Jurisdiction D News from Noridian Administrative Services, LLC.

# Happenings

September 2007
Issue No. 7

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



## In This Issue…



## FYI



## EDUCATIONAL



## NPI

## REMINDERS



## CLAIM FORM



## BILLING



## FRAUD/ABUSE



## CERT



## APPEALS



## ENROLLMENT



## FORMS



## COVERAGE



## WHEELCHAIR/POWER MOBILITY DEVICE

# Alphabetical Listing...

# Jurisdiction D DME MAC Supplier Contacts and Resources

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

| | |
|---|---|
| Columbus Day* | October 8, 2007 |
| Veterans Day* | November 12 (Observed) |
| Thanksgiving | November 22 and 23 |
| Christmas Day | December 24 and 25 |

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

## Sources for "Jurisdiction D Happenings" Articles

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

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

## Summary of Supplier Manual Updates

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

| Chapter | Subheading | Supplier Manual Update | Change Date |
|---|---|---|---|
| Chapter 13 | Redeterminations/ Reopenings | Added fax number and instructions for faxing redetermination and reopening requests | 8/20/07 |
| Chapter 15 | DME MACs | Revised EDI contact name | 7/31/07 |
| Chapter 16 | Level II HCPCS Codes | Revised L0430 code description | 7/19/07 |

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."

## IVR Usage

To provide an efficient and more streamlined service to you as a supplier, CMS and NAS encourage DME suppliers to use the Interactive Voice Response (IVR). The specific services for which NAS strongly encourages suppliers to use the IVR include:

- Part A/B beneficiary eligibility
- Claim status
- Deductible status
- Check status
- Check history

Hours of availability for the services identified above are:

- Monday – Friday, 6:00 am – 8:00 pm CT

The IVR is available 24/7 to provide callers with the following general services:

- Reference telephone numbers
- DME addresses
- Redetermination information
- CERT information
- Hours of operation

The IVR telephone number is 1-877-320-0390.

IVR instructions are available at www.noridianmedicare.com/dme/contact/docs/ivr_guide.pdf on the NAS DME web site.

It is very important suppliers report errors or problems with the IVR to the Supplier Contact Center at 1-866-243-7272 immediately so NAS can troubleshoot the issue and report this to our technical staff.

## Timeliness Standards for Processing 'Other-Than-Clean' Claims

**MLN Matters Number: MM5513**
**Related Change Request (CR) #: 5513**
**Related CR Release Date: July 20, 2007**
**Related CR Transmittal #: R1312CP**
**Effective Date: January 1, 2008**
**Implementation Date: January 7, 2008**

**Provider Types Affected**

Providers and suppliers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative Contractors (DME 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) 5513 which implements requirements for timeliness standards for processing other-than-clean claims. The article is informational in nature and requires no action on your part.

The Centers for Medicare & Medicaid Services (CMS) published instructions in a separate transmittal to implement requirements for all carriers and Medicare Administrative Contractors (MACs) for timeliness standards for processing other-than-clean claims, and CR5513 implements those same requirements for FIs, A/B MACs, DME MACs, and RHHIs, effective for claims received on or after January 1, 2008.

**Background**

The Social Security Act (Section 1869(a)(2); http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) mandates that Medicare process all "other-than-clean" claims and notify the provider/supplier filing such claims of the determination within 45 days of receiving such claims. The Social Security Act (Section 1869; http://www.ssa.gov/OP_Home/ssact/title18/1869.htm) further defines the term "clean claim" as meaning "a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this title." Claims that do not meet the definition of "clean" claims are "other-than-clean" claims, and they require investigation or development external to the contractor's Medicare operation on a prepayment basis.

A Medicare contractor should process all "other-than-clean" claims and notify the provider and beneficiary of their determination within 45 calendar days of receipt. (See Medicare Claims Processing Manual, Publication 100-4, Chapter 1, Section 80.2.1 for the definition of "receipt date" and for timeliness standards for clean claims; http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf)

However, when the Medicare contractor develops the 'other-than-clean' claim by asking the provider/supplier or beneficiary for additional information, the Medicare contractor should cease counting the 45 calendar days on the day that the Medicare contractor sends the development letter to the provider/supplier and/or beneficiary. Upon receiving the materials requested in the development letter from the provider/supplier and/or beneficiary, the Medicare contractor should resume counting the 45 calendar days.

**EXAMPLE:**

A Medicare contractor receives a claim on June 1st, but does not send a development letter to the provider/supplier/ and/or beneficiary until June 5th. In this example, 5 of the 45 allotted calendar days will have already passed before the Medicare contractor requested the additional information. Upon receiving the information back from the provider/supplier and/or beneficiary, the Medicare contractor has 40 calendar days left to process the claim and notify the individual that filed the claim of the payment determination for that claim.

Medicare contractors should follow existing procedures relative to both 1) the length of time the provider/supplier and/or beneficiary is afforded the opportunity to return information requested in the development letters and 2) situations where the provider/supplier and or beneficiary does not respond.

This timeliness standard does not apply:

- Where the Social Security Administration blocks a beneficiary's Health Insurance Claim Number (HIC);
- Where there is a problem with the beneficiary's record in Medicare's files are not subject to this instruction;
- Where the claim is rejected by the translator software;
- Where CMS instructs Medicare contractors to hold certain claims for processing, e.g., while system changes are being made to handle such claims correctly; or
- To claims submitted by a hospice and these claims are to be processed per instructions in the Medicare Claims Processing Manual (Chapter 1, Section 50.2.3; http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf)

**Additional Information**

The official instruction, CR5513, issued to your FI, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1312CP.pdf on the CMS web site.

## Electronic Funds Transfer Standardizations and Revisions to Medicare Claims Processing Manual (Chapter 24)

**MLN Matters Number: MM5586**
**Related Change Request (CR) #: 5586**
**Related CR Release Date: July 9, 2007**
**Related CR Transmittal #: R1284CP**
**Effective Date: July 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), Fiscal Intermediaries (FIs), Part

## FYI CONT'D

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) 5586 which revises the *Medicare Claims Processing Manual*, Chapter 24 (General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims).

Effective July 1, 2007, your Medicare contractor will conduct Administrative Simplification Compliance Act (ASCA) reviews annually of at least 20% of providers submitting CMS 1500 paper claims who were not already reviewed in the past 2 years and found to have fewer than 10 FTEs employed by the practice. In addition, contractors will insure that the addenda record is sent with the Medicare claim payment when an ACH format is used to transmit an EFT payment to a financial institution but the remittance advice is separately transmitted to a provider. This will assist with reconciliation of the payment and the information that explains the payment. The EFT format will be the National Automated Clearinghouse Association (NACHA) format CCP - Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) as mentioned in the X12N 835 version 004010A1 implementation guide.

**Background**

Change Request (CR) 5586 provides the following revisions to the *Medicare Claims Processing Manua*l (Chapter 24, Sections 40.7 and Section 90.5.3) regarding electronic funds transfer (EFT) and the identification of providers to be reviewed.

**Contractor Roles in Administrative Simplification Compliance Act (ASCA) Reviews and Identification of Providers to be Reviewed**

Each carrier, DME MAC and B MAC (not FIs or RHHIs at this time) conducts an ASCA review annually of 20% of those providers still submitting CMS 1500 paper claims. Medicare contractors will not select a provider for a quarterly review if:

- A prior quarter review is underway and has not yet been completed for that provider;
- The provider has been reviewed within the past two years, determined to be a "small" provider as fewer than 10 FTEs are employed in that practice and there is no reason to expect the provider's "small" status will change within two years of the start of the prior review; or
- Fewer than 30 paper claims were submitted by the provider to Medicare during the prior quarter.

**Electronic Funds Transfer (EFT)**

Although EFT is not mandated by the Health Insurance Portability and Accountability Act (HIPAA), EFT is the required method of Medicare payment for all providers entering the Medicare program for the first time and any existing providers, not currently receiving payments by EFT, who are submitting a change to their existing enrollment data. Providers must submit a signed copy of Form CMS-588 (Electronic Funds Transfer Authorization Agreement) to their Carriers, DME MACs, A/B MACs, FIs, and/or RHHIs. For changes of information, DME MACs will verify the authorized official on the CMS-855 form. In addition, Medicare contractors will not approve any requests to change the payment method from EFT to check.

Carriers, DME MACs, A/B MACs, FIs and RHHIs must use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an X12 835 transaction, then the NACHA format CCP (Cash Concentration/Disbursement plus Addenda –CCD+) is used to make sure that the addenda record is sent with the EFT, because providers need the addenda record to re-associate dollars with data. Carriers, DME MACs, A/B MACs, FIs, and RHHIs must:

- Transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim, and
- Designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

**Note: Medicare contractors will not approve any requests to change payment method from EFT to check.**

**Additional Information**

The official instruction, CR5586, issued to your carrier, intermediary, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R1284CP.pdf on the CMS web site.

# Revision to Medicare Publication 100-09, Chapter 3 – Provider Inquiries and Chapter 6 - Provider Customer Service Program Updates

**MLN Matters Number: MM5597 Revised**
**Related Change Request (CR) #: 5597**
**Related CR Release Date: July 13, 2007**
**Related CR Transmittal #: R20COM**
**Effective Date: May 23, 2007**
**Implementation Date: July 30, 2007**

**Note**: This article was revised on July 16, 2007, to reflect changes that CMS made to CR5597. The transmittal number, CR release date, and the Web address for accessing CR5597 were changed. All other information remains the same.

**Provider Types Affected**

All physicians, suppliers, and providers who submit written inquiries to, or contact the toll-free lines at, their Medicare contractors [fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), DME Medicare Administrative Contractors (DME/MACs), and/or regional home health intermediaries (RHHIs).]

**Provider Action Needed**

CR5597 contains a number of revisions to the *Medicare Contractor Beneficiary and Provider Communications Manual*, including changes for authenticating providers

who make inquiries of Medicare contractors. Due to the Medicare fee-for-service contingency plan for the National Provider Identifier (NPI), the NPI will not be a required authentication element for general provider telephone and written inquiries until the date that the Centers for Medicare & Medicaid Services (CMS) requires it to be on all claim transactions. In this contingency environment, the provider transaction access number (PTAN) is your current legacy provider identification number. Your PTAN, which may be referred to as your legacy number by some Medicare fee-for-service provider contact centers (PCCs), will be the required authentication element for all inquiries to Interactive Voice Response (IVR) systems, customer service representatives (CSRs), and written inquiry units. **While the authentication rules are part of CR5597, for complete details about these rules under the Medicare NPI contingency plan, see *MLN Matters* article SE0721**, which you will find at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0721.pdf on the CMS web site.

**The remainder of this article provides information on the highlights of changes announced in CR5597.**

**Background**

CR5597 modifies *Medicare Contractor Beneficiary and Provider Communications Manual,* Publication 100-09. These changes are summarized as follows:

**Overlapping Claims—New Rules**

- Medicare often receives multiple claims for the same beneficiary with the same or similar dates of service. An overlap occurs when the date of service or billing period of one claim seems to conflict with the date on another claim, indicating that one of the claims may be incorrect.
- When an inquiry regarding an overlapping claim is received, only the Medicare contractor initially contacted by the provider can authenticate the provider. The provider will be authenticated by verifying the name, PTAN/ legacy number or NPI, beneficiary name, Health Insurance Claim Number (HICN), and date of service for post-claim information, or date of birth for pre-claim information. Authentication does not need to be repeated when the second contractor is contacted.
- Contractors shall release overlapping claim information whether a provider inquires about a claim that was rejected for overlapping information, or if the provider found overlapping information when checking eligibility for a new admittance.
- For specific information regarding the resolution of claims rejected by Medicare's Common Working File (CWF) system, refer to the *Medicare Claims Processing Manual*, Chapter 27, §50 at http://www.cms.hhs.gov/manuals/downloads/clm104c27.pdf on the CMS web site.

**Information Available on the IVR**

- **USE THE IVR whenever possible**. Providers should be aware that if a request for claim status or eligibility is received by a CSR or written inquiry correspondent and the requested information is available on the IVR, the CSR/correspondent will probably encourage you to use the self-service options that are available.
- If at any time during a telephone inquiry, you request information that can be found on the IVR the CSR will most likely refer you back to the IVR.

**Information Available on the Remittance Advice (RA)**

- **USE THE RA whenever possible.** If a CSR or written inquiry correspondent receives an inquiry about information that is available on an RA, the CSR/correspondent will discuss with the inquirer how to read the RA in order to independently find the needed information. The CSR/correspondent will inform the inquirer that the RA is necessary in order to answer any specific questions for which the answers are available on the RA. Providers should also be aware that any billing staff or representatives that make inquiries on his/her behalf will need to have a copy of the RA.
- To make your job easier you may use the Medicare Remit Easy Print (MREP) software. Information about MREP is available at: http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp on the CMS web site.
- Providers may also take advantage of national training materials available to educate themselves and their representatives about reading an RA. The national training materials include the MLN product, *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* which is available at http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf on the CMS web site.
- Also available is a web site that serves as a resource allowing providers to check the definitions of *Claim Adjustment Reason Codes and Remittance Advice Remark Codes*. This information is available at http://www.wpc-edi.com/products/codelists/alertservice on the Washington Publishing Company web site.
- There is a web-based training course, *Understanding the Remittance Advice for Professional Provider*s, which is available at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1 on the CMS web site. The course provides continuing education credits and contains general information about RAs, instructions to help interpret the RA received from Medicare and reconcile it against submitted claims, instructions for reading Electronic Remittance Advices (ERAs) and Standard Paper Remittance Advices, and an overview of the MREP software that Medicare provides free to providers for viewing ERAs.

**Authentication of Beneficiary Elements—additions to current rules.**

CR5597 contains, within its attachments, a detailed table showing the data elements that are released in response to provider inquiries for beneficiary information. A key new provision allows Medicare contractors to release abdominal aortic aneurysm screening information to providers. CR5597 is available at http://www.cms.hhs.gov/Transmittals/downloads/R20COM.pdf on the CMS web site.

## FYI CONT'D

**Additional Key Points of CR5597**

- Medicare's CSRs have the discretion to end a provider telephone inquiry if the caller places them on hold for two minutes or longer. Where possible, the CSR will give prior notice that a disconnection may occur.
- If a provider requests a copy of the Report of Contact made during a telephone response to a written inquiry, Medicare contractors will send you a letter detailing the discussion. This letter may be sent to you by e-mail or fax, if you request, unless the details include specific beneficiary or claim related information.
- When your Medicare contractor schedules a training event for which there is a charge for attendance and you register and pay, but are unable to attend, you may be entitled to a refund of some or all of your payment. But, to receive such a refund, **you must notify the contractor before the event**.

**Additional Information**

For complete details regarding this Change Request (CR) please see the official instruction (CR5597) 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/R20COM.pdf on the CMS web site.

# Clarification About Medical Privacy of Protected Health Information

**MLN Matters Number: SE0726**

**Provider Types Affected**

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

**Provider Action Needed**

The purpose of this Special Edition (SE) article, SE0726, is be sure that heath care providers are aware of the helpful guidance and technical assistance materials the U.S. Department of Health and Human Services (HHS) has published to clarify the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), specifically, the educational material below. Remind individuals within your organization of:

- the Privacy Rule's protections for personal health information held by providers and the rights given to patients, who may be assisted by their caregivers and others, and
- that providers are permitted to disclose personal health information needed for patient care and other important purposes.

**HHS Privacy Guidance**

HHS' educational materials include a letter to health care providers with the following examples to clarify the Privacy Rule:

**HIPAA does not require patients to sign consent forms before doctors, hospitals, or ambulances can share information for treatment purposes:**

Providers can freely share information with other providers where treatment is concerned, without getting a signed patient authorization or jumping through other hoops. Clear guidance on this topic can be found in a number of places:

- Review the answers to frequently asked questions (FAQs) in the "Treatment/Payment/Health Care Operations" subcategory, or search the FAQs on a likely word or phrase such as "treatment." The link to the FAQs may be found at http://www.hhs.gov/hipaafaq/ on the HHS web site.
- Consult the Fact Sheet, "Uses and Disclosures for Treatment, Payment, and Health Care Operations," which is at http://www.hhs.gov/ocr/hipaa/guidelines/sharingfortpo.pdf on the HHS web site.
- Review the "Summary of the HIPAA Privacy Rule" at http://www.hhs.gov/ocr/privacysummary.pdf on the HHS web site.

**HIPAA does not require providers to eliminate all incidental disclosures:**

- The Privacy Rule recognizes that it is not practicable to eliminate all risk of incidental disclosures. That is why, in August 2002, HHS adopted specific modifications to that Rule to clarify that incidental disclosures do not violate the Privacy Rule when providers and other covered entities have common sense policies which reasonably safeguard and appropriately limit how protected health information is used and disclosed.
- OCR guidance explains how this applies to customary health care practices, for example, using patient sign-in sheets or nursing station whiteboards, or placing patient charts outside exam rooms. At the HHS/OCR web site, see the FAQs in the "Incidental Uses and Disclosures" subcategory; search the FAQs on terms like "safeguards" or "disclosure"; or review the Fact Sheet on "Incidental Disclosures". The fact sheet is at http://www.hhs.gov/ocr/hipaa/guidelines/incidentalud.pdf on the HHS web site.

**HIPAA does not cut off all communications between providers and the families and friends of patients:**

- Doctors and other providers covered by HIPAA can share needed information with family, friends, or with anyone else a patient identifies as involved in his or her care as long as the patient does not object.
- The Privacy Rule also makes it clear that, unless a patient objects, doctors, hospitals and other providers can disclose information when needed to notify a family member, or anyone responsible for the patient's care, about the patient's location or general condition.
- Even when the patient is incapacitated, a provider can share appropriate information for these purposes if he believes that doing so is in the best interest of the patient.

## FYI CONT'D

- Review the HHS/OCR web site FAQs http://www.hhs.gov/hipaafaq/notice/488.html in the sub-category "Disclosures to Family and Friends."

