Jurisdiction D News from Noridian Administrative Services, LLC.

# Happenings

October 2007
Issue No. 8

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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# Alphabetical Listing...

# Jurisdiction D DME MAC Supplier Contacts and Resources

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

**Web site: www.noridianmedicare.com**

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

| Mailing Addresses | |
|---|---|
| **Claims, Redetermination Requests and Correspondence**<br>Noridian Administrative Services<br>PO Box 6727<br>Fargo ND 58108-6727 | **Benefit Protection**<br>Noridian Administrative Services<br>Benefit Protection – DME<br>PO Box 6736<br>Fargo ND 58108-6736 |
| **Electronic Funds Transfer Forms**<br>Noridian Administrative Services<br>PO Box 6728<br>Fargo ND 58108-6728 | **Electronic Data Interchange**<br>CIGNA Government Services<br>Attn: DMERC EDI<br>PO Box 690<br>Nashville TN 37202 |
| **Administrative Simplification Compliance Act Exception Requests**<br>Noridian Administrative Services<br>PO Box 6737<br>Fargo ND 58108-6737<br>Fax: 888-523-8449 | **Program Safeguard Contractor**<br>Medical Review<br>IntegriGuard, LLC<br>2121 N 117 Avenue Suite 200<br>Omaha NE 68164<br>Fax: 402-498-2306 |

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

| Other DME MACs | | |
|---|---|---|
| Jurisdiction A: NHIC, Corp | 1-866-419-9458 | www.medicarenhic.com |
| Jurisdiction B: National Government Services | 1-877-299-7900 | www.adminastar.com |
| Jurisdiction C: CIGNA Government Services | 1-866-270-4909 | www.cignagovernmentservices.com |

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

FYI

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

## 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 4 | Certificates of Medical Necessity | Changed number of days to 45 for the supplier to receive the written prescription after the face-to-face examination | 10/15/07 |
| Chapter 9 | General Medical Policy Information | Added instructions to access LCDs and Policy Articles | 10/9/07 |

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

## Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (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."

## CMS Issues Final Rule Prohibiting Physician Self-Referral

CMS issued final regulations prohibiting physicians from referring Medicare patients for certain items, services and tests provided by businesses in which they or their immediate family members have a financial interest. This regulation is the third phase of the final regulations implementing the physician self-referral prohibition commonly referred to as the Stark law.

"These rules protect beneficiaries from receiving services they may not need *and* the Medicare program from paying potentially unnecessary costs," said Herb Kuhn, CMS acting deputy administrator.

This third phase of rulemaking (Phase III) responds to public comments on the Phase II interim final rule published March 26, 2004, in the ***Federal Register***. The rule does not establish any new exceptions to the self-referral prohibition, but rather makes certain refinements that could permit or, in some cases, require restructuring of some existing arrangements, CMS officials explained.

The final rule, which was put on display Monday, August 27, 2007, was published in the September 5, 2007, ***Federal Register.*** To view the rule, go to: http://www.cms.hhs.gov/PhysicianSelfReferral/04a_regphase3.asp. For more information, visit the following link on the CMS web site: http://www.cms.hhs.gov/PhysicianSelfReferral/

To view the entire press release, please click here: http://www.cms.hhs.gov/apps/media/press_releases.asp

## FYI CONT'D

# Required Use of Tamper-Resistant Prescription Pads for Outpatient Drugs Prescribed to Medicaid Recipients on or After April 1, 2008

**MLN Matters Number: SE0736 Revised**

**Note:** This article was revised on October 2, 2007, to change the effective date from October 1, 2007, to April 1, 2008. This change was a result of the "Extenders Law", which was signed September 29, 2007, delaying the implementation date for all paper Medicaid prescriptions to be written on tamper-resistant paper. Under the new law, all written Medicaid prescriptions must be on tamper-resistant prescription pads as of April 1, 2008. CMS will issue additional guidance on this implementation delay as it becomes available. All other information remains the same.

**Provider Types Affected**

This issue impacts all physicians, practitioners, and other providers who prescribe Medicaid outpatient drugs, including over-the-counter drugs, in States that reimburse for prescriptions for such items. Pharmacists and pharmacy staff especially should be aware of this requirement as it may affect reimbursement for prescriptions. The requirement is applicable regardless of whether Medicaid is the primary or secondary payer of the prescription being filled.

**Background**

Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007 was signed into law on May 25, 2007. Section 7002 (b) of that Act addresses the use of tamper-resistant prescription pads and offers guidance to State Medicaid agencies.

On August 17, 2007, the Centers for Medicare & Medicaid Services (CMS), issued a letter to State Medicaid Directors with guidance on implementing the new requirement.

**Key Points of the CMS Letter to Your State Medicaid Director**

- As of April 1, 2008, in order for outpatient drugs to be reimbursable by Medicaid, all written, non-electronic prescriptions must be executed on tamper-resistant pads.
- CMS has outlined three baseline characteristics of tamper-resistant prescription pads, but each State will define which features it will require to meet those characteristics in order to be considered tamper-resistant. **To be considered tamper resistant on April 1, 2008, a prescription pad must have at least one of the following three characteristics:**
    - One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form;
    - One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber;
    - One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.
- No later than October 1, 2008, to be considered tamper resistant, States will require that the prescription pad have all three characteristics.
- Several States have laws and regulations concerning mandatory, tamper-resistant prescription pad programs, which were in effect prior to the passage of section 7002(b). CMS deems that the tamper-resistant prescription pad characteristics required by these States' laws and regulations meet or exceed the baseline standard, as set forth above.
- Your State is free to exceed the above baseline standard.
- Each State must decide whether they will accept prescriptions written in another state with different tamper proof standards.
- CMS believes that both e-prescribing and use of tamper-resistant prescription pads will reduce the number of unauthorized, improperly altered, and counterfeit prescriptions.

**Situations in Which the New Requirement Does Not Apply**

The requirement does not apply:

- When the prescription is electronic, faxed, or verbal; (CMS encourages the use of e-prescribing as an effective means of communicating prescriptions to pharmacists.)
- When a managed care entity pays for the prescription;
- To refills of written prescriptions presented to a pharmacy before April 1, 2008; or
- In most situations when drugs are provided in nursing facilities, intermediate care facilities for the mentally retarded, institutions for mental disease, and certain other institutional and clinical facilities.

**Note:** The letter issued by CMS to State Medicaid Directors states that emergency fills are allowed as long as a prescriber provides a verbal, faxed, electronic, or compliant prescription within 72 hours after the date on which the prescription is filled. PLEASE NOTE also that Drug Enforcement Administration (DEA) regulations regarding controlled substances may require a written prescription.

## EDUCATIONAL

# Ask the Contractor Teleconference for Small Suppliers

NAS is pleased to announce our upcoming schedule of **small supplier** teleconferences for the remainder of 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.

The remaining teleconference for **small suppliers in 2007** will be held at 3:00 pm CT on:

- December 19, 2007

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

## Upcoming Ask the Contractor Teleconferences

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

- December 11, 2007

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

## Q & A from August 22, 2007, Small Supplier Ask the Contractor Teleconference

Prior to taking questions, NAS provided the following updates:

**NPI**

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

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

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

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

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

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

CMS also recently released a data dissemination policy on how the medical community can obtain NPIs for referring/ordering providers. See the CMS or NAS web site for more information. This NPI information was released on September 4.

**Telephone Reopenings**

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

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

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

If the 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.

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

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

**MSP Inquiry/Refund Form**

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

The following questions and answers are from the August 22, 2007, Ask-the-Contractor Small Supplier conference call. In some cases, the original answers given during the call may have been expanded to provide further detail. These were current as of this event. Please check our web site for updates.

**Q1. What is the appropriate code to use for a nebulizer replacement? The last guideline suppliers were given was to use E1399RP (DME, miscellaneous, replacement and repair). When I use this code, it denies as an invalid code.**

A1. You need to bill the replacement with the appropriate nebulizer code (E0570-E0585) and a narrative explaining why the nebulizer is being replaced if the nebulizer you are replacing is less than five years old.

**Follow-up Question: When was it published that I should not use the miscellaneous code E1399?**

NAS published an article on March 13, 2007, entitled "Billing Unlisted HCPCS Codes" which states in part as follows:

> 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.

**Q2. What should a supplier do when we get a prescription/order for an item and the Medicare allowed amount is less than the supplier cost? If we provide the item to the patient, we are basically donating it. Therefore, would an Advance Beneficiary Notice (ABN) be appropriate for the cost difference?**

A2. This a business decision that you, as a participating supplier, will need to make.

An ABN would not be appropriate unless you believe Medicare will deny or down code the item based on medical necessity.

If, however, you do not accept assignment, then you can bill the patient for the amount over and above what Medicare allows and pays.

**Q3. I have patients who have mattresses that are only eighteen months to two years old; the warranty expired after one year. How do I bill for a replacement mattress?**

A3. You would bill for the replacement mattress with a narrative explaining why the mattress needs replacement. The charge will initially deny after which you can request a redetermination with documentation supporting the need for a new mattress that is less than five years old. Remember, just because the warranty has expired does not mean that the item is no longer useful.

Furthermore, the Medicare Benefit Policy Manual, Chapter 15, Section 110.2 C addresses replacement DME and states in part as follows:

> Equipment, which the beneficiary owns or is a capped rental item, may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.). A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item.
>
> Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment. If the item of equipment has been in continuous use by the patient on either a rental or purchase basis for the equipment's useful lifetime, the

beneficiary may elect to obtain a new piece of equipment. Replacement may be reimbursed when a new physician order and/or new CMN, when required, is needed to reaffirm the medical necessity of the item.

The reasonable useful lifetime of durable medical equipment is determined through program instructions. In the absence of program instructions, carriers may determine the reasonable useful lifetime of equipment, but in no case can it be less than 5 years. Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. Replacement due to wear is not covered during the reasonable useful lifetime of the equipment. During the reasonable useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary. (See subsection A.)

**Follow-up Question: How do I bill for replacement parts?**

The replacement part is billed with the HCPCS code that describes the part or with a "not otherwise classified code." If you are using a "not otherwise classified code'" you need to include a description of the item in the narrative of your claim and the manufacturer's suggested retail price.

**Q4. Can a podiatrist provide diabetic shoes to a resident of a nursing home?**

A4. If the beneficiary is in a Medicare covered Part A skilled nursing home (SNF) stay, the diabetic shoes would be considered part of the SNF's consolidated billing and the supplier would need to look to the SNF for payment.

If the beneficiary is not in a Medicare covered Part A SNF stay, then the diabetic shoes are billed to the DME MAC for payment.

Information regarding consolidated billed can be found in the Supplier Manual, Chapter 5, located in the News and Publications section of the NAS web site. The lists of codes that are included in SNF consolidated billing can be accessed from the CMS web site www.cms.hhs.gov/SNFConsolidatedBilling/02l_2007Update.asp#TopOfPage

**Q5. I am getting electronic billing rejection notices stating that the HCPCS code/modifier is invalid for the date period. I make, what I assume, is the appropriate correction but am still rejected. What am I doing wrong?**

A5. For assistance, please call the EDI help desk at 1-866-224-3094 with your specific examples.

