in effect.
- From Code – depending on the type of crosswalk (predecessor or successor) this displays either the code itself or the predecessor of the code. See code K0148 as an example. K0148's predecessors are A4204 and A4205. Both A4204 and A4205 were combined into K0148. K0148's successors are K0242, K0243, and K0244. A product previously coded as K0148 is now one of these codes. The user should view the detail of each code to determine the correct code to use. The notes section may also offer guidance.
- To Code – depending on the type of crosswalk (predecessor or successor) this displays either the code itself or the successors of the code.
- Notes – helpful notes about the crosswalk.

Available Fee Schedules table: DMECS contains the national CMS fee schedules from 1998 and forward. This table lists the time periods for which a fee schedule was published for the code. You can pick the time period of interest.

II. Search for Modifier

DMECS contains all modifiers listed on the CMS HCPCS file beginning with the 2006 file.

All searches are wild card searches against the modifier short and long descriptions. You may search by a whole word or modifier or part of the word or modifier. You have the option to enter no search criteria and select Go to obtain a complete listing of all modifiers. Please note that this option is only available for the modifier search, because the number of modifiers is small.

III. Search for a Fee Schedule

The SADMERC provides fee schedule amounts for HCPCS Level II codes listed on the CMS DMEPOS Fee Schedules. DMECS contains the fee schedules from 1998 and forward. The CMS DMEPOS fee schedule is issued annually and updated quarterly. Updates are complete replacements and are retroactive to the first of the year.

The search for fee schedules requires entry of a complete HCPCS code and date of service. The date of service field defaults to the current date.

Fee Schedule Screen

If the HCPCS code you enter is not found on a fee schedule, DMECS provides you with contact information for the DME MACs.

The fees are displayed in a table. The table by default lists all states. You can limit the table to a specific state by modifying the search. Use your browser scroll bar to scroll to the end of the screen. You will see the Modify Search options. Use this tool to limit the states shown in the fee schedule table to one state and change the HCPCS code you are viewing. You must select Go for the changes to occur. To the right of Modify Search is a table of Available Fee Schedules listing the time periods for which we have a fee schedule for the code you have selected. The date of service time period you are currently viewing is highlighted. You can change the time period of the fee schedule table displayed by selecting a new time period.

IV. Search DMEPOS Product Classification List

The SADMERC responds to requests for product reviews, primarily received from manufacturers. Results of product review coding decisions are posted in the DMEPOS Product Classification Lists.

All criteria entered are treated as wild cards so you may search by a whole word or part of a word. You may search on all or one of the following:

- Manufacturer/Distributor – name of the manufacturer or distributor of the product
- Product Name – name of the product as marketed to the public
- Model Number – may also be known as product number, part number, reference or stock number
- HCPCS Code
- Classification - based on the primary HCPCS code assigned to the product. The list of classifications in DMECS is extensive, approximately 67 groupings. Future plans may include shortening the list. To view the classifications, click on the drop down box. For customers familiar with the previous classifications used, please see the following table for a crosswalk.

Previous Classifications	DMECS Classifications
Noncovered Item or Service	Routinely Denied Items
Commodes	Commodes
CPAP Systems and Respiratory Assist Devices	These items will be separated into the following classifications: • CPAP • Respiratory Assist Devices • Ventilators
Enteral Nutrition	Enteral Nutrition
External Infusion Pumps	Infusion Pumps and Related Drugs