**HIPAA does not stop calls or visits to hospitals by family, friends, clergy or anyone else:**

- Unless the patient objects, basic information about the patient can still appear in the hospital directory so that when people call or visit and ask for the patient, they can be given the patient's phone and room number, and general health condition.
- Clergy, who can access religious affiliation if the patient provided it, do not have to ask for patients by name.
- See the FAQs in the "Facility Directories" at http://www.hhs.gov/hipaafaq/administrative/ on the HHS web site.

**HIPAA does not prevent child abuse reporting:**

Doctors may continue to report child abuse or neglect to appropriate government authorities. See the explanation in the FAQs on this topic, which can be found, for instance, by searching on the term "child abuse;" or review the fact sheet on "Public Health" that can be reviewed at http://www.hhs.gov/ocr/hipaa/guidelines/publichealth.pdf on the HHS web site.

**HIPAA is not anti-electronic:**

Doctors can continue to use e-mail, the telephone, or fax machines to communicate with patients, providers, and others using common sense, appropriate safeguards to protect patient privacy just as many were doing before the Privacy Rule went into effect. A helpful discussion on this topic can be found at http://www.hhs.gov/hipaafaq/providers/smaller/482.html on the HHS web site.

**Additional Information**

The HHS complete listing of all HIPAA medical privacy resources is available at http://www.hhs.gov/ocr/hipaa/ on the HHS web site.

For a full list of educational materials, visit http://www.hhs.gov/ocr/hipaa/assist.html on the HHS web site.

# 2007 MCPSS Shows Positive Results for Medicare's Fee-for-Service Contractors

**MLN Matters Number: SE0733**

**Provider Action Needed**

No action is needed. This article is informational only and provides a summary of the findings from the second annual survey by Medicare to assess provider satisfaction with service from Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs)).

**Background**

The Centers for Medicare & Medicaid Services (CMS) reports that most Medicare health care providers continue to find satisfaction with the services provided by Medicare contractors.

The Medicare Contractor Provider Satisfaction Survey (MCPSS), recently conducted by CMS for the second year, is designed to garner objective, quantifiable data on provider satisfaction with the fee-for-service contractors that process and pay Medicare claims. The survey revealed that 85 percent of respondents rated their contractors between 4 and 6 on a 6-point scale, with "1" representing "not at all satisfied" and "6" representing "completely satisfied." The national average score for 2007 is 4.56.

Contractors received an overall composite score for the seven business functions of the provider-contractor relationship: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider audit and reimbursement. For all contractor types, a contractor's handling of provider inquiries surpassed claims processing as the key predictor of a provider's satisfaction. CMS has provided contractors information for process improvement based on individual MCPSS results.

The MCPSS was sent early this year to more than 36,000 randomly selected providers, including physicians, suppliers, health care practitioners and institutional facilities that serve Medicare beneficiaries across the country. The survey was expanded this year to include hospice locations and federally qualified health centers.

The full results of the 2007 survey are now available at http://www.cms.hhs.gov/MCPSS on the CMS web site.

In January 2008, the next MCPSS will be distributed to a new sample of Medicare providers. The views of each provider in the survey are important because they represent many other organizations similar in size, practice type and geographical location. If you are one of the providers randomly chosen to participate in the 2008 MCPSS implementation, you have an opportunity to help CMS improve service to all providers.

## EDUCATIONAL

# Ask the Contractor Teleconference for Small Suppliers

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

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

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

## EDUCATIONAL CONT'D

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.

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

- October 24, 2007
- December 19, 2007

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

# Ask the Contractor –DME - Questions and Answers June 12, 2007

**Prior to taking questions, NAS provided the following updates**

**Revised CMS 1500 Claim Form**

Please review the information posted to our web site regarding the common errors NAS is seeing on the revised CMS-1500 paper claim form. When using the new CMS-1500 Form (08/05), suppliers must change the printing specifications so that the correct claim information is printed within the confines of the appropriate boxes. The boxes that have changed are:

**Box 17a has been split horizontally into 17a and 17b**. 17a, the top shaded box is for the 1G qualifier for the UPIN. The unshaded bottom box is for the NPI.

**Boxes 24A through 24J:** Service lines-not allowed for billing of 12 claim lines. Medicare does not use the shaded area in 24A through 24H.

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

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

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

NAS is returning claims that do not meet the printing specifications with an educational letter stating how to correct the claims and informing suppliers that claims must be resubmitted.

Another important update regarding the CMS 1500 claim form is that only the revised CMS-1500 claim form can be submitted as of July 2, 2007. Based on mail times and the cut-off for assigning a receipt date, suppliers must mail all "old" versions of the CMS-1500 claim form no later than Monday, June 25. Old claim forms received after this time frame will be returned if more than 30 claims are submitted or you will receive notification via letter for mailings of less than 30 claims.

**NPI**

CMS has implemented a contingency plan for covered entities who did not meet the May 23, 2007, deadline for compliance with the NPI regulations. See MLN Matters 5595 for more information. Key points are:

- For some period after May 23, 2007, Medicare will allow continued use of legacy numbers; it will also accept transactions with only NPIs, and transactions with both NPI and legacy identifiers.
- CMS recognizes that the National Council for Prescription Drug Program (NCPDP) format permits reporting of only one identifier, and will accept either the NPI or legacy number on the NCPDP format until May 23, 2008.
- Medicare has been assessing health care provider submission of NPIs on claims submitted. As soon as the number of claims submitted with an NPI for primary providers is sufficient to do so, Medicare will begin rejecting claims without an NPI for primary providers following appropriate advance notice.
- Once a decision is made to begin requiring NPIs on claims, primary providers i.e., billing and pay-to providers must be identified by their NPIs or claims will be rejected.
- All other providers are considered secondary providers and include referring, ordering, and "other" providers. Legacy numbers are acceptable for secondary providers until May 23, 2008.
- 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 information on how remittance advices will be affected by the reporting of the NPI, see MLN Matters 5081 and 5452.

## EDUCATIONAL CONT'D

**Telephone Reopenings**

NAS would like to remind suppliers that we offer telephone reopenings. Telephone reopenings can be reached by dialing (888) 826-5708 between the hours of 8 am to 4 pm CT Monday through Friday. There is a limit of 5 reopenings per phone call.

The types of inquires that can be handled as phone reopenings for any type of DMEPOS are:

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

There are some types of corrections that cannot be requested as phone reopenings. The following situations must be submitted in writing as a redetermination along with supporting documentation:

- Codes requiring review by our medical staff
- Timely denials
- Late files
- Requests that require documentation
- ABN issues
- Adding GA or GY modifiers (changing liability)
- Medicare Secondary Payer (MSP) - 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, the changes cannot be initiated by the phone reopening area and should be sent in writing to the Recoupment team.

Because some issues are more complicated than others and may require more research time or consultation with medical staff, the DME MAC reserves the right to decline the telephone reopening and may request that the supplier submit a written reopening or redetermination request.

We also wanted to remind suppliers that written redetermination requests must contain an original signature. Any requests received in July and after without a signature will be dismissed as invalid requests.

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

The following questions and answers are from the June 12, 2007, Ask-the-Contractor conference call. In some cases, the original answers given during the call may have been expanded to provide further detail. These were current as of this event. Please check our web site for updates.

**Q1. Once the NPI number is required for the primary provider, will the claim reject if it also contains the legacy ID number? For secondary providers prior to May 23, 2008, will my claim deny if I only report the NPI and not the legacy UPIN number?**

A1. We have not received the guidelines regarding submitting both the NPI and the legacy number once NPIs are required for primary providers. When CMS provides guidance, we will post the claim instructions on our web site.

Your claim will not reject if you only report an NPI for your secondary providers (ordering physicians).

**Q2. How is the first dose of an antiemetic billed in a hospital outpatient setting? CR4301 instructed us to bill the first dose to the fiscal intermediary (FI) and the remaining doses to the DME MAC. Now my clearinghouse is telling me that all three doses should be billed to the DME MAC. What is correct?**

A2. CR 4301 states that hospitals bill multi-day supplies of take home oral anti-emetic drugs to the appropriate DME MAC and to bill their FI for outpatient services when the service includes an oral anti-emetic drug so long as no more than one day's drug supply is given to the beneficiary and the beneficiary receives additional services.

**Q3. How can we find out if our patient is in a skilled nursing facility (SNF) prior to billing the DMEPOS? Many times we bill the DMEPOS, get paid for that service, and a few months later we are asked to refund our payment. Why isn't the claim denied at the onset?**

A3. Prior to billing Medicare for DMEPOS, you can call the Supplier Contact Center and ask the representative to look at the patient's history for a SNF Part A covered stay. Keep in mind, however, the SNF may not bill Medicare until the end of the month for a current stay or at the end of the entire stay so the information provided is based only on the claims submitted as of the date of inquiry. This is why Medicare will occasionally pay a DME claim only to find out later the patient was in a Part A SNF covered stay, which results in a refund request.

If you believe that you should have been paid for the service rendered and that the recoupment request is an error, call the Supplier Contact Center. The call representative will research further and advise you as to the circumstance that resulted in the recoupment request. If Medicare recouped in error, we will send the supplier a refund along with any interest paid as a result of the error.

For additional information on SNF consolidated billing and a listing of HCPCS codes that can be billed to the DME MAC during a covered SNF Part A stay, see www.cms.hhs.gov/SNFConsolidatedBilling/01_Overview.asp

**Q4. We have a group NPI, an individual NPI, and a DMEPOS supplier NPI. Where should the DME NPI be placed on the CMS-1500 claim form?**

A4. For DMEPOS claims, place the DME supplier NPI in item 33a on the CMS-1500 claim form.

**Q5. My question is in reference to DME upgrades. We have been receiving requests for additional documentation when we bill the GK (actual item/service ordered by physician, item associated with the GA and GZ modifiers), GL [medically unnecessary upgrade provided instead of standard item, no charge, no advance beneficiary notice ([ABN)], and GA (waiver of liability statement on file) modifiers. Is there something we should be doing to prevent these requests, including occasional duplicate requests?**

A5. This is an update to the answer provided at the call:

CR5367 addresses the billing of upgraded items and instructs suppliers how to bill for upgraded items. This CR also instructs DME MACs to review these claims to see if the upgraded item includes features that exceed the official code description for the item, to ensure that the ABN is not being used to substitute a different item or service that is not medically appropriate for the beneficiary's medical condition for the original item or service, to ensure that the appropriate HCPCS code for the reasonable and necessary item with the actual charge for the item is being used properly, and to ensure that the reasonable and necessary item/service is being associated with the appropriate GA or GZ modifier. NAS interpreted this to mean that all these claims must be manually reviewed for this information, which meant that additional documentation was needed from suppliers for these claims. We have further discussed this situation with CMS and they have informed us that this was not the intent of this CR. Therefore, most documentation requests for upgrade claims will stop but NAS will still be reviewing some upgrade claims. Therefore, there is the potential that suppliers will occasionally receive documentation requests for this situation.

**Q6. Usually when I bill electronically for supplies and use the KX (specific required documentation on file) and NU (new equipment) modifiers, I never hear back as to whether my claim paid or denied. Is there a problem with these modifiers?**

A6. You should receive a report, titled an Electronic Receipt Listing, regarding accepted and rejected claims. If, after review of the report, you are unable to determine why your claims are being rejected, call the EDI help desk at 866-224-3094. A representative will explain the rejection.

**Q7. I am new in this business and am waiting to become a Medicare supplier, but the process is taking so long. I received my state license in February and then sent all the information to Medicare. Recently I had my on-site inspection, but I still haven't heard anything. How long should this process take?**

A7. NAS is not responsible for enrolling DMEPOS suppliers in the Medicare program. The National Supplier Clearinghouse handles this process. You can reach them via telephone at 866-238-9652. They should be able to tell you how much longer it will take for you to become a Medicare supplier.

**Q8. Can you explain the payment cycle and what can throw that payment cycle off by a few days? We are very fluid in our billing with our patient base not changing very much, but occasionally we see changes in the payment cycle, which really throws off the cash flow. We bill electronically Monday through Friday so why wouldn't we receive payment Monday through Friday? Finally, what would keep us from receiving a confirmation on submitted claims the next day if we submit every morning, excluding Friday, before 11:00 a.m.?**

A8. NAS is processing 95% or more of all electronic claims within in the processing standard established by CMS. Therefore, your payment cycle should not be changing other than the few holidays we have had since the first of year. For electronic claims we cannot release payment until 13 days after receipt; for paper claims Medicare cannot release payment until 29 days after receipt.

In researching this supplier's specific claim and payment history, NAS found this supplier was sent three to five payments per week, every week, for the past five months.

Regarding electronic claim confirmations, there should be nothing that would prevent suppliers from receiving claim confirmations the day after they have been submitted.

**Q9. I have a question on the DME Information Form (DIF) 10126 for enteral nutrition. The DIF has a place to enter height and weight if required. When is height and weight required?**

A9. If you are submitting this DIF electronically, these items are required. The medical policy addressing parenteral nutrition provides guidance on when height and weight are required on the DIF. This policy can be accessed at www.edssafeguardservices.eds-gov.com/default.asp

**Q10. We have had some interest from patients receiving both heat and cold therapy. There is no LCD/NCD on this, so how do we determine the medical criteria and documentation that is needed for someone to receive this benefit? One of the codes at issue is E0230 (ice cap or collar).**

A10. Medicare has a medical policy addressing Cold Therapy (E0218-water circulating cold pad with pump); this item is not considered reasonable and necessary. You can access this policy from the web site noted in A9.

HCPCS code E0230 is considered by Medicare to be a non-covered item.

Regarding heat therapy, the National Coverage Determinations Manual, Publication 100-03, Section 280.1 states that Medicare will cover heating pads and lamps if the contractor's medical review staff determines the patient's medical condition is one for which the application of heat in the form of a heating pad or lamp is therapeutically effective. Therefore, your documentation would need to support why heat therapy is effective for your patient.

**Q11. What does it mean when I am told that an account is suspended? I called the contact center on a particular account and this is what I was told. The representative could not give me any additional information, but said she'd get back to me within ten days.**

A11. The caller was asked to fax her supplier number and issue for NAS to research; however, nothing has been received at the time of this publication.

## EDUCATIONAL CONT'D

**Q12. Medicare is recouping payments when a patient is in a managed care organization. We bill diabetic supplies with span dates and Medicare guidelines say our shipping date should be the date of service. On the shipping date/ date of service the beneficiary was in Fee for Service (FFS) Medicare but later during the span date the beneficiary went to a Medicare managed care program. We have been instructed by NAS to refund the entire payment and then re-bill only for the time the beneficiary was part of FFS Medicare. If we split the billing, how do we prove 'proof of delivery' to the managed care organization?**

A12. After researching the nature of diabetic supplies and the billing of this item with span dates, NAS has made the decision to no longer recoup these services when a beneficiary makes the change from FFS Medicare to a managed care organization during the said date span.

**Q13. I received an overpayment letter from NAS for services provided to a beneficiary in 2005, however the overpayment request did not provide a reason for the refund. Furthermore, when I called the contact center, they were not able to provide me with a reason. I don't mind refunding, but I'd like to know the reason why. How can you help me?**

A13. The supplier was asked to fax her overpayment letter to NAS for further research. NAS found that the supplier had received an initial letter from the Benefit Integrity Support Center (BISC) explaining that a request for refund would be forthcoming from NAS. This supplier was personally contacted by the NAS recoupment department and now understands the reasoning behind the refund request.

**Q14. We are having trouble with the PR204 remittance advice message (Patient Responsibility: This equipment is not covered under the patient's current benefit plan). The Medicaid program is saying they will not pay on this code and that this code does not replace the PR 96 (Patient Responsibility: Non-covered charge). Medicaid states that the way PR204 is worded means the item is not part of the Medicare benefit so they won't cover the DME item either. Medicaid suggested we contact CMS and have CMS call Medicaid with additional information on this code. What would you suggest we do?**

A14. This is a change that was made by CMS and they are aware of this code and the concerns expressed by Medicaid. NAS has had discussions with CMS on how to educate the crossover companies on this code, which became effective February 28, 2007. We would also encourage the Medicaid offices to contact CMS for further information on this code.

**Q15. If we have a homeless patient requesting equipment from us, is it our responsibility to verify that the address they are giving is actually their residence? Some homeless people will give a motel address where they will stay for the day just so they can receive a piece of equipment. What is our responsibility when they are asking for a power wheelchair or scooter?**

A15. Medicare uses the beneficiary address on file in our claims processing system to process claims. This address comes from the Social Security Administration through the Common Working File (CWF). Whatever address CWF supplies us, no matter how permanent, is the address we will recognize for processing the claim. You may want to ask this patient at what address they receive their social security benefits if they receive this via a mailed check to help you know what the address on file might be.

However, just because a beneficiary comes to you and wants an item of DMEPOS does not mean that a physician will order the item or that the beneficiary will meet medical necessity for the item. If, however, you have an order and the patient does meet medical necessity for the item then, in the case of the power wheelchair or scooter, an on-site evaluation of the patient's home prior to delivery is required to verify that the patient can adequately maneuver the device that is provided, considering physical layout, doorway width, doorway thresholds, and surfaces. There must be a written report of this evaluation available upon request. This on-site evaluation should help determine if the place of residence is valid. If your patient is homeless, a homeless shelter (04) is a valid place of service for DME claims.

**Q16. I have several claims for E0265 (total electric hospital bed), which NAS paid in error. I called the contact center and was told an edit had been placed into the system to allow this upgrade. Do you know anything about that? The E0265 should be a non-covered benefit.**

A16. You are correct in that this code was paid in error by NAS; the total electric hospital bed should be down-coded and paid as the least costly medically appropriate alternative for the comparable semi-electric bed. NAS is working to have the processing system corrected so this no longer happens and is stopping these claims so they can be paid appropriately.

**Q17. When will we be notified of the allowed amounts for the new K-codes for the CPAP machines and can we bill for diabetic test strips when a patient is in a covered Part A home health episode?**

A17. NAS published the fee schedule amount for the new K-codes (K0553, K0554, K0555) on June 14, 2007. These codes are effective July 1, 2007.