**Q6. When billing for a new prosthesis, I know that I need to put the K-level in the progress notes when an initial prosthetic device is ordered and provided. However, if at some time in the future the patient needs a new socket, for example, due to weight loss or gain, do I need to document the K-level again at that time?**

A6. The K-level determines the functional level of the amputee. Therefore, even though progress notes are not submitted with each claim, you would want your progress notes to contain all the pertinent information for the particular item billed as Medicare can request this information at any time.

**Q7. Where can I find information on the Administrative Simplification Compliance Act (ASCA)?**

A7. NAS has this information in the Claims section of our web site under the subtitle Electronic Data Interchange.

**Q8. Is there a time period that must be met before a new ankle foot orthosis (AFO) can be replaced?**

A8. See the answer for question three above. Generally, five years is considered the useful lifetime for all DMEPOS with the exception of prosthetic devices (artificial limbs).

**Q9. I am looking to provide a portable oxygen concentrator to a beneficiary as a cash pay item, but how do I bill that item to Medicare or am I not required to bill the item to Medicare? My electronic billing software does not allow me to bill for the purchase of an item that is considered a capped rental item. Many times the beneficiary wants this extra equipment for their convenience.**

A9. NAS is researching this question based on information in the Local Coverage Determination (LCD) for oxygen and oxygen equipment which addresses purchased oxygen systems and states that any purchased system billed to Medicare will be denied as contractual obligation and an ABN could not be used.

When we finalize the answer, we will post it to our web site.

**Q10. Can I bill Medicare for a CPAP machine when the patient is in a SNF or nursing home?**

A10. Chapter Five of the Supplier Manual, located on our web site, states that the following items can be billed to the DME MAC for consideration of payment when the beneficiary is in either a SNF [place of service (POS) 31] or a nursing home (POS 32):

- Prosthetics, orthotics and related supplies
- Urinary incontinence supplies
- Ostomy supplies
- Surgical dressings
- Oral anticancer drugs
- Oral antiemetic drugs
- Therapeutic shoes for Diabetics
- Parenteral/enteral nutrition (including E0776BA, the IV pole used to administer parenteral/enteral nutrition)
- ESRD - dialysis supplies only
- Immunosuppressive drugs

Respiratory devices are not included in this list of items, and therefore, could not be billed to the DME MAC for payment if the beneficiary is in a SNF or a nursing home.

**Q11. What are the claim filing timelines?**

A11. The timelines for filing claims can be found in Chapter Six of the Supplier Manual. Generally, you have a minimum of 15 months from the date of service to file a claim to Medicare for payment. However, if you accept assignment and delay submitting the claim for more than 12 months after the date of service, you will receive a 10% reduction

in your payment as a penalty for the delay. You have until December 31, 2007, to file services provided between October 1, 2005, and September 30, 2006.

**Q12. I sent an oxygen certification of medical necessity (CMN) to a treating physician four times because each time the physician would note a different length of need: three months, three months, four months, and twelve months. Do I need to do a revised CMN or recertification CMN at the end of the second 12 months? I did a recertification at the end of the first 12 months.**

A12. The initial date of the CMN determines the recertification date. If the length of need expires after the recertification date, then you need a revised CMN.

**Q13. Do we need the physician's address and phone number as well as the beneficiary's address and phone number on each prescription?**

A13. The written order requirements include the following:

- Beneficiary name
- Detailed description of the item to be dispensed including each separately billable component
- The treating physician's signature
- The date the treating physician signed the order
- The start date of the order if it is different from the signed date.

Neither a beneficiary address and phone number nor a physician address and phone number are required on the order/prescription.

**Q14. When billing for a month of supply kits for enteral feedings are there a set number of items that must be in each kit? I have been told that to provide 30 supply kits I need to supply 30 syringes even if the beneficiary doesn't use 30 syringes.**

A14. The LCD addressing enteral nutrition states as follows regarding feeding supply kits:

> The codes for feeding supply kits (B4034-B4036) include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the patient for one day. Supplies include but are not limited to bags, tubing, syringes, irrigation solution, dressings (any type), tape, etc. Individual items may differ from patient to patient and from day to day. Only one unit of service may be billed for any one day (underlining for emphasis only). Units of service in excess of one per day will be denied as not separately payable.

**Q15. Can I still report the physician's UPIN on the CMS-1500 claim form?**

A15. You can continue to report the UPIN on the CMS-1500 claim form in box 17a along with the 1G qualifier until May 23, 2008. However, if you know the ordering physician's NPI number, you should begin billing that in item 17b. Physicians' NPIs can be accessed on the National Plan & Provider Enumeration System web site at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

# Update on National Provider Education Materials on Medicare Preventive Services

A new preventive services brochure entitled ***Diabetes-Related Services,*** ICN# 006840, is now available from the Centers for Medicare & Medicaid Services' (CMS), Medicare Learning Network (MLN). This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of diabetes screening tests, diabetes self-management training, medical nutrition therapy, and supplies and other services for Medicare beneficiaries with diabetes. The new brochure is available as a downloadable pdf file on the Medicare Learning Network's (MLN) Publications web page at *http://www.cms.hhs.gov/MLNProducts/downloads/DiabetesSvcs.pdf* on the CMS web site.

The following preventive services brochures have recently been updated:

***Adult Immunizations,*** ICN# 006435

This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of influenza, pneumococcal, and hepatitis B vaccines and their administration.

http://www.cms.hhs.gov/MLNProducts/downloads/Adult_Immunization.pdf

***Bone Mass Measurements,*** ICN# 006437

This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of bone mass measurement services.

http://www.cms.hhs.gov/MLNProducts/downloads/Bone_Mass.pdf

***Cancer Screenings,*** ICN# 006434

This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of the following screening services: mammography, colorectal, prostate, Pap test, and pelvic exam.

http://www.cms.hhs.gov/MLNProducts/downloads/Cancer_Screening.pdf

***Expanded Benefits,*** ICN# 006433

This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of three preventive services: the initial preventive physical examination (IPPE), also known as the Welcome to "Medicare Physical" Exam or the "Welcome to Medicare" visit, ultrasound screening for abdominal aortic aneurysms, and cardiovascular screening blood tests.

http://www.cms.hhs.gov/MLNProducts/downloads/Expanded_Benefits.pdf

***Glaucoma Screening,*** ICN# 006436

This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of glaucoma screening services.

http://www.cms.hhs.gov/MLNProducts/downloads/Glaucoma.pdf

***Smoking and Tobacco-Use Cessation Counseling Services,*** ICN# 006767

This tri-fold brochure provides health care professionals with an overview of Medicare's coverage of smoking cessation services.

http://www.cms.hhs.gov/MLNproducts/downloads/smoking.pdf

These seven national provider education brochures are available for download on the MLN Publications' web page as pdf files. Print copies of these brochures will be available in approximately 4 to 6 weeks.

## Top Ten Telephone Inquiries and Solutions

The purpose of this article is to assist suppliers with solutions to the "Top Ten" telephone inquiries that our Supplier Contact Center received from July – September 2007. Our web site, www.noridianmedicare.com, contains excellent information to assist with supplier inquiries.

**1. DME Same or Similar Equipment**

Suppliers should ask the beneficiary specific questions during the intake process to help determine whether a beneficiary may have received a similar item in the past. For example, if the beneficiary asks for a walker, the supplier should ask the beneficiary if they have ever been provided a walker in the past by another supplier. The next series of questions would be asking about the use of a cane, wheelchair or other mobility devices.

The Interactive Voice Response (IVR) system also provides CMN information on specific HCPCS codes. Call the IVR by dialing 1-877-320-0390. To check for CMN status, enter the beneficiary's HICN, first and last name, birth date and a HCPCS code. The IVR will provide the initial certification date, date of recertification, and length of need.

**2. Entitlement**

The IVR provides beneficiary eligibility information including when the beneficiary became eligible for Medicare. By entering the same information listed in item one, the IVR will provide the Parts A and B effective and termination dates and if the Part B deductible has been met for the current and prior years. The IVR will also provide a new Medicare number if applicable, HMO information, MSP information, and home health and hospice information based on the date of service entered.

It is the supplier's responsibility to determine whether the patient is entitled to receive Medicare benefits. It is also imperative to report the Medicare number or HICN as listed on the beneficiary's Medicare Health Insurance Card.

**3. Frequency/Dollar Amount Limitation**

Suppliers should review the documentation section of each individual medical policy to verify the utilization guidelines and the documentation requirements needed when billing for quantities of supplies greater than those described in the policy. Each claim submitted for quantities of supplies greater than those described in the policy must have documentation supporting the medical necessity of the higher utilization. This supporting information should be reported in item 19 on the CMS-1500 or the narrative field of an electronic claim. The policies can be accessed from the Coverage Section of the NAS DME web site by going to the subsection titled "Local Coverage Determinations" and clicking on the link to the "CMS Medicare Coverage Database – Current LCDs."

**4. Certification Requirements**

Oxygen, pneumatic compression devices, osteogenesis stimulators, transcutaneous electrical nerve stimulators, and seat left mechanisms require CMNs, and external infusion pumps and enteral and parenteral nutrition require DIFs. Suppliers should be knowledgeable regarding the medical policies for these items, which in turn will aid in completing the CMNs and DIFs. In addition, the forms contain instructions for completing the form. All CMNs and DIFs are located on the DME web site, www.noridianmedicare.com, under the Coverage or the Forms section. The medical policies can be accessed from the Coverage section of the NAS DME web site.

Additional information regarding CMN requirements can be found in Chapter 4 of the Supplier Manual found on the DME web site in the News and Publications section.

**5. Claim Not on File**

Medicare will not process or may return claims due to incomplete or invalid information and will notify suppliers of the errors through education status letters. These claims are considered unprocessable; they must be corrected and submitted as new claims. If you call the IVR for the status of a claim and no claim is on file, verify that you have completed the claim form appropriately by looking at a copy of the submitted claim and checking the following items:

- Item 1A – Verify the HICN is correct. Most HICNs have 9 digits and either leading or ending alpha character(s)
- Item 11 – Completed with either NONE or a policy number
- Item 17, 17a and/or 17b – Physician name, UPIN with 1G qualifier and/or NPI
- Item 21 – Diagnosis coded to the highest specificity
- Item 24E – One diagnosis code pointer (1 or 2 or 3 or 4)
- Item 33a and or 33b – NPI in correct format, legacy number, if billed, in the correct format and preceded with 1C qualifier and one space

If you bill electronically, verify that the claim was transmitted and not rejected during EDI front-end processing as listed on an error report.

**6. Payment Explanation/Calculation**

Most DMEPOS are paid based on a fee schedule established by CMS for each state or territory. The

beneficiary's permanent address will determine the amount allowed by Medicare for a particular service. Drugs, however, have the same allowance regardless of where the beneficiary resides. Medicare pays 80% of the allowed amount for DMEPOS and drugs and biologicals. The most current fee schedules are located in the News and Publications section the NAS DME web site.

**In addition, the remittance advice message may also help to explain the Medicare payment amount.**

**7. CWF Rejects**

During the intake process, suppliers should be asking beneficiaries very specific questions, especially regarding home health. For example, ask the beneficiary if anyone is coming into the home to aid in any way. If your patient is in a covered home health episode, some of the items you provide may be included in the home health prospective payment system (PPS) regardless of the reason the beneficiary is receiving home health benefits. A list of the items included in a covered home health episode is found at www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp#TopOfPage

**8. Other Issues**

Suppliers are encouraged to visit the NAS DME web site frequently to stay abreast of Medicare changes. The latest news regarding policy changes, claim filing issues and other important information is found in the "What's New" section of the web site.

