Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

May 2007
Issue No. 4

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

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Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers		
Interactive Voice Response System	1-877-320-0390	24 hours a day, 7 days a week for all functions except Claim Status and Beneficiary Eligibility, which are available 6 am to 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 www.cignamedicare.com/edi/dmerc/index.html
Administrative Simplification Compliance Act Exception Requests Noridian Administrative Services PO Box 6737 Fargo ND 58108-6737 Fax: 888-523-8449	**Program Safeguard Contractor** Medical Review IntegriGuard, LLC 2121 N 117 Avenue Suite 200 Omaha NE 68164 Fax: 402-498-2306 www.edssafeguardservices.eds-gov.com/providers/dme/default.asp

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.palmettogba.com/sadmerc
National Supplier Clearinghouse	1-866-238-9652	www.palmettogba.com/nsc
Centers for Medicare & Medicaid Services		www.cms.hhs.gov

FYI

Holiday Schedule

Holiday Schedule for 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 5	Oxygen Equipment and Contents Billing Chart	Revised chart to include E1392 and K0738 and new payment guidelines for 2007	4/5/07
Chapter 16	Level II HCPCS Codes	Added K codes effective July 1, 2007	4/5/07
Chapter 16	Level II HCPCS Codes	Deleted older codes and updated CMN/DIF Form numbers	3/12/07

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

MLN Matters Articles Search Feature

The full-text search feature of the MLN Matters articles located on the CMS Web site is now available. The search link is located at the top of the 2004, '05, '06, and '07 pages at www.cms.hhs.gov/MLNMattersArticles/. This enables users to search title, text, and body for any article needed, even if you only have the topic or general subject to start with. Give it a try!

Medicare Learning Network Product News

Revised errata sheets and downloadable versions (April 2007) of *The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* and *The Facilitator's Guide – Companion to Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals* have been posted on the Centers for Medicare & Medicaid Services Medicare Learning Network. To access these publications, visit www.cms.hhs.gov/MLNProducts/MPUB/list.asp.

Medicare Learning Network Matters Disclaimer Statement

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

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

EDUCATIONAL

Upcoming Ask the Contractor Teleconferences

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

If you have a question on your mind and are not sure who to

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

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

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

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

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

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

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

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

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

Ask the Contractor Teleconference for Small Suppliers

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:

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

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

Ask the Contractor - DME Small Supplier - Questions and Answers

February 21, 2007

NAS created the "small supplier" Ask the Contractor teleconference to allow small suppliers, those with ten or fewer full time employees, the chance to speak directly to NAS on the topic of their choice. The following questions and answers are from the first small supplier Ask-the Contractor teleconference on **February 21, 2007**. In some cases, the original answers given during the call may have been expanded to provide further detail.

Q1. I am a single proprietor who has been turned down for submitting paper claims. What can I do to continue to submit paper claims?

A1. NAS asked the caller to fax her documentation for review. Her documentation was received and reviewed and an ASCA waiver was granted on February 23, 2007.

Q2. When a beneficiary has rented an item for 13 months under the category "capped rental" with a delivery after January 1, 2006, does the title need to be transferred to the beneficiary?

A2. Yes, title of the equipment needs to be transferred to the beneficiary after 13 months of rental under the revised guidelines effective for services with an initial rental date on/after January 1, 2006.

Q3. After an oxygen dependent patient has rented oxygen equipment for 36 months under the revised capped rental

regulations, will there be codes that allow for additional oxygen contents for the patient-owned equipment? Currently Medicare only allows for one tank of oxygen a month for patient owned portable equipment.

A3. This is a clarification to the answer provided during the conference call.

At this time we have not been informed of new oxygen contents codes for patient owned equipment. Currently oxygen contents are included in the allowance for rented oxygen systems. Stationary oxygen contents (E0441 and E0442) are separately payable only when the coverage criteria for home oxygen have been met and they are used with a patient owned stationary gaseous or liquid system respectively. Portable contents (E0443 and E0444) are separately payable only when the coverage criteria for home oxygen have been met and:

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

If the criteria for separate payment of contents are met, they are separately payable regardless of the date that the stationary or portable system was purchased. Medicare currently allows one monthly billing unit of oxygen contents per month regardless of the amount of oxygen needed per month for owned equipment.

Q4. Could you make it simpler with the three-way conversations between Medicare, the supplier, and the beneficiary? These conversations are difficult when the beneficiary has dementia or doesn't speak English.

A4. Since the implementation of the Jurisdiction D contract, Noridian Administrative Services has not required the beneficiary to be part of the telephone conversations between the supplier and the Contact Center when checking eligibility or for same and similar equipment.

Q5. We are having trouble getting our infusion pumps paid. They deny CO16, claim service lacks information needed for adjudication. When we call the Supplier Contact Center for assistance, they cannot tell us what is missing.

A5. NAS asked to caller to call the Contact Center with her examples. Upon review, NAS found that the previous contractor had not set up the infusion pump CMNs correctly. The CMNs were corrected and reopenings were done on the denied claims.

Q6. My question deals with the oxygen concentrators billed under HCPCS codes E1390 and E0431. In the past we billed with modifiers RR (rental), KH (initial claim, first month), KI (second or third month), KJ (fourth - fifteenth months), and KX (documentation on file). Do I need to continue with the KH, KI, and KJ modifiers?

A6. This is a revised answer from the answer provided during the teleconference.

The designated month modifiers (KH, KI, KJ) historically have not been used for oxygen. You do, however, need to continue using the following Q modifiers:

- QE - Prescribed amount of oxygen is less than 1 LPM
- QF - Prescribed amount of oxygen exceeds 4 LPM and portable oxygen is prescribed
- QG - Prescribed amount of oxygen is greater than 4 LPM
- QH - Oxygen conserving device is being used with an oxygen delivery system

Q7. We do custom orthotics and sometimes we bill Medicare for a denial so the claim can be sent to another insurance that will allow for the orthotic. I use the GY modifier (statutorily excluded) in those cases. Over the last couple of the months those claims haven't been given the appropriate denial of patient responsibility. Should I be using a different modifier? These patients don't qualify for orthotics because they are not diabetic.

A7. Contact the Supplier Contact Center at 1-866-243-7272 with the specific patients and they can initiate telephone reopenings on those claims. The claims will then be denied as patient responsibility.

NAS is also in the process of changing the processing system so in the future claims billed with a GY modifier deny appropriately with a patient responsible denial.

Q8. I understand that I can now bill for three months worth of supplies (i.e., disposable filters for a CPAP A7038). When I put in the date of service such as 02/21/07 - 05/21/07, my software won't accept because I am billing in the future.

A8. This is a clarification to the answer given during the conference call.

With DME Medicare you can bill for three months worth of supplies. The correct way to bill your filters are on one line with the delivery date as the date of service and six as the units (Medicare allows two filters per month.). You should also add a narrative stating, "three months supply."

Q9. I have a question regarding multiple page claims. We sometimes have claims that are three to four pages long. We put "continued" at the bottom of the claim forms but the claims are being allowed one page at a time, not all at the same time. When we call the Supplier Contact Center about this problem, we are told that the claims need to be resubmitted with all the documentation behind each page. What can be done to eliminate this?

A9. Because all paper claims are scanned into the processing system, each claim form needs to stand on its own merit. Placing "continued" on the bottom of the claim does not guarantee that the claims will be scanned together. The claims need to be unstapled to scan each page so it is possible that they could become separated.

In addition, wheelchairs no long require a CMN so unless the policy states that you need to provide documentation, the claims can be submitted without documentation. The doctor's order, the letter of medical necessity and the chart notes must be kept in your file but they do not need to be submitted to Medicare with every claim. The KX modifier (documentation on file) that you place on the HCPCS codes tells Medicare that you have all the documentation to support the medical necessity for the equipment.

Follow-up Question: But I have denied claims on the basis that the element alone does not support the need for this equipment. Therefore, I believe I need to send chart notes.

The caller was asked to fax these examples for research. The examples have not been received at the time of this publication.

Q10. When should I collect the deductible from the patient? Is it at the time of service, when I receive a notification of allowance from NAS, or after I receive notification from the supplemental insurance if there is one?

A10. It is basically your choice as to when you collect the deductible. It is easier to collect this after the claim has been processed by NAS and the supplemental insurance because if you collect too much, you will need to refund the overage to the beneficiary.

Q11. After 13 months the beneficiary owns the equipment under the revised capped rental regulations. After the beneficiary owns the equipment, how do we get paid for maintaining or repairing the equipment?

A11. Medicare does allow for labor and parts to repair equipment as long as repairing the equipment is more cost effective than replacing the item. If the parts are covered under warranty, then Medicare will only allow for the labor. The labor portion is billed under HCPCS code E1340. The fee for this code is not posted to the Web site, but if you wish to know the allowance for your state, call the Supplier Contact Center and they will provide you with that information.

We also posted to our Web site the MLN Matters 5461, which addresses changes in maintenance and servicing due to the Deficit Reduction Act for capped rental and oxygen. You can access this article at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5461.pdf

Q12. Is the assistive technology supplier going to be grandfathered in or will we need to take a test to become an assistive technology supplier?

A12. NAS has not heard anything that would prevent you from continuing as you are with your training; in other words, it's business as usual with assistive technology suppliers. At some time in the future there may be specific standards.

Q13. I work for a company that does sleep studies on one side of the building and dispenses CPAP, BiPAP and VPAP (variable positive airway pressure) DME on the other side of the building. Neither side is accredited. I have heard that if we aren't accredited by an agency there will no longer be Medicare reimbursement. How do we go about getting accredited since we are providing two different types of service with the same business name in the same building?

A13. Your DME services will eventually need to be accredited but the date by which you need to be accredited has not been finalized. However, you can begin the accreditation process at any time. The list of DMEPOS accrediting organizations can be found at www.cms.hhs.gov/CompetitiveAcqforDMEPOS/downloads/DMEPOS_Accreditation_Organizations.pdf.

In addition, you may elect to be accredited for your sleep study services, which you bill to Medicare Part B. Information regarding this can be found on the Internet by searching for sleep lab accreditation.

Q14. All our claims are sent through a billing agency. In the past we needed CMNs for the CPAPs and BiPAPs but this billing agency isn't asking for them. Why?

A14. Medicare no longer requires CMNs for CPAP and BiPAP equipment; however, you must have the documentation to support medical necessity in your records as Medicare can request that documentation at any time.

Q15. For what length of time does Medicare consider a sleep study valid? We have a patient who had a sleep study done in 1999 and now wants a new CPAP machine. That sleep study showed medical necessity, but its also quite old.

A15. There is no published length of time that is required between when a sleep study was done and the application of the therapy. Remember, however, that you will need to have a copy of that sleep study in the patient's chart.

Q16. I have a question regarding claims billed with the GA modifier (ABN on file). We have submitted claims for equipment or repairs with the GA modifier and expected not to be paid; however, we have been paid. This results in our need to submit voluntary refunds. How can this be avoided?

A16. If, on the face of the claim, the service appears payable based on a medical policy, the claim will be paid. Therefore, we recommend that you either place a note in item 19 as to why this service shouldn't be paid or use the GY modifier (item or service statutorily excluded or does not meet the definition of any Medicare benefit) if it fits your situation.

Q17. It was first indicated that we would not be required to supply new oxygen concentrators to our existing clients; however, the last HME News indicated that the equipment we provide should last five years or it would be the supplier's responsibility to replace the equipment if it broke down. Which is correct?

A17. There is not a clear direction from CMS at this point. The HME News may have implied this because the useful life of DME equipment is noted to be five years.

Q18. If I am billing electronically, are there time limits when I am in a billing mode b.ut get interrupted and need to leave my computer? If I leave, will I be able to get back to where I left off or will I need to start completely over?

A18. In most software, you will not lose your data if you leave your work area for a period time. You enter all your data first and then transmit, perhaps at the end of the day, when all the data is entered.

Q19. If I choose to bill electronically, will someone come to my office to assist in setting this up?

A19. We do not have the capability to provide on site assistance, but we do have a help desk that will assist you in getting started. We also provide free software that you can download from our Web site. We can then walk you through the steps from installation through your first submission of a batch claims to downloading your receipt listing which gives you a confirmation of claims being sent.

Billing electronically will open up more opportunities for you. The EDI help desk phone number is 866-224-3094. If you give us a call we can walk you through the steps you need to take first.

Q20. Do I need two separate NPI numbers, one for Medicare and one for Medicaid?

A20. No. You only have one NPI number for billing all insurances including Medicare. That is the purpose of the NPI.

Q21. Under the old capped rental regulations, I sent the beneficary a rental or purchase option letter during the tenth month. With the new regulation effective January 1, 2006, is this necessary?

A21. No, rental/purchase option letters are no longer needed with patients whose first rental month began in January 2006. We do encourage you to educate the beneficaries up front during the first rental month that they will own the equipment after 13 months.

Q22. We have a patient that requires excessive diabetic supplies. Is the ABN used in that case? The doctor has written a prescription for testing nine times a day and I am currently getting paid, but in the future if I don't get paid I would want to bill the patient. Secondly, if I do use an ABN, does the patient sign it at the beginning of the prescription or do they sign it continuously for all the refills?

A22. If the doctor writes a prescription for testing nine times a day and you provide that amount of strips you are not at risk. But remember there should also be documentation in the record to support why the patient needs to be tested that often in case Medicare would dispute your dispensing the high amount.

In addition, the glucose monitors Local Coverage Determination accessed from the Program Safteguard Contractor's (PAC's) Web site at www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp addresses the coverage criteria and utilization and states as follows:

If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months. . . .

If quantities of test strips, lancets or lens shield cartridges that exceed the utilization guidelines are provided and (payment) criteria are not met, the amount in excess will be denied as not medically necessary.

Therefore, if the patient wants additional strips beyond what the doctor prescribes or if the quantity exceeds the utilization guidelines and the payment criteria are not met, then you are at risk and would need to have the patient sign an ABN for the overage. You can either have the ABN signed each time you dispense the item or you can use a single ABN covering an extended course of treatment provided the ABN identifies all item and services for which the supplier believes Medicare will not pay. One year is the limit for use of a single ABN for an extended course of treatment. If the course of treatment extends beyond one year, a new ABN is required for the remainder of the course of treatment. In addition, if, as the extended course of treatment progresses, additional items or services are to be furnished for which the supplier believes Medicare will not pay, the supplier must separately notify the patient in another ABN that Medicare is not likely to pay for the additional items or services.

Q23. We are interested in submitting claims electronically but the last I heard is that I need a dial-up modem to bill Medicare. Is that correct?

A23. To bill directly to Medicare, you need a dial-up modem. However, if you choose to do business with a clearinghouse or a billing service, they would have the dial-up modem and you would not need it.

NAS also works with Vision Share and IVANS, two companies that allow you to submit claims via a digital modem where you have an Internet connection open. This allows you to take advantage of high-speed methods; those companies have a direct connection to Medicare. For further information visit the EDI contractor's Web site at www.cignamedicare.com/edi/dmerc/.

Q24. My question is regarding the TENS unit CMN. For example, I have a patient that was prescribed a TENS unit by a military facility. We get the patient when he wants to purchase the unit, however, the patient won't have a TENS trial on file with Medicare. When we send the CMN to the physician to complete Section B, the physician will advise us that the patient had a TENS trial in his office and that he doesn't feel he can answer question six accurately. As a supplier, how do I deal with that when this military physician never bills anything to Medicare?

A24. This is an issue between you and the physician. The Medicare regulations are quite clear regarding the TENS CMN and a required TENS trial before Medicare will make payment. For more information on the TENS CMN for purchase see www.cms.hhs.gov/MLNMattersArticles/downloads/MM5107.pdf

Q25. How do I locate new or revised HCPCS codes?