Diabetic test strips are not included in the home health PPS and are billed to the appropriate DME MAC. The complete list of HCPCS codes included in a covered home health episode can be found at www.cms.hhs.gov/HomeHealthPPS/03_coding&billing.asp#TopOfPage

**Q18. Is there a new CMN for pneumatic compression devices formerly called lymphedema pumps? I haven't been able to locate it.**

A18. CMS-846 is the CMN for pneumatic compression devices. It can be accessed from either the Coverage section or the Forms section on the NAS web site at www.noridianmedicare.com/dme

**Q19. I received a letter asking for a refund for services provided to a patient in 2005. The letter stated that the patient was in an HMO at the time the service was rendered. This patient used my equipment and I cannot even pick it up. How am I supposed to get paid for this equipment if Medicare won't pay? Furthermore, NAS did not provide me with the name of the HMO involved.**

## EDUCATIONAL CONT'D

A19. You will need to refund the Medicare payment, but you can then bill the HMO. To find out the name of the HMO and how to contact them, call the Supplier Contact Center at 1-866-243-7272 for assistance.

**Follow-up Question: Why did it take NAS nearly two years to determine that an HMO was involved?**

We are often notified that recoupments are needed due to periodic audits of insurance records. After these audits are completed, NAS receives data regarding which claims were paid by Medicare in error, when in fact the patient had HMO coverage on the date in question. Sometimes it takes time for claims to get processed by another entity and for the national claim records to get updated and the benefit coordinated.

**Additional Question: Is there a retroactive regulation for rental items if my supplier number is revoked for six months and then is reinstated? Will Medicare pay for rental items for the time when my supplier number was inactive?**

Medicare will not cover services for the time period when your supplier number was revoked.

**Q20. I have a question on catheters, specifically A4351 (intermittent urinary catheter, straight tip, with or without coating). The LCD clearly states these catheters are reimburseable on a weekly basis. When we have billed for an additional amount, we have done so under the previous guidelines where we split the claim with four units on one line and 100 units on the second line with modifiers indicating this is beneficiary liable. NAS, however, is paying the full amount. When I called about this, I was told NAS is allowing the total amount because we are adding the KX modifier (specific documentation on file). We need to use this modifer to show Medicare that we have documentation to support the patient has permanent urinary incontence or retention. How can we get these claims properly paid?**

A20. To be paid correctly for these claims, bill the A4351KX on the first line with the quanity that should be allowed each month. The second line should be billed with A4351 and the GA (waiver of liability statement on file) modifier and the additional units that should be denied as patient responsibility. This is assuming you have notified the beneficiary that the additional units do not meet the medical necessity guidelines and that you had the beneficiary sign an Advance Beneficiary Notice (ABN). If you have not had the beneficiary sign an ABN, the services will be denied as supplier responsibility.

**Q21. Can a supplier bill Medicare without billing the state medical assistance agency or other secondary insurance companies? Also, do I need to enroll as a supplier with them and with other secondary insurance companies? I am asking this question because when suppliers are audited, the auditors want to know what happened to the 20% coinsurance payment.**

A21. NAS cannot answer your question regarding enrolling with other insurance programs. We are only responsible for Medicare. We would suggest that you contact the state insurance commissioner regarding enrolling with other insurance agencies, including the state medical assistance agency. In addition, if you have questions about Medicare auditors and their asking about the 20% coinsurance payment you can contact the Office of the Inspector General at www.oig.hhs.gov.

**Q22. If a physician is retired, how do we go about getting his NPI number?**

A22. CMS addressed this issue during their June 14, 2007, Roundtable on NPPES Data Dissemination teleconference. CMS stated that all health care providers need an NPI for use today. If, however, the physician is retired he wouldn't be practicing medicine any longer.

With that in mind, the beneficiary would need to find a different primary care physician. If the beneficiary's new physician agrees that your patient still needs the DMEPOS that you are providing, you can use the new physician's NPI.

**Q23. I have a question about J7609, Albuterol, and J7645, Ipratropium. Those codes were denied as noncovered for claims submitted from January 1 through March 20, 2007. When I called the Supplier Contact Center, I was told NAS was doing a mass adjustment on those codes. Can you tell me the status of that adjustment?**

A23. At the time of this call, the criteria for this adjustment were being analyzed. The mass adjustments for these claims were initiated in early July and all claims should be adjusted by early August.

**Q24. We utilize Express Plus to submit our Medicare claims. Will there be an upgrade to this software so we will be able to submit the NPI correctly? Where is the NPI placed in Express Plus?**

A24. The most current version of Express Plus is 4.3.4. To enter the NPI in this software, from the file menu, select the file maintenance menu and look for provider maintenance. Highlight your supplier number and click on edit. There is a box on the right hand side titled NPI, which is where the NPI can be reported.

**Q25. I have a question regarding the 60-day break-in-service (BIS) issue for oxygen. We are having claims denied because we're told we need to recertify the patient for oxygen rather than having an initial CMN. Currently we are providing an initial CMN because the patient has been without oxygen for longer than 60 days. How do we solve this problem? We have the same issue with CPAP machines. In some cases we have patients that were initially certified for these items in 2003 or 2004, but then they quit using the item so nothing has been billed to Medicare for three years or longer. When we bill in 2007, we're told that the patient needs recertification rather than an initial CMN.**

A25. When there is lengthy break-in-service, such as you have described, we would need a new initial CMN for the item at issue, rather than a recertification CMN. If an initial CMN has already been billed, but due to a break-in-service, a "new" initial CMN is submitted, please indicate BIS in the claim narrative (NTE segment for electronic claims or Item 19 on the CMS 1500 claim form). This will allow our claims staff to add the "new" initial CMN to our system so claims can be processed and paid, if appropriate, based on the latest initial CMN.

We will provide feedback to the contact center on this issue to re-educate on what type of CMN is required when a break-in-service occurs.

This supplier was also asked to fax NAS examples so we could research to determine if there were other issues involved, however, no examples were provided at the time of this publication.

**Q26. I am getting denials with remark code M124 (Missing indication of whether the patient owns the equipment that requires the part or supply). I have been able to get one of my claims corrected and paid by calling Telephone Reopenings but when I called on the second claim I was told I needed to request a written request for redetermination. Why could one be done as a reopening and the other not done as a reopening? Why were these denied initially?**

A26. The caller was asked to fax the example. After researching the claim it was determined that NAS denied the charge in error. The denied line has been adjusted for payment.

**Follow-up question. There was a question earlier regarding hot and cold therapy and where to find information on those services. My question is about E0217 (water circulating heat pad with pump). There is a price for this code listed in the fee schedule but there is no information on this code in the Supplier Manual nor is there a LCD that addresses this code. How can I find out the payment criteria for this code? Some of my claims with this code have paid and some have denied based on medical necessity. They were submitted in exactly the same way.**

There are many codes that do not have written specific criteria that must be met for payment. Heating pads, however, are addressed in a general manner in the Medicare National Coverage Determinations Manual, Chapter 1, Part 4, Section 280.1 which states that heating pads are covered if the contractor's medical staff determines patient's medical condition is one for which the application of heat in the form of a heating pad is therapeutically effective. This section can be found in its entirety at www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf.

If your claim has denied, NAS recommends that you request a redetermination and included a valid detailed written order, the patient's medical record containing information that supports the medical necessity of the item that is provided, and a delivery slip.

The caller was asked to fax in examples of both paid and denied services for research, however, at the time of this publication no examples were received.

**Q27. NAS is sending us education status letters telling us not to place a description of the code on the claim form. Has that been a change?**

A27. A code description should not be reported on the claim form in item 24.

The only time a description is needed is when you bill a non-descriptive code like A9999 (Miscellaneous DME supply or accessory, not otherwise specified). In this case you report the description of your supply in item 19 on the CMS-1500 claim form. A description is never reported in item 24.

**Q28. We provide supplies in multiple states for which we are licensed and we are currently waiting to be licensed in additional states. Can we do business in those states where we are awaiting licensing?**

A28. NAS recommends that you contact the National Supplier Clearinghouse at 1-866-238-9652 with this question.

**Q29. NAS has been sending us education status letters, however, they are going to an old address and we no longer have access to that mail. Our correct address has been on file with the NSC since last October and they have confirmed this. When I speak to the customer service people at NAS, they advise me that the correct address is on file.**

A29. The caller was asked to provide both the correct and the incorrect address along with the NSC number for research. At the time of this publication, no information has been received.

**Q30. We had many claims that paid with the GY modifier (Item or service statutorily excluded or does not meet the definition of any Medicare benefit). We were calling Telephone Reopenings to have these corrected but recently were told that instead NAS was doing a mass adjustment on the claims that had paid in error. Could you tell me the status of that adjustment?**

A30. This is a corrected answer to the answer provided during the teleconference.

You were provided erroneous information when you were told that NAS was doing a mass adjustment on the services paid in error with the GY modifier appended to the HCPCS codes. At this time no mass adjustment is planned.

You should have been told that charges that will result in a reduction of payment cannot be initiated by the Telephone Reopenings area and should be sent in writing to the Recoupment team. This can easily be done by utilizing the interactive "Refund to Medicare" found on the NAS web site at www.noridianmedicare.com/dme/forms/docs/ref_med_dme.pdf

**Follow-up Question. We have a patient in a SNF who has exhausted her Medicare benefits but is receiving enteral nutrition. Can the enteral nutrition items be billed to the DME MAC for payment?**

Enteral nutrition can be billed to the DME MAC if the patient is in stay not covered by Part A. The enteral nutrition local coverage determination states as follows:

> Enteral nutrition provided to a patient in a Part A covered stay must be billed by the SNF to the fiscal intermediary. No payment from Part B is available when enteral nutrition services are furnished to a beneficiary in a stay covered by Part A. However, if a beneficiary is in a stay not covered by Part A, enteral nutrition is eligible for coverage under Part B and may be billed to the DMEMAC by either the SNF or an outside supplier.

The entire medical policy can be accessed at www.edssafeguardservices.eds-gov.com

**Q31. If the patient owns the piece of medical equipment, for example a hospital bed, can the supplier still bill the DME MAC for maintenance and service?**

A31. No, the supplier cannot bill for routine maintenance and service when the patient owns the equipment.

**Q32. In many cases the medical records received from the physicians do not document the patient's problem; many times they just send a list of diagnosis codes. Can the physician write a summary of the patient's problems as a substitute to not documenting the patient's condition in the past? In other words, the progress notes we receive just say the patient has this, this and this without any further explanation. With many of the higher end pieces of equipment this information would not support medical necessity.**

A32. A physician can write a summary to his progress notes, but a summary is not the same as a progress note written at the time of the physician visit. The documentation guidelines in chapter three of the Supplier Manual state as follows:

> ….. neither a physician's order nor a CMN nor a DIF nor a supplier-prepared statement nor physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier-prepared statement or physician attestation (if applicable). There must be clinical information in the patient's medical record which supports the medical necessity for the item and substantiates the answers on the CMN (if applicable), or information on a supplier prepared statement, or physician attestation (if applicable).

**Q33. Who is allowed to sign for equipment upon delivery if a patient, for example, is in an Alzheimer's unit of a nursing home? I also have cases where Medicare is recouping the payment because the patient says they never received the equipment even though the patient signed the delivery slip. What do I do in those cases?**

A33. You have a right to request a redetermination on recoupment cases if you disagree with the reason for the recoupment.

Regarding who can sign and accept a delivery on behalf of a patient, chapter three of the Supplier Manual states as follows:

> Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary. . . . . The relationship of the designee to the beneficiary should be noted on the delivery slip obtained by the supplier (i.e., spouse, neighbor, etc.). The signature of the designee should be legible. If the signature of the designee is not legible, the supplier/shipping service should note the name of the designee on the delivery slip.

## Ask the Contractor –DME - Questions and Answers June 20, 2007

**Prior to taking questions, NAS provided the following updates:**

**Revised CMS 1500 Claim Form**

Please review the information posted to our web site regarding the common errors NAS is seeing on the revised CMS-1500 paper claim form. When using the new CMS-1500 Form (08/05), suppliers must change the printing specifications so that the correct claim information is printed within the confines of the appropriate boxes. The boxes that have changed are:

**Box 17a has been split horizontally into 17a and 17b.** 17a, the top shaded box is for the 1G qualifier for the UPIN. The unshaded bottom box is for the NPI.

**Boxes 24A through 24J**: Service lines-not allowed for billing of 12 claim lines. Medicare does not use the shaded area in 24A through 24H.

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

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

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

NAS is returning claims that do not meet the printing specifications with an educational letter stating how to correct the claims and informing suppliers that claims must be resubmitted.

Another important update regarding the CMS 1500 claim form is that only the revised CMS-1500 claim form can be submitted as of July 2, 2007. Based on mail times and the cut-off for assigning a receipt date, suppliers must mail all "old" versions of the CMS-1500 claim form no later than Monday, June 25. Old claim forms received after this time frame will be returned if more than 30 claims are submitted or you will receive notification via letter for mailings of less than 30 claims.

**NPI**

CMS has implemented a contingency plan for covered entities who did not meet the May 23, 2007, deadline for compliance with the NPI regulations. See MLN Matters 5595 for more information. Key points are:

- For some period after May 23, 2007, Medicare will allow continued use of legacy numbers; it will also accept transactions with only NPIs, and transactions with both NPI and legacy identifiers.
- CMS recognizes that the National Council for Prescription Drug Program (NCPDP) format permits reporting of only one identifier, and will accept either the NPI or legacy number on the NCPDP format until May 23, 2008.

## EDUCATIONAL CONT'D

- Medicare has been assessing health care provider submission of NPIs on claims submitted. As soon as the number of claims submitted with an NPI for primary providers is sufficient to do so, Medicare will begin rejecting claims without an NPI for primary providers following appropriate advance notice.
- Once a decision is made to begin requiring NPIs on claims, primary providers i.e., billing and pay-to providers must be identified by their NPIs or claims will be rejected.
- All other providers are considered secondary providers and include referring, ordering, and "other" providers. Legacy numbers are acceptable for secondary providers until May 23, 2008.
- 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 information on how remittance advices will be affected by the reporting of the NPI, see MLN Matters 5081 and 5452.

**Telephone Reopenings**

NAS would like to remind suppliers that we offer telephone reopenings. Telephone reopenings can be reached by dialing (888) 826-5708 between the hours of 8 am and 4 pm CT Monday through Friday. There is a limit of 5 reopenings per phone call.

The types of inquires that can be handled as phone reopenings for any type of DMEPOS are:

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

There are some types of corrections that cannot be requested as phone reopenings. The following situations must be submitted in writing as a redetermination along with supporting documentation:

- Codes requiring review by our medical staff
- Timely denials
- Late files
- Requests that require documentation
- ABN issues
- Adding GA or GY modifiers (changing liability)
- Medicare Secondary Payer (MSP) - 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, the changes cannot be initiated by the phone reopening area and should be sent in writing to the Recoupment team.

Because some issues are more complicated than others and may require more research time or consultation with medical staff, the DME MAC reserves the right to decline the telephone reopening and may request that the supplier submit a written reopening or redetermination request.

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

The following questions and answers are from the June 20, 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. We have retired physicians who have not applied for an NPI and do not plan to do this. In addition, the CMNs these physicians completed to establish medical necessity were for lifetime use. Do I need a revised CMN with an active physician who has an NPI and do I need a new oxygen saturation test done for the revised CMN?**

A1. This is a corrected answer from the answer provided during the teleconference.

Once a physician retires, it is assumed that this physician is no longer the physician of record. The Supplier Manual states as follows regarding this situation:

> If DME MAC PSCs learn that the physician of record is no longer the treating physician, the supplier shall obtain from the physician currently responsible for the patient's pulmonary condition a current fully completed oxygen CMN. After review of this oxygen CMN, DME MACs continue monthly payments if the evidence establishes medical necessity. Their records must be updated to identify the new treating physician.

**Q2. Seat lift mechanisms require a CMN. Question number four asks, "Once standing does the patient have the ability to ambulate?" The Local Coverage Determination (LCD) states that for a seat lift mechanism to be covered the patient must met all criteria including the patient having the ability to ambulate once standing. Therefore, if a patient is in a wheelchair they do not qualify for this item, correct? We occasionally have beneficiaries who call Medicare and are told the mechanism will be covered even if they are in a wheelchair. That makes it difficult for us as suppliers.**

A2. You are correct that the patient must have the ability to ambulate once standing to qualify for a seat lift mechanism. A beneficiary confined to a wheelchair would not qualify for this item.

We will follow-up with the beneficiary contact center on this issue.

**Q3. I believe a Final Rule was published the beginning of this year stating that no corrections could be made to a prescription for a power mobility device (PMD). Does this apply to all prescriptions or are there some items where the prescription can be corrected? We are having physicians who rewrite the entire prescription because a mistake was made on a diagnosis code.**

A3. NAS could not locate a final rule regarding corrections to PMD prescriptions. Medicare communicates changes such as this through a MLN Matters article or through other written notification from your contractor.

The guidelines that Medicare has for prescriptions as they relate to PMDs are that the prescription must contain the beneficiary's name, the date of the face-to-face examination, the diagnoses and conditions that support the claim for the PMD, a description of the specific PMD required, and the expected length of time the beneficiary will the need the equipment. This prescription must signed and dated by the physician or treating practitioner and must be received by the supplier within 45 days after the face-to-face examination or within 45 days after the date of discharge from the hospital in the case of a recently hospitalized beneficiary.

**Q4. If the supplier needs the prescription and supporting documentation for a PMD from the physician within 45 days, does that mean business or calendar days?**

A4. Suppliers need this information within 45 calendar days.

**Q5. What happens if a patient had, for example, a hospital bed provided for a few months by another supplier and then returned it because they no longer required it, but now months later they need it again? Will I, as a different supplier, receive the full 13 months of rental payment or only the remaining months from the original rental?**

A5. Once there is a break in service lasting over 60 days, a new capped rental period begins. For additional information about breaks in service, see the chapters 3-5 of the Supplier Manual located on the NAS web site under News and Publications.