Suppliers should also subscribe to the NAS email list to receive emails with the latest news and information twice a week on Tuesdays and Fridays.

**9. Eligibility**

It is the supplier's responsibility to determine whether the patient is entitled to receive Medicare benefits and to report the Medicare number as shown on the patient's Medicare Health Insurance card. The easiest way to do this is to make a copy of the patient's Medicare card when service is requested and keep this copy in the patient's file.

When submitting claims for payment, verify that you are submitting a nine numeric plus alpha suffix or prefix Medicare number and that there are no transposition errors. The claim also must be submitted with the patient's name exactly as it is shown on the Medicare card; no nicknames will be accepted.

**10. Status/Explanation/Resolution**

Suppliers can check the status of claims by calling the IVR between 6 am and 6 pm CT. Enter the supplier number, patient HICN, first and last name, and date of service. The IVR will report if the claim has processed, denied, or is pending, the submitted amount for a denied claim or the allowed/payment amount for a paid claim, the payment or denial date, and the check number.

If the claim denied, to get additional information say, "claim details." The IVR will then provide the claim control number, the number of line items, the detail of each line item, and the diagnosis.

# Top Ten Written Inquiries

The top ten written inquiries for July through September are listed below along with tips and reminders about submitting these requests to NAS.

**1. Reference Resources Referral/Request**

NAS offers several ways of locating information on our web site.

The Search function is available in the upper right corner on all pages of the web site. The Quick Search looks for the keyword on the entire web site. By using the Advanced Search, the user can narrow the search down to a specific area of the web site.

On the DME homepage, each of the categories of our web site is listed with an arrow next to it. When the mouse is hovered over the arrow, the contents of that category are listed.

Also, the Site Map is available on every page near the Search tool. This index has been alphabetized for each category on our web site.

**2. Misrouted Written Correspondence**

Suppliers should ensure information is being sent to the correct location. NAS has been receiving correspondence for the National Supplier Clearinghouse and the EDI Helpdesk. Other Medicare contact information is available on our web site. Sending inquiries and information to an incorrect entity may cause a delay in processing.

**3. Payment Explanation/Calculation**

The Written Correspondence staff receives redetermination requests after claims have already been paid. Suppliers should ensure a claim has not been paid before submitting these requests to NAS by calling the IVR at 877-320-0390 or by referencing the remittance advice.

**4. Issue Not Identified/Incomplete Information Provided**

When sending inquiries to NAS, clearly state the question. This will ensure NAS has all of the information needed to answer the request. If information is submitted without a specific request, the Written Correspondence staff will reply with a letter indicating the inquiry was incomplete, causing a delay in receiving a response.

**5. Filing/Billing Instructions**

When resubmitting a claim, do not attach any type of correspondence, such as a reopening, redetermination or inquiry form or include unnecessary narrative on the claim, such as "corrected claim." Doing so may delay the processing of the claim.

**6. 1500 Form Item**

NAS provides a CMS-1500 (08-05) claim form tutorial to assist in completing each Item of the claim. By hovering the mouse over a specific Item, a box will appear with the required information for that Item. Clicking on an Item in the tutorial provides complete claim form instructions.

**7. Other Issues**

Many of the emails and letters received at NAS in the last few months were from suppliers notifying us of their NPI.

NAS does not need to be notified of the NPI assigned to suppliers. Instead, suppliers are instructed to bill a small number of claims using only the NPI. If these claims are not rejected, the supplier can gradually increase the volume. If any claim is rejected due to provider identifier issues, first verify the NPI to make sure it was entered correctly. If the NPI is correct, then data in either the NPPES or Medicare provider files is incorrect. Check the accuracy of the following fields in the NPPES record and/or 855 provider enrollment record:

- EIN (for organization providers), SSN (for individual providers)
- Other Provider Identification Numbers (in NPPES where type = Medicare. This is where providers, when they apply for their NPIs, may, as an option, list the Medicare legacy identifier(s) that needs to be linked to the NPI).
- Business Location Address (from NPPES and provider enrollment records)
- Master Address (from provider enrollment records)
- Other Address (from provider enrollment records)
- Legal Name or Legal Business Name

Once data is corrected, please wait a few days for the systems to update and test again with a small number of claims. It is critical that suppliers test with the NPI immediately.

Additional emails included in "Other" are informational messages from other companies.

**8. Process/Rights**

When sending reopening or redetermination requests, ensure the claim has appeal rights. Claims denied as unprocessable with remittance advice remark code MA130 need to be resubmitted as a new claim with the correction.

**9. EMC Filing Requirements**

NAS has been receiving reopening and redetermination requests on claims that are submitted on paper instead of electronically and the supplier does not have the ASCA exception waiver. This denial does not have appeal rights. Suppliers must resubmit the claim electronically in order to have these claims processed. If a reopening or redetermination is requested on this denial, a letter will be sent back to the supplier with this explanation.

**10. CWF Rejects**

To ensure timely processing, please make sure that paper claims and correspondence are mailed to the correct DME Jurisdiction. Reference the other DME MAC web sites for mailing information:

Jurisdiction A-NHIC - www.medicarenhic.com/dme

Jurisdiction B-National Government Services - www.adminastar.com

Jurisdiction C-CIGNA Government Services - www.cignagovernmentservices.com



## NPI Registry and Training Package Available

The NPI Registry and the downloadable file are now available. To view the Registry, visit https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do on the web. The downloadable file is available at http://nppesdata.cms.hhs.gov/cms_NPI_files.html on the web.

Additionally, the final module in the NPI Training Package is now available. Module 4, Data Dissemination, is now available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPI_Module4_Data_Dissemination.pdf on the CMS web site. This module describes the policy by which CMS will make certain NPPES data available, as well as the data CMS is disclosing.

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

## NPI Registry Update and Important NPI Information for Medicare Providers

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

Many of you have noted the recent instability of NPPES and the NPI Registry. CMS has begun implementing changes that should eliminate the instability. We expect that these changes will be completed as soon as possible. NPPES will remain in operation while these changes are being made but the NPI Registry will remain down until all changes have been implemented. We expect the NPI Registry to be back in operation as soon as possible. We apologize for this inconvenience.

The downloadable file is available at http://nppesdata.cms.hhs.gov/cms_NPI_files.html on the web.

**Important Information for Medicare Providers**

**For Physicians and Non-Physician Practitioners who Bill Medicare**

Your Medicare carrier has contacted, or will be contacting you, about the date Medicare will begin rejecting your claims if the NPI and legacy number pairs used on your Medicare claims are not compatible. If you bill using only the NPI, please skip to the last paragraph.

Some incorporated physicians and non-physician practitioners have obtained NPIs as follows: an individual (Entity Type 1) NPI for the physician or non-physician practitioner and an organization (Entity Type 2) NPI for the

corporation. If you enrolled in Medicare as an individual and obtained a Medicare Provider Identification Number (PIN) as an individual, and you want to use your NPI and your PIN pair in your Medicare claims, be sure you use your individual NPI with your individual PIN. Pairing your corporation's NPI with your individual PIN will result in your claims being rejected. If you wish to bill Medicare with your corporation's NPI, then you must be sure your corporation is enrolled in Medicare so that it can be assigned a PIN. Please contact your servicing Medicare carrier for more information about this enrollment. Until your corporation has been enrolled in Medicare, you may continue to bill by using your individual NPI with your individual PIN to ensure no disruption in your claims being processed and paid. Please note that similar problems may result if you bill Medicare by using your individual NPI with your corporation's PIN (if the corporation is enrolled and has been assigned a PIN). In other words, when billing with the NPI/PIN pair, you must use compatible NPIs and PINs.

NPI-Only Billers: Make sure the NPI you are using is compatible with your Medicare enrollment. For example, if you enrolled in Medicare as an individual, then you should be using an individual (Entity Type 1) NPI.

**Enumeration Tip for DME Suppliers**

Medicare has also reported instances of incorrect billing by DME suppliers to DME MACs. DME suppliers must ensure that if they enumerate as individuals in the National Supplier Clearinghouse (NSC), they must obtain NPIs for themselves as individuals (Entity type 1) in NPPES. If they enumerate as organization in the NSC, they must obtain NPIs for the organizations (Entity type 2) in NPPES.

**Pay Attention: Informational Edits Today = Future Claim Rejections!**

We strongly urge Medicare providers to pay attention to the informational edits they may be receiving on the remittance advice (either electronic or paper). These edits are generated to help providers identify problems that will cause claims to reject in the future. A recent MLN Matters article lists these informational edits and their meanings. Visit http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf on the CMS web site to view the article.

**Reminder ---Medicare Carriers and DME MACs Will Begin Transitioning their Systems to Start Rejecting Claims when the NPI and Legacy Provider Identifier Pair cannot be found on the Medicare Crosswalk**

Since May 29, 2007, Medicare Fiscal Intermediaries, as well as Part B CIGNA Idaho and Tennessee, have been validating NPIs and legacy provider identifier pairs submitted on claims against the Medicare NPI Crosswalk. Between the period of September 3, 2007 and October 29, 2007, all other Part B carriers and DME MACS will begin to turn on edits to validate the NPI/legacy pairs submitted on claims. If the pair is not found on the Medicare NPI crosswalk, the claim will reject. Contractors have been instructed to inform providers at a minimum of 7 days prior to turning on the edits to validate the NPI/legacy pairs against the NPI Crosswalk.

If your remittance advice contains informational edits today, we strongly urge you to validate that the NPPES has ALL of the NPI and legacy numbers you intend to use on claims and for billing purposes. If NPPES is correct, and you continue to receive informational edits, you should ensure that your Medicare enrollment information is up to date. If it is not, you may need to submit a completed CMS-855 (Medicare provider enrollment form). When completing the CMS-855, please list all of the NPIs that will be used in place of legacy identifiers. When applying for an NPI, please include ALL of your Medicare legacy numbers. (NPPES can accept only 20 Other Provider Identifiers, but is being expanded to accept more in the future.) If the information is different between Medicare and NPPES, there is a very good chance your claims will reject. NPPES data may be verified at https://nppes.cms.hhs.gov on the web.

**Clarification Regarding Provider Response Times for Contractor Inquiries**

As stated in CR 5649, Transmittal number 1262 dated June 8, 2007, all Medicare providers could receive phone calls and/or letters from their contractors in the event that a claim suspends due to problems with mapping a provider's NPI to a legacy provider identifier. In last month's NPI message, we noted the number of days for a provider to respond to this type of contractor inquiry. To clarify, if the provider does not respond within the timeframe issued during the phone call with, or on the letter they receive from their contractor, the contractor will return the claim as unprocessable. The contractor will ensure that it is in compliance with the Medicare Program Integrity Manual (Publication 100-08), chapter 10, section 17.2 regarding the release of information.

**Upcoming WEDI NPI Audiocast**

The Workgroup for Electronic Data Interchange will host an NPI audiocast on October 17th. Visit http://www.wedi.org/npioi/index.shtml on the WEDI web site to learn more. Please note that there is a cost to participate in WEDI events.