A25. For DME suppliers, NAS recommends that you purchase a new HCPCS Level II coding manual every year. We also do provide a list of new, revised, and deleted HCPCS codes at the beginning of each year. They were published on our Web site at www.noridianmedicare.com/dme/ on January 9, 2007, and are also located in Chapter 16 of the Supplier Manual located on our Web site in the News and Publications section.

Q26. What if I have a beneficiary who contacts me a few months after he owns the equipment under the revised capped rental regulations and says that his medical condition has changed; he no longer needs the equipment and wants me to pick it up. Can I pick the equipment up if the beneficiary asks?

A26. You would need to buy the equipment back from the beneficiary at fair market value.

Ask the Contractor - DME - Questions and Answers

March 13, 2007

The following questions and answers are from the March 13, 2007, Ask-the-Contractor conference call. In some cases, the original answers given during the call may have been expanded to provide further detail.

Q1. My question is regarding patient owned power mobility equipment. This equipment was purchased for the patient approximately three years ago by Missouri Medicaid because Medicare denied payment based on medical necessity. The equipment now needs repair. The patient contacted Medicare and was told Medicare would pay for the repair. Has there been a change in policy? It has always been my understanding that Medicare would deny repairs if they also had previously denied the equipment.

A1. You are correct. Medicare will not allow for repairs on equipment that had previously been denied by Medicare.

Follow-up question: This beneficiary called 1-800-MEDICARE to get this information and does not believe what I have told him. How do I handle that? Furthermore, the CSR that he spoke with could find no record of the wheelchair ever being submitted to Medicare for payment when I have a remittance advice (RA) showing the charge was denied. I needed that RA showing that he did not meet the Medicare guidelines for a wheelchair in order to bill Medicaid.

You can refer the beneficiary to these Q & A once they are posted and advise him that the answer came directly from the carrier. If the beneficiary needs resolution now, advise him to call 1-800-MEDICARE and ask them to elevate his call to a complex inquiry. His inquiry will then be transferred back to us, the Jurisdiction D contractor. We will then send him the information in writing.

Regarding the issue of the CSR not showing the claim, it is possible the denied claim from 2003 was purged.

You should also be aware that the payment guidelines for wheelchairs have changed significantly over the past few years. You may want to review those guidelines to see if the patient now meets the Medicare criteria for a wheelchair. If he now meets the guidelines and goes through the entire qualification process, including the physician order and a face-to-face examination, then Medicare may cover his repairs.

Q2. Over the last month or two I have been having problems with oxygen CMNs and recertifications. I don't believe the recertifications are pulling into the processing system correctly with my EDI billing. For an example, I have a patient who was recertified in February 2006 and should be certified for life. His claims from February 2006 through November 2006 processed correctly. Then his claims began denying. I looked at my electronic submission and I had all the CMN information entered correctly; however, when I called the contact center I was told that I hadn't completed one of the questions correctly. Is anything being done to get the CMN information corrected or will I need to continue asking for redeterminations on these denied claims?

A2. One claim was received for NAS to research. We found the claim was denied in error. The CMN was updated and the claim was reopened.

Q3. My question involves span dates and diabetic supplies. We received notification from NAS that you could not accept claims with dates of service spanning two calendar years. The notification provided us with direction as to how to file this type of claim. We were told to put the correct ending span date in the NTE SEGMENT. When does this direction begin because all of my December 2006 claims had span dates ending in 2007 and paid correctly? Will Noridian be correcting this programming error and for how long does Noridian intend to process this issue differently from the other three DME MACs?

A3. Noridian received an email earlier today regarding this issue and is in the process of researching; however, we have noticed other claims also paying with span dates that cross calendar years. At this time we're assuming the idea of not spanning calendar years came from the Part B side of the Noridian Administrative Services business because Part B does not allow spanning over two calendar years. The DME processing system does allow the spanning of calendar years and the article posted to our Web site is incorrect. That article has since been removed from our Web site.

Q4. My question addresses purchase option letters. What is the procedure at the end of the thirteenth month of capped rental? Does the item automatically convert to a purchase at the end of the thirteenth month?

A4. Purchase options letters are no longer required in the tenth month of a capped rental; however, we do encourage you to educate your patient at the beginning of the rental period. The item automatically converts to a purchase after the thirteenth month.

Q5. I have also seen large numbers of oxygen denials in comparison to very few from the other carriers. Has Noridian identified a situation where the recertifications are not being acknowledged or pulled over correctly? I was told that our facility received 175 denials. The recertifications have been on file and claims were paid until recently.

A5. The caller was asked to fax specific examples for research. The examples have not been received at the time of this publication.

Q6. We have several fair hearings that were submitted to the previous carrier prior to Q2A or Rivertrust handing reconsiderations. We have been trying for the past several years to get decisions on these hearing requests. The contact center can offer us no help with these hearings. What is the easiest way to get information on these fair hearings?

A6. The caller was asked to fax specific examples for research. The examples have not been received at the time of this publication.

Q7. If a customer service representative cannot answer my question, I ask for a supervisor. Why doesn't the supervisor ever return my call?

A7. A supervisor should make an initial contact with you within 24 hours of the referral. If you haven't been getting a response and you have examples, please call back into the contact center and ask to speak to either Laurie Severtson or Bill Laverdure. The supervisory staff will also be instructed that initial contact must be made within 24 hours of the initial call. In addition, not all telephone calls require a supervisor callback. If the customer service representative cannot answer the question during the call, they are allowed ten days for research and a callback, per CMS regulations.

Q8. I have a question on CPAP supplies. Medicare allows one A7034 (nasal interface with or without head strap) every three months and one A0735 (headgear) every six months. What happens if the patient comes back after three months and he doesn't like the A0734? If he gets another mask, it won't fit the A0735. How can I handle billing a second headgear within the six month time period?

A8. The medical policy addressing CPAPs can be accessed at www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp and states as follows regarding accessory quantities:

Quantities of supplies greater than those described in the policy as the usual maximum amounts, in the absence of documentation clearly explaining the medical necessity of the excess quantities, will be denied as not medically necessary.

However, if the patient required a different mask because the initial mask did not work for him, then a second headgear within six months is medically necessary. You would need documentation to support this situation. In addition, you would submit your charge with a narrative in item 19 of the CMS-1500 claim form or the corresponding field for your electronic billing stating that the patient needed new headgear due to the change in the mask.

Q9. The patient was supposed to be recertified on February 10, 2007, for oxygen, but was not retested until February 17, 2007. The initial length of need was 12 months. Would the oxygen CMN be classified as a new initial CMN, a revised CMN, or a recertified CMN and would a new rental period begin?

A9. This is a corrected response to the answer provided during the teleconference on March 13, 2007.

The oxygen medical policy accessed at www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp states as follows:

Initial CMN is required . . . when a Group I patient with a length of need less than or equal to 12 months was not retested prior to Revised Certification/ Recertification, but a qualifying study was subsequently performed. The Initial Date on this new CMN is the date of the subsequent qualifying blood gas study.

Your rental months will continue to be counted towards the 36 total months because there was not a break in service.

Q10. Will the IVR be updated or provide more realistic explanations of options? It needs to be more user friendly. Sometimes when I ask the IVR if a specific date of service has been received or if there are any denials, the IVR will tell me the Medicare number isn't in the system and that I need to call the contact center, or it will go into a cycle saying it doesn't recognize and then it will disconnect.

A10. If you are asking eligibility questions, the IVR needs to check each CWF host and that can take a bit of time. However, the IVR should be providing you with claim status information quickly.

NAS held a meeting with the IVR programmers soon after the Ask the Contractor Teleconference and tuned the application, which should improve the efficiency of the IVR. If you continue to have issues with the IVR, please notify a customer service representative and we will make every effort to resolve the issue.

Q11. We are a rehab supplier and continue to have some serious delays with our claims for a variety of reasons. Our claims are detailed and have a lot of attachments. They tend to cause some problem with all carriers. We would like to meet with someone at NAS to see if we can resolve the problems.

A11. NAS contacted this supplier for a list of the supplier numbers involved. Analysis of the pending claims was completed and the aged claims were worked. Each supplier location is in the process of gathering the top reasons for denials for further discussion.

Q12. We have had several claims submitted electronically where we included the CMN but get a denial saying the item is not medically necessary. When I call the contact center, I'm told NAS received the CMN but it didn't get downloaded. When this happens I need to request redeterminations. This seems to be a problem and I would like to know what can be done to resolve it?

A12. The caller provided NAS with two claim examples that were referenced during the teleconference. The first claim was missing break-in-service dates and a new initial CMN. The supplier was contacted and advised to resubmit the claim with a new initial CMN and the break of services dates noted in the narrative section of the claim.

The second claim was denied as not a medical necessity based on the CMN. The supplier was advised to submit a redetermination and show medical necessity.

Q13. When I use the miscellaneous HCPCS code E1399 for billing, for example a nose replacement on a mask that broke, will the code be allowed if I place a description of the miscellaneous code in item 19 of the CMS-1500 claim form?

A13. The code will be considered for payment if you provide us all the information needed to make that decision and that information includes placing a code description in item 19.

Q14. I recently attended a meeting in which it was mentioned that suppliers would need to send beneficiaries letters in the thirteenth month regarding warranties and if the supplier was going to provide any repairs. Is this now a requirement especially if we are going to provide repairs? And are we expected to do repairs?

A14. The Federal Register Final Rule titled "Deficit Reduction Act of 2005 Changes to Medicare Payment for Oxygen Equipment and Capped Rental Durable Medical

Equipment" requires the supplier of a capped rental item to disclose no later than two months before title transfers whether it will continue to maintain and service the item. More specified instructions have not yet been provided by CMS.

Follow-up Question: Are we expected to do repairs and what if we repair something that wasn't purchased from us? Will Medicare allow that repair?

The beneficiary can take his or her equipment to anyone who is capable of doing the repair. You, as a supplier, can repair anyone's equipment. Medicare does allow for reasonable and necessary repairs as long as the repair is more cost effective than replacement. If, however, Medicare denied the initial purchase, then the repair would also be denied. You can always call the contact center to verify the equipment prior to the repair.

Q15. I, too, am having trouble with my recertifications and have been told that it has to do with my electronic billing. When I call the EDI help desk, they are not showing my item has been recertified. Should I also fax you a sample of my denials? I did send a recert in November and got paid for that month but then got denials for the subsequent three months because a recert wasn't on file.

A15. The caller provided NAS with one claim example referenced during the teleconference. This beneficiary also had a break in his oxygen service. Therefore, the supplier was contacted and advised to resubmit the claim with the appropriate break in oxygen service dates in the narrative and a new initial CMN. These types of denials cannot be addressed as reopenings.

Q16. We are having a lot of situations where the patient is on disability and we bill to the primary, private insurance company. Then all of a sudden we're told the patient has Medicare. When we talk to the patient we're told he just got his card but when we call to verify we're told that the patient's eligibility has been made retroactive to a specific date. This requires us to refund the other insurance company and pursue payment from Medicare. We can go back and get all the documentation etc. to bill Medicare but the Supplier Manual states that we must have patient authorization before we ship the item. What is your recommendation for pursuing these claims?

A16. If the patient is still living you can get his signature now before submitting the claims to Medicare. The authorization that the patient signs allowing you to bill Medicare is not date specific.

Follow-up Question: What do I do if the claims are past timely filing?

You will need to place a narrative on the claim as to why the claim wasn't filed timely.

The balance of this answer is a correction to the answer provided during the teleconference regarding appealing the claims if they are denied based on timely filing.

CR 4041 states that a claim that was denied as untimely cannot be appealed. The MLN Matters associated with this CR can be read in its entirety at www.cms.hhs.gov/MLNMattersArticles/downloads/MM4041.pdf

Q17. What are the documentation requirements for hospital beds since CMNs are no longer required for this piece of equipment?

A17. The local coverage determination for hospital beds accessed at www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp will provide you with the documentation requirements for this item.

To expand on those requirements, the LCD states that the patient must meet one or more of four criteria noted in the policy. Therefore, the patient's medical record, which the physician has in his office, must reflect the need for the item billed. In addition, your file must include the signed and dated order for the item billed.

When billing the bed to Medicare, you will then append a KX modifier (specific required documentation on file) to the HCPCS code to tell Medicare that you have all the required documentation to support the medical need for this item.

Q18. I am confused on the Advanced Determination of Medicare Coverage (ADMC) forms. I sent in two last year but sent them too many times because I wasn't aware of what information I needed to include with the request. These ADMCs were denied because I submitted them too many times but I was advised that I could still submit claims for the items. Noridian denied the services. When I call the contact center I was told that because the ADMC was denied then Noridian also needed to deny. Why would that happen when the ADMC denial states that their denial does not reflect that Medicare will also deny? I was also told by IntegriGuard to submit the claim with the KX modifier for extra documentation, but how can I do that when I didn't send IntegriGuard the claim in the first place? The claim is kicked out of the system if I append the KX modifier because it was never submitted before.

A18. The caller was asked to provide NAS with examples after which we verified that the examples had been received by the redeterminations team and would proceed through the redetermination portion of the appeal process.

NAS then advised this supplier that even though IntegriGuard denied the ADMC, Medicare may allow for the service, however the KX modifier would need to be appended to the procedure code to show Medicare that the correct documentation was on file; there is no need to submit the documentation when the KX modifier is appended to the procedure code.

Follow-up Question: Is the face-to-face examination for wheelchairs required for all wheelchairs or for only those where I am asking for ADMC?

This is a revised answer to the answer provided during the teleconference. The face-to-face examination is required for all power mobility devices (PMDs). It not required for manual wheelchairs.

Q19. I am in the process of applying to be a DMEPOS supplier. What can and what can't I do before my Medicare supplier number is issued? Can I consult with Medicare patients before I have the Medicare number?

A19. This is a revised answer from the answer provided during the teleconference.

You are allowed to see/consult with Medicare patients before your supplier number is issued, however, you should advise these patients that you currently don't have a Medicare supplier number but are in the process of obtaining one. By doing so the patient can decide if they can delay receiving their DMEPOS until after your number is issued. None of the services that you provide prior to being issued a supplier number will be reimbursed by Medicare.

You cannot bill Medicare for any DMEPOS until after the issue date of your supplier number. That means that the delivery date of an item cannot be prior to the issue date of your Medicare supplier number.

If you need clarification or additional information regarding enrolling as a Medicare supplier, contact the National Supplier Clearinghouse at 866-238-9652.

Q20. My question deals with submitting multiple diagnosis codes for a single patient. If I list the wrong primary diagnosis code, for example, for a diabetic person who needs inserts or shoes, and the claim is denied, can I send that claim back through Express Plus with a narrative stating that the primary code for the claim was erroneously placed in the wrong box?

A20. You should call telephone reopenings at 1-888-826-5708 and request a reopening of the claim. Reporting the wrong diagnosis pointer on the line item is considered a clerical error and can be corrected in this way. It is not appropriate to resubmit the claim for this type of correction.

Q21. Under the new capped rental policy, is Noridian requiring us to continue placing the BP modifer (the beneficiary has been informed of the purchase and rental options and has elected to purchase the item) during the 11th, 12th, and 13th months even though that regulation is going away with the new guidelines? I have denials for 11th, 12th, and 13th month rentals stating that a required modifier is missing.