**Q6. If a patient underwent a transplant when Medicare was his secondary payer, will Medicare cover his immunosuppressive drugs?**

A6. Immunosuppressive drugs are covered if the patient meets the following criteria:

1) Immunosuppressive drugs are prescribed following either:

a) Kidney, heart, liver, bone marrow/stem cell, lung, or heart/lung transplant; or

b) Whole organ pancreas transplant performed concurrent with or subsequent to a kidney transplant because of diabetic nephropathy (performed on/after July 1, 1999); or

c) Intestinal transplant (performed on/after April 1, 2001); or

d) Pancreatic islet cell transplant performed on/after October 1, 2004, that is conducted as part of a National Institutes of Health sponsored clinical trial; and

2) The transplant met Medicare coverage criteria in effect at the time (e.g., approved facility; national/local medical necessity criteria; etc); and

3) The patient was enrolled in Medicare Part A at the time of the transplant; and

4) The patient is enrolled in Medicare Part B at the time that the drugs are dispensed; and

5) The drugs are furnished on or after the date of discharge from the hospital following a covered organ transplant.

**Q7. I had an Advance Determination of Medicare Coverage (ADMC) request returned to me because I used the referring physician's NPI instead of his UPIN. Is this appropriate?**

A7. At this time the processing system will not accept an ADMC without a UPIN, however, NAS is currently working to get this corrected. In the interim you will need to continue submitting your ADMCs with the ordering physician's UPIN rather than his NPI.

**Q8. Will my Express Plus software automatically update to allow me to report the physician's NPI instead of his UPIN?**

A8. The most current version of Express Plus is 4.3.6, which has the fields for NPI; however, an older version, 4.3.4, also has the NPI fields. If you have any other version of Express Plus, go to the EDI web site at www.cignagovernmentservices.com/edi/dmerc/index.html to download the appropriate Express Plus upgrade.

The version number of Express Plus is indicated in the upper left corner of the main menu.

**Q9. I submitted a claim in January for diabetic supplies. Medicare denied it on the basis that the prescription was not current. I requested a redetermination after which Medicare reversed its original decision and paid the claim. The same thing happened in February; my claim was initially denied but was paid after requesting a redetermination. In March my claim was also denied. Is there anything that can be done so I don't have to continue requesting redeterminations on the same item?**

A9. In researching this case NAS found the ordering physician had been found guilty of committing fraud in the state of California and was forced to forfeit her medical license. Therefore, the claims at issue were paid in error and will need to be recouped, and all additional claims should remain denied.

**Q10. I have a patient who has had a power wheelchair for many years. This patient has now developed Alzheimer's disease and is unable to safely use the power wheelchair. Therefore, we provided him with a manual wheelchair. The initial rental claim was paid with the use of the KH (first month rental) modifier but the second month, billed with the KI (second or third month rental) denied based on the same/similar edits. I was told I would need to request a redetermination on each of the subsequent denied months. What can I do?**

A10. In researching this case, NAS found that Medicare paid for a power wheelchair (K0011) for this patient on July 7, 2005. Based on this information it was found that the rental

claim for the manual chair (K0003) billed to Medicare 21 months later was paid in error and the additional months were denied correctly based on the same/similar edits.

If the supplier does not agree with denial decisions, it is the supplier's responsibility to appeal those denials with documentation to support why Medicare should allow the particular service.

**Q11. I was told a new CMN is coming for hospital beds. Does that mean I will need to have my old hospital bed CMNs redone?**

A11. There is not a new/revised CMN for hospital beds forthcoming. Furthermore, Medicare eliminated CMNs for hospital beds and support surfaces furnished on/after October 1, 2006.

**Q12. I have a client who will be eligible for Medicare August 1, 2007. His physician is ordering him a wheelchair. Can we begin the process now or must we wait until the client is actually eligible for Medicare?**

A12. You can begin the process prior to the beneficiary becoming eligible for Medicare as long as you follow the guidelines for the wheelchair and do not deliver the chair until the beneficiary is actually eligible for Medicare.

**Q13. I have a patient with a manual wheelchair that he can no longer propel. Therefore, he is being upgraded to a power wheelchair. In the past we have gotten a letter of medical necessity explaining why the patient can no longer self-propel the chair. Is that still necessary when it is basically a duplicate of what the physician has already put in the patient's chart?**

A13. What Medicare is looking for in cases such as these is documentation to support why the patient needs to upgrade from one type of equipment to another. That information will most likely be included in the patient's progress notes; it does not need to be reported to Medicare in the form of a letter.

**Q14. When submitting a paper claim for repairs done on a non-covered wheelchair, we are getting paid. We submitted the claim with the GA (waiver of liability statement on file). Why is this happening when we know Medicare should not pay for repairs on a non-covered item? Medicare actually denied the wheelchair.**

A14. If Medicare denied the wheelchair initially, Medicare should not have paid for the repairs. It is helpful to include a comment on the claim that Medicare did not pay for the wheelchair as this helps explain why the GA modifier was reported.

The caller was asked to fax in examples of these paid claims; however, at the time of this publication no examples had been received.

**Q15. We are providing a trapeze bar for a patient who is renting the hospital bed from another supplier. We have the prescription signed by the physician but the other supplier does not have a signed prescription for the hospital bed. Medicare paid the first four months of rental but has denied the additional months. When I called the contact center I was told that Medicare would not allow any additional payments because there is no hospital bed on file. If this is so, then why were the first four months allowed?**

A15. The caller was asked to fax the example for research; however, at the time of this publication no example had been received.

**Q16. I have a patient who has been in a SNF for over a year. Can I provide this patient a power wheelchair? If we cannot provide a new power wheelchair, can we provide the repairs to the old chair?**

A16. When a patient is a resident of a nursing home, it is the responsibility of the nursing home to provide the patient with a wheelchair when needed along with any needed repairs to that piece of equipment. Therefore, if you repair a wheelchair provided for a Medicare beneficiary residing in a SNF or nursing home, you would need to look to the nursing home for payment of the repairs.

**Q17. I have heard that I can have a lifetime prescription for diabetic testing supplies as long as the beneficiary is not testing outside of the Medicare guidelines. Is this correct?**

A17. The Local Coverage Determination (LCD) addressing glucose monitors and related supplies states that a new order is needed only when there is a change in testing frequency. However, if your state has guidelines that require the patient to be seen by their physician yearly and a new prescription written, then you must follow the state guidelines.

The Medicare requirement that a beneficiary needs a new order every 12 months for diabetic supplies was eliminated as of July 1, 2005. An order is valid for whatever timeframe is indicated on the order and an order can be written for a lifetime. State guidelines must be followed as referenced above.

**Q18. I believe you noted in a previous teleconference that Medicare would allow for a repair if it were less costly to replace than to repair the item with a rule of thumb of 60% of the replacement cost. How does Medicare calculate the 60% of the replacement cost? Is that the reimbursement amount or is it the manufacturer's suggested retail price (MSRP)?**

A18. This is a corrected response from the response given during the teleconference.

The quote of 60% of the replacement cost pertains to prosthetic devices only. The Medicare Benefit Policy Manual, Chapter 15, Section 120 states as follows:

> Payment may be made for the replacement of a prosthetic device that is an artificial limb, or replacement part of a device if the ordering physician determines that the replacement device or part is necessary because of any of the following:
>
> 1) A change in the physiological condition of the patient;
>
> 2) An irreparable change in the condition of the device, or in a part of the device; or
>
> 3) The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.
>
> This provision is effective for items replaced on or after April 1, 2001. It supersedes any rule that that provided a 5-year or other replacement rule with regard to prosthetic devices.

The replacement of other DMEPOS due to normal wear and tear is addressed in Section 110.2 of the same manual referenced above and states in part as follows:

> 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.

Both of these references can be read in their entirely at www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf

**Q19. When I do a repair on a wheelchair that was originally provided by another supplier, do I place the serial number of the wheelchair and the repair time in the narrative section of the claim?**

A19. If you are repairing a wheelchair, report the type of wheelchair (manual, power, etc) and the date of purchase in the narrative field. If you are also billing a part with an unlisted HCPCS code, place a description of what was provided in the narrative field (i.e., leg rests).

Code your labor as HCPCS code E1340 where the code description states that each 15 minutes equals one unit of time.

**Q20. Does Medicare reimburse for sales tax?**

A20. Medicare does not reimburse separately for sales tax. The Medicare Claims Processing Manual, Chapter 23, Section 80.3.1, states the following:

Sales taxes where appropriate were included in the calculation of reasonable charges computed. They were also accounted for in the calculation of the base fee schedules for DME and orthotic/prosthetic devices. The Consumer Price Index used to update fee schedules also accounts for sales tax. Therefore, contractors do not make any additional payment for sales taxes and do not make adjustments in fees to reflect local changes in tax rates.

**Q21. If I have a capped rental item that began prior to the change over on January 1, 2006, I may have several years where I can bill for maintenance and servicing. If the ordering physician for this item of equipment is now retired or deceased and doesn't have an NPI, how can I bill the claim after May 23, 2008?**

A21. CR 5584 states that you can continue to submit claims with UPINs for the ordering physicians until further notice. However, once you are mandated to use the referring physician's NPI number instead of the UPIN, you will need to obtain the NPI for the beneficiary's new primary care physician; at this time CMS has stated there will be no surrogate NPIs.

# 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 April - June 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. 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 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.

**4. 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."

**5. Payent 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.

**6. 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.

**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. Status/Explanation/Resolution**

Suppliers can check the status of claims by calling the IVR between 6am and 8 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.

**10. Medical Necessity**

Suppliers are encouraged to consult the LCD and policy article for individual medical policy coverage criteria. The LCDs can be accessed from the NAS DME web site, Coverage section, by selecting "Local Coverage Determinations (LCDs)" followed by "CMS Medicare Coverage Database – Current LCDs."

If you receive a medical necessity denial on a claim, you have the option to submit a written signed request to appeal the decision. If you make this choice, NAS recommends using the "DME Inquiry/Redetermination" interactive form located on this web site and submitting it along with all pertinent medical documentation supporting the need for the item at issue to:

Noridian Administrative Services
PO Box 6727
Fargo ND 58108-6727

You may also fax your signed request with all documentation to 1-888-408-7405.

## Top Ten Written Inquiries

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

**1. 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.

**2. 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.

**3. 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.

**4. 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.

**5. 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.

**6. Claim Processing Error**

To request a reopening on a claim, either call Telephone Reopenings at 888-826-5708 between 8:00 am – 4:00 pm, Monday through Friday, or fax the request to 888-408-7405. When faxing the request, use the DME Reopening form to ensure all required information is provided.

**7. 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.

**8. Claim Denials-Contractual Obligation Not Met**

If a supplier receives an Additional Documentation Request (ADR) letter, it is very important the requested information is mailed back to the address on the ADR letter along with a copy of the letter. If these steps are not followed, the claim could deny as the requested information was not received timely.

It is also important to be aware of the Administrative Simplification Compliance Act (ASCA) enforcement. Suppliers may only submit paper claims in limited situations. Information on ASCA is found on our web site.

**9. 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.

**10. Cancellation of Claim/Returned Claim/Billed in Error**

To submit a refund to NAS DME, complete the Refunds to Medicare form. NAS uses this information to process the refund properly. If any information requested on the form is not provided, processing of the refund will be delayed.

The supplier must also include a check payable to Medicare DME. Mail both the Refunds to Medicare form and the check to:

Medicare Refunds-DME
PO Box 6727
Fargo ND 58108-6727

## NAS Web site Enhancement: Rotating Announcements

NAS is pleased to introduce a new feature on our web site, an announcement/attention section to help suppliers easily identify important information. Rotating announcements have been implemented to help draw attention to important information and updates regarding DME homepage.

The announcements are scheduled to rotate once every six seconds; however, a provider can pause the current announcement by placing the mouse cursor over any part of the announcement. Select the area of the announcement titled "read more" to access the web page with more detailed information regarding the announced topic. Use the "Previous" and "Next" links to navigate between announcements without the need to wait for the six second scheduled rotation to occur.


NAS appreciates the feedback our supplier community offers through the "Web site Feedback" link as well as through the online, random survey coordinated at the request of CMS by a third party company.

## EDUCATIONAL CONT'D

# Publications Available from CMS' Medicare Learning Network

The following publications are now available in downloadable format from the Centers for Medicare & Medicaid Services' Medicare Learning Network:

The Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals (July 2007 version) can be accessed at http://www.cms.hhs.gov/MLNProducts/downloads/physicianguide.pdf. This guide offers general information about the Medicare Program, becoming a Medicare provider or supplier, Medicare payment policies, Medicare reimbursement, evaluation and management documentation, fraud, abuse, inquiries, overpayments, and appeals.

The Facilitator's Guide (companion to the Medicare Physician Guide): A Resource for Residents, Practicing Physicians, and Other Health Care Professionals that includes all the information and instructions necessary to prepare for and present a Medicare Resident, Practicing Physician, and Other Health Care Professional Training Program, is also now available at http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=dual,%20keyword&filterValue=facilitator&filterByDID=0&sortByDID=1&itemID=CMS061390&intNumPerPage=10

The Medicare Billing Information for Rural Providers, Suppliers, and Physicians, which consists of charts that provide billing information for Rural Health Clinics, Federally Qualified Health Centers, Skilled Nursing Facilities, Home Health Agencies, and Critical Access Hospitals, is available at http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf.

Visit the Medicare Learning Network ~ it's free

# Latest from the Medicare Learning Network

The Certificate of Medical Necessity (CMN) web-based training (WBT) course is now available with continuing education credits and can be accessed through the MLN Web Based Training Modules link at www.cms.hhs.gov/MLNProducts under the "Related Links Inside CMS" section.

The CMN WBT course contains information about the Certificate of Medical Necessity, commonly known as a CMN. This course will be helpful to physicians, health care professionals, and medical administrative staff in the completion, submission and maintenance of the documentation required to verify the CMN.

# Guide to Medicare Preventive Services

The 2nd Edition of ***The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*** is now available in downloadable format from the Centers for Medicare & Medicaid Services, Medicare Learning Network (MLN). This comprehensive guide provides fee-for-services health care providers and suppliers with coverage, coding, billing and reimbursement information for preventive services and screenings covered by Medicare. This guide gives clinicians and their staff the information they need to help them in recommending Medicare-covered preventive services and screenings that are right for their Medicare patients and provides information needed to effectively bill Medicare for services furnished. To view online, go to http://www.cms.hhs.gov/MLNProducts/downloads/mps_guide_web-061305.pdf on the CMS web site.

## NPI

# Dissemination of Data from NPPES to begin September 4, 2007

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

**UPDATE!**

The National Plan and Provider Enumeration System (NPPES) health care provider data that are disclosable under the Freedom of Information Act (FOIA) will be disclosed to the public by the Centers for Medicare & Medicaid Services (CMS). In accordance with the e-FOIA Amendments, CMS will be disclosing these data via the Internet. Data will be available in two forms:

1. A query-only database known as the NPI Registry.
2. A downloadable file.

CMS is extending the period of time in which enumerated health care providers can view their FOIA-disclosable NPPES data and make any edits they feel are necessary prior to our initial disclosure of the data.We must build in time to resolve any errors or problems that may be encountered with edits that health care providers submit. Therefore, in order to ensure edits are reflected in the NPI Registry when it first becomes operational and in the first downloadable file, health care providers need to submit their edits no later than Monday, August 20, 2007. Health care providers who submit edits on paper need to ensure that they are mailed in time for receipt by the NPI Enumerator by that date.

CMS will be making FOIA-disclosable NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry will become operational on September 4 and the downloadable file will be ready approximately one week later.

Health care providers should refer to the document entitled, "Information on FOIA-Disclosable Data Elements in NPPES," dated June 20, 2007 (found on the CMS NPI web page at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPPES_FOIA_Data%20Elements_062007.pdf) for assistance in making their edits. Some of the key data elements that are FOIA-Disclosable are:

- NPI
- Entity Type Code (1-Individual or 2-Organization)
- Replacement NPI

## NPI CONT'D

- Provider Name (First Name, Middle Name, Last Name, Prefix, Suffix, Credential(s), OR the Legal Business Name for Organizations)
- Provider Other Name (First Name, Middle Name, Last Name, OR 'Doing Business As' Name, Former Legal Business Name, Other Name. for Organizations)
- Provider Business Mailing Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Provider Business Location Address (First line address, Second line address, City, State, Postal Code, and Country Code if outside U.S., Telephone Number, Fax Number)
- Health care Provider Taxonomy Code(s)
- Other Provider Identifier(s)
- Other Provider Identifier Type Code
- Provider Enumeration Date
- Last Update Date
- NPI Deactivation Reason Code
- NPI Deactivation Date
- NPI Reactivation Date
- Provider Gender Code
- Provider License Number
- Provider License Number State Code
- Authorized Official Contact Information (First Name, Middle Name, Last Name, Title or Position, Telephone Number)

The delay in the dissemination of NPPES data does not alter the requirement that HIPAA covered entities must comply with the requirements of the NPI Final Rule no later than May 23, 2008. All NPI contingencies that may be in place must be lifted by that date.

**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.

# Submitting NPI and Medicare Legacy Identifiers

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

Effective October 29, 2007, NAS as the Jurisdiction D DME MAC 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 to the provider.

When the claim is returned, a provider should first verify that the correct NPI was submitted. If correct, you will need to verify that your legacy identifier (PIN or 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 your contractor if you need more information.

To fully understand if a supplier's information is valid on both the crosswalk and the contractor's provider file, suppliers are encouraged to submit a small number of claims using the NPI only. If no claims are rejected, the number of claims submitted can gradually increase. If any claim is rejected due to provider identifier issues, the supplier should follow the steps above to correct the information. Once data is corrected, the supplier should wait a few days for the system to update and test again by submitting a small number of claims with the NPI only.

More information and education on the NPI may be found at the CMS NPI page, http://www.cms.hhs.gov/NationalProvIdentStand on the CMS web site. Also, providers can apply for an NPI online at https://nppes.cms.hhs.gov.

# Information Regarding Importance of Reporting Legacy Numbers in NPPES

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

The reporting of legacy numbers in the "Other Provider Identifier"/"Other Provider Identifier Type Code" fields in the National Plan and Provider Enumeration System (NPPES) will assist Medicare in successfully creating linkages between providers' NPIs and the identifiers that Medicare has assigned to them (such as NSCs).