**Still Confused?**

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

## Potential Issues Related to Clearinghouse and Billing Service Practices

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

As part of efforts to fully implement the NPI, Medicare FIs, carriers, and A/B MACs have begun calling providers who are not sending their NPI on claims or are sending incorrect NPI information. It has come to CMS' attention that:

## NPI CONT'D

- Some Clearinghouses may be stripping the National Provider Identifier (NPI) off the claim prior to its submission to Medicare for claims processing. Clearinghouses may be adding the NPI back onto the Remittance Advice, so that providers are unaware that NPIs are being removed prior to being sent forward.
- Some billing services (or "key" shops) are not putting the NPI on the claim, contrary to provider instructions.
- Some clearinghouses are not forwarding, to providers, carrier NPI informational claim error messages designed to help the provider understand the problems Medicare is encountering in attempts to crosswalk the NPI to legacy identifiers.

Medicare Contractors are turning on edits to begin validating the NPI/legacy pair against the Medicare NPI Crosswalk. If the pair on the claim is not found on the crosswalk, the claim **will** reject. Stripping the NPI submitted by a provider from the claim adversely affects Medicare provider incentive cash flow, payers that receive crossover claims, and the efforts of Medicare to fully implement NPI.

If you are a Clearinghouse or billing service that is stripping or not sending the NPI, Medicare would like to better understand the reasons behind this practice as well as the expected timeframe during which this will continue to occur. Therefore, we ask those willing to discuss this problem with CMS staff to please contact Aryeh Langer at Aryeh.langer@cms.hhs.gov or Nicole Cooney at Nicole.cooney@cms.hhs.gov before October 10, 2007.

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

**MLN Matters Number: MM5452 Revised**
**Related Change Request (CR) #: 5452**
**Related CR Release Date: September 21, 2007**
**Related CR Transmittal #: R1343CP**
**Effective Date: July 2, 2007**
**Implementation Date for DME suppliers: July 2, 2007**
**Implementation Date for other providers: April 7, 2008**

**Note**: This article was revised on September 21, 2007, to reflect a change made to the implementation dates in CR5452. For DME suppliers billing DME MACs, the implementation date remains the same. For other providers who bill Medicare carriers, fiscal intermediaries, including Regional Home Health Intermediaries, and/or Part A/B Medicare Administrative Contractors (A/B MACs), the implementation date is now April 7, 2008. The CR transmittal date, number, and Web address for accessing CR5452 were also changed. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

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

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

**Background**

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

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

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

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

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

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

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

- **Electronic Remittance Advice (ERA)** - Under this scenario, Medicare will report the NPI at the Payee level as the Payee primary ID, and the TIN (Employer Identification Number (EIN) Social Security Number (SSN) (EIN/SSN)) in the REF segment as Payee Additional ID. Medicare will report any relevant

Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs, as appropriate, will also report relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, there will be one remittance advice, and one check/Electronic Funds Transfer (EFT) per NPI.

- **Standard Paper Remittance (SPR)** - Medicare will insert the appropriate Payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional note.
- **PC Print Software** - Medicare will show the Payee NPI at the header level and add the relevant Rendering Provider NPI at the claim level if different from the Payee NPI.
- **MREP Software** - Medicare will show the Payee NPI at the header level and add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI, and any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI.

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

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

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

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

**Implementation**

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

- For claims submitted to DMERCs and/or DME MACs, the changes will be implemented on July 1, 2007.
- For claims submitted to other Medicare contractors, the implementation will occur on **April 7, 2008**.

**Additional Information**

For complete details regarding this Change Request (CR) please see the official instruction (CR5452) issued to your Medicare FI, RHHI, DMERC, DME/MAC, or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1343CP.pdf on the CMS web site. The revised sections of Chapter 22—Remittance Advice of the *Medicare Claims Processing Manual* are attached to CR5452.

## Discontinuance of UPIN Registry

**MLN Matters Number: MM5584 Revised**
**Related Change Request (CR) #: 5584**
**Related CR Release Date: September 14, 2007**
**Related CR Transmittal #: R222PI**
**Effective Date: May 29, 2007**
**Implementation Date: June 29, 2007**

**Note:** This article was revised on September 17, 2007, to reflect changes made to CR5584, which CMS re-issued on September 14, 2007. The article was revised to show that the UPIN Registry web site and lookup functionality will be available through May 23, 2008. Information was added regarding the release of information, including NPIs, via the NPPES. The CR transmittal number, Web address for accessing CR5584, and the CR release date were also changed. All other information remains the same.

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 5584 which announces that the Centers for Medicare & Medicaid Services (CMS) will discontinue assigning Unique Physician Identification Numbers (UPINs) on June 29, 2007.

The National Provider Identifier (NPI) is a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the NPI will replace the use

of UPINs and other existing legacy identifiers. (However, CMS recently announced a contingency plan that allows for use of legacy numbers for some period of time beyond May 23, 2007. Under the Medicare FFS contingency plan, UPINs and surrogate UPINs may still be used to identify ordering and referring providers and suppliers until further notice.) Information on that contingency plan is at http://www.cms.hhs.gov/NationalProvIdentStand/08_NPI%20Contingency%20Planning.asp#TopOfPage on the CMS site.

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

**Background**

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

On January 23, 2004, the Secretary of Health and Human Services published a Final Rule in which the Secretary adopted a standard unique health identifier to identify health care providers in transactions for which the Secretary has adopted standards (known as HIPAA standard transactions). This identifier is the National Provider Identifier (NPI). The NPI will replace all legacy provider identifiers that are used in HIPAA standard transactions, including the UPIN, to identify health care providers. All HIPAA covered entities (health plans, health care clearinghouses, and those health care providers who transmit any data electronically in connection with a HIPAA standard transaction) are required by that regulation to begin using NPIs in these transactions no later than May 23, 2007 (small health plans have until May 23, 2008). Medicare is also requiring the use of NPIs in paper claims no later than May 23, 2007, but see the note in the following box regarding the May 23, 2007 implementation by Medicare.

**Important Note: Effective May 23, 2007, Medicare FFS is establishing a contingency plan for implementing the National Provider Identifier (NPI). In this plan, as soon as Medicare considers the number of claims submitted with an NPI for primary providers (Billing, pay-to and rendering providers) is sufficient, Medicare (after advance notification to providers) will begin rejecting claims without an NPI for primary providers, perhaps as early as July 1, 2007. For more information on this contingency plan, please visit the NPI dedicated web site at www.cms.hhs.gov/NationalProvIdentStand/. This contingency plan does not affect CMS plans to discontinue assigning UPINs on June 29, 2007 or to disable the UPIN "look-up" functionality as of May 23, 2008.**

The CMS discontinued assigning UPINs on June 29, 2007, but CMS will maintain its UPIN public "look-up" functionality and Registry web site (http://www.upinregistry.com/) through May 23, 2008. In addition, CMS published the NPPES Data Dissemination Notice (CMS-6060-N) in the Federal Register on May 30, 2007. This Notice describes the policy by which information, to include NPIs, may be disseminated by CMS from the National Plan and Provider Enumeration System (NPPES).

**Additional Information**

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

The official instruction, CR5584, issued to your carrier, intermediary, RHHI, A/B MAC and DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R222PI.pdf on the CMS web site.

## Delete References to Required Reporting of NPI on/after May 23, 2007 and Revise to "When Effective" Date

**MLN Matters Number: MM5678**
**Related Change Request (CR) #: 5678**
**Related CR Release Date: August 31, 2007**
**Related CR Transmittal #: R1328CP**
**Effective Date: October 1, 2007**
**Implementation Date: October 1, 2007**

**Provider Types Affected**

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

**Provider Action Needed**

This article is informational in nature and is based on Change Request (CR) 5678 which updates Chapter 80 of the *Medicare Claims Processing Manual* to delete references to the May 23, 2007 mandatory date for entry of the National Provider Identifier (NPI) on claims. The effective date for providers to use only the NPI on Medicare claims will be officially announced at a later date, as previously communicated to providers in the MLN Matters article corresponding to CR5595. That article is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS web site.

## NPI CONT'D

**Background**

The National Provider Identifier (NPI) final rule, published in the Federal Register on January 23, 2004 (http://www.access.gpo.gov/su_docs/fedreg/a040123c.html; Health and Human Services Department Rules), established the standard for a unique identifier for each health care provider for use in health care transactions. Medicare contractors were to be required to enter NPI in certain items and fields of paper claim forms and electronic equivalents on or after May 23, 2007.

However, on April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance regarding contingency planning for the implementation of the NPI. For some time after May 23, 2007, Medicare Fee for Service (FFS) will allow continued use of legacy numbers (Unique Physician Identification Numbers (UPINs) and Provider Identification Numbers (PINs)), as well as accepting transactions with only NPIs. The effective date for providers to use only the NPI only on claims and to cease entering UPINs and PINs will be officially announced at a later date, as previously communicated to providers in the MLN Matters article corresponding to CR5595. That article is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS web site. This article reflects CR5678, which simply amends Chapter 80 of the *Medicare Claims Processing Manual* to reflect that the use of the NPI will be mandated for Medicare FFS claims at a future date.

**Additional Information**

The official instruction, CR5678, issued to your carrier, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1328CP.pdf on the CMS web site.

## BILLING

# Maintenance and Service

Please be aware that maintenance and service cannot be paid until the entire 15 months of rent have been approved and checks mailed. In addition, the maintenance and service must be submitted to NAS on a separate claim from the last month of capped rental.

# Preventing Duplicate Claim Denials

If more than one claim is submitted for the same item for the same date of service, the second claim will be denied as duplicate. Submitting duplicate claims:

1. **May delay payment;**
2. **Could cause you to be identified as an abusive biller; or**
3. **May result in an investigation for fraud if a pattern of duplicate billing is identified.**

Although NAS believes that most suppliers are not deliberately trying to receive duplicate payment by submitting duplicate claims, NAS wants to remind suppliers that submitting such duplicate claims for the same item is inappropriate and asks you to discontinue this practice. Although Medicare is prohibited by law from paying claims immediately, over 90% of clean, payable claims are paid within 30 days. Therefore, once you submit a claim, please don't keep re-submitting until you get paid. One submission is all that is required.

NAS suggests that if you have not received payment after 30 days and are concerned about your payment to verify the claim status using the Interactive Voice Response System by calling 1-877-320-0390. If the claim is not found, we would suggest verifying with a call center representative by calling 1-866-243-7272.

NAS also encourages suppliers to verify that your claim system is not set up to automatically rebill every 30 days or at any other set time intervals. Suppliers can also check the EDI reports to verify claims were received and accepted or which claims may have rejected. If you are unsure how to check these reports, call EDI at 1-866-224-3094.

NAS appreciates your cooperation in avoiding duplicate billing. Doing so will help us process all claims more efficiently and cost-effectively so that timely payments can continue to be made.

# Alert Regarding Transition of Medigap Claim-Based Crossover Process

The Centers for Medicare & Medicaid Services (CMS) has made a decision to delay the use of the new Coordination of Benefits Agreement (COBA) Medigap claim-based identifiers on incoming Part B claims or claims for durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) until October 1, 2007. This represents a change from previous CMS direction issued in accordance with Transmittal 283, Change Request (CR) 5662, and the accompanying MLN Matters Article.

Because of the CMS delay, physicians and other suppliers shall inform their billing vendors not to include any newly assigned 5-byte COBA Medigap claim-based identifiers, as referenced at http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf, on incoming Medicare claims before October 1, 2007. If participating providers or suppliers include the newly assigned COBA Medigap claim-based ID on incoming claims before October 1, 2007, Medicare will **not** cross the claims over to the Medigap insurer.