A21. CR 5010 states that you must continue to use the BP, BR, and BU modifiers with respect to capped rental periods that began prior to January 1, 2006. However, for capped rental items that began on/after January 1, 2006, NAS is not requiring you to use these modifiers with the exception of PEN pumps and electric wheelchairs. PEN pumps and electric wheelchairs continue to require the BP, BR, and BU modifiers.

You must continue to use the KH, KI, and KJ modifiers with all capped rental items regardless of the date the rental began.

Follow-up Question: We are also having trouble with our oxygen CMNs not being placed into the system accurately. We are being told to send them to redeterminations when we don't even know what to fix or what is wrong.

The caller was asked to fax specific examples for research. The examples have not been received at the time of this publication.

Q22. I have a question regarding billing length of time for oxygen. This patient was certified for oxgyen in 2002 and recertified in 2003. In February 2007, the patient changed physicians and suppliers. Is this patient now considered a lifer or rather a 36 months patient?

A22. If your patient was certified in 2002 and recertified in 2003, she would be considered certified for life regarding oxygen; however, beginning January 1, 2006, the patient would have reverted to the 36 month capped rental for her oxygen equipment. Also, as the patient's new supplier, make sure you have an order for the oxygen.

Q23. We are also experiencing problems with the oxygen CMN recertifications, but my question pertains to the KX modifier requirement for hospital beds and specifically to the full electric hospital beds which are not covered by Medicare. Sometimes we provide the full electric bed as a free upgrade and sometimes the physician orders a full electric bed. Are we allowed to use the KX modifier in those instances?

A23. You are allowed to use the KX modifier in those instances.

In addition, CR 5367 provides billing instructions when furnishing upgraded DMEPOS items to beneficiaries at no additional charge. If this is the situation, you bill the non-upgraded item rather than the item you actually furnished along with the GL modifier (medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN).

Follow-up Question: What about hospital bed accessories such as trapeze bars and things that are under the product category of hospital beds? Noridian has informed us that we should use the KX modifier on those procedure codes if it is indeed a hospital bed accessory but Jurisdictions A and B have told us not to use the KX modifier on the bed accessories.

NAS is standing by the instruction to place the KX modifier on hospital bed accessories if the beneficiary meets the criteria for the accessory.

Follow-up comment: The Deficit Reduction ACT (DRA) does instruct suppliers to notify patients that their equipment will convert to ownership. Suppliers also need to provide the patient with the manufacturer's warranty and/or operating manual.

Thank you for the information. We are waiting for specific instruction from CMS regarding this.

Q24. I called on some denied claims where the patients have been certified for many years. I was told to put a comment in the narrative stating, "Please look for prior CMNs." I don't believe that is my responsibility. If the CMNs didn't transfer from the prior contractor, it is Noridian's responsibility to get that previous information. What is Noridian going to do about this?

A24. This is a corrected answer from the answer provided during the teleconference.

The customer service representative gave you an incorrect response when you were told to place the above referenced comment in the narrative.

To the best of our knowledge, NAS has received and loaded all prior CMNs into the processing system. Furthermore, if

the initial CMN was not entered in this jurisdiction, we can search the Common Working File (CWF) for the CMN if it was loaded by another jurisdiction. Therefore, if you have examples of this situation we would need examples to review.

Follow-up Question: When can the supplier say enough is enough? These claims should have been paid initially and should not need to go to redeterminations etc. Furthermore, doing a reopening, as you suggested, isn't going to work in these cases if Noridian doesn't have record of the original CMN.

The caller was asked to fax specific examples for research. No examples have been received at the time of this publication.

Q25. Are there any plans to get the Medicare Secondary Payer department to answer supplier questions? The customer service representatives don't know how to answer my questions.

A25. We do have a Medicare Secondary Payer department to assist with our questions, but they do not take outside telephone calls. If you do not agree with the answer given to you by the customer service representative, ask them to send you the reference or documentation to support their answer. If the representative refuses to give you that information, ask to speak to a supervisor.

Follow-up Question: Why can't I speak directly to someone in the Medicare Secondary Payer (MSP) department? Other jurisdictions allow us to speak to MSP.

It is a CMS requirement that all general inquiries including MSP related questions be handled by the contact center. If there is a specific MSP question that cannot be addressed by the CSR, a callback will be taken and the CSR will work with the MSP department for resolution. If you are experiencing continued difficulties with MSP related questions, please ask to speak to a team lead.

Q26. We have some wheelchair claims where we are unable to get the documentation for medical necessity. In those cases we have the patients sign an ABN, but Noridian is paying on those claims. What can we do so this stops happening?

A26. In the comment field you need to indicate why this service shouldn't be allowed. In addition, if the criteria aren't being met and the policy states as such, you can use the GY modifier (item or service statutorily excluded or does not meet the definition of any Medicare benefit) on the claim. That will tell Medicare that this service isn't payable in this instance. If you have been paid for services that shouldn't have been paid, please refund Medicare with an explanation as to why you are refunding.

Q27. We need written clarification on how to bill Medicare as the secondary payer for the E2402 (negative pressure wound therapy electrical pump, stationary or portable). We have a primary payer who pays daily where Medicare pays monthly. If we lump all the daily claims together, Medicare denies because those claims don't match with Medicare's monthly billing. The CMS manual states we can never alter the claim. How should these claims be submitted to Medicare for the secondary payment?

A27. We are currently researching this question and at the time of this publication we have not come to a resolution. When we finalize the answer, we will post it to our Web site.

Centers for Medicare & Medicaid Services Launches DOQ-IT University

New Interactive Learning Tool Educates Physicians in the Adoption and Implementation of Electronic Health Records and Care Management Practices

On April 11, 2007, the Centers for Medicare & Medicaid Services (CMS) announced the national launch of DOQ-IT (Doctor's Office Quality Information Technology) University, or DOQ-IT U, to support health information technology (HIT) in physicians' offices.

DOQ-IT U is an interactive, Web-based tool designed to provide solo and small-to-medium sized physician practices with the education for successful HIT adoption, including lessons on culture change, vendor selection and operational redesign, along with clinical processes. The nationally available e-learning system is available at no charge.

"CMS is pleased to launch DOQ-IT University, the first of its kind e-learning platform, to provide assistance to physicians across the United States in the adoption and implementation of electronic health records and care management practices," said CMS Acting Administrator Leslie V. Norwalk, Esq. "DOQ-IT U's interactive platform, self-paced curriculum, and associated tools provide physicians with easy access to the resources they need to help ensure that patients receive the highest quality of care at all times."

DOQ-IT U will provide lessons in assessment, planning and implementation methodologies that will be disease and population specific, incorporating clinical decision support and evidence-based medicine guidelines. This e-learning platform will be utilized to provide physicians with a self-paced curriculum and associated tools, based on adult learning principles, available at their convenience. Additional features, such as surveys, utilization tracking, and Continuing Medical Education/Continuing Education Unit (CME/CEU) offering/issuing capabilities will also be included in the near future.

The first learning sessions (modules), available now, focus on physician office workflow redesign, culture change, and communication necessary for successful Electronic Health Record (EHR) adoption, implementation of care management, and the incorporation of a strong patient self-management component to clinical care. Disease specific modules, starting with diabetes, will include a patient self-management component, which is critical to successfully managing patients with chronic disease.

DOQ-IT U is being developed and managed by the Quality Improvement Organization (QIO) program, under contract to CMS. A QIO is present in each U.S. state, territory, and the District of Columbia.

A technical advisory panel (TAP) composed of leading medical experts from the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), the American Board of Internal Medicine (ABIM), Healthcare

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Information and Management Systems Society (HIMSS), Private Payers, American Health Information Management Association (AHIMA), and Patient Self Management experts, has been convened and will provide content, consultation and evaluation of the care management/DOQ-IT U modules.

For more information, please see CMS' DOQ-IT U Web site at: http://elearning.qualitynet.org.

COMPETITIVE BIDDING

Important News about the Medicare DMEPOS Competitive Bidding Program

The Centers for Medicare & Medicaid Services has announced that the Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies Competitive Bidding Program Final Regulation is now on display at the Office of the Federal Register. CMS has also announced the first 10 metropolitan areas in which competition will occur as well as the first items to be competitively bid. Visit the CMS Website at www.cms.hhs.gov/competitiveacqfordmepos/ to view the rule and obtain additional information.

Announcement of the DMEPOS Competitive Bidding Implementation Contractor Web Site

The Centers for Medicare & Medicaid Services is pleased to announce the newly established Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Implementation Contractor (CBIC) web site. CMS has contracted with Palmetto GBA, the CBIC, to conduct certain functions relating to the administration of the DMEPOS Competitive Bidding Program. These functions include: preparing the request for bids (RFB), performing bid evaluations, and ensuring that suppliers meet all applicable financial and quality standards. In addition, Palmetto GBA will support CMS efforts to conduct an education program for beneficiaries, suppliers and referral agents. Palmetto GBA also assists CMS and its contractors in monitoring the program's effectiveness, access and quality. This web site will contain important and up-to-date information on the Medicare DMEPOS Competitive Bidding Program. Please follow this link to gain access to the CBIC Web site: www.cms.hhs.gov/competitiveacqfordmepos/01_overview.asp?

NOTICE TO ALL SUPPLIERS INTERESTED IN COMPETITIVE BIDDING

To ensure the safety and security of all suppliers interested in participating in the Competitive Bidding Program, all suppliers will have to be authenticated before you will be able to submit a bid. It is imperative that all information that you have provided to the National Supplier Clearinghouse (NSC) is up-to-date for successful authentication to occur. If you have not updated your NSC information, or if you are unsure if the information is correct, please contact the NSC.

Important DMEPOS Competitive Bidding Announcement

In order to participate in the Medicare DMEPOS Competitive Bidding Program, suppliers must meet quality standards and be accredited by a CMS-approved Deemed Accreditation Organization. Suppliers that are interested in bidding under the new program must be aware of two key deadlines:

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

Bidding is expected to open in late April 2007. For a list of the CMS-approved Deemed Accreditation Organizations and information about the Medicare DMEPOS Competitive Bidding program, visit www.cms.hhs.gov/CompetitiveAcqforDMEPOS/

To view a Special Edition MLN Matters article on this topic, visit www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf

Initial Registration Is Now Open for Suppliers Interested in Competitive Bidding for DMEPOS

The initial registration process is now open and available to all suppliers interested in participating in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program. Interested suppliers will submit their bids using an Internet application. To help ensure the privacy of all bids, all suppliers must complete initial registration in the Internet application to get a USER ID and password. Suppliers need to complete this initial registration process early. We strongly recommend that they do so well before the bid window opens to avoid a delay in being able to submit bids. Bidding is currently scheduled to open in late April 2007.

The initial registration process requires the authorized official, as identified in Section 15 of the CMS 855S, to complete the information required in the Internet application. The authorized official's information must match the information on file at the National Supplier Clearinghouse. The USER ID and password will be mailed to the authorized official if his/her submitted information matches exactly the data on file for last name, date of birth, Social Security number and supplier number. The USER ID and password will be delivered in 2 separate mailings to the authorized official at the correspondence address (Section 2A.2) listed on the CMS 855S. An authorized official only needs ONE USER ID and password in order to submit bids for any company for which he/she was listed as the authorized official on the CMS 855S.

To complete this initial registration and obtain a USER ID and password, please go to https://applications.cms.hhs.gov.

Suppliers must have the USER ID and password before they can enter a bid into the competitive bidding Internet application. However, the USER ID and password cannot be used until the bidding window opens, which is expected in late April 2007.

Please read the user guide for the Individuals Authorized Access to CMS Computer Services (IACS) application before attempting initial registration. This guide can be found on the Competitive Bidding Implementation Contractor's website at www.dmecompetitivebid.com/cbic/cbic.nsf/(pages)/home. If you have any questions about the initial registration process, please contact the Competitive Bidding Implementation Contractor (CBIC) helpdesk on 1-877-577-5331. The helpdesk will be available Monday – Friday 6:00 a.m. – 9:00 p.m. prevailing Eastern Time and on Saturday 9:00 a.m. – 3:00 p.m. prevailing Eastern Time.

A MLN Matters article regarding this registration process will be forthcoming. Additional information on the DMEPOS Competitive Bid Program can be found in MLN Matters article MM5574 at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5574.pdf. Information on accreditation for suppliers can be found in MLN Matters article SE0713 at www.cms.hhs.gov/MLNMattersArticles/downloads/SE0713.pdf.

Important note: For added security, when suppliers use their USER IDs and passwords to access the Competitive Bid Submission System for the first time, they will need to complete a brief authentication process. The information required for this process must also match the information in the National Supplier Clearinghouse file. If you successfully completed the initial registration and received your USER ID and password, please enter your information exactly as you did for initial registration when completing the Competitive Bid Submission System authentication process. Failure to do so may delay your ability to use the system.

Program Instructions Designating the Competitive Bidding Areas and Product Categories Included in the CY 2007 DMEPOS Competitive Bid Program

MLN Matters Number: MM5574
Related Change Request (CR) #: 5574
Related CR Release Date: April 3, 2007
Related CR Transmittal #: R1218CP
Effective Date: April 2, 2007
Implementation Date: April 9, 2007

Provider Types Affected

Section 1847 of the Social Security Act requires the Secretary of the Department of Health and Human Services (HHS) to establish and implement programs for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) under which competitive bidding areas are established throughout the United States for the furnishing of certain competitively priced items and services for which payment is made under Part B (the Medicare DMEPOS Competitive Bidding Program"). **Suppliers who bill Medicare for DMEPOS must be aware of this program.**

Provider Action Needed

This article and Change Request (CR) 5574, recently released by the Centers for Medicare & Medicaid Services (CMS), provide an overview of the DMEPOS Competitive Bidding Program that will be implemented starting in 2007. **Suppliers who bill Medicare for DMEPOS must be aware of this program.**

Background

Section 1847 of the Social Security Act requires Medicare to establish and implement programs under which competitive bidding areas are established throughout the United States for contract award purposes for the furnishing of certain competitively priced items for which payment is made under Medicare Part B (the "Medicare DMEPOS Competitive Bidding Program"). Competitive bidding provides a way to harness marketplace dynamics to create incentives for suppliers to provide quality items in an efficient manner, at a reasonable cost to the Medicare beneficiaries while producing significant savings to the Medicare program.

Section 1847(a)(1)(A) of the Act requires that competitive bidding programs be established and implemented in areas throughout the United States. Section 1847(a)(1)(B) of the Act provides the Centers for Medicare & Medicaid Services (CMS) with the authority to phase-in competitive bidding programs so that the competition under the programs occurs in 10 of the largest Metropolitan Statistical Areas (MSAs) in 2007; 70 additional MSAs in 2009; and additional areas after 2009.

The CMS will conduct competitive bidding programs in which certain suppliers will be awarded contracts to provide certain DMEPOS items to Medicare beneficiaries. Suppliers must submit bids for items that fall within product categories for which they want to be considered for selection as a contract supplier.

The Medicare DMEPOS Competitive Bidding Program will apply to a variety of DMEPOS product categories. The product categories will be comprised of products identified by individual Healthcare Common Procedure Coding System (HCPCS) codes. Contract suppliers will be selected from the suppliers that have the lowest bids and that meet all relevant Medicare program requirements.

The MSAs, product categories and HCPCS codes for each product category are available at http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/01_overview.asp on the CMS website.

Exceptions to this program may be granted for items and services for which the application of competitive acquisition is not likely to result in significant savings or to permit continuity of an existing relationship between a beneficiary and supplier with respect to furnishing either a rental item or oxygen. The statute also allows CMS to exempt certain areas from the program, such as rural areas or areas with low population density within urban areas that are not

competitive, unless there is a significant national market for mail order for a particular item or service.