You should be aware that if you remove your legacy numbers from the "Other Provider Identifier"/"Other Provider Identifier Type Code" fields, linkages that Medicare has established using the reported Medicare legacy numbers will be broken and your Medicare claims could be rejected.

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.

## NPI Located on Remittance Notices

The EDI Helpdesk is receiving many calls because suppliers are stating their remittance notices (835) do not show a supplier number. However, in most cases, the NPI was billed on the claim.

If the NPI is billed on the claim, this will be posted on the 835. If a supplier is using MREP (Medicare Remit Easy Print) to create the remittance notice into a readable format, this will also show the NPI.

However, some callers are stating they use vendor 835 software and either this is blank or a Tax ID is posting to their software. In these cases, the EDI Helpdesk recommends the supplier contact their software vendor.

Additional information is found in MLN Matters Special Edition 0725, Important Information for Providers/Suppliers Regarding NPPES Errors, Using the NPI on Medicare Claims and 835 Remittance Advice Changes. Other sources include MLN Matters 5452 and MLN Matters 5081.

## The NPI is Here. The NPI is Now. Are You Using It?

Health plans are progressing to transition to full NPI implementation. Be sure to stay informed about the steps you need to take to bill correctly and test your NPI with all of the health plans with whom you do business.

**National Plan and Provider Enumeration System (NPPES) FOIA-Disclosable Data to be Available on September 4, 2007**

NPPES health care provider data that are disclosable under the Freedom of Information Act (FOIA) will be disclosed to the public by the Centers for Medicare & Medicaid Services (CMS). In accordance with the e-FOIA Amendments, CMS will be disclosing these data via the Internet. Data will be available in two forms:

1. A query-only database, known as the NPI Registry.
2. A downloadable file.

CMS has extended the period of time in which enumerated health care providers can view their FOIA-disclosable NPPES data and make any edits they feel are necessary prior to our initial disclosure of the data. CMS will be making FOIA-disclosable NPPES health care provider data available beginning Tuesday, September 4, 2007. The NPI Registry will become operational on September 4 and the downloadable file will be ready approximately one week later.

CMS has posted several documents to help providers understand what the downloadable file will look like, including a "Read Me" file, Header File, and Code Value document for the downloadable file on the CMS NPI web page at http://www.cms.hhs.gov/NationalProvIdentStand/06a_DataDissemination.asp.

**Important Information for Medicare Providers**

**Starting September 3, 2007, Medicare Carriers and DME MACs Will Begin Transitioning their Systems to Start Rejecting Claims when the NPI and Legacy Provider Identifier 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 Crosswalk.

If you are receiving 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 information edits, you should ask your contractor to validate the provider information in their system. If the contractor information is not correct, you may be instructed to submit an enrollment form or CMS-855. Please include ALL of your NPI/Legacy numbers in NPPES AND all of your NPIs that are to be used in place of your legacy on the CMS-855. If the information is different in the two systems, there is a very good chance your claim will reject. NPPES data may be verified at https://nppes.cms.hhs.gov on the web.

**Medicare Efforts to Minimize Rejections and Suspensions**

CMS CR5649, Transmittal number 1262 dated June 8, 2007, instructed Medicare Contractors to identify providers with the highest volume of rejections (or potential rejections/informational edits) due to invalid NPI information. They were also instructed to identify providers who are not submitting their NPI. Contractors have begun calling providers that fit these categories. If you are contacted, you may be asked to validate your NPPES information or confirm that the information in the Contractor's Provider file is correct. If you are not submitting your NPI at this time, your Contractor will ask: why you are not submitting it, the date you plan to submit it, and will ask you to send a small batch of claims using your NPI only, if possible.

Additionally, 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. This could happen in the instance where one NPI is tied to several legacy identifiers. If it is determined that the claim suspended due to incorrect data in the Contractors provider file or NPPES, the provider will be requested to either update their information in NPPES and/or submit an updated CMS-855 form.

If the provider does not respond within 14 calendar days to this communication, the Contractor will return the claim as unprocessable. Conversely, if the provider does respond, it may furnish the Legacy number over the phone; however, 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.

## NPI CONT'D

**Reporting a Group Practice NPI on Claims**

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

Medicare has also reported instances of incorrect billing occurring with DME MAC's. Providers must ensure that if they enumerate as individuals in the National Supplier Clearinghouse (NSC), they must enumerate as individuals in NPPES. If they enumerate as organizations in NSC, they should do the same in NPPES.

**Update to 835 Remittance Advice Changes in MLN SE0725**

In MLN SE0725 Medicare described the 835 changes that would occur for the 835 Remittance Advice and that those changes would occur July 2, 2007, for DME MACS only. The article also went on to note that Medicare would notify providers when the Part A Institutional and Part B Professional 835 would be changing. Medicare 835 Electronic Remittance Advices will reflect the noted changes on Remittances for Part A and Part B, starting April 7, 2008.

**Transcript for August 2nd Roundtable Now Available**

The transcript for the August 2nd, Medicare FFS Q&A Session: Common Billing Errors, Roundtable is now available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/aug_2_npi_transcript.pdf on the CMS NPI page.

**Reminder: Recent MLN Matters Articles**

Several recent Special Edition MLN Matters articles contain important billing information for Medicare providers and suppliers, including:

- How to use the NPI correctly on Part A and Part B claims http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf
- Information on use of the NPI on the new CMS 1500 and UB-04 Forms http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0729.pdf

**General Medicare Claims Processing Reminder**

Unrelated to the NPI, Fee-for-Service Medicare claims can be rejected by contractors for a variety of reasons including:

- Incorrect billing information,
- The provider has been terminated from the program
- The beneficiary is not eligible for Medicare
- The claim was sent to the wrong contractor

If a provider has questions about a claim rejected by a FI/carrier or MAC, the provider should contact the contractor directly. It is never appropriate to direct the beneficiary, who received the service billed on the claim, to the 1-800-Medicare toll free line to resolve a claim rejection.

**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.

# Incorrect Implementation Schedule Published

**Important Information for Medicare Providers**

It has come to CMS' attention that a trade publication recently published a schedule of implementation dates, by contractor, for claim rejections based on the inability to locate an NPI/legacy identifier pair on the Medicare NPI Crosswalk. The dates listed in the publication are incorrect. Providers will be advised by their Medicare contractor as to the particular timeframe for their transition. Any other published schedules are unofficial and may have inaccurate dates. Medicare providers are urged to only rely on information from their Medicare contractors.

Providers may find a recent MLN Matters article helpful in determining how to use the NPI on Part A and Part B claims. You can view the article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0725.pdf on the CMS web site.

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.

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

# Important Information for Providers/ Suppliers Regarding NPPES Errors, Using NPI on Medicare Claims and 835 Remittance Advice Changes

**MLN Matters Number: SE0725**

**Provider Types Affected**

Physicians, providers, and suppliers who submit claims to Medicare fee-for-service contractors (Carriers, Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs), Part A/B Medicare Administrative Contractors (A/B MACs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs))

**Provider Action Needed**

Certain information you enter into the National Plan and Provider Enumeration System (NPPES) in order to obtain and maintain your National Provider Identifier (NPI) is used by Medicare in processing claims.

If the information you entered in NPPES is not correct, your claims may reject. It is important to verify that information was entered correctly. Other guidance in this article will also help assure your claims are processed timely and correctly.

The Centers for Medicare & Medicaid Services (CMS) recommends that physicians, providers, and suppliers validate their NPPES data and be sure their staff are aware of the key elements that need to be correct as explained in this article. Also, you may want to be sure your staff are aware of the important billing tips in this article.

**Background**

As Medicare begins to implement the NPI into its systems, several enumeration and billing errors have been identified that may result in claim rejections.

**Common Enumeration Errors in NPPES**

Below are some of the more frequent errors providers have been making when applying for NPIs:

- **Errors in Employer Identification Number (EIN)**: As a reminder, providers that are organizations are required to report the EIN when they apply for an NPI (on-line, paper, and electronic file interchange (EFI)). That EIN may also be the Taxpayer Identification Number (TIN). With the revised NPI Application/Update Form (CMS-10114) (to be used beginning July 10, 2007, for on-line, paper, and EFI), organizations that are subparts will be required to report the legal business name (LBN) of their "parent" and the "parent's" TIN. The applicant will continue to be required to report its EIN. **If the EIN error is on the Medicare provider enrollment record, the provider should submit a CMS-855 to the Medicare contractor to correct it.**
- **Invalid or incomplete data within the 'Other Provider Identifiers' section of the NPPES online application, such as:**
  - The absence of the Medicare legacy number,
  - Not having the 'Type' listed as Medicare for a Medicare provider number, and/or
  - Reporting Medicare provider numbers that do not belong to the provider applying for the NPI and, therefore, should not be linked to the assigned NPI.
- **Reporting an Incomplete Identifier:** Medicare providers/ suppliers need to ensure that, if reporting their Medicare legacy identifiers to NPPES, they report the full identifier. This means that suffixes to the OSCAR/Certification Numbers are to be reported. If the full identifier is not reported, it will be impossible for Medicare to establish the linkage from the NPI to that particular Medicare legacy identifier when using NPPES data and the NPI crosswalk.
- **Having More than the Allowable Number of Legacy Numbers**: At the present time, the NPPES can capture a grand total of 20 "Other Provider Identification Numbers." While this adequately accommodates the majority of providers/suppliers, it does not accommodate all of them. NPPES will be expanded to capture more than 20 "Other Provider Identification Numbers" at a future date. Medicare providers/suppliers who have more than 20 Medicare legacy identifiers that need to be linked directly to the NPI to be assigned should contact their Medicare fee-for-service contractors to determine how best to inform those contractors of all of the Medicare legacy identifiers.
- **Listing Legacy Numbers that Do Not Belong to the Applicant**: The provider/supplier should make sure that any Medicare legacy identifier(s) (OSCAR/Certification Number, Provider Identification Number (PIN), Unique Physician Identification Number (UPIN), and National Supplier Clearinghouse (NSC) Number) entered in that field in NPPES are those that will need to be linked directly to the NPI to be assigned. That is, do not list in the "Other Provider Identification Numbers" section identifiers that belong to providers other than the one that is applying for the NPI. Specific examples follow in the "Do's and Don'ts" section below.

**Dos and Don'ts When Reporting "Other Provider Identification Numbers" in NPPES**

- **For a Medicare physician or other practitioner applying for an NPI**: DO include your UPIN (if one was assigned) and your PIN when applying for an NPI. DO NOT include the PIN of your group practice or clinic if you are affiliated with a group practice or clinic.
- **For a Medicare group practice or clinic applying for an NPI**: DO include your PIN. DO NOT include the PINs or UPINs of any of the members of the group practice or clinic.
- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy/DME supplier**: DO include both NSC Numbers (pharmacy and DME supplier).
- **For a Medicare pharmacy that is enrolled as both a pharmacy and a DME supplier that is applying for an NPI as a pharmacy**: DO include the NSC number assigned to the pharmacy, but DO NOT include the NSC number assigned to the DME supplier.

## NPI CONT'D

- **For a Medicare pharmacy that is applying for an NPI as a DME supplier**: DO include the NSC Number assigned to the DME supplier. DO NOT include the NSC Number assigned to the pharmacy.
- **For a Medicare hospital swing bed unit that is applying for an NPI as a swing bed unit**: DO include the OSCAR/Certification Number assigned to the swing bed unit. DO NOT include the OSCAR/Certification Number assigned to the hospital.
- **For a Medicare hospital that is applying for an NPI but does not want swing bed units or rehabilitation units (if they have these units) to have their own NPIs**: DO include the OSCAR/Certification number assigned to the hospital and the OSCAR/Certification Numbers assigned to both the swing bed unit and the rehabilitation unit.

If Medicare providers/suppliers determine that they should make changes to their NPPES records, they may do so by going to NPPES at https://nppes.cms.hhs.gov/ at any time and updating their information. Or, if they prefer, they may send updates on the paper NPI Application/Update Form (CMS-10114). Forms may be requested by calling the NPI Enumerator at their toll-free number, which is 1-800-465-3203, TTY 1-800-692-2326. The revised CMS-10114 is to be used beginning July 10, 2007. These forms can be obtained from the Enumerator, as outlined above, or you may download the form from the CMS Forms page at http://www.cms.hhs.gov/cmsforms on the Web.

CMS recommends that Medicare providers/suppliers make a copy of their NPPES information by doing a "print screen" of their NPPES record or make a photocopy of the completed paper NPI Application/Update form and keep it on hand for reference if they encounter problems.

**Common Error in Reporting Change of Ownership to Medicare**

**Delays in reporting Change of Ownership**: Whenever there is a change of ownership, the provider is responsible for reporting that change to the appropriate Medicare contractor within 30 days. Providers are supposed to report that change on the CMS-855.

**How to Use Your NPI When Billing Medicare Part A (Institutional) Claims to a Fiscal Intermediary (FI) or A/B MAC**

For providers who submit electronic Part A institutional claims to Medicare FIs or A/B MACs, a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Failure to properly submit the NPI in the correct loops may cause the claim to reject. Organization providers should utilize their NPI in the 2010AA or 2010AB loop. The attending, operating or other physicians should be identified in the 2310A, B and C loops respectively. If 2420A loop is used, the Attending Physician NPI must be submitted.

**Below is a guide to use when submitting primary NPI's:**

| Name/Loop | Legacy Information | NPI Information |
|---|---|---|
| Billing Provider 2010AA Loop | OSCAR | Provider NPI |
| Pay to Provider 2010AB Loop | OSCAR | Provider NPI |
| Attending Physician 2310A Loop | PIN, UPIN | Physician NPI |
| Operating Physician 2310B Loop | PIN, UPIN | Physician NPI |
| Other Physician 2310C | PIN, UPIN | Physician NPI |
| Attending Physician 2420A | PIN, UPIN | Physician NPI |

Some Medicare FIs and A/B MACs have developed front-end reason codes that will return claims to the providers when the NPI and Legacy combination submitted does not match the NPI crosswalk.

If a reject or RTP (Return to Provider) is received, **providers are encouraged to verify that their NPI/Legacy combination is valid in NPPES first at https://nppes.cms.hhs.gov/.**

**The following is a listing of Front-end Processing Reason Codes:**

| Code | Description |
|---|---|
| 32000 | This claim has been rejected because the intermediary has no record of the Medicare provider number submitted. |
| 32102 | The claim contains an NPI but the first digit of the NPI is not equal to "1", "2", "3","4" or the 10th digit of the NPI does not follow the check digit validation routine. Please verify billing and, if appropriate, correct.<br>**Online providers – press PF9 to store the claim.<br>**Other providers – return to the intermediary. |
| 32103 | NPI/OSCAR pair on the claim is not present in the Medicare NPI Crosswalk File.This edit applies to the NPI associated with the OSCAR number. Please verify provider billing number and, if appropriate, please correct either NPPES or your CMS-855 information.Please verify all of your information in NPPES. You should validate that the NPI/OSCAR pair you are using on the claim reflects the OSCAR number that you reported to NPPES. You may view/correct your NPPES information by going to https://nppes.cms.hhs.gov If your NPPES information is correct, and you have included all Medicare legacy identifiers (OSCARS) in NPPES, but you are still experiencing problems with your claims that contain a valid NPI, you may need to submit a Medicare enrollment application (i.e. – the CMS 855). Please contact your contractor prior to submitting a CMS-855 form. |

## NPI CONT'D

| | |
|---|---|
| 32104 | The NPI and the legacy (OSCAR) number are present on the claim and the NPI is present in the Crosswalk File, but the associated legacy (OSCAR) number in the Crosswalk file does not match the legacy (OSCAR) number on the claim.<br>Please verify billing number and, if appropriate, correct.<br>***Online providers – Press PF9 to store the claim.<br>***Other Providers – Return to the intermediary. |
| 32105 | The NPI is present in the Crosswalk File but the NPI corresponds to more than one legacy (OSCAR) number.<br>Enter the OSCAR number associated with the NPI submitted. Please verify billing number and, if appropriate, correct.<br>***Online providers – Press PF9 to store the claim.<br>***Other providers – Return to the intermediary. |
| 32107 | The NPI for the attending physician on the claim is not present in the Crosswalk File.<br>Please verify billing number and, if appropriate, correct.<br>***Online providers – Press PF9 to store the claim.<br>***Other providers – Return to the intermediary. |
| 32108 | The attending physician's NPI and UPIN are present on the claim and the attending physician's NPI is present in the Crosswalk File, but the attending physician's UPIN in the Crosswalk File does not match the attending physician's UPIN on the claim.<br>Please verify the UPIN and, if appropriate, correct.<br>***Online providers – Press PF9 to store the claim.<br>***Other providers – Return to the intermediary. |
| 32109 | The operating physician's NPI on the claim is not present in the Crosswalk File.<br>Please verify billing number and, if appropriate, correct.<br>***Online providers – Press PF9 to store the claim.<br>***Other providers – Return to the intermediary. |
| 32110 | The operating physician's NPI and UPIN are present on the claim and the operating physician's NPI is present in the Crosswalk File, but the operating physician's UPIN in the Crosswalk File does not match the operating physician's UPIN on the claim.<br>Please verify the UPIN and, if appropriate, correct.<br>***Online providers – Press PF9 to store the claim.<br>***Other providers – Return to the intermediary. |
| 32111 | The other physician NPI on the claim is not present in the Crosswalk File.<br>Please verify the billing number and, if appropriate, correct.<br>***Online providers – Press PF9 to store the claim.<br>***Other providers – Return to the intermediary. |
| 32112 | The other physician's NPI and UPIN are present on the claim and the other physician's NPI is present in the Crosswalk File, but the other physician's UPIN in the Crosswalk File does not match the other physician's UPIN on the claim.<br>Please verify the UPIN and, if appropriate, correct.<br>***Online providers – Press PF9 to store the claim.<br>***Other providers – Return to the intermediary. |
| 32113 | The taxonomy code entered is invalid.<br>Or, a taxonomy code is required when the NPI is present in the Crosswalk File and the NPI corresponds to more than one legacy (OSCAR) number.<br>Please verify the billing number and, if appropriate, correct.<br>***Online providers – Press PF9 to store the claim.<br>***Other providers – Return to the intermediary. |

**If your FI or A/B MAC is using the MEDATRAN claims translator, below is a list of EDI Inbound Reject codes you may receive:**

| Edit | Loop | Edit Description |
|---|---|---|
| 99 | 2010AA | The NPI/Legacy combination does not match the NPI crosswalk. |
| 99 | 2010AB | The NPI/Legacy combination does not match the NPI crosswalk. |
| 99 | 2310A,B,C | The NPI/Legacy combination does not match the NPI crosswalk. |
| 99 | 2420A | The NPI/Legacy combination does not match the NPI crosswalk. |

**How to Use Your NPI When Billing Medicare Part B (Professional) Claims to Carriers and A/B MACs**

For providers who submit electronic professional claims to Medicare Part B carriers and A/B MACs, CMS test data indicates that a high volume of claims have been received where the NPI/legacy identifier combinations cannot be validated by the Medicare NPI crosswalk.