Providers that use PC-Ace or other free billing Medicare software need to ensure this product is updated to reflect the newly assigned 5-byte COBA Medigap claim-based IDs but must ensure that the new identifiers will not be applied on incoming Medicare claims before October 1, 2007.

Effective with October 1, 2007, and as specified in Transmittal 283, CR 5662, physicians and other suppliers that bill using paper forms, i.e., those granted an exception for billing electronically under the Administrative Simplification Compliance Act (ASCA), shall include the

newly assigned 5-byte identifier (number will fall in the range 55000 through 59999) within item 9-D of incoming paper CMS-1500 claim forms. These providers should complete items 9A through 9D, in accordance with previous procedures, to ensure they will successfully trigger a Medigap claim-based crossover. Providers that are required to bill Medicare electronically using the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim shall include the newly assigned 5-byte only COBA Medigap claim-based ID (range=55000 to 59999) in field NM109 of the NM1 segment within the 2330B loop. Retail pharmacies that bill National Council for Prescription Drug Programs (NCPDP) batch claims to Medicare shall include the newly assigned Medigap identifier within field 301-C1 of the T04 segment of their incoming NCPDP claims.

## Clarification Concerning Provider Billing Procedures Related to Transition of Medigap Claim-Based Crossover Process to Coordination of Benefits Contractor on October 1, 2007

**MLN Matters Number: SE0743**

**Provider Types Affected**

Physicians and suppliers submitting claims to Part B Medicare contractors (including carriers, Medicare Administrative Contractors (A/B MACs), and durable medical equipment MACs (DME MACs).

**Provider Action Needed**

As instructed in *MLN Matters* article MM5601, all providers that bill their claims to Part B carriers, A/B MACs, or DMACs should, effective with October 1, 2007, begin to include a new Coordination of Benefits Agreement (COBA) Medigap 5-byte COBA ID (range 55000 to 59999) on incoming Medicare paper claims (CMS-1500), or incoming Health Insurance Portability and Accountability Act (HIPAA) 837 professional (version 4010A1), or National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 claims to trigger crossovers to those Medigap insurers that are participating in the Centers for Medicare & Medicaid Services (CMS) new COBA Medigap claim-based process.

Providers should be including **only** the new 5-byte COBA Medigap claim-based ID on incoming Medicare claims effective October 1, 2007, for the purpose of triggering crossovers to those Medigap insurers that have been assigned a COBA Medigap claim-based ID that falls in the range of 55000 through 59999. The link to the Medigap Billing ID spreadsheet, which providers or their billing vendors should consult for this purpose, remains as http://www.cms.hhs.gov/COBAgreement/Downloads/Medigap%20Claim-based%20COBA%20IDs%20for%20Billing%20Purpose.pdf on the CMS web site.

**Though the number of entities that have requested COBA Medigap claim-based IDs is currently not very large, providers and their billing vendors should continue to consult this listing for purposes of noting changes. Please be assured the list is complete and accurate**. Providers or their billing vendors should include **only** the Medigap COBA IDs on this list (range 55000 through 59999) on Medicare claims for purposes of triggering crossovers to Medigap insurers. Providers or their billing vendors should **not** include any of the eligibility file-based COBA IDs (ranges 00001-29999; 30000-54999; 60000-69999; 70000-79999; and 80000-89999) on inbound claims to Medicare.

Effective October 1, 2007, if a provider or its billing vendor files a Medicare claim with a COBA ID other than the COBA Medigap IDs on the above-referenced Medigap Billing ID list, Medicare will generate an MA-19 message on the provider's 835 electronic remittance advice (ERA) or other remittance advice in use. This message indicates: "Information was **not** sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer."

As a reminder, all entities that participate in the COBA eligibility file-based crossover process or automatic complementary crossover process may be referenced at http://www.cms.hhs.gov/COBAgreement/Downloads/Contacts.pdf on the CMS web site.

Providers should **not** contact those insurers or payers listed as participating in the automatic crossover process for purposes of determining whether CMS has assigned them a COBA Medigap claim-based ID. As aforementioned, providers or their billing vendors should also **not** utilize COBA ID information from this listing on their incoming Medicare claims for the purpose of triggering Medigap claim-based crossovers. **IMPORTANT**: Not every Medigap insurer is utilizing the automatic crossover process for the purpose of identifying **all** of its covered members or policyholders for crossover purposes and for receiving crossover claims for those Medicare beneficiaries. An example of this scenario is as follows: If the COBC was approached by a new Medigap insurer that specified that it needed to apply for a Medigap claim-based ID (range 55000 to 59999) for various segments of its covered membership, but will utilize the automatic complementary crossover process for the remainder of its Medigap membership, the COBC would, following execution of the COBA crossover agreement with the insurer, assign it two COBA IDs—one for automatic crossover (range 30000 to 54999 for automatic Medigap eligibility file-based crossover) and the other for Medigap claim-based crossover (55000 to 59999). Thus, this Medigap insurer would appear on **both** the listing of automatic crossover insurers as well as the Medigap Billing ID listing at the respective URL links on the COB web site, referenced above.

**Background**

All supplemental insurers are required to sign a national COBA crossover agreement with CMS' Coordination of Benefits Contractor (COBC) if they participate in CMS' automatic complementary crossover (COBA eligibility file-based crossover) process **or** in the COBA Medigap claim-based crossover process. Providers should know that it is **never** their responsibility to request or obtain new Medigap

5-byte IDs for their patients' Medigap insurers through the signing of a national COBA crossover agreement.

In *MLN Matters* article, MM5662, CMS informed its affected provider community that, during June through August 2007, its COBC would assign a new 5-byte COBA Medigap claim-based identifier (range=55000 to 59999) to a Medigap insurer after it has signed a national crossover agreement with the COBC. Despite repeated outreach communications to the health insurance industry, not all Medigap insurers have, as instructed, contacted the COBC to specify which approach, among three available options, they will exercise to ensure continued receipt of crossover claims on and after October 1, 2007.

The three (3) options available to each Medigap insurer for addressing its receipt of Medicare crossovers remain as follows:

- If applicable, continue to participate **fully** in the automatic crossover process (or COBA eligibility file-based crossover process) and discontinue use of any claim-based Medigap IDs;
- Continue to participate in part in the automatic crossover process for a segment of the insurer's covered membership but request a COBA Medigap claim-based ID through the COBC to address crossovers for the remaining segments; or
- Request a new COBA Medigap claim-based crossover ID through the COBC, with the understanding that the Medigap insurer would prefer **not** to participate in the automatic crossover process.

To be clear, if a Medigap insurer is currently participating **fully** in the automatic (or COBA eligibility file-based) crossover process, it merely needs to inform the COBC of this decision. Upon doing so, that Medigap insurer will experience no disruption in its receipt of crossover claims. Based upon its most recent review of trending, CMS has noted that the vast majority of the larger, more commonly known Medigap insurers, which were already participating **fully** in the Medicare automatic crossover process, have informed CMS and the COBC that they plan to continue to participate fully in the automatic crossover process for purposes of fulfilling their mandatory Medigap crossover payment responsibilities on behalf of their Medigap policyholders. In other words, the majority of the larger, more commonly known Medigap insurers have exercised option #1, above.

**Additional Information**

You can find *MLN Matters* articles MM5061 and MM5662 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5601.pdf and http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5662.pdf on the CMS web site.

# RARC and CARC Update

**MLN Matters Number: MM5721**
**Related Change Request (CR) #: 5721**
**Related CR Release Date: September 28, 2007**
**Related CR Transmittal #: R1345CP**
**Effective Date: October 1, 2007**
**Implementation Date: October 1, 2007**

**Provider Types Affected**

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

**Provider Action Needed**

CR 5721, from which this article is taken, announces the latest update of X12N 835 Health Care RARCs and X12N 835 and 837 Health Care CARCs, effective October 1, 2007. Be sure billing staff are aware of these changes.

**Background**

For transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice, there are two code sets – Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) – that must be used to report payment adjustments, appeal rights, and related information. Additionally, for transaction 837 coordination-of-benefits (COB), CARC must be used. These code sets are updated on a regular basis. Medicare contractors must use only currently valid codes, and make the necessary changes on a regular basis as per this recurring code update CR or the specific CR that describes the change in policy that resulted in the code change.

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

As mentioned earlier in CR 5634, at least one remark code must be used with the following 5 CARCs:

**16** - Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

**17** - Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided. (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

**96** - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

**125** - Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be

comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

**A1** - Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)

Both code lists are updated three times a year, and are posted at http://wpc-edi.com/codes on the Internet. Please note that in order to synchronize with the CARC update schedule, the RARC list will be updated in early November, March and July instead of the current schedule of early December, April and August. **The lists at the end of this article summarize the latest changes to these lists, as announced in CR 5721, to be effective on and after October 1, 2007 for Medicare**.

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

**Additional Information**

You can see the official instruction issued to you're A/B MAC, FI, carrier, DME MAC, or RHHI regarding these latest RARC and claim adjustment reason code updates by going to CR 5721, located at http://www.cms.hhs.gov/transmittals/downloads/R1345CP.pdf on the CMS web site.

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

**Remittance Advice Remark Code changes**

**New Remark Codes**

| Code | Current Narrative | Medicare Initiated |
|---|---|---|
| **N380** | The original claim has been processed, submit a corrected claim. | No |
| **N381** | Consult our contractual agreement for restrictions/ billing/payment information related to these charges. | No |
| **N382** | Missing/incomplete/invalid patient identifier. | No |
| **N383** | Services deemed cosmetic are not covered | No |
| **N384** | Records indicate that the referenced body part/tooth has been removed in a previous procedure. | No |
| **N385** | Payment has been adjusted because notification of admission was not timely according to published plan procedures. | No |
| **N386** | This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD. | Yes |
| **N387** | You should submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. | Yes |

**Modified Remark Codes**

The following codes have been identified as "Informational" codes, and modified to add the word "Alert" in front of the current text.

| | | | | |
|---|---|---|---|---|
| M4 | MA15 | N59 | N155 | N353 |
| M6 | MA18 | N84 | N156 | N355 |
| M9 | MA19 | N85 | N162 | N358 |
| M17 | MA26 | N88 | N177 | N360 |
| M27 | MA28 | N89 | N183 | N363 |
| M32 | MA44 | N130 | N185 | N364 |
| M39 | MA45 | N132 | N187 | N367 |
| M70 | MA59 | N133 | N189 | |
| M118 | MA62 | N134 | N196 | |
| MA01 | MA68 | N136 | N202 | |
| MA07 | MA72 | N137 | N210 | |
| MA08* | MA77 | N138 | N211 | |
| MA10 | N1 | N139 | N215 | |
| MA13 | N21 | N140 | N220 | |
| MA14 | N23 | N154 | N352 | |

*Code MA08 text has been modified further as follows:

| Old Text for MA08 | New Text for MA08 |
|---|---|
| You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare. | **Alert:** Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare. |

**NOTES**: Some remark codes may only provide general information that may not necessarily supplement the specific explanation provided through a reason code and in some cases another/other remark code(s) for an adjustment. Codes that are "Informational" will have "Alert" in the text to identify them as informational rather than explanatory codes. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated. An example of an informational code:

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

The above information is sent per state regulation but does not explain any adjustment. These informational codes should be used only if specific information about adjudication (like appeal rights) needs to be communicated but not as default codes.