Additional Information

To view the official instruction, CR5574 issued to your Medicare contractor, go to http://www.cms.hhs.gov/Transmittals/downloads/R1218CP.pdf on the CMS website.

Information on the final rule is available by going to http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS/02_regsnotices.asp on the CMS site. Once there, click on the download for CMS-1270-F.

If you have questions or need assistance regarding competitive bidding, contact the Competitive Bidding Program Helpline at 1-877-577-5331 or use the "Contact Us" feature at http://www.dmecompetitivebid.com on the Web.

ACCREDITATION

Accreditation Information for Suppliers of DMEPOS

MLN Matters Number: SE0713 Revised

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

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

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

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

- All surveys are performed on site at the supplier location.
- All surveys are unannounced.

ACCREDITATION CONT'D

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

Status of Accreditations

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

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

Additional Information

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

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

Visit http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0713.pdf to view the complete MLN Matters article on the CMS website.

NPI

CMS Clarifies Guidelines for NPI Deadline Implementation

The Centers for Medicare & Medicaid Services (CMS) announced that it is implementing a contingency plan for covered entities (other than small health plans) who will not meet the May 23, 2007, deadline for compliance with the National Provider Identifier (NPI) regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

The final rule establishing the NPI as the standard unique health provider identifier for health care providers was published in 2004 and requires all covered entities to be in compliance with its provisions by May 23, 2007, except for small health plans, which must be in compliance by May 23, 2008.

"The enforcement guidance released today clarifies that covered entities that have been making a good faith effort to comply with the NPI provisions may, for up to 12 months, implement contingency plans that could include accepting legacy provider numbers on HIPAA transactions in order to maintain operations and cash flows." said CMS Acting Administrator Leslie V. Norwalk, Esq.

The NPI is an identifier that will be used by covered entities to identify health care providers, eliminating the current need for multiple identifiers for the same provider. The NPI replaces all "legacy" identifiers that are currently being used, such as Medicaid provider IDs, individual plan provider IDs, UPINs, etc., and will be required for use on health care claims and other HIPAA transactions.

CMS made the decision to announce this guidance on its enforcement approach after it became apparent that many covered entities would not be able to fully comply with the NPI standard by May 23, 2007. This guidance would protect covered entities from enforcement action if they continue to act in good faith to come into compliance, and they develop and implement contingency plans to enable them and their trading partners to continue to move toward compliance. HHS recognizes that transactions often require the participation of two covered entities and that non-compliance by one covered entity may put the second covered entity in a difficult position.

The enforcement process is complaint driven and will allow covered entities to demonstrate good faith efforts and employ contingency plans. If a complaint is filed against a covered entity, CMS will evaluate the entity's "good faith efforts" to comply with the standards and would not impose penalties on covered entities that have deployed contingencies to ensure that the smooth flow of payment continues. Each covered entity will determine the specifics of its contingency plan. Contingency plans may not extend beyond May 23, 2008, but entities may elect to end their contingency plans sooner. Medicare will announce its own contingency plan shortly.

CMS encourages health plans to assess the readiness of their provider communities to determine the need to implement contingency plans to maintain the flow of payments while continuing to work toward compliance. Likewise, we encourage health care providers that have not yet obtained NPIs to do so immediately, and to use their NPIs in HIPAA transactions as soon as possible. Applying for an NPI is fast, easy and free. Visit the National Plan/Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov/.

A critical aspect of implementing the NPI is the ability for covered entities to match a provider's NPI with the many legacy provider identifiers that have been used to process administrative transactions. CMS plans to make data available from the NPPES system that will assist covered entities in developing these "crosswalks."

Further information concerning this issue is available on the CMS Web-site at http://www.cms.hhs.gov. The site also contains contingency plan guidance for the industry in a document titled "Guidance on Compliance with the HIPAA National Provider Identifier Rule."

Provider Education for Handling Issues Related to Deceased Providers

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

NPI CONT'D

Provider Types Affected

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

Background

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

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

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

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

Key Points of CR5508

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

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

Additional Information

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

CLAIM FORMS

Important Medicare Notice Regarding the Revised Form CMS-1500

In July 2006 the Form CMS-1500 (12-90) was revised by the National Uniform Claim Committee (NUCC) predominantly for the purpose of accommodating the National Provider Identifier. Since that time, the industry has been preparing for the implementation of the revised Form CMS-1500 (08-05). In September 2006 Medicare announced that it would implement the revised Form CMS-1500 (08-05) on January 1, 2007, with dual acceptability of both versions until March 31, 2007. Medicare further announced that beginning April 1, 2007, the only acceptable version of the form would be the Form CMS-1500 (08-05) and that the prior version, Form CMS-1500 (12-90), would be rejected.

It has recently come to our attention that there are incorrectly formatted versions of the revised form being sold by print vendors, specifically the Government Printing Office (GPO). After reviewing the situation, the GPO has determined that the source files they received from the NUCC's authorized forms designer were improperly formatted. This resulted in the sale of both printed forms and negatives, which do not comply with the form specifications.

Given the circumstances, ***CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline*** while this situation is resolved. Medicare contractors will be directed to continue to accept the Form CMS-1500 (12-90) until notified by CMS to cease. At present, we are targeting June 1, 2007, as that date. In addition, during the interim, contractors will be directed to return, not manually key, any Form CMS-1500 (08-05) forms received, which are not printed to specification. By returning the incorrectly formatted claim forms back to you, we are able to make you aware of the situation, which will allow you to begin communications with your form supplier.

CLAIM FORMS CONT'D

The following will help you to properly identify which form is which. The old version of the form contains "Approved OMB-0938-0008 FORM CMS-1500 (12-90)" on the bottom of the form (typically on the lower right corner) signifying the version is the December 1990 version. The revised version contains "Approved OMB-0938-0999 FORM CMS-1500 (08-05)" on the bottom of the form signifying the version is the August 2005 version. The best way to identify if your CMS-1500 (08-05) version forms are correct is by looking at the upper right hand corner of the form. On properly formatted claim forms, there will be approximately a ¼" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications.

Questions may be directed to Brian Reitz at Brian.Reitz@cms.hhs.gov.

Improper Reporting on NPI, Supplier Number and UPIN on Revised CMS-1500 Claim Form

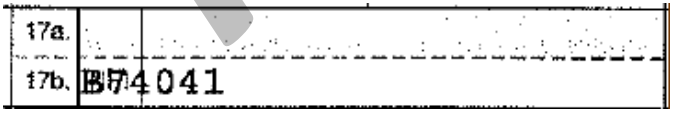
Below are some of the errors NAS is seeing on the revised CMS-1500 (08-05) claim form.

The complete instructions for the revised CMS-1500 claim form can be found on our Web site in the Claims section. The instructions are also located in the Internet Only Manual (IOM) at www.cms.hhs.gov/manuals/downloads/clm104c26.pdf. As a reminder, NAS sends an Education Status Letter for every unprocessable claim received, including the types of errors outlined below. This letter provides you with the claim control number, the beneficiary's name and Health Insurance Claim Number (HICN), and the date(s) of service to identify which claim could not be processed. The claim is also returned to you.

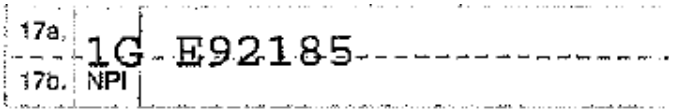
1. **Items 17a and 17b – UPIN and NPI of Referring Physician**
   - Item 17a – Report the 1G qualifier, a space, and the UPIN of the referring physician
   - Item 17b – Report the NPI of the referring physician

Below are examples of **incorrect** placement in items 17a and 17b

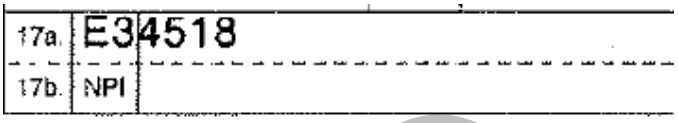
In this example, the UPIN is placed in item 17b; it should be placed in the larger portion of 17a. During the transition period, the 1G qualifier should also be placed in the smaller portion of 17a.



In this example, the UPIN and 1G qualifier are in the correct boxes but they are misaligned.



In this example, the UPIN is also misaligned in item 17a. The UPIN should be placed in the large portion of 17a and the ID qualifier 1G should be placed in the smaller portion of 17a.



This example shows the **correct** placement of the UPIN and the NPI. This example should be followed throughout the transition to NPI ending May 22, 2007. Beginning May 23, 2007, you will no longer use any portion of item 17a.

17a	1G	E12345
17b	NPI	1234567890

2. **Items 33, 33a and 33b – Billing Provider Information and Phone Number**
   - Item 33 – Report the phone number, name, and address of the billing supplier
   - Item 33a – Report the NPI of the billing supplier
   - Item 33b – Report the 1C qualifier, space, and the NSC number

Below are some examples of **incorrect** placements in item 33, 33a, and 33b.

In this example the supplier omitted the NSC number in item 32b and instead placed a telephone number in 32b.

33. BILLING PROVIDER INFOR & PH #( )	
DME Medical Supplier 421 Anyplace Road Somewhere, MO 12121	
a.NPI	b.(555) 123-4567 P

In this example the supplier reported their NSC number below the address. It should be placed in item 33b preceded with the 1C qualifier and a space.

33. BILLING PROVIDER INFOR & PH #( )	
DME Medical Supplier 421 Anyplace Road Somewhere, MO 12121 555-123-4567 1234567890	
a. NPI	b. P

This example is nearly correct, however, the space between the 1C qualifier and the NSC number is omitted.

33. BILLING PROVIDER INFOR & PH #(555) 123-4567 DME Medical Supplier 421 Anyplace Road Somewhere, MO 12121	
a. 0987654321	b. 1C1234567890 P

This example shows the **correct** placement of an NPI number and an NSC (legacy) number during the transition period ending May 22, 2007.

33. BILLING PROVIDER INFOR & PH #(555)123-4567 DME Medical Supplier 421 Anyplace Road Somewhere, MO 12121	
a. 0987654321	b. 1C 1234567890 P

Remember, after the transition to NPI ending May 22, 2007, you will no longer report anything in items 17a and 33b. The NPI is replacing the UPIN and will be placed in item 17b, while the NPI is replacing your NSC number and will be placed in 33a.

As a final note, suppliers may need a software update to print correctly on the revised (08-05) CMS-1500 claim form.

Revised CMS 1500 Claim Form Errors

NAS wants to alert the supplier community about the large number of unprocessable paper claims we are receiving on the revised CMS 1500 claim form (08/05). This situation has caused a considerable backlog of claims that are not able to pass front-end screening and has resulted in **claims being returned to suppliers**. Due to the sheer volume of these unprocessable claims, there have been delays in getting them out timely.

Below are the errors that we are seeing on the revised CMS 1500 claim form:

- National Provider Identifiers are not in the correct format (not 10 digits or do not start with a 1, 2, 3 or 4) or they are not reported in the correct box on the claim form.

  Suppliers must enter the legacy supplier number (NSC #) and NPI in the correct boxes on the revised CMS 1500 claim form. NAS has provided complete CMS 1500 claim form instructions for the revised form in the Claims section of our website. Suppliers can also refer to the Medicare Claims Processing Manual, Chapter 26 for complete instructions for the old version (12/90) and the revised version (08/05) of the CMS 1500 claim form. The following web link also includes the printing specifications for the revised form: www.cms.hhs.gov/manuals/downloads/clm104c26.pdf

- A second common error occurs in the layout or alignment of information. When the revised CMS 1500 claim form (08/05) is being submitted, some suppliers have not changed their print layout from the old CMS 1500 claim form (12/90). As a result, the information being entered does not line up correctly on the new form.

  The items on the CMS 1500 claim form that have changed are 17a, 17b, 24A through 24J, 32 and 33. Suppliers must ensure the NSC and/or NPI numbers are printing in the correct boxes on the new form. If claims are not printing correctly, contact your software vendor about a software update for the revised claim form to allow the data to be printed correctly on the revised form. **Do not use the revised CMS-1500 claim form (08/05) until your software is corrected as this will result in claims payment delays**, which may result in cash flow problems for your business.

- For item 17a, the top, shaded box is for the qualifier and UPIN. Use the qualifier 1G in the small shaded portion of 17a, followed by the six digit UPIN in the larger shaded portion of 17a. The bottom unshaded box, item 17B, already contains the NPI indicator in the small portion. In the larger portion of item 17B, submit the NPI of the referring/ordering physician.

- The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines. **At this time, the shaded area in 24A through 24H is not used by Medicare. If additional information is submitted in this area, the claims may be returned.**

- Box 24E was shifted slightly to the right. This will cause the diagnosis pointers to fall into the modifier boxes of 24D if suppliers do not change their printing specifications.

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

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

CMS has also announced that there had been some printing problems with the formatting of the revised form being sold by print vendors, specifically the Government Printing Office (GPO). The correct revised version contains "Approved OMB-0938-0999 Form CMS-1500 (08-05)" on the bottom of the form.

To identify if your version is formatted correctly look at the upper right hand corner of the form. On properly formatted forms there will be approximately a ¼" gap between the tip of the red arrow above the vertically stacked word "CARRIER" and the top edge of the paper. If the tip of the red arrow is touching or close to touching the top edge of the paper, then the form is not printed to specifications. Contact your forms supplier immediately. CMS is delaying the implementation of the revised form to allow resolution of this situation.

CLAIM FORMS CONT'D

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

A great solution to all of these problems is to submit your claims electronically. It's fast and easy! Electronic claims are paid twice as fast as paper claims. Refer to the web links below for information about free or low cost electronic claim billing software and how to become an electronic submitter.

www.cignamedicare.com/edi/dmerc/getstarted.html

www.cignamedicare.com/expressplus/index.html

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

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

Note: This article was revised on March 20, 2007, to eliminate the words "electronically submitted" from the bullet point at the top of page 3. All other information remains the same.

Provider Types Affected

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

Provider Action Needed

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

Background

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

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

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

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

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

Additional Information

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

Revisions to Form CMS-1500 Submission Requirements

MLN Matters Number: MM5489
Related Change Request (CR) #: 5489
Related CR Release Date: March 30, 2007
Related CR Transmittal #: R1215CP
Effective Date: April 1, 2007
Implementation Date: April 30, 2007

Provider Types Affected

Physicians, non-physician practitioners, and suppliers who bill Medicare contractors (Part A/B Medicare Administrative Contractors (A/B MACS), carriers, durable medical equipment regional contractors (DMERCS) and DME Medicare Administrative Contractors (DME MACs) for their services using the Form CMS-1500.

Background

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare and Medicaid programs for claims from physicians and suppliers. The language contained in the Medicare Claims Processing Manual, Chapter 26, regarding the Form CMS-1500 is being updated to reflect current processing guidelines and incorporate recent data collection decisions made by CMS.

Key Points

CR5489 makes the following updates to the CMS-1500 requirements:

- The requirement to submit the provider's Social Security Number in Box 25 has been removed;
- The requirement to report the PIN of the Skilled Nursing Facility in Box 23 has been removed; and
- Clarification language was added to Box 17a, indicating the qualifier 1G precedes the Unique Physician Identification Number (UPIN).

In addition, language has been added regarding the completion of Item 25 (the provider of service or supplier federal tax identification number). Medicare providers are not required to complete this item for crossover claim purposes, since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the Coordination of Benefits (COB) outbound claim. However, tax identification information is used in the determination of accurate National Provider Identification (NPI) reimbursement. Thus, reimbursement of claims submitted without tax identification information may be delayed.