Even if you have validated your NPPES data, failure to properly submit the NPI in the correct loops may cause the claim to reject. Group providers should utilize the GROUP NPI in the 2010AA or 2010AB loop. The INDIVIDUAL or MEMBER OF GROUP NPI should only be submitted in the 2310B or 2420A loops.

## NPI CONT'D

**Below is a guide to use when submitting primary NPI's:**

| Name/Loop | Legacy Information | NPI Information |
|---|---|---|
| Billing Provider 2010AA Loop | Group PIN Individual PIN | Group NPI Individual NPI |
| Pay to Provider 2010AB Loop (this should only be submitted if different from Billing Provider) | Group PIN Individual PIN | Group NPI Individual NPI |
| Rendering Provider 2310B Loop (this should only be submitted if a group practice) | Individual / Member of Group PIN | Individual / Member of Group NPI |
| Rendering Provider 2420A Loop (this should only be submitted if a group practice) | Individual / Member of Group PIN | Individual / Member of Group NPI |

Some carriers and A/B MACs will return the informational messages or edits below when the NPI and legacy identifier combination submitted does not match the NPI crosswalk. As of the date of this article, claims with NPI/legacy identifiers are not rejecting because Part B contractors (except CIGNA Tennessee and Idaho), have "crosswalk bypass" logic in their system that will allow invalid pairs to process on the legacy number. The informational edits you are receiving are a warning that your claims will reject when the logic is removed. Providers are encouraged to verify that the NPI/legacy identifier combination is valid on NPPES at https://nppes.cms.hhs.gov prior to submission of Medicare claims.

**Following is a listing of the edits you may receive when billing Professional Part B claims:**

| Edit Number | Loop | Edit Description |
|---|---|---|
| M340 | 2010AA | The NPI/Legacy combination does not match the NPI crosswalk. |
| M341 | 2010AB | The NPI/Legacy combination does not match the NPI crosswalk. |
| M343 | 2310B | The NPI/Legacy combination does not match the NPI crosswalk. |
| M347 | 2420A | The NPI/Legacy combination does not match the NPI crosswalk. |

**Important Reminders Regarding 835 Remittance Advice Changes Effective July 2, 2007 for DME Suppliers Submitting Claims to DME MACS Only.**

DME suppliers are reminded that important changes will occur on your electronic remittance advice and your standard paper remittance actions, effective July 2, 2007. As of that date when you have submitted an NPI on your claim, your DME MAC will report on the 835 (or via the Medicare Remit Easy Print (MREP) Software) as follows:

- The billing/pay-to NPI will be reported at the Payee level (Loop 1000B in N104 with the XX qualifier in N103 of the 835),
- The TIN (EIN/SSN) will be reported in the REF segment (Loop 1000B, data field REF 02 with qualifier TJ in REF 01 of the 835) as Payee Additional ID,
- Any relevant Rendering Provider NPI will be reported at the claim level (Loop 2100, data field NM 109 with qualifier XX in NM 108 on the 835) if different from the Payee NPI, and
- Any relevant Rendering NPI(s) will be reported at the service line level (Loop 2110, data field REF 02 with qualifier HPI in REF 01 on the 835) when different from the claim level Rendering NPI.

When you do not report your NPI, but report your legacy National Supplier Clearinghouse (NSC) number on a claim, Medicare will continue to report legacy numbers in generating your remittance advice. Further information regarding the remittance changes may be found in CR5452, which is at http://www.cms.hhs.gov/Transmittals/downloads/R1241CP.pdf or in the related *MLN Matters* article, MM5452, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5452.pdf on the CMS web site.

**Important NOTE: The 835 Remittance Advice changes listed above will be effective for other providers submitting Part A Institutional claims and Part B Professional claims, at a later date. Medicare will notify submitters when a date is determined.**

**Additional Information**

You may also want to review MLN Matters article SE0679, which has additional information on the overall NPI activity. This article is at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0679.pdf on the CMS web site. Important information regarding current NPI implementation contingency plan is in article MM5595, which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf.

# Medicare's Implementation of NPI: Second in Series of Special Edition MLN Matters Articles on NPI-Related Activities

**MLN Matters Number: SE0555 Revised**

This article was revised on August 7, 2007, to delete a reference to the NPI viewlet, which is no longer available on the CMS web site. Previously, the article was revised on May 18, 2007, to add this statement that Medicare FFS has announced a contingency plan regarding the May 23, 2007 implementation of the NPI. For some period after May 23, 2007, Medicare

## NPI CONT'D

FFS will allow continued use of legacy numbers on transactions; accept transactions with only NPIs; and accept transactions with both legacy numbers and NPIs. For details of this contingency plan, see the MLN Matters article, MM5595, at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5595.pdf on the CMS web site.

**Provider Types Affected**

Providers and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries. In addition, organizations or associations that represent providers and plan to obtain NPIs for those providers should take note of this article.

**Part 1: Information That Applies to All Providers**

**Background**

All health care providers are eligible to receive NPIs. All HIPAA covered health care providers, whether they are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, a provider's NPI will not change. The NPI remains with the provider regardless of job or location changes.

HIPAA covered entities such as providers completing electronic transactions, health care clearinghouses, and large health plans, must use only the NPI to identify covered health care providers in standard transactions by **May 23, 2007**. Small health plans must use **only** the NPI by **May 23, 2008**.

**Obtaining and Sharing Your NPI**

Providers and suppliers may now apply for their NPI on the National Plan and Provider Enumeration System (NPPES) web site, https://nppes.cms.hhs.gov. The NPPES is the only source for NPI assignment.

The NPI will replace health care provider identifiers in use today in standard health care transactions by the above dates. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

Health care providers should apply for their NPIs as soon as it is practicable for them to do so. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment. Providers may apply for an NPI in one of three ways:

- An easy web-based application process is available at https://nppes.cms.hhs.gov.
- A paper application may be submitted to an entity that assigns the NPI (the Enumerator). A copy of the application, including the Enumerator's mailing address, is available at https://nppes.cms.hhs.gov. A copy of the paper application may also be obtained by calling the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
- With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

**Knowing the NPI Schedule of Your Health Plans and Practice Management System Companies**

Providers should be aware of the NPI readiness schedule for each of the health plans with which they do business, as well as any practice management system companies or billing companies (if used). They should determine when each health plan intends to implement the NPI in standard transactions and keep in mind that each health plan will have its own schedule for this implementation. Your other health plans may provide guidance to you regarding the need to submit both legacy numbers and NPIs.

Providers should submit their NPI(s) on standard transactions only when the health plan has indicated that they are ready to accept the NPI. Providers should also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date. also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date.

**Sharing Your NPI**

Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are: Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are:

- Any provider with which they do business (e.g., pharmacies); Any provider with which they do business (e.g., pharmacies);
- Health plans with which they conduct business; and Health plans with which they conduct business; and
- Organizations where they have staff privileges. Organizations where they have staff privileges.

We understand that providers have many questions related to EFI or bulk enumeration, NPPES Data Dissemination, and the Medicare subparts policy. We have included information currently available on these key topics in this article and will continue to provide updates, as more information becomes available.

**Electronic File Interchange (EFI) - Formerly Known as Bulk Enumeration**

The Centers for Medicare & Medicaid Services (CMS) is in the process of putting into place a mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many health care providers, with provider approval, to the NPPES within a single electronic file. For example, a large group practice may want to have its staff handle the NPI applications for

## NPI CONT'D

all its members. If an organization/provider employs all or a majority of its physicians and is willing to be considered an EFI submitter, EFI enumeration may be a good solution for that group of providers.

**The EFI Steps**

Once EFI is available, concerned entities will follow these steps:

- An organization that is interested in being an EFI organization will log on to an EFI home page (currently under construction) on the NPPES web site (https://nppes.cms.hhs.gov) and download a certification form.
- The organization will send the completed certification form to the Enumerator to be considered for approval as an EFI organization (EFIO).
- Once notified of approval as an EFIO, the entity will send files in a specified format, containing NPI application data, to the NPPES.
- Providers who wish to apply for their NPI(s) through EFI must give the EFIO permission to submit their data for purposes of applying for an NPI.
- Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.
- The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s). An EFIO may also be used for updates and deactivations, if the providers agree to do so.

**National Plan and Provider Enrollment System (NPPES) Data Dissemination Policy**

CMS expects to publish a notice regarding its approach to NPI data dissemination in the coming months. The notice will propose the data dissemination strategy and processes. The approach will describe the data that CMS expects to be available from the NPPES, in compliance with the provisions of the Privacy Act, the Freedom of Information Act, the Electronic FOIA Amendments of 1996, the NPPES System of Records Notice, and other applicable regulations and authorities.

**Crosswalks**

Each health plan may create its own crosswalk, to cross check NPI and legacy identifiers. To that end, CMS stresses the importance of health care providers entering all of their current identification numbers onto their NPI application to facilitate the building of the crosswalks.

**Subparts of a Covered Organization**

Covered-organization health care providers (e.g., hospitals, suppliers of durable medical equipment, pharmacies, etc.) may be made up of components (e.g., an acute care hospital with an ESRD program) or have separate physical locations (e.g., chain pharmacies) that furnish health care, but are not themselves legal entities. The Final NPI rule calls these entities "**subparts**" to avoid confusion with the term health care "components" used in HIPAA privacy and security rules. Subparts cannot be individuals such as physicians, e.g., group practices may have more than one NPI, but individual members of that group practice by definition are not and cannot be "subparts."

The NPI was mandated to identify each health care provider, not each service address at which health care is furnished. Covered organization providers must designate as subparts (according to the guidance given in the NPI Final Rule) any component(s) of themselves or separate physical locations that are not legal entities and that conduct their own standard transactions. Covered organizations/providers must obtain NPI(s) for their subparts, or instruct the subparts to obtain their own NPIs. The subparts would use their NPIs to identify themselves in the standard transactions they conduct.

The NPI Final Rule also gives covered organizations/providers the ability to designate subparts should there be other reasons for doing so. Federal regulations or statutes may require health care providers to have unique billing numbers in order to be identified in claims sent to federal health programs, such as Medicare.

In some cases, health care providers who need billing numbers for federal health programs are actually components of covered health care providers. They may be located at the same address as the covered organization provider or they may have a different address.

In situations where such federal regulations or statutes are applicable, the covered organization providers would designate the components as subparts and ensure that they obtain NPI(s) in order to use them in standard transactions. The NPI will eventually replace the billing numbers in use today.

**What Providers Can Do to Prepare for NPI Implementation**

- Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.
- Check with your billing services, vendors, and clearinghouses about NPI compliance and what you need to do to facilitate the process.
- Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.
- Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

**Part 2: Information That Applies to Medicare Fee-For-Service (FFS) Providers Only**

**All Medicare providers** are reminded that they will be required to use the NPI in **Medicare claims transactions**.

**NPI Transition Plans for Medicare FFS Providers**

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

## NPI CONT'D

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

**Crosswalk**

The Medicare health plan is preparing a crosswalk to link NPI and Medicare legacy identifiers exclusively for Medicare business, which should enable Medicare to continue claims processing activities without interruption. NPI(s) will be verified to make sure that they were actually issued to the providers for which reported. Medicare will use the check digit to ensure the NPI(s) are valid.

**Subparts Policy**

CMS is currently developing policy on how Medicare providers should identify Medicare subparts. Further details will be provided when this policy is finalized.

**Resources for Additional Information**

**Coming Soon**: CMS is developing a MLN web page on NPI for Medicare FFS providers, which will house all Medicare fee for service educational resources on NPI, including links to all *MLN Matters* articles, frequently-asked-questions, and other information. CMS will widely publicize the launch of this web page in the coming weeks.

You may wish to visit http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp#TopOfPage regularly for the latest information about the NPI.

The Federal Register notice containing the NPI Final Rule is available at http://www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf on the CMS web site.

There are some non-CMS Web sites that have information on NPI-related issues. While CMS does not necessarily endorse those materials, there may be information and tools available that might be of value to you.

You may also find some industry implementation recommendations and white papers on the NPI at http://www.wedi.org, which is the site of the Workgroup for Electronic Data Interchange (WEDI).

## REMINDERS

### Item 24J Reminder

DME suppliers are not mandated to report a supplier identifier, such as the NSC number, legacy number or NPI in item 24J on the CMS-1500 claim form. Suppliers may leave item 24J blank but should report the NPI number in item 33a and/or the legacy number preceded by the 1C qualifier and a space in item 33b.

### Correspondence and Claim Reminders

NAS would like to provide suppliers with a few reminders for submitting claims and correspondence:

- Part A and Part B claims and correspondence mailed to NAS must be sent separately from DME claims and correspondence to the correct PO box. **Effective September 1, 2007, if Part A or Part B claims or correspondence are mailed in the same envelope with DME claims or correspondence, copies of the Part A and Part B documents will be returned to the provider.** The submitted claims or correspondence for Part A or Part B will not be processed. NAS mailing information is found in the Contact Us section of the NAS web site.
- Ensure Jurisdiction D DME claims and correspondence is mailed to the correct address. The previous contractor, CIGNA Government Services, is receiving claims for Jurisdiction D inappropriately. DME Jurisdiction D claims and correspondence should be mailed to:

  Noridian Administrative Services
  PO Box 6727
  Fargo ND 58108-6727

## REMINDERS CONT'D

- Suppliers who have received Advance Determination of Medicare Coverage (ADMC) decisions should not send these with paper claims. NAS has these ADMC decisions on file therefore copies are not needed.

## Correspondence and Claim Reminders

Suppliers should note the following reminders when mailing claims and correspondence to NAS:

- Be sure to use the appropriate DME PO Box when sending correspondence to NAS. A complete listing of NAS DME addresses is found on our web site in the Contact section.
- Do not include Part A or Part B claims or correspondence with DME claims in the same envelope. These need to be sent to each PO Box separately.
- 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
- To ensure timely processing of claims, do not attach any type of correspondence, such as a letter or a redetermination, inquiry or reopening request form. It is also not necessary to indicate that a claim is a corrected or resubmitted claim anywhere on the claim form. Doing so may delay or impede the processing of the claim.

## Reminder on CMN/DIF Forms

As a reminder, the effective date for the new CMN/DIF forms is July 1, 2007. Therefore, if an old CMN/DIF form is submitted on or after July 1, 2007, the claim will be denied for an invalid CMN/DIF.

**The following table is a list of the newly revised CMNs that are acceptable on or after July 1, 2007:**

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

**The following table identifies the new DIFs that are acceptable on or after July 1, 2007:**

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

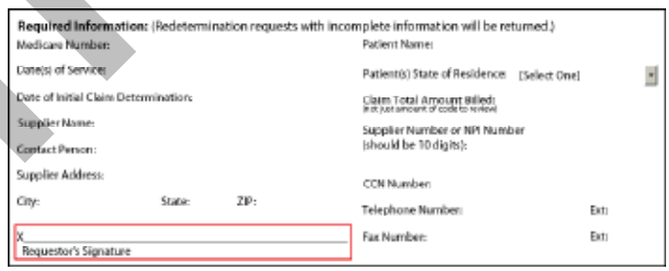
Complete details and instructions are provided in *MLN Matters 5571.*

## Reminder: Signature Required on Redetermination Requests

NAS continues to receive many redetermination requests without the signature of the requesting party. Effective July 1, 2007, all redetermination requests received without the appellant's signature are being dismissed as incomplete requests.

CMS has provided guidelines on the required information, including the signature of the requesting party, in the *Medicare Claims Processing Manual*, Chapter 29, Appeals of Claims Decisions, Section 310.1, Filing a Request for Redeterminations.

The following shows the section of the DME Inquiry/ Redetermination form that must contain the requestor's signature:




The original notice to suppliers was provided in the article titled "Signature Required on Redetermination Requests" posted to the What's New section of our web site on June 21, 2007.

## CLAIM FORM

## Important Guidance on New CMS-1500 and UB-04 Forms

**MLN Matters Number: SE0729**

**Provider Types Affected**

All providers using the new forms CMS-1500 or UB-04 to bill Medicare contractors (carriers, fiscal intermediaries (FI), or Medicare Administrative Contractors MACs)) for services provided to Medicare beneficiaries.

## CLAIM FORM CONT'D

**What You Need to Know**

This *MLN Matters article*, SE0729, provides you valuable information about the new CMS 1500 and UB-04 forms.

**Background**

**CMS Form 1500 Version 08-05**

In 2006, the Centers for Medicare & Medicaid Services (CMS) introduced the revised Form CMS-1500 (08-05). This new version of the form, revised to accommodate the reporting of the National Provider Identifier (NPI), was developed through a collaborative effort headed up by the National Uniform Claim Committee (NUCC), which is chaired by the American Medical Association (AMA), in consultation with the CMS.

The committee includes representation from key provider and payer organizations, as well as standards setting organizations, one health care vendor, and the National Uniform Billing Committee (NUBC). As such, the committee is intended to have an authoritative voice regarding national standard data content and data definitions for non-institutional health care claims in the United States.

Although CMS prefers that you submit all claims to Medicare electronically, the Administrative Simplification Compliance Act Public Law 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32 provide for exceptions to the mandatory electronic claim submission requirement. Therefore, Medicare will receive, and process, paper claims (using the new [08-05] version of the CMS-1500 form) only from physicians and suppliers who are excluded from the mandatory electronic claims submission requirements.