**Deactivated Remark Codes**

| Code | Current Narrative | Notes |
|---|---|---|
| **N14** | Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount. | Deactivated effective 10/1/07. Consider using Reason Code 45 |
| **N361** | Payment adjusted based on multiple diagnostic imaging procedure rules | Deactivated effective 10/1/07. Consider using Reason Code 59 |

**X12 N Health Care Claim Adjustment Reason Code Changes**

**Explanation of Start, Last Modified, and Stop**

- **Start** - Every code has a start date. This is the date when the code was first available in the code list.
- **Last Modified** - When populated, this is the date of the code list release when the definition of the specific code was last modified by the committee. This date represents a point when the definition changed from one wording to another.
- **Stop** - When populated, this date identifies that the code can no longer be used in original business messages after that date. The code can only be used in derivative business messages (messages where the code is being reported from the original business message). For example, a CARC with a stop date of 02/01/2007 would not be able to be used by a health plan in a CAS segment in a claim payment/remittance advice transaction (835) dated after 02/01/2007 as part of an original claim adjudication. The code would still be able to be used after 02/01/2007 in derivative transactions, as long as the original usage was prior to 02/01/2007. Derivative transactions include: secondary or tertiary claims (837) from the provider or health plan to a secondary or tertiary health plan, an 835 from the original health plan to the provider as a reversal of the original adjudication. The deactivated code is usable in these derivative transactions because they are reporting on the valid usage (pre-deactivation) of the code in a previously generated 835 transaction.

**New Reason Codes**

| Code | Current Narrative | Notes |
|---|---|---|
| **202** | Payment adjusted due to non-covered personal comfort or convenience services. | Start: 02/28/2007 |
| **203** | Payment adjusted for discontinued or reduced service. | Start: 02/28/2007 |
| **204** | This service/equipment/drug is not covered under the patient's current benefit plan | Start: 02/28/2007 |
| **205** | Pharmacy discount card processing fee | Start: 07/09/2007 |
| **206** | NPI denial - missing | Start: 07/09/2007 |
| **207** | NPI denial - Invalid format | Start: 07/09/2007<br>Stop: 05/23/2008 |
| **208** | NPI denial - not matched | Start: 07/09/2007 |
| **209** | Per regulatory or other agreement, the provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use Group code OA) | Start: 07/09/2007 |
| **210** | Payment adjusted because pre-certification/authorization not received in a timely fashion | Start: 07/09/2007 |
| **211** | National Drug Codes (NDC) not eligible for rebate, are not covered. | Start: 07/09/2007 |

**Modified Reason Codes**

| Code | Current Narrative | Notes |
|---|---|---|
| **59** | Charges are adjusted based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) | Start: 01/01/1995<br>Last Modified: 02/28/2007 |
| **197** | Payment adjusted for absence of recertification/ authorization. This change effective 1/1/2008: Payment adjusted for absence of precertification/ authorization/notification. | Start: 10/31/2006<br>Last Modified: 07/09/2007 |

## BILLING CONT'D

| | | |
|---|---|---|
| **115** | Payment adjusted as procedure postponed or canceled. This change effective 1/1/2008: Payment adjusted as procedure postponed, canceled, or delayed. | Start: 01/01/1995<br>Last Modified: 07/09/2007 |
| **85** | Interest amount. This change effective 1/1/2008: Patient Interest Adjustment (Use Only Group code PR) Notes: only use when the payment of interest is the responsibility of the patient | Start: 01/01/1995<br>Last Modified: 07/09/2007 |

**Deactivated Reason Codes**

| Code | Current Narrative | Notes |
|---|---|---|
| **A2** | Contractual adjustment.<br>*Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code. The "Stop" date of 1/1/2008 may change.* | Start: 01/01/1995<br>Stop: **01/01/2008**<br>Last Modified: 02/28/2007 |
| **207** | NPI denial - Invalid format | Start: 07/09/2007<br>Stop: **05/23/2008** |

In addition, CR5721 contains a comprehensive list of deactivated reason codes. These codes have been deactivated prior to publication of CR5721 and have been included in previous CRs. Because of a policy change, the deactivation date may have moved from a specific version to a specific date. Contractors will not use any of these codes in any original business messages, but these codes may be used in derivative business messages (messages where the code is being reported from the original business message). This list can be viewed by accessing CR5721 at the Web address cited in the "Additional Information" section (above) of this article.

## CERT

# CERT Documentation

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

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

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

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

Mail all requested documentation to:

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

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

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

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

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

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

## FORMS

# Revised Instructions for Inquiry/ Redetermination and Reopening Form

The inquiry/redetermination and reopening form instructions have been revised to state "One request form per beneficiary, per claim." Suppliers do not need to submit a separate form for each service on a claim for which they are requesting a reopening or redetermination. Only one request form is needed for each claim, not for each service on the claim.

## EDI

# CSI/BE DDE Update

In order to obtain access to the Claim Status Inquiry (CSI) and/or Beneficiary Eligibility (BE) Direct Data Entry (DDE) system, the following steps must be taken. First, a signed EDI Enrollment Form and Jurisdiction D EDI Customer Profile must be on file with the Jurisdiction D EDI Department. The EDI department will then forward the request to the security team at Noridian Administrative Services. The security team will then send the Medicare Jurisdiction D DME MAC DDE/CSI User ID form to you. This form must be completed in order to obtain a user ID and password for access to the CSI and/or BE system. The form is located on the NAS web site using the following link: https://www.noridianmedicare.com/dme/forms/docs/dde_csi_user_id_form.pdf

Every individual associated with the supplier needing CSI/BE access must complete one of these forms with the supplier number(s) that will be used to access the CSI/BE via DDE. **NOTE:** Each individual will need their own ID; IDs can no longer be shared.

Effective October 9, for password resets or updates to current access, contact NAS security staff. If you have any questions regarding these changes or completing the DDE/CSI User ID form, please contact the NAS DME security staff:

Jasminka Keric 701-433-3135
Jolene Merrigan 701-433-3031

Questions can also be emailed to externalsecuritydme@noridian.com.

Please fax or mail all DDE/CSI User ID forms using the information listed below:

Noridian Administrative Services
Attn: DME Security Department
PO Box 6727
Fargo, ND 58106-9319
Fax #: 701-433-3388

If you have a question about using the CSI/BE via DDE or about transmitting claims to JURISDICTION D, please call the JURISDICTION D EDI helpdesk at 866-224-3094.

# New Feature on Jurisdiction D EDI Web site!

A section has been added to the Jurisdiction D EDI Web site titled NPI & EDI claims. This section has information to assist you in resolving claims that are rejected for issues surrounding your National Provider Identifier (NPI). This section contains NPI FAQs received in the EDI department, NPI Rejection Codes and links to CMS and the National Plan and Provider Enumeration System (NPPES) for additional NPI information.

Beginning October 29, 2007, Jurisdiction D will reject all claims submitted with invalid NPI numbers. The EDI department cannot make changes to data transmitted on the claim. In all cases, once a claim is rejected, for any reason, the claim has to be corrected and retransmitted.

If you have any additional questions, please contact the EDI Helpdesk at 866-224-3094.

# Healthcare Provider Taxonomy Codes Update for October 2007

This article provides notice to Medicare providers of modifications, additions and deletions to the Healthcare Provider Taxonomy Codes (HPTC) maintained by the National Uniform Claim Committee (NUCC) for standardized classification of healthcare providers. The NUCC updates the code set twice a year with changes effective April 1 and October 1.

**Background**

The HPTC list is available from the Washington Publishing Company (WPC) www.wpc-edi.com/codes/taxonomy in two forms. The first form is a free Adobe PDF download. The second form, available for purchase, is an electronic representation of the code set that facilitates automatic loading of the codes.

**Policy**

The Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities comply with the requirements in the electronic transaction format implementation guides adopted as national standards. The institutional and professional claim electronic standard implementation guides (X12 837-I and 837-P) each require use of valid codes contained in the HPTC set when there is a need to report provider type or physician, practitioner, or supplier specialty for a claim.

Valid HPTCs are those codes approved by the NUCC for current use. Terminated codes are not approved for use after a specific date and newly approved codes are not approved for use prior to the effective date of the code set update in which each new code first appears. Although the NUCC generally posts their updates on the WPC Web page three months prior to the effective date, changes are not effective until April 1 or October 1 as indicated in each update.

Specialty and/or provider type codes issued by any entity other than the NUCC are not valid and Medicare would be guilty of non-compliance with HIPAA if Medicare contractors accepted claims that contain invalid HPTCs. Taxonomy code changes are to be applied to claims processed on and after the implementation date of this change request.

## CODING

# Correct Billing for Q4093 and Q4094

NAS has received some questions on the appropriate modifiers to use for the new codes Q4093, the concentrated form of Albuterol or Levalbuterol and Q4094, the unit dose form of Albuterol or Levalbuterol. **Q4093 should be billed by itself, with no modifiers. Q4094 requires the usage of the KO modifier to indicate a single drug unit dose form.**

## CODING CONT'D

This follows the same instructions for billing J7611, J7612, J7613 and J7614 as referenced in the Nebulizers - Code Changes and Revised Billing Instructions article published in January 2007. The applicable sentece from this article follows:

The following is a list of codes for **FDA-approved** concentrate and unit dose inhalation solutions that will remain valid: J2545, J7608KO, **J7611, J7612, J7613KO, J7614KO**……

The code descriptions are listed below for reference:

**HCPCS Codes Not Payable for Dates of Service on or after July 1, 2007**

| HCPCS Code | Description |
|---|---|
| **J7611** | Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg |
| **J7612** | Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg |
| **J7613** | Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg |
| **J7614** | Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg |

**HCPCS Codes Payable for Services on or After July 1, 2007**

| HCPCS Code | Description |
|---|---|
| **Q4093** | Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol) |
| **Q4094** | Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (Albuterol) or per 0.5 mg (Levalbuterol) |

Suppliers are also reminded that for any unit dose form of a nebulizer drug, the KO modifier must be submitted. If the drug code is billed without a modifier or is billed with a KP or KQ modifier, the claim will be rejected or denied as unprocessable due to an invalid code or invalid procedure code/modifier combination.

## REIMBURSEMENT

# Quarterly October 2007 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

**MLN Matters Number: MM5710**
**Related Change Request (CR) #: 5710**
**Related CR Release Date: September 12, 2007**
**Related CR Transmittal #: R1334CP**
**Effective Date: October 1, 2007**
**Implementation Date: October 1, 2007**

**Provider Types Affected**

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

**Provider Action Needed**

This article is based on Change Request (CR) 5710, which informs Medicare providers of the availability of the October 2007 Average Sales Price (ASP) drug pricing file for Medicare Part B drugs as well as the revised January 2007, April 2007, July 2007 and October 2006 ASP payment files (**if CMS determines that revisions are necessary to the latter files**). CR5710 also advises Medicare providers that ASP Not Otherwise Classified (NOC) files will be available for retrieval from the CMS ASP webpage as well as the revised January 2007, April 2007, July 2007 and October 2006 ASP NOC files (**if CMS determines that revisions are necessary to the latter files**). Providers should make certain that your billing staffs are aware of these changes.

**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 Outpatient Prospective Payment System (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, DME MACs, FIs, A/B MACs, and/or RHHIs) with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis. CMS also posts these files to its web site at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/.