Additional Information

CR5489 is the official instruction issued to your Medicare contractor. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1215CP.pdf on the CMS website. The revised Chapter 26, section 10.4, of the Medicare Claims Processing Manual is attached to CR5489.

Extension for Acceptance of Form CMS-1500 (12-90)

MLN Matters Number: MM5568
Related Change Request (CR) #: 5568
Related CR Release Date: March 19, 2007
Related CR Transmittal #: R1208CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

Physicians, non physician practitioners and suppliers who submit claims for their services using the Form CMS-1500 to Medicare contractors (carriers, Part A/B Medicare Administrative Contractors (A/B MACs), durable medical equipment regional carriers (DMERCs), and/or DME Medicare Administrative Contractors (DME/MACs)). **Be aware that some of the new Form CMS-1500 (08-05) forms have been printed incorrectly. This article contains details on this issue.**

Background

Form CMS-1500 is one of the basic forms prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program. It is only accepted from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32. The Form CMS-1500 (12-90) was revised in July of 2006 to accommodate the reporting of the National Provider Identifier (NPI).

Recently it came to the attention of CMS that there are incorrectly formatted versions of the revised form being sold by print vendors. After reviewing the situation, CMS determined that the source files received from the authorized forms designer were improperly formatted. This resulted in the sale of printed forms and negatives which do not comply with the form specifications.

Therefore, CMS has decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. The specific formatting issue involves top and bottom margins only, but may not be isolated to only top and/or bottom.

Key Points of CR5568

- CR5568 states that the Form CMS-1500 (12-90) will continue to be accepted until CMS instructs otherwise.
- All Form CMS-1500 (08-05) forms received by Medicare contractors that are incorrectly formatted will be returned to the provider or supplier if the Medicare contractor is unable to scan the form with its Optical Character Reader scanning equipment. An incorrectly formatted form is one that is ¼" or more off in the top, bottom, right, and/or left margins.
- The best way to identify the incorrect forms is by looking at the upper right hand corner of the form. If the tip of the red arrow above the vertically stacked word "CARRIER" is touching or close to touching the top edge of the form, then the form is not printed to specifications.

CLAIM FORMS CONT'D

There should be approximately ¼" between the tip of the arrow and the top edge of the paper on properly formatted forms.

- Providers submitting the Form CMS-1500 (12-90) are only required to submit their legacy provider number on that form, since the CMS-1500 (12-90) cannot accommodate the NPI. **It is important to note that this issue involves the paper claim form only, not the electronic claim format, which can accommodate the NPI. In addition, this situation does not affect the current NPI implementation date of May 23, 2007.**

Additional Information

To see the official instruction (CR5568) issued to your Medicare carrier, A/B MAC, DME MAC, or DMERC, go to http://www.cms.hhs.gov/Transmittals/downloads/R1208CP.pdf on the CMS web site.

To view the original communication from CMS regarding this issue, visit http://www.cms.hhs.gov/ElectronicBillingEDITrans/downloads/1500%20problems.pdf on the CMS site.

BILLING

BP, BR and BU Modifiers

Please **discontinue** using the BP, BR, and BU modifiers on all paper and electronic claims submitted for most capped rental items with rental periods beginning January 1, 2006. This change is due to the implementation of Section 5101 of the Deficit Reduction Act of 2005.

These modifiers, however, are required on parenteral and enteral pumps and electric wheelchairs regardless of the date of the first rental period and on all capped rental items where the first rental period began prior to January 1, 2006.

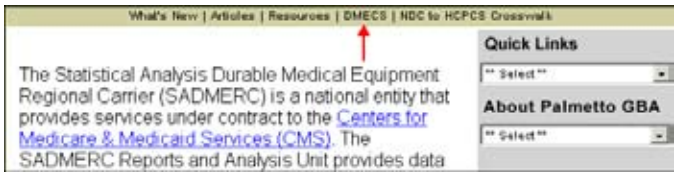
Billing Unlisted HCPCS Codes

When billing for DME items, select the HCPCS code that accurately identifies the equipment. If a code does not exist, the appropriate unlisted HCPCS code may be billed.

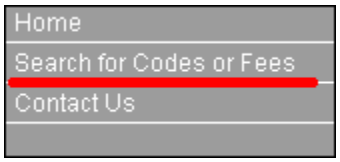
Effective May 1, 2007, NAS will no longer correctly code unlisted HCPCS ("dump codes" such as E1399) when a valid code is available. These claims will be denied as unprocessable and a corrected claim will need to be resubmitted.

NAS is receiving claims with unlisted codes when valid HCPCS are available. SADMERC (Statistical Analysis Durable Medicare Equipment Regional Carrier) assists with determining appropriate HCPCS codes to use when submitting claims to Medicare and is an excellent resource to use when coding.

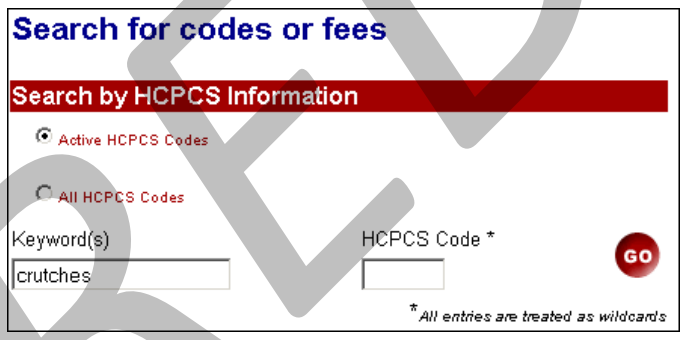
When visiting their website, www.palmettogba.com/sadmerc, select DMECS (Durable Medical Equipment Coding System) found above the SADMERC description.



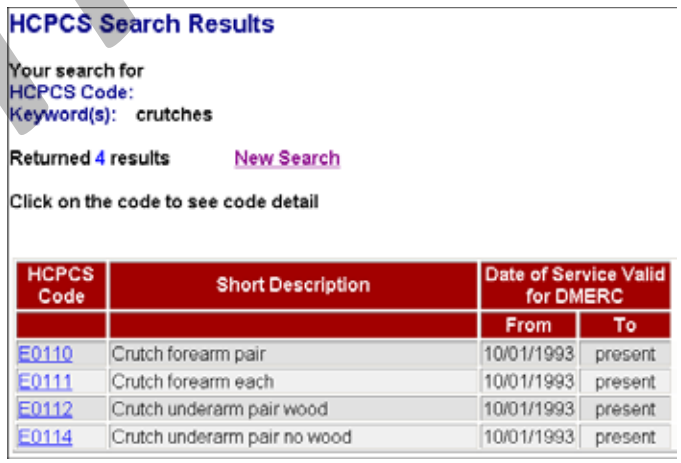
On the next page, select "Search for Codes or Fees" located on the left side.



From here, a variety of information can be entered. For example, NAS received a claim billed with E1399 and the narrative "crutches." To find a valid code, enter the word "crutches" in the Keywords area under HCPCS and select "Go."

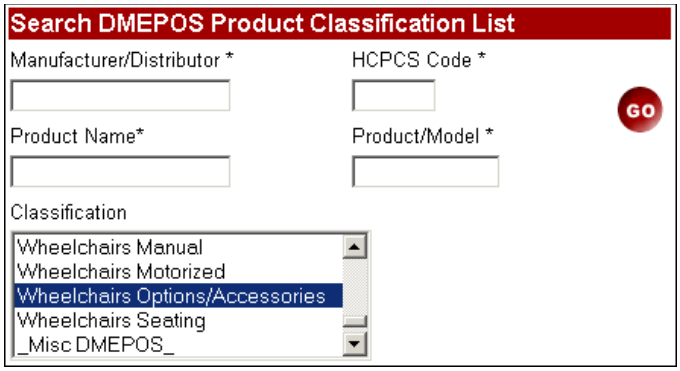


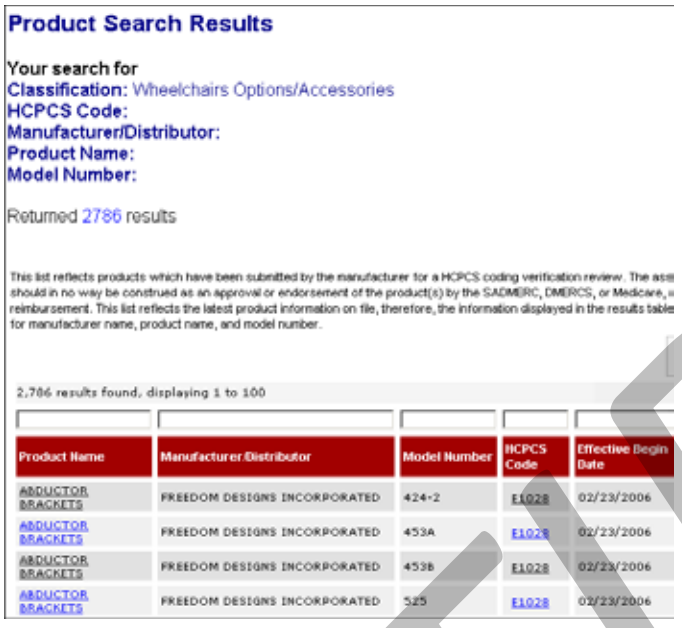
A listing of descriptions and HCPCS are shown. Instead of billing with the unlisted code, the supplier can decide which of the following codes best describes the item and bill with the valid code.



HCPCS Code	Short Description	Date of Service Valid for DMERC	
		From	To
E0110	Crutch forearm pair	10/01/1993	present
E0111	Crutch forearm each	10/01/1993	present
E0112	Crutch underarm pair wood	10/01/1993	present
E0114	Crutch underarm pair no wood	10/01/1993	present

NAS receives many unlisted codes for wheelchair accessories. For example, claims are being billed with unlisted codes for wheel bearings, battery chargers and footrests; however, valid codes are available for these items. Another option when looking for valid codes through SADMERC is using the "Search DMEPOS Product Classification List."





By selecting the category, in this case "Wheelchair Options/ Accessories," and "Go," a list of all products is shown, including the manufacturer and model number.

There are many ways to contact SADMERC: through email, telephone and in writing. Visit their website for additional instruction and contact information.

If an unlisted HCPCS code must be used, a concise description of the code is required in Item 19 on the CMS-1500 claim form or the NTE segment, 2400 loop (line level) for electronic claims. If the description does not fit in this area, documentation attachments must be included for paper claims.

It is the supplier's responsibility to ensure all information required to process the unlisted code is included with the claim form at the time of submission.

Remember, effective May 1, 2007, claims will be denied if submitted with an unlisted HCPCS and a valid code is available.

Tips When Sending Claims and Correspondence

Noridian Administrative Services (NAS) would like to offer the following tips in order to process claims and answer correspondence quickly and accurately.

- Upon receipt of an unprocessable claim denial or an education status letter, submit a **new** claim on a **new** CMS 1500 claim form or a new electronic claim with all the information corrected. Do not write or stamp "corrected claim" or "resubmission" anywhere on the CMS-1500 claim form. If the written correspondence team receives a copy of a CMS-1500 claim form in response to the unprocessable claim denial, a letter will be written asking that a new CMS-1500 claim form be submitted.
- When submitting the new revised CMS-1500 claim (08-05) form, follow the printed instructions found in the Claims section of our Web site. Many of the revised CMS-1500 (08-05) claim forms are improperly completed, resulting in Education Status Letters explaining the error.
- When submitting a new claim, do not include the Remittance Advice (RA) showing the original denial. When a RA is sent with a new claim, the mail is routed to our written correspondence team. This will delay the processing of your new claim.
- It is inappropriate to stamp information in any item on the CMS-1500 claim form that does not normally belong there. For example, if one were to stamp "resubmission" or "corrected claim" across Item 24, the claim would be returned, as this information does not belong in Item 24. Item 19 is the appropriate place to report additional information about the claim.
- Do not send tracer claims or requests to NAS. For **immediate** response to claim status/tracer questions, please call the IVR at 1-877-320-0390. The IVR is available from 6:00 a.m. – 8:00 p.m. CT.
- Clearly state your request on all correspondence. You may use the interactive Redetermination/Inquiry form found on our Web site in the Forms section to help you provide us with all the necessary information. A fully completed form assists our mailroom in getting your request to the appropriate department timelier.
- Please include a valid Health Insurance Claim Number (HIC), date of service and/or ICN on all redeterminations, reopenings or inquiries. This information can be found on the RA.
- When submitting "redetermination" requests, please verify that you are sending the requests to the jurisdiction that processed the original claim. Sending requests to the incorrect contractor will delay processing.
- Use the "Redetermination/Inquiry" form found in the DME portion of the Noridian Administration Services web site. Using the Part B form will delay processing.

Span Dates & Calendar Year Article Retracted

The "Span Dates & Calendar Year" article posted to our web site in January 2007 and in the Happenings 2 published on February 6, 2007, has been retracted. The DME MAC claim processing system accepts and correctly processes claims with dates of service spanning two calendar years (i.e., 11/12/2006 – 2/11/2007).

Common Billing Errors to Avoid when Billing Medicare Carriers

MLN Matters Number: SE0712

Provider Types Affected

Physicians and providers billing Medicare carriers for services provided to Medicare beneficiaries

Provider Action Needed

This special edition article includes some general information regarding the most frequent errors that are found in claims submitted to Medicare carriers. The article is intended to help you correctly complete your Medicare claims so they will not be denied, rejected, or delayed because of incorrect or incomplete information.

Background

The Administrative Simplification Compliance Act and its implementing regulation (42 CFR 44.32, http://www.gpoaccess.gov/cfr/retrieve.html) require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003 (except from small providers with limited exceptions).

All Medicare providers, except for small providers defined in regulation, must bill Medicare electronically. A "small provider" is defined in the Federal Register (42 CFR 424.32(d)(1)(vii), http://www.gpoaccess.gov/cfr/retrieve.html). To simplify, Medicare will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 full time employees (FTEs) that bill a Medicare carrier or DMERC to be small. Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

Common Billing Errors

The following list includes common billing errors that you should avoid when submitting your claims to Medicare carriers:

- The patient cannot be identified as a Medicare patient. Always use the Health Insurance Claim Number (HICN) and name as it appears on the patient's Medicare card.
- Item 32 (and the electronic claim equivalent) requires you to indicate the place where the service was rendered to the patient including the name and address –including a valid ZIP code– for all services unless rendered in the patient's home. Please be advised that any missing, incomplete, or invalid information recorded in this required field will result in the claim being returned or rejected in the system as unprocessable. Any claims received with the word "SAME" in Item 32 indicating that the information is the same as supplied in Item 33 are not acceptable. (**NOTE:** *References to an item number, such as item 32, refer to paper claim forms. However, note that the whenever an article number is used in this article, the related concept and information required also applies to equivalent fields on electronic claims.*)
- The referring/ordering physician's name and UPIN were not present on the claim. Please keep in mind this information is required in Item 17 and 17a on all diagnostic services, including consultations. In addition, be aware of the new requirements for use of National Provider Identifiers (NPIs). To learn more about NPIs and how to obtain your NPI, see the MLN Matters article SE0679 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf on the CMS web site. Also, see the MLN Matters articles SE0555, SE0659, and MM4203 for important information regarding CMS' schedule for implementing the NPI. The articles are at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf, http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0659.pdf, **and** http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf, respectively.
- Evaluation and management (E&M) procedure codes and the place of service do not match. An incorrect place of service is being submitted with the E&M procedure code. (Example: Procedure code 99283, which is an emergency room visit, is submitted with place of service 11, which is office).
- Please keep in mind, when billing services for more than one provider within your group, that you must put the individual provider number in Item 24k, as Item 33 can only accept one individual provider number. Also, please make sure the provider number on the claim is accurate and that it belongs to the group. (Also, remember that as of May 23, 2007, NPIs are to be used.)
- Diagnosis codes being used are either invalid or truncated. Diagnosis codes are considered invalid usually because an extra digit is being added to make it 5 digits. Please remember not all diagnosis codes are 5 digits. Please check your ICD-9-CM coding book for the correct diagnosis code.
- Procedure code/modifier was invalid on the date of service. Remember that, as of January 1, 2005, CMS no longer provides a 90-day grace period for billing discontinued CPT/HCPCS codes. (**Note:** *Please read the Medicare provider bulletins, especially at the end of each year, as Medicare list all the additions, deletions, and code changes for the following year.*)
- Claims are being submitted with deleted procedure codes. This information can also be found in the CPT Book. It is important to be using a current book.
- When Medicare is secondary, Item 11, 11a, 11b, and 11c must be completed.