CMS began accepting the revised form CMS-1500 in January 1, 2007, planning to discontinue the older version on April 1, 2007; however formatting issues forced CMS to extend this date to July 2, 2007. At that time, CMS began returning the 12-90 version of the form. While the Government Printing Office (GPO) is not yet in a position to accept and fill orders for the revised CMS-1500 form, CMS' research indicates the form is widely available for purchase from print vendors.

For assistance in locating the form, you can contact the NUCC at http://www.nucc.org/, or you might consider using local print media directories to search for print vendors, contacting other providers to inquire on their source for the form, or searching for "CMS-1500 (08-05)" or "CMS-1500 08/05" on the internet to locate online print vendors. You should ask for samples before ordering to ensure that the formatting is correct.

Some important details in completing the new CMS-1500 form are as follow:

- If you previously populated boxes 17a (referring provider), 24j (rendering provider), and 33 (billing provider) with your legacy number, you should now begin using your NPI also.
- The billing provider NPI goes in box 33a. In addition, if the billing provider is a group, then the rendering provider NPI must go in box 24j. If the billing provider is a solo practitioner, then box 24j is always left blank. A referring provider NPI goes in box 17b.
- If the information in block 33 (billing) is different than block 32 (service facility), you should populate block 32 with the address information.

You can learn more about the new version of the CMS-1500 by reading MLN Matters article MM5060 (Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500), released September 15, 2006. You can find that article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf.

**UB-04 Information**

At its February 2005 meeting, the National Uniform Billing Committee (NUBC) approved the UB-04 (CMS-1450) as the replacement for the UB-92. The UB-04, the basic form that CMS prescribes for the Medicare program, incorporates the National Provider Identifier (NPI) taxonomy, and additional codes; and is only accepted from institutional providers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Public Law 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

Effective March 1, 2007, institutional claim filers such as hospitals, SNFs, hospices, and others were to have begun using the UB-04, with a transitional period between March 1, 2007, and May 22, 2007 (during which time either the UB-92 or the UB-04 may have been used). On and after May 23, 2007: 1) The UB-92 has become no longer acceptable (even as an adjustment claim); and 2) All institutional paper claims must be submitted on the UB-04.

You should note that while most of the data usage descriptions and allowable data values have not changed on the UB-04, many UB-92 data locations have changed and, in addition, bill type processing will change. Some details of the form follow:

- The UB-04 (Form CMS-1450) is a uniform institutional provider bill suitable for billing multiple third party payers. A particular payer, therefore, may not need some of the data elements.
- When filing, you should retain the copy designated "Institution Copy" and submit the remaining copies to your Medicare contractor, managed care plan, or other insurer.
- Instructions for completing inpatient and outpatient claims are the same unless otherwise noted.
- If you omit any required data, your contractor will either ask you for them or obtain them from other sources and will maintain them on its history record. It will not obtain data that are not needed to process the claim.
- Data elements in the CMS uniform electronic billing specifications are consistent with the UB-04 data set to the extent that one processing system can handle both. The definitions are identical, although in some situations, the electronic record contains more characters than the corresponding item on the form because of constraints on the form size not applicable to the electronic record. Further, the revenue coding system is the same for both the Form CMS-1450 and the electronic specifications.

## CLAIM FORM CONT'D

- For the UB-04, the billing provider's NPI is entered in Form Locator (FL) 56. The attending provider's NPI is entered in FL76. The operating provider's NPI is entered in FL77. Up to 2 other provider NPIs can be entered in FL78 and FL79.

You can find more information about the UB-04 (Form CMS-1450) by reading *MLN Matters* article MM5072 (Uniform Billing (UB-04) Implementation – UB-92 Replacement), released November 3, 2006. You can find that article at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf. The CR, from which that article was taken, contains a copy of the UB-04 form (front and back) in PDF format, a crosswalk between the UB-04 and the UB-92, and the revised portion of the *Medicare Claims Processing Manual*, Chapter 25 (Completing and Processing the CMS 1450 Data Set), Sections 70 (Uniform Bill - Form CMS-1450 (UB-04)) and 71 (General Instructions for Completion of Form CMS-1450 (UB-04)). These sections contain very detailed instructions for completing the form.

For assistance in obtaining UB-04s you can contact the NUBC at http://www.nubc.org/.

## BILLING

# Infusion Therapy-Billing for Denial

Many suppliers provide infusion drugs and supplies that are not covered under the External Infusion Pumps policy (DME benefit) or under another specific statutory benefit (i.e., intravenous immune globulin for primary immunodeficiency, home dialysis supplies, immunosuppressive drugs following organ transplant). The following provides guidance on the correct billing in these situations.

1. **Drug is not administered with a durable infusion pump (i.e., it is administered by drip infusion or by using an elastomeric or other disposable infusion pump [A4305, A4306])**

A DME MAC Information Form (DIF) does not need to be submitted in this situation.

If the supplier elects to submit a claim, then code A4221 (Supplies for maintenance of drug infusion catheter, per week) and/or A4223 (Infusion supplies not used with external infusion pump, per cassette or bag) must be used as appropriate for the infusion-related supplies.

If the drug has a specific code, it must be used. If there is no specific code for the drug, it is submitted using code J3490 (unclassified drug); do not use J7799. A description of the drug and dosage must be entered in Item 19 of the paper claim form or the electronic equivalent.

If the supplies and/or drug are not eligible for coverage under any Medicare benefit, then the modifier GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) must be added to the code. In addition, a brief explanation of use of the modifier GY must be included on the claim (e.g., "not administered with a durable infusion pump"). The modifier GY must not be used for a drug or related supplies when that drug is administered with a DME infusion pump-even if the supplier knows that the claim will be denied based on medical policy or individual consideration.

Codes submitted in this way will be denied as statutorily noncovered.

2. **Drug is administered with a durable infusion pump (E0779-E0791, K0455)**

A claim for the pump must be submitted and the initial claim for the pump must include a DIF. If a DIF is not submitted, the claim will be rejected as insufficient information.

Supplies are submitted using the appropriate code(s)-A4221, A4222, K0552.

If the drug has a specific code, it must be used; if not, use code J7799. If code J7799 is submitted, include the name of the drug and the indications for its use in Item 19 of the paper claim or the electronic equivalent.

**The modifier GY must not be used in these situations.**

If the DME MAC determines that the drug is not medically necessary for the stated indication or if it determines that the pump is not necessary to administer the drug even though the drug itself may be medically necessary, the pump, the drug and related infusion supplies are all denied as not medically necessary. A "coverage" (i.e., no Medicare benefit) denial will not be applied in these situations, and the limitation on liability provisions are applied. Suppliers should obtain an Advance Beneficiary Notice (ABN) in these situations.

# MREP Enhancements and RARC and CARC Updates

The MREP software is scheduled to be updated each July, if needed. The MREP updates that are made will be based on suggestions received from users, contractors and CMS and include the updates to the CARC and RARC files that occurred in the previous year. In order to address the CARC and RARC updates that occur throughout the year prior to the next MREP version release, CMS will provide a link to the updated CARC and RARC file on the CMS Web site at http://www.cms.hhs.gov/AccesstoDataApplication/02_MedicareRemitEasyPrint.asp for the provider/supplier community to download after each of the three updates are made. When it is necessary to download and import the updated CARC and RARC file into MREP, refer to the instructions on page 63 of the Medicare Remit Easy Print User Manual.

# Medigap Claim-Based Crossover Moves to Consolidated, Standardized Process

This announcement is to inform you that, effective October 1, 2007, the Centers for Medicare & Medicaid Services (CMS) will transfer the mandatory Medicare supplemental (Medigap) insurance claim-based crossover process from its Medicare contractors to the national Coordination of Benefits Contractor (COBC). The definition of a "Medicare supplemental (Medigap) policy" is found at §1882(g)(1) of the Social Security Act, the text of which is being attached for your reference. The Medigap crossover process is mandated by §1842(h)(3)(B) of Title XVIII of the Social Security Act and is activated when 1) a participating Medicare provider includes a specific identifier on the beneficiary's claim and 2) the beneficiary assigns payment rights to that provider.

**What does this mean to you?**

The CMS is expecting your organization to contact the COBC during June 2007 regarding your need to sign a national Coordination of Benefits Agreement (COBA) that will enable you to continue receiving Medigap claim-based crossover claims. You may reach the COBC for this purpose by dialing 1-646-458-6740. The executed COBA will address claim transfer protocols, the frequency of the claim transfers (available options include daily, weekly, bi-weekly, or monthly), and the standard crossover fee. After your organization has signed the COBA, you will be assigned a new 5-byte COBA Medigap claim-based identifier. All participating providers will then have access to the Medigap insurer's new COBA Medigap claim-based identifier prior to October 1, 2007, and will be required to include this new identifier on your policy or certificate holders' incoming Medicare claims to successfully trigger mandatory Medigap claim-based crossovers.

With the transition of the Medigap claim-based crossover process to the COBC, Medigap insurers will enjoy the benefit of only needing to interact with one entity when they have questions or concerns. In addition, the Medigap insurers will now receive their claims and invoices from a single entity rather than individually from numerous Medicare contractors across the nation.

Effective October 1, 2007, CMS will discontinue the use of all non-standard claim formats, including National Standard Format (NSF) and paper claims. As "covered entities" under the final Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets rule, Medigap insurers must be able to accept the standard HIPAA American National Standards Institute (ANSI) X12-N 837 professional coordination of benefits (COB) version 4010-A1 claim. In addition, your organization should be able to accept National Council for Prescription Drug Programs (NCPDP) version 5.1 batch standard 1.1 Part B drug claims. However, CMS is not mandating receipt of NCPDP batch standard claims at this time. CMS will advise your organization when acceptance of these claims is required. Therefore, effective October 1, 2007, your organization will receive Part B physician and supplier claims in the HIPAA ANSI X12-N 837 professional claim (with receipt of NCPDP batch standard claims to follow in the future). In accordance with volume 55, number 225 of the November 21, 1990, Federal Register Notice, CMS will exclude non-assigned, fully paid original and fully paid adjustment claims, fully denied original and fully denied adjustment claims, and non-monetary adjustment claims from its national COBA Medigap claim-based crossover process with your organization.

Medigap insurers will continue to receive their crossover claims from their associated Medicare contractors at their currently designated frequency and in their currently designated claims format during the interim period from June 1 to September 30, 2007. Until October 1, 2007, the only change to the current Medigap claim-based process is that the Medigap insurer will be replacing its current identifier that initiates claim-based crossover to the 5-byte COBA Medigap claim-based identifier for processing purposes. This change will occur shortly after execution of the COBA.

**What can my organization do to be prepared for the October 1, 2007, change?**

Since your organization will no longer receive Medigap claim-based crossovers from CMS' Medicare contractors effective October 1, 2007, CMS strongly encourages all Medigap insurers that are currently receiving their crossovers via this methodology to act now and contact the COBC at 1-646-458-6740 to obtain more information about signing the national Coordination of Benefits Agreement (COBA). Your COBA will need to be signed during the months from June to August 2007, to allow your organization sufficient time for testing with the COBC in advance of the October 1, 2007, implementation. In addition, since Medicare will exclusively be crossing claims over to your organization in the standard HIPAA ANSI X12-N 837 professional claim format effective October 1, 2007, your organization may need to consider planning now to contract with an outside vendor that is able to accept the standard HIPAA claims format on your behalf.

Upon receipt of your COBA Medigap claim-based identifier, your organization should initiate provider and member education on the use of the new identifier. CMS recommends that, in accordance with §1882(c)(3)(C) of the Social Security Act, you consider issuing new cards to your Medigap policy and certificate holders that inform them of the new COBA Medigap claim-based ID for your organization. This will assist your policy or certificate holders with ensuring that their providers include the correct number on their incoming claims to Medicare. In addition, Medicare will be conducting extensive provider education concerning the new COBA Medigap crossover process through its Medicare contractor provider communication channels and web sites.

If your organization currently provides an eligibility file to initiate COBA Medigap crossovers, you may simply add all policy or certificate holders to your COBA eligibility file and maintain your current COBA identifier. In addition, please contact your COBC EDI or CMS representative for information on discontinuing your current Medigap claim-based crossover contract(s) with the Medicare contractor(s) if applicable.

## BILLING CONT'D

**What other details should my organization know?**

Effective with claims received after your COBA has been executed, your previously assigned Other Carrier Name and Address (OCNA) or N-key Medigap identifier will no longer be accepted on participating provider claims as a basis for triggering the crossing over of adjudicated claims to your organization. Also, unless your organization has executed a COBA with the COBC prior to October 1, 2007, your organization will be unprepared to test the new process with the COBC and, consequently, will be unable to receive production claim-based crossover claims following the implementation of the new process on October 1, 2007.

Starting October 1, 2007, claims will exclusively be selected for crossover to your organization through the new COBA Medigap claim-based crossover process. CMS' Medicare contractors will cease crossing claims directly to your organization. In addition, all current Medigap claim-based crossover recipients are advised that CMS' Medicare contractors will automatically terminate any existing crossover agreements with your organization no later than October 31, 2007, following your receipt of the final or residual claims that were tagged for crossover directly from the Medicare contractors prior to October 1, 2007.

If your organization has already signed a COBA with the COBC to participate in the eligibility file-based crossover process but you wish to continue receipt of claim-based crossovers for a portion of your policy or certificate holders, your organization will need to sign a new COBA (base agreement and attachment) to address your receipt of claims via the COBA Medigap claim-based crossover process.

The CMS and its COBC look forward to working with your organization to ensure a smooth transition from your current Medigap claim-based crossover process to the consolidated COBA Medigap claim-based crossover process.

**Additional Information**

*Definition of a Medicare Supplemental (Medigap) Policy*

In accordance with §1882 (g)(1) of Title XVIII of the Social Security Act, a *Medicare supplemental policy* is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include a Medicare+Choice plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A). For purposes of this section, the term "policy" includes a certificate issued under such policy.

# Update to Place of Service Code Set to Add Code for Prison/Correctional Facility - VMS Only

**MLN Matters Number: MM5331**
**Related Change Request (CR) #: 5331**
**Related CR Release Date: July 13, 2008**
**Related CR Transmittal #: R1288CP**
**Effective Date: July 1, 2006**
**Implementation Date: January 7, 2008**

**Provider Types Affected**

Suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided in prison/correctional facility settings.

**What you need to know**

CR 5331, from which this article is taken, announces the addition of place of service (POS) code "09" for a prison/correctional facility setting.

**Background**

As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with the statute's standards and implementation guides. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains. Further, as a payer, Medicare must be able to recognize, as valid, any code from the CMS-maintained, HIPAA-standard POS code set that appears on the HIPAA standard claim transaction.

This POS code set provides setting information that both Medicare and Medicaid need in order to appropriately pay their claims. Medicaid sometimes has a greater need for POS specificity than Medicare, and many of the new codes developed over the past few years have been developed to meet Medicaid's more specific needs. While Medicare does not always need this greater specificity in order to appropriately pay its claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

CR 5331, from which this article is taken, updates the current Medicare fee-for-service POS code set to add a new code (POS code "09") for prison/correctional facility and will implement the systems and contractor-level changes needed for Medicare to adjudicate claims with the new code.

Your DME MAC will develop the necessary policies to adjudicate claims containing this new code, and will accept it as valid. You should also be aware that your DME MAC must continue to comply with CMS current policy that, in

most cases, does not allow payment for Medicare services in a penal institution. The addition of a POS code for a prison/correctional facility setting does not supersede this policy. (See *Medicare Claims Processing Manual* (100-04, Section 10.4, Chapter 1, available at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf on the CMS web site.)

The implementation of this change will be based on claims processed on or after January 7, 2008, even though the effective date shows July 1, 2006. The effective date is based on HIPAA requirements for nonmedical data code sets, but the changes in CR5331 apply to claims Medicare processes on or after January 7, 2008.

**Additional Information**

You can find more information about the prison/correctional facility POS code update to the POS code set by going to CR 5331, located at http://www.cms.hhs.gov/Transmittals/downloads/R1288CP.pdf on the CMS web site.

## Claim Status Category Code and Claim Status Code Update

**MLN Matters Number: MM5687**
**Related Change Request (CR) #: 5687**
**Related CR Release Date: July 23, 2007**
**Related CR Transmittal #: R1314CP**
**Effective Date: January 1, 2008**
**Implementation Date: January 7, 2008**

**Provider Types Affected**

Physicians, providers, and suppliers who submit Health Care Claim Status Transactions 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) 5687, which provides the January 2008 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, A/B MACs, DME MACs, FIs, and RHHIs).

Effective January 1, 2008, Medicare contractors are to use codes posted on July 9, 2007, at the http://www.wpc-edi.com/codes web site. Chapter 31 of the *Medicare Claims Processing Manual*, Section 20.7 - Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277 discusses these codes in more detail. You may review section 20.7 at: http://www.cms.hhs.gov/manuals/downloads/clm104c31.pdf on the Centers for Medicare & Medicaid Services (CMS) web site.

**Background**

Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) must use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction. These codes indicate the general category of a claim's status (accepted, rejected, additional information requested, and so on). The national Code Maintenance Committee maintains the Claim Status Category and Claim Status codes.

The national Code Maintenance Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and makes decisions about additions, modifications, and retirement of existing codes. The codes sets are available at http://www.wpc-edi.com/content/view/180/223/. This page has previously been referenced by the following URL address: http://www.wpc-edi.com/codes. Included in the code lists are specific details, including the date when a code was added, changed, or deleted.

All code changes approved during the June 2007 committee meeting were posted on that site on July 9, 2007. One of the decisions made during this June meeting by this Maintenance Committee was to allow the industry more lead time for implementation of code changes. At least 6 months lead time will be allowed for industry implementation of all Claim Status-related code changes as well as Claim Adjustment Reason Code changes (the same committee maintains these code sets). As result, **changes approved in June 2007 will be effective January 1, 2008**.