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Miscellaneous Durable Medical Equipment and Supplies	• Automatic External Defibrillator • CPM Devices (Continuous Passive Motion) • Canes/Crutches • Dialysis Supplies & Equipment • Glucose Monitor • Heat/Cold Application • HFCWO Device • Hospital Beds/ Accessories • IPPB • Impotence Aid • Mech In-exsufflation Devices • Negative Pressure Wound Therapy (NPWT) • Orthopedic Footwear • Osteogenesis Stimulator • Ostomy Supplies • Other Neuromuscular Stimulators (NMES) • Oxygen Supplies/ Equipment • Speech Generating Devices • Suction Pump • TENS (Transcutaneous Electrical Nerve • Stimulators) • Tracheostomy • Traction Equipment • Ultraviolet Devices • Misc DMEPOS • Misc Drugs
Nebulizers	Nebulizer and Related Drugs
Orthotics and Prosthetics	These items will be separated into the following classifications: • Breast Prostheses • Dynamic Splint • Eye Prostheses • Facial Prostheses • Lower Limb Orthoses • Lower Limb Prostheses • Orthotic/Prosthetic Repair • Upper Limb Orthoses • Upper Limb Prostheses • Voice Prostheses
Patient Lifts and Seat Lifts	These items will be separated into the following classifications: • Patient Lifts • Seat Lift Mechanisms
Pneumatic Compression Devices	Pneumatic Compression Devices
Power Operated Vehicles	Power Operated Vehicles
Pressure Reducing Support Surfaces – Group 1	Support Surfaces
Pressure Reducing Support Surfaces – Group 2 and 3	Support Surfaces
Rollabout Chairs	Misc DMEPOS
Therapeutic Inserts for Diabetics	Diabetic Shoes
Therapeutic Shoes for Diabetics	Diabetic Shoes
TLSOs	Spinal Orthoses
Transport Chairs	Misc DMEPOS
Urological Supplies	Urological Supplies
Walkers	Walkers
Wheelchair Accessories	Wheelchair Options/ Accessories
Wheelchair Backs (New K Codes)	Wheelchair Seating
Wheelchair Cushions	Wheelchair Seating
Wheelchair Cushions (New K Codes)	Wheelchair Seating
Wheelchairs – Manual	Wheelchairs – Manual
Wheelchairs – Power	Wheelchair Motorized
Wheelchairs – Pediatric	These will be placed in the appropriate wheelchair category based on whether the chair is manual or motorized.

Product Search Results Screen

As HCPCS codes are deleted from the HCPCS Level II code set or marked as invalid by the DMERC/MAC, appropriate changes to the products on the classification list are made. Therefore, you may see multiple entries for a product. Please be sure to pay attention to the effective dates for the coding decision. If viewing the multiple lines for a product from the Product Search Results table is cumbersome, we suggest clicking on the link for the product name to obtain product detail, which helps you to isolate the multiple entries.

The default sort of the table is by product name. You may sort the table by other columns by clicking on the column heading. The table will be sorted by the values in that column. You may also subset your table by entering criteria in the fields above each column heading.

Columns appearing in the table are as follows:

- Product Name
- Manufacturer/Distributor
- Model Number
- HCPCS Code – The coding decision may be a single code (i.e., B4155), a combination of codes separated by + signs indicating the codes should be billed together (i.e., K0011+K0021+K0031+K0108), or a choice of codes depending on certain attributes of the product. Choices may be listed in one of three ways.
    1. Together and separated by the word 'or' (i.e., K0004 or K0005).
    2. Listed as a range (i.e., A6200 – A6205). Ranges are typically given when sizes and/or border type are the deciding factor for coding. This often occurs for surgical dressings.
    3. Listed in separate rows in the table. To determine the correct choice for your product, use the Comments column and click on the code to link to the HCPCS detail screen to obtain more information about the code. Comments will also provide information for items coded using miscellaneous HCPCS codes.
- Effective Begin Date = the date coding was assigned based on a product review or the date a change in coding occurred.
- Effective End Date = the date the coding assignment ended.
- Comments = information pertinent to the coding of the product. We encourage users to make it a habit to read the comments before billing.

When notified by the manufacturer or distributor, the SADMERC tracks changes to product name, manufacturer name, and model number. In the case of changes, the Product Search Results screen displays the most current product name, manufacturer/distributor name and model number on file. Therefore, the information in the table may differ from the criteria entered for the product name, manufacturer name and model number. This feature allows the user to search using the prior product information. To verify the results, select the link on product name to go to the Product Detail screen. The Previously Labeled As table gives the history of name changes.

Product Detail Screen

The Product Detail screen contains two tables. The Previously Labeled As table gives the user the history of changes to product name, manufacturer name and model numbers submitted to the SADMERC. This is helpful since the Product Search Results screen displays the most current product name, manufacturer/distributor name and model number on file. The Coding History table gives the user the coding history for the product. Unfortunately, the information in the Coding History table is incomplete at this time. If a product has been submitted to the SADMERC multiple times for review, this table may not reflect each submission. To see all submissions, please view the coding history given on the Product Search Results screen. The information in the table on the Product Search Results screen is complete.

Suppliers should contact the SADMERC if they have questions.

DME News
901 40th Street South, Suite 1
Fargo, ND 58103-2146