Billing Tips

The following topics will assist you with correct billing and help you complete and submit error free claims:

A. Provider Numbers

Individual vs. Group PIN - Use the individual rendering provider identification number (PIN) on each detail line. Make sure the group number, when applicable, corresponds to the appropriate individual PIN. When a physician has more than one PIN (private practice, hospital, etc.), use the appropriate PIN for the services rendered. A rendering provider number, if not a solo number, must always belong to the group number that is billing. Electronic submitter ID numbers (not UPINs) should be entered in place of the PIN (group or individual). When billing any service to Medicare, if you have doubts as to which provider number to use, please verify with your carrier. (Remember to use NPIs on claims as of May 23, 2007.)

"Zero-Filling" - Do not substitute zeros or a submitter identification number where a Medicare PIN, UPIN, or NPI is required.

B. Health Insurance Claim (HIC) Numbers

HIC Accuracy – Your carrier receives numerous claims that are submitted with invalid or incorrect HIC numbers. These claims require manual intervention and can sometimes result in beneficiaries receiving incorrect EOMB information. Please be certain the HIC number you are keying is entered correctly, and is also the HIC that belongs to the patient (based on what is on his/her Medicare card) for which you are billing.

HIC Format - A correct HIC number consists of 9 numbers immediately followed by an alpha suffix. Take special care when entering the HIC number for members of the same family who are Medicare beneficiaries. A husband and wife may have a HIC number that share the same Social Security numerics. However, every individual has their own alpha suffix at the end of the HIC number. In order to ensure proper claim payment, it is essential that the correct alpha suffix is appended to each HIC. No hyphens or dashes should be used.

"Railroad Retirees" - Railroad Retirement HIC numbers generally have two alpha characters as a prefix to the number. These claims should be billed to United Health Care Insurance Company, at this address:

Palmetto Government Benefit Administrators
Railroad Medicare Services
PO Box 10066
Augusta, GA 30999-0001

C. Name Accuracy

Titles should not be used as part of the name (e.g., Dr., Mr., Rev., M.D., etc.). Be sure to use the name as it appears on the patient's Medicare card.

Non-Medicare Claims - Do not send claims for non-Medicare beneficiaries to your Medicare carrier.

D. Complete Address

U.S. Postal Addressing Standards - It is very important to meet the U.S. Postal addressing standards. Patient and provider information must be correct. This is necessary so that checks and Medicare Summary Notices (MSNs) or remittance notices arrive at the correct destination. It is also to ensure the quickest service to your office.

- A deliverable address may contain both a street name and number or a street name with a Post Officer (P.O.) Box number.
- A P.O. Box by itself is acceptable.
- A Rural Route (RR) number must be with a box number. Note: It is incorrect to key P.O. in front of the box number when given with a rural route.
- A star route number is not a deliverable address. Use highway contract route (HC) instead of star route.
- RD numbers are no longer valid. If there are rural routes still existing in your area, the correct number should be preceded by RR, then the box number.
- A box number or a RR number by itself is not deliverable.
- A street name without a number can not be delivered.
- Do not use % or any other symbol when denoting an "in care of" address. C/O is appropriate.
- As always, no commas, hyphens, periods, or other special characters should be used.

Nursing Home or Skilled Nursing Facility Address - For a facility such as a nursing home or skilled nursing facility, it is preferred that a street name and number be supplied. In some cases, this information is not available, but if it is, please use it. Please verify the accuracy of your address before you send this information.

Apartment Complex - An apartment complex (words such as apartments, towers, or complex indicate such) should contain a street address and an apartment number. Again, this information is not always available, but should always be used when it exists.

Development Center / Trailer Park - If a development center or trailer park is given, it should contain the street address and number, if that information is part of the complete address.

"No Street Address" (NSA) - NSA (No Street Address) **is not acceptable.** This is not a deliverable address.

Changes to Provider Address - Please notify your carrier in writing of any address changes for your office practice.

E. Diagnosis and Procedure Codes

Make sure you keep current with valid diagnosis and procedure codes. HIPAA requires that Medicare conform to these standard code sets reported codes must be valid as of the date of service. Remember that Medicare can no longer allow a grace period for using deleted codes.

Additional Information

Medicare Claims Processing Manual

The *Medicare Claims Processing Manual* (Publication 100-04) contains detailed instructions on Medicare's claims processes and detailed information on preparation and submission of claims. This manual is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS web site.

MLN Matters

MLN Matters is a series of articles that CMS prepares especially for providers. These articles provide information on new and/or deleted procedure and diagnosis codes, changes to the Medicare Physician Fee Schedule and other changes that impact physicians and providers. These articles are available at http://www.cms.hhs.gov/MLNMattersArticles/ on the CMS website.

Listservs

Listservs are electronic mailing lists that CMS uses to get new information into the hands of physicians and providers as quickly as possible. To get your Medicare news as it happens, join the appropriate listserv(s) at http://www.cms.hhs.gov/apps/mailinglists/ on the CMS website.

Part C Plan Type Display on the Medicare's Common Working File - CR5538 Rescinds and Fully Replaces CR 5349

MLN Matters Number: MM5538
Related Change Request (CR) #: 5538
Related CR Release Date: April 13, 2007
Related CR Transmittal #: R1219CP
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 is quite descriptive, is now available at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/.

Background

The CWF displays information on the Medicare Part C (now known as Medicare Advantage) contract number in which a beneficiary is enrolled, including the plan type description associated with the contract, and currently, CWF displays the label "HMO" for these contracts. In many of these cases, the "HMO" label is incorrect because the list of possible plan type descriptions has grown much larger since the creation of the Medicare Advantage (MA) programs.

This situation has especially become problematic for Medicare beneficiaries who are enrolled in MA Private Fee-for-Service (PFFS) contracts because PFFS contracts are labeled as "HMO" in CWF. Consequently, some providers are not recognizing that they can offer services to those beneficiaries enrolled in a MA PFFS contract.

To address this issue, the Health Plan Management System (HPMS) will modify the existing HMO address file exchange process with CWF in order to supply the list of available contract numbers and their corresponding plan type descriptions. With this new data, CWF can correctly display one of the following plan type descriptions: HMO, PPO, POS, Indemnity, or FFS Demo. The following table provides additional information to providers regarding these plan type descriptions:

Plan Type Description	Brief Guidance on Treating Patient	Additional Information
HMO	Call plan for authorization.	Managed Care plan with a provider network. Limited or no out-of-network coverage with the exception of emergency services.
PPO	You may treat the patient.	Has a network of providers. In return for higher cost sharing, members can go out of the plan network for all plan services, including supplemental benefits.
POS	You may treat the patient subject to plan rules. Contact the plan for details.	A limited out-of-network option offered by HMO plans. Contact plan for details.
Indemnity	You may treat the patient.	If this is a PFFS plan, you must follow the PFFS plan's terms and conditions of payment. If this is a Medical Savings Account (MSA) plan, the member may pay you directly.
FFS Demo	You may treat the patient.	Beneficiaries remain in original Medicare and are entitled to all fee-for-service benefits. There are no changes to Medicare FFS billing instructions or claims processing.

Additional Information

The official instruction, CR5538, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at www.cms.hhs.gov/Transmittals/downloads/R1219CP.pdf on the CMS website.

BILLING CONT'D

Medically Unlikely Edits

MLN Matters Number: MM5495
Related Change Request (CR) #: 5495
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R1202CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

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

Background

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

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

Key Points

- CR5495 announces the upcoming release of the next version of the MUEs, which is version 1.1.
- CR5495 states that Medicare carriers and A/B MACs will deny the entire claim line from non-institutional providers with units of service that exceed MUE criteria and pay the other services on the claims.
- FIs and A/B MACs will RTP claims from institutional providers with units of service that exceed MUE criteria.
- An appeal process will not be allowed for RTP'ed claims as a result of an MUE. Instead, providers should determine why the claim was returned, correct the error, and resubmit the corrected claim.
- Providers may appeal MUE criteria by forwarding a request the carrier or A/B MAC who, if they agree, will forward the appeal to the National Correct Coding Contractor.
- Excess **charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a "provider liability")**, and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

Additional Information

For complete details regarding this Change Request (CR) please see the official instruction (CR5495) issued to your Medicare carrier, FI, A/B MAC, DME MAC, DMERC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1202CP.pdf on the CMS website.

ENROLLMENT

Importance of Keeping Supplier Information Current

DMEPOS supplier standard # 2 requires ALL suppliers to notify the NSC of any change to the information provided on the CMS 855S application form within 30 days of the change. This is especially important for suppliers who will be involved in the Medicare DMEPOS Competitive Bidding Program. These suppliers must ensure the information listed on their supplier files is accurate to enable participation in this program.

The Medicare DMEPOS Competitive Bidding Program will be phased-in beginning in 2007.

Suppliers must understand the importance of keeping their supplier information current. Information and instructions on how to submit a change of information may be found on the NSC Web site (www.palmettogba.com/nsc) and by the following this path: Supplier Enrollment/Change of Information/Change of Information Guide. For more information on the Medicare DMEPOS Competitive Bidding Program please visit the CMS Competitive Bidding Web site (www.cms.hhs.gov/CompetitiveAcqforDMEPOS/).

Reporting Changes to the National Supplier Clearinghouse

Supplier standard number two requires that any change of supplier information provided on the CMS 855S application form must be reported to the National Supplier Clearinghouse within 30 days of the change.

It is important to include the supplier number and NPI in section 1B when requesting any changes. Per CMS instruction, the NSC will not be able to process any change without the NPI. Suppliers are required to list their NPI and to submit a copy of the NPI notification from the NPI enumerator each time any enrollment documentation is sent.

It takes approximately 45 days to process a change of information request. Sometimes, however, there are delays in the processing. The following reasons could cause a delay:

- Failure to respond to a development request within 14 days. If a response is not received timely, the updates will not be made and the supplier will be required to submit the request again.
- Failure to list the NPI and provide a copy of notification from the NPI enumerator.
- Failure to provide current licenses.
- Change of information does not have an original signature and date.

If a supplier does not update a change in address, a Do Not Forward flag may be added to the supplier file. Medicare contractors are required to use "Return Service Requested"

envelopes for all checks, remittance advices and overpayment demand letters that are mailed to suppliers. If any of these are returned by the Post Office, the Medicare contractor is required to put a DNF flag on the supplier file. The supplier's checks are then in a "hold" status until the payment address is updated and processed through the NSC and the DME MAC records are updated. The flag will then be end-dated and the checks released.

For complete instructions, forms and requirements for updating supplier information, see the NSC website at www.palmettogba.com/nsc. This website includes a Change of Information Guide and Helpful Hints for Completing the CMS 855S. Suppliers can also call the NSC at 1-866-238-9652 for assistance.

Revised CMS 588 Form

The National Supplier Clearinghouse reminds suppliers to submit the revised CMS 588 form with the CMS 855S form when initially enrolling with the NSC or enrolling an additional location.

The revised CMS 588 form is the Electronic Funds Transfer Authorization Agreement. If the current version is not submitted, processing time will increase because the NSC will have to develop for this information. The revised CMS 588 form shows "FORM CMS-588 (08/06) EF 09/2006" in the bottom left corner and is available on the CMS website and the NAS website under the Forms section.

The NSC also reminds suppliers to ensure the proper contractor name is listed in Section V of the CMS 588 form. The DME MACs/DMERC are unable to process this form without the correct name indicated. This will also lead to development and delays in processing if this section is not properly completed. Below are the names that should be listed in Section V of the CMS 588 form:

Jurisdiction A- NHIC, Corp.

Jurisdiction B- National Government Services

Region C DMERC- Palmetto GBA

Jurisdiction D- Noridian Administrative Services

Note: Due to the transition of the Region C DMERC to the Jurisdiction C DME MAC, Palmetto GBA will continue to accept the CMS 588 with it listed as the contractor until May 11, 2007. After that date, suppliers required to submit the CMS 588 form to the NSC should list Cigna Government Services as the contractor in Section V.

If you have any questions on the EFT form when submitting it with the CMS 855S form, call the NSC at 1-866-238-9652 or visit their website at www.palmettogba.com/nsc.

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.

CERT Documentation Contractor

Livanta, the CERT Documentation Contractor (CDC), has changed their call center hours. Their customer service representatives are now available from 8:00 am to 6:00 pm EST at 1-301-957-2380.

As the CDC, Livanta requests and receives medical documentation, provides a web site for suppliers to verify address and contact information on and maintains a call center to assist suppliers with questions.

The CDC requests documentation by calling the supplier and faxing or mailing a request on the first day. If records are not received, on days 30 and 45, another call is made to the supplier and another fax or mailed request is sent. On day 60, a letter is sent and if no documentation is received, on day 76 the claim is scored as an error.

CERT CONT'D

Livanta's preferred method of medical record receipt is by fax (1-240-568-6222). However, suppliers may mail their documentation to:
Livanta
CERT Documentation Office
Attn CID #: XXXXX
9090 Junction Drive Suite 9
Annapolis Junction MD 20701

Once documentation is received, it is forwarded to AdvanceMed for review.

Visit the Claims section of our website for more information on CERT, including links to helpful web sites, CERT FAQs and CERT error descriptions.

FORMS

New Forms for Reopenings and Redeterminations

Noridian Administrative Services is always exploring new ways to utilize technology to simplify and improve service to our suppliers. Due to requests from suppliers, a new form has been created for requesting a DME reopening, which is separate from the form used to send a written inquiry to DME or request a redetermination.

This new DME reopening form is an interactive form that may be completed online and then printed and mailed directly to the DME reopenings PO box, along with the appropriate documentation. The DME reopening form is located in the Forms section under the "Appeals" heading.

The DME inquiry/redetermination form is available for redetermination requests. This is also an interactive form that may be completed online and then printed and mailed directly to the PO box listed on the form, along with the appropriate documentation. The DME inquiry/redetermination form is located in the Forms section under the "Appeals" heading.

The use of these forms is encouraged when requesting a redetermination or reopening to expedite the processing of these requests. Please discontinue use of the previous versions of these forms.

NSC Model Forms

The following forms are provided by the National Supplier Clearinghouse to assist suppliers in meeting certain supplier standards.

The first form, "Model Warranty Information Form," addresses supplier standard number six, which requires the supplier to inform Medicare beneficiaries about the warranty coverage of any piece of equipment or any supply provided. The standard states:

A supplier honors all warranties expressed and implied under applicable State law. A supplier must not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items or for services covered under warranty. This standard applies to all purchased and rented items, including capped rental items, as described in Sec. 414.229 of this subchapter. The supplier must provide, upon request, documentation that it has provided beneficiaries with information about Medicare covered items covered under warranty, in the form of copies of letters, logs, or signed notices.