As announced in late 2006, CMS has been working further to ensure that more accurate and, as appropriate, separate

payment is made for single source drugs and biologicals under Section 1847A of the Social Security Act. As part of this effort, CMS reviewed how the terms "single source drug," "multiple source drug," and "biological product" are made operational in the context of payment under section 1847A. For the purposes of identifying "single source drugs" and "biological products" subject to payment under section 1847A, generally CMS (and its contractors) will utilize a multi-step process. CMS will consider:

- The Food and Drug Administration (FDA) approval,
- Therapeutic equivalents as determined by the FDA, and
- The date of first sale in the United States.

For a biological product (as evidenced by a new FDA Biologic License Application or other relevant FDA approval) or a single source drug (that is, not a drug for which there are two or more drug products that are rated as therapeutically equivalent in the most recent FDA Orange Book) first sold in the United States after October 1, 2003, the payment limit under Section 1847A for that biological product or single source drug will be based on the pricing information for products produced or distributed under the applicable FDA approval. As appropriate, a unique HCPCS code will be assigned to facilitate separate payment. Separate payment may also be made operational through use of existing specific HCPCS codes or "not otherwise classified" HCPCS codes.

**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 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 or the drug is furnished incident to a professional service. **The payment allowance limits were not 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 or the drug is furnished incident to a professional service.
- The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department and, then, is paid at reasonable cost.
- The payment allowance limits for drugs and biologicals 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 (or other application) approved by the FDA, are based on the published wholesale acquisition cost (WAC) or invoice pricing, except under OPPS where the payment allowance limit is 95 percent of the published AWP. The payment limit is 100 percent 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 and biologicals that are produced or distributed under a new drug application (or other new application) approved by the 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 of the WAC, or invoice pricing if the WAC is not published, except under OPPS where the payment allowance limit is 95 percent of the published AWP. 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. Medicare contractors determine payment limits for radiopharmaceuticals based on the methodology in place in November 2003 in the case of radiopharmaceuticals furnished in other than the hospital outpatient department. 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 September 18, 2007, the October 2007 ASP file will be available for download from the CMS ASP web site. If CMS determines that revisions are needed to the January 2007, April 2007, July 2007, and October 2006 ASP payment files, those revised files will also be available for retrieval from the CMS ASP webpage. 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 web site. These quarterly 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 for Claims Processed or Reprocessed on or after October 1, 2007 |
|---|---|
| October 2006 | October 1, 2006 through December 31, 2006 |
| January 2007 | January 1, 2007 through March 31, 2007 |
| April 2007 | April 1, 2007 through June 30, 2007 |
| July 2007 | July 1, 2007 through September 30, 2007 |
| October 2007 | October 1, 2007 through December 31, 2007 |

**Note: The absence or presence of a 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. Note that pricing for compounded drugs is done by your local Medicare contractor.

**Additional Information**

To see the official instruction (CR5710) issued to your Medicare carrier, FI, A/B MAC, DME MAC, or RHHI. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1334CP.pdf on the CMS web site.

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

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

**Provider Types Affected**

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

**Background**

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

Change Request (CR) 5740 provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2008. Payment on a reasonable charge basis is required for these items by regulations contained in 42 CFR 405.501 at: http://www.gpoaccess.gov/cfr/retrieve.html on the Internet. The 2008 payment limits for splints and casts will be based on the 2007 limits that were announced in CR 5382 last year, increased by 2.7 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2007. The MLN Matters article related to CR 5382 can be viewed at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5382.pdf on the CMS web site.

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

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

DME MACs will compute 2008 customary and prevailing charges for the codes identified in the following tables using actual charge data from July 1, 2006, through June 30, 2007. For these same codes, they will compute 2008 IIC amounts

## REIMBURSEMENT CONT'D

for the codes identified in the following tables that were not paid using gap-filled amounts in 2007. These tables are:

**Dialysis Supplies Billed With AX Modifier**

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

**Dialysis Supplies Billed Without AX Modifier**

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

**Dialysis Equipment Billed With AX Modifier**

| | | | |
|---|---|---|---|
| E0210NU | E1632 | E1637 | E1639 |

**Dialysis Equipment Billed Without AX Modifier**

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

Carriers and A/B MACs will make payment for splints and casts furnished in 2008 based on the lower of the actual charge or the payment limits established for these codes. **Contractors** will use the 2008 reasonable charges or the attached 2008 splints and casts payment limits to pay claims for items furnished from January 1, 2008 through December 31, 2008. **Those 2008 payment limits are in Attachment A at the end of this article**.

**Additional Information**

Detailed instructions for calculating:

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

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

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

**2007 Payment Limits for Splints and Casts**

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

## COVERAGE

# Repair and Replacement-Frequently Asked Questions

**Q1. Will Medicare pay for repairs to a piece of equipment that was obtained prior to the client being covered by Medicare?**

A1. The beneficiary must meet current Medicare reimbursement criteria for the equipment in order to be repaired if Medicare did not purchase the item. If it was obtained prior to Medicare coverage or if another payer purchased the equipment, the supplier must obtain the required documentation to verify coverage and to determine if the item is covered by a warranty.

**Q2. How is a product replaced prior to the 5-year life expectancy?**

A2. The replacement of a product before the 5-year life expectancy can only be done if the item is irreparably damaged, for example by a natural disaster such as fire, flood, etc. Replacement due to wear and tear before the 5-year lifetime is not covered. Refer to the September 2003 articles for additional information.

**Q3. For repairs, may travel time be charged using the A9900 procedure code for DME supply or A9270 non-covered service?**

A3. Travel time is included in the reimbursement of parts and labor and MAY NOT be paid separately. If a supplier chooses to bill separately, code A9901 (DME delivery, set-up, and/or dispensing service component of another HCPCS code) must be used. This code is autodenied as a CO denial. HCPCS code A9270 must not be used.

**Q4. Is a re-manufactured part with a warranty from the manufacturer considered new or used equipment?**

A4. A re-manufactured part with a warranty is considered used. It should be billed using the appropriate modifier, UE.

**Q5. A beneficiary is prescribed a new power wheelchair to replace his existing chair, which is eight years old. It is impossible to repair the old unit for less than 50% of the replacement allowable for a new chair. Assuming the repairs carry a limited warranty, would the patient ONLY qualify for repairs or would the 5-year useful lifetime apply?**

A5. If a chair has reached its 5-year life expectancy, the chair can be replaced. However, if a chair reaches its 5-year life expectancy, is in good working order, and meets the beneficiary's medical needs, it should not automatically be replaced.

# Refractive Lenses

**Hydrophilic (Soft) Contact Lenses – Coding Guidelines and Coverage**

Refractive lenses are prosthetic devices allowable for coverage under Medicare only when used to restore vision in the absence of a natural lens, either due to surgical removal or congenital absence, and only with a physician's written order. Coverage is limited to diagnosis of pseudophalka (condition resulting from surgical removal of the lens and replacement with an intraocular lens - ICD-9 V43.1), acquired aphakia (condition resulting from surgical removal of the lens without replacement with an intraocular lens - ICD-9 379.31) and congenital aphakia (ICD-9 743.35). Lenses provided for other diagnosis are noncovered and will be denied.

Refractive lenses are covered even though the surgical removal of the natural lens occurred before Medicare entitlement.

Coverage for Medicare beneficiaries with pseudophakia (ICD-9 V43.1) is limited to one pair of eyeglasses or contact lenses following removal of natural lens due to disease (cataract) or injury, and replacement of that lens with an Intraocular Lens (IOL). Replacement frames, eyeglass lenses and contact lenses are noncovered. (See the Refractive Lens LCD and LCD Article for more detail regarding this coverage.)

Coverage for Medicare beneficiaries with aphakia (ICD-9 379.31, 743.35) is limited to the following lenses or combinations of lenses when determined to be medically necessary:

- Bifocal lenses in frames; or
- Lenses in frames for far vision and lenses in frames for near vision; or
- When a contact lens(es) for far vision is prescribed (including cases of binocular and monocular aphakia), payment will be made for the contact lens(es), and lens(es) in frames for near vision to be worn at the same time as the contact lens(es) and lenses in frames to be worn when the contacts have been removed.

Hydrophilic (soft) contact lenses (V2520 – V2523) are available with varying degrees of durability, (e.g., daily change, weekly, monthly, etc). One unit of service for hydrophilic contact lenses (V2520 – V2523) describes a one-year supply of lenses for one eye for a specific refraction. The year's supply of contact lenses includes routine replacement of the lenses as well as replacements due to torn lenses. Claims for additional units of service for the same eye and same refraction within one year after the initial date of service would be denied as not separately payable.

If there is a change in refraction, a new supply of lenses is covered for patients who are aphakic (i.e., who have had a cataract removed but do not have an implanted intraocular lens [IOL] or who have congenital absence of the lens). However, a new supply of lenses is not covered for patients who are pseudophakic (i.e., who have an IOL) because of statutory limits of coverage.

When hydrophilic soft contact lenses (V2520–V2523) are used as a corneal dressing or bandage for the treatment of acute or chronic corneal pathology, (bullous keratopathy, dry eyes, corneal ulcers, keratitis, etc), they will be denied as noncovered because they do not meet the definition of a prosthetic device in this situation.

See the Refractive Lens LCD and Policy Article for more detail regarding coverage, coding, and documentation requirements for Refractive Lenses.

## COVERAGE CONT'D

# Medicare Clinical Trial Policy

**MLN Matters Number: MM5719**
**Related Change Request (CR) #: 5719**
**Related CR Release Date: September 7, 2007**
**Related CR Transmittal #: R74NCD**
**Effective Date: July 9, 2007**
**Implementation Date: October 9, 2007**

**Provider Types Affected**

All physicians, providers, and suppliers who submit claims related to clinical trials to Medicare contractors (carriers, Medicare Administrative Contractors (A/B MACs), durable medical equipment Medicare Administrative Contractors (DME/MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs)).

**Provider Action Needed**

This article is based on Change Request (CR) 5719, which implements two changes to the 2000 clinical trial policy by: (1) modifying for clarity the language describing coverage of an investigational item/service in the context of a clinical trial, and, (2) adopting coverage with evidence development (CED). The remainder of the 2000 clinical trials policy continues without change.

CR 5719 states that for items and services furnished on and after July 9, 2007, the routine costs of a clinical trial include all items and services that are otherwise generally available to Medicare beneficiaries (i.e., there exists a benefit category, it is not statutorily excluded, and there is not a national non-coverage decision) that are provided in either the experimental or the control arms of a clinical trial. The investigational item or service itself is excluded, *unless otherwise covered outside of the clinical trial*.

In addition, the National Coverage Determination (NCD) is revised to add coverage with evidence development (CED). CED is for items and services in clinical research trials for which there is some evidence of significant medical benefit, but for which there is insufficient evidence to support a "reasonable and necessary" determination. CED is determined through the NCD process, and conditional upon meeting standards of patient safety and clinical evidence, items and services not otherwise covered would be considered "reasonable and necessary" in the context of a clinical trial. Coverage determined under CED is implemented via subsequent NCDs, CRs, and *MLN Matters* articles specific to the coverage issue.

Make certain your billing staffs are aware of these changes. Medicare contractors will adjust claims processed prior to the implementation date of this change if you bring such claims to their attention.