The "Model Complaint Resolution Protocol" form addresses standard number 19, which requires the supplier to have a protocol in place to resolve complaints received from Medicare beneficiaries regarding services rendered. The standard states:

A supplier must have a complaint resolution protocol to address beneficiary complaints that relate to supplier standards in paragraph (c) of this section and keep written complaints, related correspondence and any notes of actions taken in response to written and oral complaints. Failure to maintain such information may be considered evidence that supplier standards have not been met. (This information must be kept at its physical facility and made available to CMS upon request.)

The third form, "Model Complaint Log Sheet," addresses standard number 20, which requires the supplier to log certain specific information about complaints received from Medicare beneficiaries. The standard states:

A supplier must maintain the following information on all written and oral beneficiary complaints, including telephone complaints, it receives:

(i) The name, address, telephone number, and health insurance claim number of the beneficiary.
(ii) A summary of the complaint; the date it was received; the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.
(iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

The final form addresses supplier standard number five, which requires suppliers to advise beneficiaries of the rent/purchase option for capped rental and inexpensive or routinely purchased items. The capped rental items are those prior to January 1, 2006. The standard states:

Advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental durable medical equipment, as defined in Sec. 414.220(a) of this subchapter. (The supplier must provide, upon request, documentation that it has provided beneficiaries with this information, in the form of copies of letters, logs, or signed notices.).

Suppliers may use these forms or customize their own to meet their needs. For questions on the forms, please call the NSC at 1-866-238-9652. These forms are also available on our website in the Forms section under the Miscellaneous heading.

Telephone Reopenings

The reopening process allows suppliers to correct clerical errors or omissions without having to request a formal redetermination. A reopening can be initiated via the telephone or in writing.

Requesting a Telephone Reopening

Effective April 2, 2007, to expedite the processing of reopenings, DME will be offering telephone reopenings. Telephone reopenings can be reached by dialing **(888) 826-5708** between the hours of **10:00 am to 4:00 pm CT** Monday through Friday. There is a limit of 10 reopenings per phone call.

Who can Request a Reopening

- Physician or Supplier
- Medicaid State agencies or the party authorized to act on behalf of the Medicaid State agency for DME claim determinations

When to Request a Reopening

Only clerical errors or omissions can be addressed via the telephone or in writing as a reopening request. Clerical errors or omissions have been defined by the Centers for Medicare & Medicaid Services (CMS) as human or mechanical errors by the Supplier or contractor.

Examples of reopenings (not an all inclusive list):

- Mathematical or computational mistakes
- Transposed procedure or diagnosis codes
- Diagnosis changes/additions
- Modifier changes/additions (KX, RR, NU, UE, KH, KI, KJ, etc.)
- Date of service changes
- Procedure code changes
- Inaccurate date entry
- Misapplication of a fee schedule
- Computer errors

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

Disclaimer: If any of the above changes, upon research, are determined to be too complex, the phone representative will inform the caller that these need to be sent in writing with appropriate documentation. If the request involves a CMN/DIF, this may be able to be sent in as a written reopening. If the request involves documentation needed to support the service, this will be referred to the redetermination team.

A request to correct a clerical error or omission that does not require medical documentation to be reviewed by a medical professional or anyone other than the contractor employee handling the call can be initiated via the telephone or in writing.

The following cannot be done as reopenings. They must be sent in writing to redeterminations.

- Negative Pressure Wounds
- Surgical Dressings/Wound Covers/Compression Stockings
- Parenteral and Enteral
- Wheelchairs/power mobility devices
- Recoupment issues
- Medicare Secondary Payer (MSP)
- Timely denials
- Late files
- Requests that require documentation
- ABN issues
- GA modifiers

To appeal a recoupment or MSP issue, the request must be mailed and addressed to the appropriate department.

When calling to request a reopening, please have the following available:

- Caller's name and phone number
- Supplier Name and number (individual or group)
- Beneficiary's Medicare Health Insurance Claim (HIC) number
- Beneficiary's last name and first initial
- Beneficiary's date of birth
- Date of service
- CCN of the claim
- Billed amount
- Procedure code in question
- Corrective action to be taken on claim

Filing Limits

- Reopening requests must be received within one year from the date the claim completed processing as determined by the date paid on the MSN, Electronic Remittance Advice (ERA) or the Standard Paper Remittance (SPR).
- Reopening requests received after the one year time limit will be dismissed as an untimely request.
- The DME MAC may, upon request by the party affected, extend the period for filing the request for reopening with appropriate documentation to support good cause for waiving the time limit.
- Good cause for late filing is found in the Medicare Claims Processing Manual, Publication 100-4, Chapter 29, Section 90.7.
- Good cause for late filing will not be considered as a telephone reopening.

Reopening requests are mandated by the Center for Medicare & Medicaid Services (CMS) to be completed by DME MAC within 60 days from the date the request is received by our office.

Reopening Notification

If your reopening is approved, an SPR or ERA will notify you of the payment determination. Suppliers will not receive a determination letter for fully favorable reopenings.

Telephone Reopening Reminders

When calling to check on the status of a claim, call the Interactive Voice Response system at (877) 320-0390. For all other questions call (866) 243-7272 to reach the Supplier Call Center. Inquiries for the status of a claim must be done via the IVR.

Claims with remittance message MA130 can never be submitted as a request for a reopening. Claims with message MA130 are considered unprocessable. The claim is missing information that is needed to process the claim or the claim information is invalid. Unprocessable claims do not have reopening rights and must be corrected and submitted as a new claim.

The mailing address for written reopenings is:

Medicare DME
Attn: Reopenings
PO Box 6727
Fargo, ND 58108-6727

NAS has provided a form for written reopenings, www.noridianmedicare.com/dme/forms/docs/nas_reopen_dme.pdf, which can also be found in the Forms section of our website, www.noridianmedicare.com.

Information Needed to Process a Redetermination

When submitting a redetermination request, the following information is required:

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

All requests received by NAS that do not contain the required information above will be handled as incomplete requests and dismissed.

To ensure all required information is included on your redetermination request, we encourage suppliers to use the DME Inquiry/Redetermination request form available at www.noridianmedicare.com/dme/forms/docs/nas_redeterm_dme.pdf.

Helpful Hints for Submitting Redeterminations

When submitting redeterminations, there are many helpful tips that can be followed to ensure timely and efficient processing of these requests. Please note some of the following general helpful hints:

- Send in all appropriate information with *each* appeal, as outlined in Chapter 13 of the Supplier Manual. This may include: medical records, CMNs, DIFs, and/or ABNs when appropriate.
- The interactive redetermination form allows for two dates or a date span to be entered in the Date(s) of Service field. If you need to enter more than two dates of service, add those dates of service to the comments section on the bottom of the form.
- CMNs that are submitted with appeals need to be signed (e.g., hand written, electronic or signature stamp) by a physician, a physician's assistant, a nurse practitioner or a clinical nurse specialist.
- A supplier must send in a CMN or DIF with every claim being appealed that required a CMN or DIF originally. If multiple CMNs or DIFs apply to the services in question, attach all applicable forms.
- If billing for supplies for over the course of a month, include the span of dates on the appeal, if submitted this way on the original claim. The date of service (DOS) reported on the redetermination form should match the DOS on the claim, unless the DOS needs to be corrected and this is part of the request (note that DOS corrections should be done as a reopening rather than a redetermination).
- Request a reopening if the claim denied because it was inadvertently submitted without the KX modifier and the correct documentation is on file. Forgetting to report the KX modifier is considered a clerical error.
- Ensure that all lines in question on a claim are requested to be reviewed on the same redetermination request. Splitting claim lines and requesting separate redeterminations for the service originally billed on one claim will cause delays in processing your request.
- Do not send a corrected claim with your redetermination request, but rather request the change to the claim on the redetermination request form. Sending in a claim with a redetermination request may slow down the processing of your request.
- Do not submit 1500 claim forms with redetermination requests. If 1500 claim forms are submitted with redetermination requests, they will be processed as new claims.
- Ensure that when submitting a redetermination, the correct contractor is being contacted.

Here are a few hints specific to certain DME services:

- For an intermittent urinary catheter redetermination, send in all appropriate documentation, including the physician notes and laboratory results, as to why the beneficiary needed the intermittent urinary catheters.

- When sending an oxygen CMN, please include an initial, recertification and revision if all apply (i.e., if the claim is denied for no revision or recertification CMN received, send in the initial CMN and the recertification CMN as the initial may not be on file in our system).
- For a Power Mobility Device (PMD) redetermination, send in face-to-face office notes as part of the documentation, along with any PT/OT evaluation and the physician order for the PMD.
- For parenteral/enteral nutrition redeterminations, ensure that the 1500 form being sent is correct. Suppliers need to enter the correct number of units for the calories each day, and must also enter the correct date or correct *date spans* in order for the system to calculate the correct payment.

Change in the Amount in Controversy Requirement for Federal District Court Appeals

MLN Matters Number: MM5518
Related Change Request (CR) #: 5518
Related CR Release Date: March 30, 2007
Related CR Transmittal #: R1211CP
Effective Date: January 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5518 which notifies Medicare contractors of an increase in the Amount in Controversy Required to sustain Federal District Court appeal rights beginning January 1, 2007.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides for an annual reevaluation, beginning in 2005, of the dollar amount in controversy required for an Administrative Law Judge (ALJ) hearing or Federal District Court review. Therefore, **CR5518 updates the *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 29, Sections 330.1 and 345.1) to announce the Amount in Controversy Requirements for ALJ or Federal District Court Appeals during 2007.**

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, 2006 was $100. The amount in controversy requirement increased to $110 for requests made on or after January 1, 2006. **CR 5518 announces that for ALJ hearing requests made on or after January 1, 2007, the amount that must remain in controversy did not change and remains at $110.**

The amount remaining in controversy requirement for Federal District Court review prior to January 1, 2006, was $1,000. That amount increased to $1,090 on or after January 1, 2006. **CR 5518 announces that for Federal District Court review requests made on or after January 1, 2007, the amount that must remain in controversy is increased to $1,130.**

Additional Information

The official instruction, CR 5518, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1211CP.pdf on the CMS website.

Reporting Test Results and Epoetin Starting Dosage in MEA Segment

NAS would like to inform suppliers about appropriate reporting of information in the MEA segment, the segment used to report test results and Epoetin starting dosage for ANSI 4010A1 electronic claims.

Some suppliers are reporting "OG", original starting dosage in MEA-01, but are not reporting the corresponding measurement qualifier of R3, Epoetin starting dosage, in MEA-02. OG is only valid when reported with R3.

When sending test results in the MEA segment, the qualifier "TR", test results should appear in MEA-01. MEA-02 should also reflect a measurement qualifier, other than R3 (Epoetin starting dosage), based on the type of test result being submitted. The test result values for MEA-02 are as follows:

CON	Concentration
GRA	Gas Test Rate
HT	Height
R1	Hemoglobin
R2	Hematocrit
R4	Creatin
ZO	Oxygen

Suppliers will receive a letter with the following wording when OG is not reported with R3 and will result in the claim not being crossed over to the beneficiary's supplemental insurer. **Note**: This is the standard wording for all claim data errors resulting in a claim not to be crossed over to the Medicare supplemental insurer.

"Medicare processed the following claim(s) that was/were marked for crossover. You were previously notified via a remittance advice that this claim/these claims, listed in the attachment, was/were sent to the patient's supplemental insurer. However, the enclosed claim(s) was/were not crossed

over to the patient's supplemental insurer due to claim data errors.

It is not necessary to resubmit the claim(s) to Medicare. In order for you to receive supplemental payment for the claim(s), you must submit the claim(s) directly to the supplemental insurer. If you have any questions please contact Customer Service at 1-877-320-0390."

Please contact your software vendor to ensure that your software is reporting the correct values as outlined above if you feel that you are receiving crossover error reports due to incorrect reporting in the MEA segment.

Downloading Files from Stratus Mailboxes Using Wildcards

During a recent audit of Stratus bulletin board system (BBS) user activity data, it was discovered that many of our users are using wildcards—data with an asterisk (*)—to download their files. Stratus is designed for the usage of wildcards, but the below guidelines should be followed:

- We recommend that download scripts use "*.7" as the wildcard. This will retrieve every file in the current directory that has never been downloaded and will exclude all files previously downloaded. Once files are downloaded, a ".cp" or ".fl" is added to the end of the filename.
- Using "*" or "*.*" as the wildcard should rarely be done and ***never*** should be used in a download script. These wildcards download every file in the current directory. Script users who receive the same file repeatedly likely have this type of wildcard in their scripts and should contact their software vendor. (Note that all files remain in the Stratus mailbox for 7 calendar days.)
- Wildcards should not include dates or the actual file name. Wildcards using a date or name entered incorrectly may prevent the user from downloading any files—even if there are files in the mailbox the user wants. ***NOTE:*** Future updates to Stratus may cause problems for this type of wildcard.
- We suggest scripts using wildcards allow their users to override them in situations in which files excluded by the script may remain in the mailbox (such as those ending in .cp or .fl).

Stratus users who download using automated scripts should review this information and discuss it with their software vendors or programmers. Download scripts that use wildcards should be updated to follow the above guidelines. Failure to do so may result in those scripts not working properly in the future.

Since Jurisdiction D EDI does not design or support automated scripts, all questions regarding scripting issues should be directed to the script programmer. However, we can answer questions about the above guidelines through our helpdesk at 866-224-3094.

Retraction of Oxygen-Initial CMN Submission Information

In late March, NAS published an article titled Oxygen-Initial CMN Submission, regarding how to submit an initial CMN to allow for portable oxygen to be added in the future. This article was retracted on March 28, 2007 after being distributed via our DME email list and was removed from our web site. Please disregard this instruction. We apologize for the inconvenience.

DMEPOS Certificates of Medical Necessity and DME MAC Information Forms for Claims Processing

MLN Matters Number: MM4296 Revised
Related Change Request (CR) #: 4296
Related CR Release Date: October 27, 2006
Related CR Transmittal #: R167PI
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Note: This article was revised on April 16, 2007, to reflect that the transition period for use of the new forms has been extended through June 30, 2007, per CR5571, which CMS released on April 13, 2007. Previously, this article was revised on October 28, 2006, to reflect changes made to CR4296. The key change is that the CR4296 applies to claims based on dates of service rather than dates of receipt. In addition, the CR release date, transmittal number, and Web address for accessing CR4296 were changed. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers using CMNs and DIFs when billing to Medicare durable medical equipment regional carriers (DMERCs)

Provider Action Needed

The Centers for Medicaid & Medicare Services (CMS) has developed improved CMNs and DIFs and consequently there are changes to the forms.

There is a transition period for claims for dates of service from October 1, 2006, through June 30, 2007, where claims for items requiring a CMN or DIF will be accepted with either the old or the new form. The improved forms also permit the use of a signature and date stamp.

Make certain that your billing staff is aware of the changes in Chapters 3 and 5 of the *Medicare Program Integrity Manual* that are outlined in this article. The new series of forms is available as part of the official instructions (CR4296) issued to your DMERC.

Background

CMNs provide a mechanism for suppliers of durable medical equipment (defined in 42 U.S.C. § 1395x(n)) and medical equipment and supplies (defined in 42 U.S.C. § 1395j(5)) to demonstrate that the item they provide meets the minimal

CMN/DIF CONT'D

criteria for Medicare coverage. Medicare DMERCs review the documentation provided by physicians, suppliers, and providers on the CMNs and DME Information Forms (DIFs) and determine if the medical necessity and applicable coverage criteria for selected DMEPOS were met.

The changes to the CMN forms have resulted in the following:

- *Medicare Program Integrity Manual*, Chapter 5, Items and Services Having Special DME Review Considerations, has been revised.
- The improved forms permit the use of a signature and date stamp that has resulted in revision of the *Medicare Program Integrity Manual*, Chapter 3, Section 3.4.1.1, Documentation Specifications for Areas Selected for Prepayment or Post Payment Medical Review.
- These new forms were approved by the Office of Management and Budget (OMB).
- For the CMS-484 form, the OMB # is 0938-0534.
- For the CMS forms 846, 847, 848, 849, 854, 10125 and 10126, the OMB # is 0938-0679.

Claims Accepted During Transition Period

The following table identifies the CMNs for claims for services provided during the transition period from October 1, 2006, through June 30, 2007. (For services on or after July 1, 2007, the old forms will no longer be accepted.)

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

Newly Revised CMNs Accepted During Transition Period

The following table identifies the newly revised CMNs that will be accepted for services provided during the transition period for claims from October 1, 2006, through June 30, 2007. For services on or after July 1, 2007, these forms will become effective for claims for items requiring a CMN.

Noteworthy changes include changing the title of CMS-484 from Home Oxygen Therapy to Oxygen. In addition, the title of CMS-846 was changed from Lymphedema Pumps to Pneumatic Compression Devices.

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

New DIFs Accepted During Transition Period

The following table identifies the new DIFs that will also be accepted during the transition period for claims for services provided from October 1, 2006, through June 30, 2007. For services on or after July 1, 2007, the new forms will become effective for claims for items requiring a DIF.

Noteworthy changes include changing CMS-851 for Infusion Pumps to a CMS-10125, External Infusion Pump DIF.

In addition, CMS-852 for Parenteral Nutrition and CMS-853 for Enteral Nutrition were combined into a CMS-10126 Enteral and Parenteral Nutrition DIF.

DME MAC FORM	CMS FORM	ITEMS ADDRESSED
09.03	10125	External Infusion Pumps
10.03	10126	Enteral and Parenteral Nutrition

The use of the CMNs for hospital beds (CMS-841) and support surfaces (CMS-842) will be eliminated for claims with dates of service on or October 1, 2006.

CMNs Eliminated

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

DME MAC FORM	CMS FORM	ITEMS ADDRESSED
01.02A	841	Hospital Beds
01.02B	842	Support Surfaces

Medicare is developing a crosswalk to link legacy supplier numbers (National Supplier Clearinghouse (NSC)) to the new National Provider Identifiers (NPI). Until that crosswalk is completed, DMERCs will require you to continue to submit your legacy/NSC number. If you choose to submit your NPI as of October 1, 2006, you must still report your legacy/NSC number until that crosswalk is operational. Similarly, treating physicians should report their UPIN (preceded by an "XX" qualifier) AND their NPI (preceded by a "1G" qualifier) until the crosswalk is operational. CMS will issue further instructions when the crosswalk approaches operational status.

CMN/DIF CONT'D

Additional Information

The official instructions issued to your DMERC regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R167PI.pdf on the CMS web site. These instructions include copies of the new forms.

CODING

New "K" Codes for Oral/Mask for Use with Continuous Positive Airway Pressure Device

MLN Matters Number: MM5525
Related Change Request (CR) #: 5525
Related CR Release Date: March 23, 2007
Related CR Transmittal #: R1210CP
Effective Date: July 1, 2007
Implementation Date: July 2, 2007

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (fiscal intermediaries (FIs), Durable Medical Equipment Regional Carrier (DMERCs), DME Medicare Administrative Contractors (DME MAC)), for services to Medicare beneficiaries for CPAP.

Provider Action Needed

Be sure billing staff are aware that, effective July 1, 2007, three new "K" codes will be established for oral/mask for use with a CPAP device.

Background

This article is based on Change Request (CR) 5525 and you need to be aware that effective July 1, 2007, the following codes will be added to the system, i.e.:

K0553	Combination oral/nasal mask, used with continuous positive airway pressure device, each
K0554	Oral cushion for combination oral/nasal mask, replacement only, each
K0555	Nasal pillows for combination oral/nasal mask, replacement only, pair

Additional Information

To see the official instruction (CR5525) issued to your Medicare FI, DME MAC, DMERC or A/B MAC, go to http://www.cms.hhs.gov/Transmittals/downloads/R1210CP.pdf on the CMS website.

COVERAGE

Summary of Recent Policy Changes

EDS, as the Program Safeguard Contractor, has recently provided the following information on oxygen contents, LCD revisions and the nebulizer policy:

Oxygen Contents-Payment Rules

Fee schedules allowances for 2007 have changed for oxygen contents. For claims with dates of service on or after January 1, 2007, if a patient owns both a stationary gaseous or liquid system and a portable gaseous or liquid system, bill two codes-one for the stationary contents and one for the portable contents.

LCD Revisions Summary for January 2007

A summary of the principal changes to the LCDs and Policy Articles effective January 1, 2007, is provided.

Nebulizers LCD-Effective July 1, 2007

Nebulizers-Policy Revision Article

Nebulizers-Policy Article-Effective July 1, 2007

Nebulizer Response to Comments March 2007

The revised medical policy on nebulizers has been released. The policy is posted on the DME PSC Web sites and the CMS Medicare Coverage Database.

Compounded Inhalation Solutions

The major change from the current policy is that all compounded inhalation solutions will be denied as not medically necessary. This change is effective for claims with dates of service on or after July 1, 2007.

A compounded inhalation solution is one in which the product that is delivered to the patient is not an FDA-approved preparation. It is produced by a pharmacy that is not an FDA-approved manufacturer and involves the mixing, combining, or altering of ingredients for an individual patient. The final product is not approved for safety and efficacy by the FDA and is not manufactured to strict federal standards. Compounded drugs are not considered interchangeable with FDA-approved products. The absence of testing for safety and effectiveness has the potential of putting a patient at increased risk of injury, illness or death.

The draft policy proposed eliminating coverage for inhalation solutions that are only available as compounded solutions. The PSCs received comments from multiple groups and individuals concerning general problems with compounded inhalation solutions. As a result of these comments and the absence of any published clinical literature defining the need for compound inhalation solutions for an individual patient, the final policy extends noncoverage of compounded solutions beyond the specific drugs listed in the draft policy. It states that all compounded inhalation solutions will be denied as not medically necessary.

COVERAGE CONT'D

HCPCS Codes

The policy revision also incorporates the new HCPCS codes and revised coding guidelines that were effective for claims with dates of service on or after January 1, 2007.

Refer to the Revision History in the Local Coverage Determination (LCD) and Policy Article for a complete list of the changes.

Levalbuterol and DuoNeb

The draft LCD that was released for comment proposed that levalbuterol be paid comparable to albuterol and that DuoNeb be paid comparable to individual unit dose vials of albuterol and ipratropium. CMS has initiated a National Coverage Analysis on Nebulized Beta Adrenergic Agonist Therapy for Lung Disease. Therefore, the PSCs are deferring a decision on the levalbuterol and DuoNeb LCD proposals pending the results of the National Coverage Analysis.

These articles are found in the What's New section of the EDS website.

INDEPENDENCE iBOT 4000 Mobility System

MLN Matters Number: MM5372
Related Change Request (CR) #: 5372
Related CR Release Date: February 23, 2007
Related CR Transmittal #: R65NCD
Effective Date: July 27, 2006
Implementation Date: April 2, 2007

Provider Types Affected

Providers and suppliers who bill Medicare durable medical equipment regional carriers (DMERCs) or durable medical equipment Medicare administrative contractors (DME MACs) for services to Medicare beneficiaries.

Key Points

- Effective for services performed on and after July 27, 2006, the Centers for Medicare & Medicaid Services (CMS) has determined that **only** the **Standard Function** of the INDEPENDENCE iBOT 4000 Mobility System meets the definition of DME under section 1861(n) of the Medicare program and is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living, e.g., toileting, feeding, dressing, grooming, bathing, in customary locations in the home.
- Effective for services performed on or after July 27, 2006, the **4-wheel, Balance, Stair, and Remote Functions** of the INDEPENDENCE iBOT 4000 Mobility System **do not meet the definition of DME** under section 1861(n) of the Medicare program.

Background

This article and related change request (CR) 5372 alerts providers that a new Section 280.15 was added to the *Medicare National Coverage Determination (NCD) Manual* as a result of the July 27, 2006, NCD decision memo for the INDEPENDENCE iBOT 4000 Mobility System.

The change clarifies the coverage policy for this particular power mobility device. The addition to the coverage manual will indicate that CMS will provide coverage for the Standard Function of the INDEPENDENCE iBOT 4000 Mobility System, which meets the definition of DME under section 1861(n) of the Social Security Act, as a wheelchair used in the patient's home that is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living, e.g., toileting, feeding, dressing, grooming, bathing, in customary locations in the home.

Medicare uses an algorithmic process in determining the presence of a mobility deficit in Chapter 1, Part 4, Section 280.3 of the *Medicare NCD Manual*, which is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp#TopOfPage on the CMS site. This approach is also outlined in the MLN Matters article, MM3791, which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3791.pdf on the CMS site.

Implementation

Medicare DMERCs and DME MACs will implement CR5372 on April 2, 2007.

Additional Information

For complete details regarding this Change Request (CR), please see the official instruction issued to your DMERC or DME MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R65NCD.pdf on the CMS web site.

REIMBURSEMENT

2006 Fourth Quarter Drug Fees

The 2006 fourth quarter drugs fees are now available on our DME Web site in the News and Publications section. They are located in the Fee Schedule Archive of the Fee Schedule subsection.

Fee Schedule Amounts for K0825, K0850, K0851 and K0859 Revised for 2006

The fee schedule amounts for codes K0825, K0850, K0851 and K0859 have been revised for claims with service dates of November 15, 2006, through December 31, 2006. Beginning April 2, 2007, Jurisdiction D will adjust previously processed claims for codes K0825, K0850, K0851 and K0859 with these dates of service if suppliers submit a request for reopening or call the Supplier Contact Center and request a reopening.

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

HCPCS	Mod	Fee
K0825	RR	$443.32
K0850	RR	$630.28
K0851	RR	$589.37
K0859	RR	$671.17

2007 Fee Schedule for Kansas Revised for K0829, K0839, K0855, K0863 and K0864

The 2007 fee schedule amounts for Kansas have been revised for codes K0829, K0839, K0855, K0863 and K0864. Jurisdiction D will adjust previously processed claims for these codes with dates of service on/after January 1, 2007, if suppliers submit a request for reopening or call Telephone Reopenings at 1-888-826-5708 and request a reopening.

The revised fees shown are the rental fees for the first three months. The rental fee is reduced by 25% for months 4-13. **These fees apply to Kansas only**.

HCPCS	Mod	State	Fee
K0829	RR	KS	$634.37
K0839	RR	KS	$626.93
K0855	RR	KS	$910.51
K0863	RR	KS	$1005.41
K0864	RR	KS	$1196.45

These fees will be reflected in the April 2007 revision of the DMEPOS Fee Schedule. Notification will be sent via email and posted to the What's New section of our web site when the revised fee schedule is available. To receive email updates, please subscribe to the NAS DME email list.

Revised 2007 DMEPOS Fee Schedule

The revised 2007 DMEPOS Fee Schedule containing all the changes identified in CR 5337 has been placed on the NAS web site in the News and Publications section.

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

MLN Matters Number: MM5537 Revised
Related Change Request (CR) #: 5537
Related CR Release Date: March 9, 2007
Related CR Transmittal #: R1203CP
Effective Date: January 1, 2007
Implementation Date: April 2, 2007

Note: This article was revised on March 16, 2007, to show the correct effective date of January 1, 2007 above. 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 DMEPOS provided to Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 5537, which provides the April 2007quarterly update to the DMEPOS fee schedules in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Be sure billing staff are aware of these changes.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Publication 100-04), Chapter 23, Section 60; http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf).

CR 5537 provides specific instructions regarding the April quarterly update for the 2007 DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a), (h), and (i)). Payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in Title 42 of the Code of Federal Regulations (42 CFR 414.102).

Key Changes

The following are key changes in the April 2007 quarterly update of the DMEPOS fee schedule:

L8690 and L8691

The A/B MACs, Local Carriers, and FIs will adjust previously processed claims for L8690 (Auditory Osseointegrated Device, Includes All Internal and External Components) and L8691 (Auditory Osseointegrated Device, External Sound Processor, Replacement), with dates of service on or after January 1, 2007, if you resubmit such claims as adjustments.

Code E1002 (Wheelchair accessory, Power Seating System, Tilt Only)

Code E1002 was added to the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2004. The fee schedule amounts that were calculated and implemented for this code included systems with tilts less than 45 degrees from horizontal. As described in the November 2006 Policy Article for Wheelchair Options/ Accessories, power tilt seating systems (falling under code E1002) must have the ability to tilt to greater than or equal to 45 degrees from horizontal. Therefore as part of this quarterly

update, **the fee schedule amounts for code E1002 are being revised in order to remove pricing information for power seating systems with tilts less than 45 degrees.**

The DME MACs, and DMERCs will adjust previously processed claims for code E1002 with dates of service on or after January 1, 2007, if they are resubmitted as adjustments.

Code E2377 (Power Wheelchair Accessory, Expandable Controller, Including All Related Electronics and Mounting Hardware, Upgrade Provided at Initial Issue)

Code E2377 was added to the HCPCS effective January 1, 2007, for use in paying claims for upgraded expandable controllers and mounting hardware provided at initial issue. The fee schedule amounts for code E2377 do not include payment for the proportional joystick and electronics/cables/junction boxes necessary to upgrade from a non-expandable controller. **Suppliers need to submit claims for the upgraded proportional joysticks and electronics provided at initial issue for dates of service on or after January 1, 2007, using HCPCS code E2399.**

Further Changes for Power Wheelchairs

CMS is in the process of making refinements to the fee schedule amounts for several HCPCS codes for power wheelchairs to be implemented as part of the April quarterly update for the 2007 DMEPOS fee schedule. Additional instructions regarding these changes will be issued in the near future under separate cover.

Additional Information

The official instruction, CR 5537, issued to your carrier, intermediary, RHHI, A/B MAC, DMERC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1203CP.pdf on the CMS website.

April 2007 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective April 1, 2007, and Revisions to the January 2007 Quarterly ASP Medicare Part B Drug Pricing Files

MLN Matters Number: MM5517
Related Change Request (CR) #: 5517
Related CR Release Date: March 16, 2007
Related CR Transmittal #: R1204CP
Effective Date: April 1, 2007
Implementation Date: April 2, 2007

Provider Types Affected

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

Provider Action Needed

This article is based on Change Request (CR) 5517 which informs Medicare contractors to download the April 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007 ASP files.

Background

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

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

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

ASP Methodology

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

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

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

Exceptions are summarized as follows:

- The payment allowance limits for blood and blood products (other than blood clotting factors) that are not paid on a prospective payment basis, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent (95%) of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis. Blood and blood products furnished in the hospital outpatient department are paid under OPPS at the amount specified for the APC to which the product is assigned.

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

On or after March 19, 2007, the revised January 2007 and April 2007 ASP files and ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP webpage, and the payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document. The CMS ASP webpage is located at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/ on the CMS site. The revised files are applicable to claims based on dates of service as shown in the following table:

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

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

Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir

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

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

Additional Information

For complete details, please see the official instruction issued to your carriers, DMERCs, DME MACs, FIs, A/B MACs, and/or RHHIs regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1204CP.pdf on the CMS website.

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