**Background**

On June 7, 2000, the President of the United States issued an executive memorandum directing the Secretary of Health and Human Services to "explicitly authorize [Medicare] payment for routine patient care costs and costs due to medical complications associated with participation in clinical trials." In keeping with the President's directive, the Centers for Medicare & Medicaid Services (CMS) engaged in defining the routine costs of clinical trials and identifying the clinical trials for which payment for such routine costs should be made. On September 19, 2000, CMS implemented its initial Clinical Trial Policy through the NCD process. On July 10, 2006, CMS opened a reconsideration of its NCD on clinical trials in the NCD Manual, section 310.1. CR5719 communicates the findings resulting from that analysis.

**Additional Information**

To see the official instruction (CR5719) issued to your Medicare FI, carrier, DME/MAC, RHHI or A/B MAC, visit http://www.cms.hhs.gov/transmittals/downloads/R74NCD.pdf on the CMS web site.

## OXYGEN

# Oxygen Reminders Clarification

On September 6, NAS published the following statement as part of an Oxygen Reminders article.

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

After further consideration of this topic, NAS is retracting the above statement and will continue to allow a revised CMN to be submitted when adding portable oxygen equipment, when a CMN has already been submitted for stationary oxygen equipment. A recertification CMN will not be required for the portable oxygen, if the stationary has been recertified.

NAS will, however, deny a revised oxygen CMN and related claims if question 4 is marked as D, signifying that portable oxygen is not being ordered. Suppliers are encouraged to verify this response and clarify with the ordering provider to ensure that this question is marked correctly when revising the oxygen CMN to add portable oxygen.

**Original Article:**

**Oxygen Policy Reminders**

Please note the following reminders when billing for oxygen and oxygen equipment to Jurisdiction D:

- The blood gas study reported on the Initial CMN must be the most recent study obtained prior to the Initial Date and this study must be obtained within 30 days prior to that Initial Date. There is an exception for patients who were on a Medicare HMO and transferred to fee-for-service Medicare. For those patients, the blood gas study does not have to be obtained 30 days prior to the Initial Date, but must be the most recent test obtained while in the HMO.

## OXYGEN CONT'D

- A break in service refers to a break in monthly billing. A change in medical condition means that the patient's condition changed to the point they no longer require the oxygen. A patient may have a break in service yet have no change in medical condition and still require the oxygen. An example of this would be if the patient were admitted into a SNF, hospital or Medicare HMO. For patients who have a break in service of at least 60 days due to a change in their medical condition and then subsequently require oxygen, a **new Initial CMN** will be required. The "new" initial CMN will reject if submitted electronically, however, the claim will suspend for missing a CMN. If there is a comment of BIS and the reason why in the narrative section of the claim, NAS claims staff will add the "new" initial CMN information into the claims processing system. If the break in service is 60 days or greater with no change in their medical condition or if the break in service is 60 days or less regardless of the change in medical condition, a new Initial CMN is **not** required.
- If a patient initially qualifies for oxygen based on a test taken during sleep, portable oxygen is denied as not medically necessary. If the patient is later tested during exercise or at rest, a new initial CMN and recertification CMN will be required for the portable system. If the initial CMN date for the stationary equipment is within 90 days of the initial date for the portable system, the recertification for the stationary can also cover the recertification on the portable. Otherwise, a separate recertification will be required for portable oxygen.
- Effective July 1, 2007 the old oxygen CMN is no longer accepted. The correct version is Form CMS-484 (09/05). When transmitting this new version electronically, note the answers for question 2 have changed. Question 4 from the old version has been eliminated. For additional questions regarding electronic transmission/mapping for the revised CMNs, call the EDI Help Desk at 1-866-224-3094, between 8 am - 5 pm CT.

Refer to the Documentation section of the Local Coverage Determination for Oxygen and Oxygen Equipment for additional information on when to submit an Initial, Recertified or Revised CMN at www.edssafeguardservices.eds-gov.com/providers/dme/lcdcurrent.asp.

## WHEELCHAIR/POWER MOBILITY DEVICE

# FAQs – Power Mobility Devices – July 2007

**Q1. Can a form that is developed by an entity other than the supplier (e.g., the Power Mobility Device [PMD] evaluation forms that have been developed by the Texas Academy of Family Practitioners) and that is completed and signed by the physician and included in the patient's chart be considered sufficient documentation of the required face-to-face examination for PMDs?**

A1. No. As stated in the Documentation Requirements section of the PMD Local Coverage Determination (LCD), physicians must document the face-to-face examination "in a detailed narrative note in their charts in the format that they use for other entries." Forms that are developed by other entities including but not limited to a supplier or professional association do not meet this requirement. Therefore, they are not sufficient by themselves to document that coverage criteria have been met. If a form is used, there must be documentation in the patient's medical record that corroborates the information on the form and verifies that coverage criteria have been met.

**Q2. A supplier pays a physical therapist (PT) or occupational therapist (OT) to do wheelchair evaluations of non-Medicare patients (e.g., Medicaid only, commercial insurance). The PT or OT performs an evaluation on a Medicare patient and the supplier does not pay the PT/OT for that evaluation. Does Medicare consider that therapist to have a "financial relationship" with the supplier in the context of the Power Mobility Devices policy?**

A2. Yes. In the situation that is described, the PT/OT is considered to have a financial relationship with the supplier. Therefore, even though the supplier does not pay the therapist for the evaluation of the Medicare patient, the evaluation of that patient cannot be considered part of the required face-to-face examination for all PMDs or the required specialty evaluation for rehab PMDs (Group 2 single and multiple power options power wheelchairs [PWCs], all Group 3 and Group 4 PWCs, and push-rim activated power assist devices for manual wheelchairs).

**Q3. Can a physical therapy assistant (PTA) or an occupational therapy assistant (OTA) who is RESNA-certified as an Assistive Technology Practitioner (ATP) provide the specialty evaluation that is required for rehab PMDs that are provided on or after April 1, 2008?**

A3. No. As with all professional services, the evaluation must be within the scope of practice of the health care provider as defined by state professional practice laws. Independent evaluations are not within the scope of practice of PTAs and OTAs.

# Power Mobility Devices-Frequently Asked Questions – October 2007

**Q1. Must the face-to-face order and the detailed product description always be two separate documents in an audit for power mobility devices?**

A1. Yes, the seven-element order specified in the Medicare Modernization Act and the detailed product description (DPD) must always be two separate pieces of paper. The seven-element order is a document that is written by the physician after completion of the face-to-face examination. The DPD is a document that is prepared by the supplier and sent to the physician AFTER the supplier receives the seven-element order and the report of the face-to-face examination from the physician.

Some suppliers refer to a prescription, given at the time of the initial office visit for a mobility evaluation, as the "face-to-face

order." This prescription seems based on the concept of the "dispensing order" that is applicable to other DME items. For Power Mobility Devices (PMDs), a dispensing order is not applicable based upon the statutory requirements for the seven-element order.

**Q2. May a supplier format the seven-element order upon receipt of a verbal order for power mobility and have the physician sign and date?**

A2. No, a supplier cannot draft a form or template to have the physician date and sign. The physician must write, sign, and date the seven-element order. The supplier can draft instructions about the requirements for the seven-element order to help educate the physician. However, suppliers cannot complete the information required in the order. As described in the previous question, no verbal dispensing orders are acceptable.

**Q3. A physician writes an order for "power wheelchair" but the client only qualifies for a scooter. Does the supplier need to get a new order for the scooter or will the home assessment and detailed product description substantiate why the patient received a scooter?**

A3. Yes, in the scenario described, the supplier would need to obtain a new seven-element order from the physician. Because the supplier is providing an item that meets Medicare coverage criteria (i.e., a POV), the seven-element order must address this item in order for the item to be covered.

In the scenario described, if the seven-element order were more general (e.g., "power mobility device"), then a new order would not be required, and the detailed product description would be sufficient to indicate physician agreement with a POV.

Given a different scenario in which the seven-element order indicated a POV and this met the coverage criteria, a new order would not be required if the supplier provided a power wheelchair. In that scenario, the supplier must bill for the power wheelchair using the "upgrade" instructions.

**Q4. If Dr. "A" performs a face-to-face assessment and orders a PT/OT evaluation and the PT/OT evaluation is sent back to Dr. A for concurrence but Dr. A is on vacation for two weeks, must we wait for Dr. A to return, or may another physician within the practice sign for the prescribing physician?**

A4. If a doctor involved in a practice is on vacation, another doctor within the practice can sign the OT/PT assessment; however, there should be a notation in the patient chart indicating why a different physician is completing the information rather than the prescribing physician.

**Q5. Can the supplier facilitate the PT/OT evaluation when the physician faxes the request for PT/OT evaluation to the supplier?**

A5. The physician must see the patient prior to writing an order for PMD. The physician should take care of the referral directly. If the supplier receives the PT/OT order, they may pass it along to the physician-selected therapist. The supplier should NOT choose the therapist. In addition, the supplier may not tell the PT/OT what to write in the evaluation.

**Q6. If a supplier does an "internal audit" and discovers there is missing patient chart information, may the physician draft a statement on letterhead or on a script pad and add it to the chart?**

A6. No, information must be contained within the patient chart record and cannot be done as an addendum to the medical record at a later point in time due to an internal audit. It is inappropriate to amend or modify the medical record "after the fact."

**Q7. If a new PMD is needed after five years of use, what documentation must be obtained? Must we start the complete process or just obtain a new order?**

A7. All new PMD requirements must be met. Many new products are available, the codes have changed, and a patient's functional status must be assessed through a face-to-face evaluation in order to establish need.

**Q8. What is reported as the date of the face-to-face examination if the examination involves more than one visit?**

A8. The face-to-face (FTF) examination process may involve more than one visit to one or more clinicians. If so, the date of the FTF examination that is entered on the seven-element order by the physician is the date of completion of the FTF examination.

The following is a common scenario: A physician sees a patient to begin the FTF examination and then refers the patient to a physical therapist (PT) or occupational therapist (OT) to perform another part of the examination. The physician receives and reviews the report from the PT/OT, indicates agreement or disagreement on the report, and then signs and dates the report. In this scenario, the date that the physician signs and dates the report is considered the date of completion of the FTF examination. That signature date is the date that the physician enters on the seven-element order as the date of the FTF examination, not the original date that the physician initially saw the patient to begin the process.

**Q9. Is the "specialty evaluation" that is required for rehab power wheelchairs considered to be part of the face-to-face examination?**

A9. No, the "specialty evaluation" that is described in the Power Mobility Devices LCD is considered a separate component in documenting the medical necessity of a rehab power wheelchair (PWC). (A rehab PWC is a Group 2 Single Power Option or Multiple Power Option PWC, a Group 3 or Group 4 PWC, or a push-rim activated power assist device.) The purpose of the FTF examination is to document the medical necessity for either a power-operated vehicle (POV) or a power wheelchair. The purpose of the "specialty evaluation" is to document the medical necessity for a specific rehab-type PWC base and its special features (e.g., power seating system, alternative drive control interface, etc.). In a case in which the physician sees a patient who needs a rehab PWC to begin the face-to-face examination and then refers the patient to a PT/OT to perform another part of the FTF exam, the PT/OT will typically also perform the specialty evaluation during that visit. In this situation, it is acceptable for the PT/OT to include the FTF exam components and the specialty evaluation components on the same report.

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