**Additional Information**

For complete details regarding this Change Request (CR) please see the official instruction (CR5687) issued to your Medicare FI, carrier, DME MAC, RHHI or A/B MAC. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1314CP.pdf on the CMS web site.

## 2008 Annual Update of HCPCS Codes for SNF Consolidated Billing for Common Working File, Medicare Carriers and Fiscal Intermediaries

**MLN Matters Number: MM5696**
**Related Change Request (CR) #: 5696**
**Related CR Release Date: August 17, 2007**
**Related CR Transmittal #: R1317CP**
**Effective Date: January 1, 2008**
**Implementation Date: January 7, 2008**

**Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare Administrative Contractors (DME MACs), Part

A/B Medicare Administrative Contractors (Part A/B MACs) and fiscal intermediaries (FIs)) for services provided to Medicare beneficiaries in SNFs.

**Provider Action Needed**

This article is based on Change Request (CR) 5696, which provides the 2008 annual update of HCPCS Codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

CR5696 provides updates to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manual*, Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

**Background**

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a non-covered stay. Changes to Health care Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule designations are used to revise these edits to allow carriers, A/B MACs, DME MACs, and FIs to make appropriate payments in accordance with policy for SNF CB contained in the *Medicare Claims Processing Manual*. These edits only allow services that are excluded from CB to be separately paid by Medicare contractors.

Physicians and providers are advised that, by the first week in December 2007, new code files will be posted at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS web site. Institutional providers note that this site will include new Excel® and PDF format files.

**Note**: It is **important and necessary** for the provider community to view the "General Explanation of the Major Categories" PDF file located at the bottom of each year's FI update listed at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS web site in order to understand the Major Categories including additional exclusions not driven by HCPCS codes.

**Additional Information**

The official instruction, CR5696, issued to your Medicare contractor regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R1317CP.pdf on the CMS web site.

## Reasons for Provider Notification of Medicare Claims Disputed/Rejected by Supplemental Payers/Insurers

**MLN Matters Number: SE0728**

**Provider Types Affected**

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, fiscal intermediaries (FIs), Medicare Administrative Contractors (A/B MACs), and durable medical equipment MACs (DME MACs).

**Provider Action Needed**

Effective for claims processed on or after July 1, 2007, when claims crossed over by Medicare to a supplemental payer/insurer are rejected or disputed by that insurer, Medicare will add a standardized message to the notification to the provider. That message will be in the form of a Dispute Reason Code, which will explain why the supplemental insurer disputed the claim.

**Background**

In *MLN Matters* article, MM3709, the Centers for Medicare & Medicaid Services (CMS) describes the notification process to Medicare providers when Medicare claims that should automatically cross to a supplemental payer/insurer-are not crossed over due to claim data errors. The notification is mailed to the correspondence address that is submitted by the provider, along with all other Medicare enrollment data, and is maintained by CMS' Medicare contractors. (MM3709 may be referenced at: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3709.pdf on the CMS web site.)

There are also situations where provider notifications are sent **after** the claim has crossed to the supplemental payer/insurer. This occurs in situations where the insurer may not be able to process the Medicare claim for supplemental payment and, therefore, rejects or disputes the claim back to CMS' Coordination of Benefits Contractor (COBC). When these situations occur, the COBC transmits a report containing the "disputed" claims to the Medicare contractor, which then notifies the provider, through a special automated correspondence, that the claim was not crossed automatically.

Beginning in July 2007, provider notifications will include standardized language for claims that have been disputed by the supplemental payer/insurer and the dispute has been accepted by the COBC. The standardized language will read: "Claim rejected by other insurer," and it will include a reason code. The following is a list of the reason codes that may be contained in the standardized language and the definition of each:

**Dispute Reason Codes:**

- 000100 - Duplicate Claim
- 000110 - Duplicate Claim (within the same ISA – IEA loop)
- 000120 - Duplicate claim (within the same ST-SE loop)
- 000200 - Claim for Provider ID/State should have been excluded
- 000300 - Beneficiary not on eligibility file
- 000400 - Reserved for future use
- 000500 - Incorrect claim count
- 000600 - Claim does not meet selection criteria
- 000700 - HIPAA Error
- 009999 - Other

When Medicare providers receive this notification, they may need to take appropriate action to obtain payment from the supplemental payer/insurer for all Dispute Reason Codes **except** for 000100, 000110, 000120, and 000400.

## FRAUD/ABUSE

# HHS Takes Further Steps To Protect Medicare From Fraudulent Durable Medical Equipment Suppliers

HHS today announced a proposed rule that will help limit the Medicare program's risk by requiring all suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to furnish the Centers for Medicare & Medicaid Services (CMS) with a surety bond. The rule would ensure that Medicare can recover erroneous payments up to $65,000 that result from fraudulent or abusive supplier billing practices.

Acting CMS Deputy Administrator Herb Kuhn said, "A surety bond will not only limit Medicare's risk to fraudulent billing, but will also help to ensure that only legitimate DMEPOS suppliers are enrolled in the program."

The proposed rule represents another HHS step in an ongoing effort to combat Medicare fraud with particular focus on DMEPOS suppliers. In May, HHS and the Department of Justice announced the establishment of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing. The proposed surety bond requirement follows announcements of two demonstration projects, one requiring that DMEPOS suppliers in South Florida and Southern California reapply to Medicare in order to maintain their billing privileges. The other demonstration requires home health agencies in the Houston area and Southern California to reapply.

The rule proposed by CMS implements section 4312 of the Balanced Budget Act of 1997. The rule would require all DMEPOS suppliers, except those that are government operated, to obtain and retain a surety bond in the amount of $65,000. The $65,000 requirement is an inflation-adjusted figure from the $50,000 surety bond amount proposed in the 1997 Act.

The HHS release is found at http://www.hhs.gov/news/press/2007pres/07/pr20070727a.html

A copy of the proposed rule can be found at http://www.cms.hhs.gov/MedicareProviderSupEnroll/downloads/DMEPOSSuretyBondRegulation.pdf

For information about Medicare fraud, visit http://www.hhs.gov/medicarefraud/.

# HHS and DOJ Announce Initiative to Fight Infusion Fraud Therapy

Today (August 20, 2007) Health and Human Services Secretary (HHS) Mike Leavitt announced an initiative designed to protect Medicare beneficiaries from fraudulent providers of infusion therapy. This two-year project will focus on preventing deceptive providers from operating in South Florida. Providers will be required to reapply to be a qualified Medicare infusion therapy provider.

"HHS continues to work with the Department of Justice (DOJ) to protect the public and Medicare by stopping fraud before it happens," Secretary Leavitt said. "This demonstration project works to bar unlawful infusion therapy providers from entering the Medicare billing system." The new infusion therapy demonstration follows similar demonstration projects previously announced by HHS.

The Centers for Medicare & Medicaid Services (CMS) will now require infusion providers who operate in several South Florida counties to immediately resubmit applications to be a qualified Medicare infusion therapy provider. Those who fail to reapply within 30 days of receiving a notice to reapply from CMS will have their Medicare billing privileges revoked. Infusion therapy providers that fail to report a change in ownership, have owners, partners, directors or managing employees who have committed a felony, or no longer meet each and every provider enrollment requirement will have their billing privileges revoked.

The DOJ is supporting HHS's new controls through a surge in prosecutions for health care fraud in South Florida. In May the DOJ and HHS announced the work of a multi-agency team of federal, state and local investigators designed specifically to combat Medicare fraud through the use of real-time analysis of Medicare billing. Since implementing the "phase one" Strike Force in Miami last March, DOJ prosecutors working with Assistant U.S. Attorneys from the Southern District of Florida have filed 47 indictments charging 65 individuals and/or entities with health care fraud in schemes that collectively billed Medicare more than $345 million. The Strike Force has convicted 26 defendants to date; 23 by plea agreement and three have been convicted in jury trials.

For your convenience, copies of the HHS Press Release and Fact Sheet on this topic are listed below.

HHS Press Release

HHS Fact Sheet

Please Note: All HHS press releases, fact sheets and other press materials are available at http://www.hhs.gov/news.

## CERT

# Verify CERT Contact Information

DME suppliers are encouraged to verify that their contact information for medical records or compliance staff on file with the CERT contractor is accurate and up-to-date. This contact information should include, but is not limited to, supplier name, National Supplier Clearinghouse Number and/or NPI, physical street address, city, state, and zip code. Post Office (P.O.) Box addresses are **discouraged** because the CDC is unable to send Certified Return Receipt Requests when required for Medical Request Letters. The CERT Documentation Contractor (CDC) also recommends that you have one point of contact at your physical location with one phone number, fax number and email address.

To verify your contact information, go to www.certcdc.com/certproviderportal/ and click on the "Provider Address Directory" on the left side of the page. On the "Provider

## CERT CONT'D

Address Directory Page" enter the NSC or NPI number and initiate a search for the contact information. If changes are needed to the listed information, suppliers can contact the CERT Documentation Contractor by phone at 301-957-2380 or by email to report the changes as guided by the CERT web site. If the search does **not** locate contact information for a supplier, the supplier is encouraged to submit contact information to the CERT Documentation Contractor by the same means as noted above.

Providing the most accurate information will assist in ensuring that CERT documentation request letters are sent to the most appropriate staff at your office therefore allowing you, the supplier, to obtain and submit medical records timely to the CERT contractor. This will avoid CERT errors and recoupment of previously paid claims.

# CERT Documentation

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

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

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

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

**Mail all requested documentation to:**
**CERT Documentation Office**
**Attn: CID #:xxxxxx**
**9090 Junction Drive, Suite 9**
**Annapolis Junction, MD 20701**

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

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

**Suppliers must submit medical records to the CDC within 75 days from the receipt date of the initial letter or claims will be denied.** The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims. Also, Medicare patients have already given authorization to release necessary medical information in order to process claims. Therefore, Medicare suppliers do not need to obtain a patient's authorization to release medical information to the CDC.

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

## APPEALS

# Reopening and Redetermination Updates

Telephone reopenings hours have been extended and are now 8am to 4 pm CT, Monday through Friday. The telephone reopenings number is 1-888-826-5708.

Due to these extended phone hours, the telephone reopening team will attend bi-monthly trainings to stay informed of current CMS changes and guidelines. The telephone reopening line will therefore not be available every other Wednesday from 8 am to 9 am CT, beginning July 18, 2007, for these training sessions. The Telephone Reopening team also reserves the right to meet during the month, at will, for training when necessary. This is in accordance with CMS guidelines that allow for training time for telephone staff. The recording on the telephone reopening line will inform callers of these training times.

NAS is also pleased to announce that we now accept faxed requests for both written reopening and redetermination requests. The new fax number is 1-888-408-7405. We encourage suppliers to use the reopenings and redetermination forms as found in the Forms section of the NAS DME web site, www.noridianmedicare.com. Please remember that DME MACs have 60 days to complete a reopening and a redetermination.

# Documentation Guide for DME Redeterminations

Medicare can provide payment for DMEPOS items if the patient's medical record reflects the need for the items provided. The patient's medical records include physician office records, hospital records, nursing home records, home health agency records, records from other health care professional and test reports.

Redetermination requests should include all pertinent medical documentation. The following table is a guide on the type of documentation that can support the request for payment. For complete documentation requirements, review the Local Coverage Determination and related policy article for each category of DMEPOS.

## APPEALS

**Note**: Although suppliers may provide additional explanatory materials, the original record cannot be altered or supplemented.

**Note**: The following list of required medical documentation is not an all-inclusive list. It is to be used as a guideline only.

| Item | Documentation Required |
|---|---|
| CPAP | • Written order<br>• Sleep study |
| Diabetic Supplies (Glucose Monitors) | • Written order<br>• Progress notes<br>• Blood glucose logs, if requesting more than allowed for by policy |
| Dialysis Supplies | • Written order, indicating Method II was ordered<br>• CMN<br>• Progress notes |
| External Infusion Pump/Covered Drugs | • DIF (if required)<br>• Written order<br>• Medical records that contain:<br>  • Name of the drug<br>  • Concentration, if applicable<br>  • Frequency of administration<br>  • Route of administration<br>  • Duration of infusion, if applicable |
| Hospital Bed | • Written order |
| Insulin Pump | • Lab results for C-Peptide levels<br>• Documentation that the patient is seen and evaluated by the treating physician at least every three months<br>• Diabetic evaluations/worksheets |
| Manual Wheelchair | • Written order<br>• Delivery ticket<br>• Pick-up ticket (if previously owned equipment) |
| Miscellaneous Supplies | • Written order |
| Nebulizer | • Written order |
| Negative Pressure Wound Therapy (NPWT) | Written order (prior to delivery) which contains:<br>• Beneficiary information<br>• Date<br>• Length of treatment<br>• Signature/UPIN or NPI of doctor |
| | Medical documentation containing:<br>• Monthly measurement of the wound in centimeters consisting of the length, width, depth<br>• Any evidence of "tunneling" if applicable |
| | Type I wounds must also include:<br>• Documentation listed above<br>• Ulcer must be that of a chronic nature<br>• Ulcer must be present for 30 days or more<br>• Evidence that conventional treatment with appropriate dressings have failed<br>• Evidence that the wound has been debrided if there is an necrotic or dead tissue in the wound<br>• Evidence the beneficiary is being turned and positioned frequently to remove pressure from the affected area<br>• Evidence that a group 2 or group 3 pressure support surface is being used if there is an ulcer on the pelvis or the posterior trunk<br>• Evidence that the moisture and incontinence is being appropriately managed<br>• Evidence that the beneficiary's nutritional status has been evaluated and addressed as adequate/ supplemented |
| | Type II wounds must also include:<br>• Type I wound documentation<br>• Evidence that if the beneficiary has diabetes, the beneficiary is part of a comprehensive diabetic management program<br>• Evidence that if the ulcer is a result of venous insufficiency, that the beneficiary had a trial of application of compression bandages, leg elevation and ambulation |
| | Type III wounds must also include:<br>• Type I and II wound documentation<br>• Evidence of a trial of conventional topical wound treatment that was failing prior to the institution of NPWT |
| Oxygen | • CMN<br>• Pick-up and delivery ticket, as applicable |
| Parenteral/ Enteral | • DIF |
| | • Category III – VI formulas: Documentation supporting the need for these categories (i.e., office notes, lab reports, etc.) |
| | • Nutrition greater than 2000 calories: Statement from the physician as to why high calorie intake is needed |
| Patient-owned external pump | • Model<br>• Serial number<br>• Date of purchase<br>• Who purchased the item |

| | |
|---|---|
| Power Mobility Device | • Face to face examination report<br>• Home evaluation<br>• Written order (prior to delivery)<br>• Detailed production description signed and dated by physician<br>• Progress notes<br>• Mobility evaluation<br>• Letter of medical necessity (as a substitute for other medical documentation<br>• Delivery ticket |
| Pneumatic Compression Device | • CMN<br>• Written order<br>• Progress notes |
| Pressure Reducing Support Surface | • Written order (prior to delivery) |
| Prosthetics/ Orthotics | • Written order<br>• Office notes |
| Refractive Lenses | • Date of cataract surgery |
| Respiratory Assist Device | • Written order<br>• Sleep study<br>• Proof that the CPAP is ineffective for group IV coverage |
| Seat Lift Mechanism | • CMN<br>• Written order (prior to delivery) |
| Suction Pump | • Written order<br>• Documentation stating "difficulty raising and clearing secretions" |
| Surgical Dressings | Written order which contains:<br>• Type of dressing<br>• Size of dressing<br>• Number of dressings<br>• Frequency of dressing change<br>• Expected duration of need<br>• Date<br>• Signature/ UPIN or NPI of doctor<br>• A new order must be obtained every three months or if the needs change or an increase in dressing requirements occurs |
| | Medical documentation that includes:<br>• Number of wounds<br>• Reason for wound<br>• Size of wound<br>• Location of wound<br>• Amount of drainage, color, odor<br>• Assessment of the wound and staging (i.e., stage I-IV) |
| TENS Unit | • CMN<br>• Written order (prior to delivery)<br>• Progress notes from physical therapist |
| | For acute post-operative pain, the documentation must include:<br>• Limited to 30 days from day of surgery<br>• Payment for over 30 days determined by individual consideration based upon documentation by attending physician<br>NOTE: This will be paid for as a rental |
| | For chronic pain, the documentation must include:<br>• Location of pain<br>• Duration of pain<br>• Presumed etiology of pain<br>• Pain present for 3 months<br>• Other treatment modalities tried and failed<br>• What other modalities have been tried<br>NOTE: This will be paid for as a purchase |
| | For chronic, intractable pain, the documentation must include:<br>• Must be used on a trail basis for a minimum of 30 days, but not to exceed 2 months.<br>NOTE: The trial period will be paid as a rental<br>• Re-evaluation of the patient at the end of the trail period<br>• How often the patient used the TENS unit<br>• Duration of each use each time<br>• Results of use<br>NOTE: After the trial period this will be paid for as a purchase |
| Tracheostomy Care Supplies | • Written order<br>• Evidence the supplies were billed following an open surgical tracheostomy |
| Urological Supplies | • Lab reports, showing urinary tract infections<br>• Progress notes – including the date that clean intermittent catheterization was started<br>• Written order |
| Wheelchair Repair/ Replacement | For patient owned equipment-repairs:<br>• Date of purchase<br>• Who purchased the equipment<br>• Model number/serial number<br>• Work order<br>• Invoice |
| | For Medicare purchased equipment-repairs:<br>• Work order<br>• Invoice |
| | Replacement:<br>• Reason for replacement<br>• All Power Mobility Device documentation |

## ENROLLMENT

# The DMEPOS Enrollment Process vs. the Accreditation Process. Is There a Difference?

Is there a difference between the DMEPOS enrollment process and the accreditation process?

**YES!** There has been some confusion regarding this issue and it is important for suppliers to understand the differences between the two processes.

The National Supplier Clearinghouse (NSC) is responsible for ensuring suppliers are in compliance with the Durable Medical Equipment, Prosthetics Orthotics and Supplies (DMEPOS) supplier standards and the Accrediting Organizations, appointed by the Centers for Medicare and Medicaid Services (CMS), are responsible for ensuring suppliers meet the Quality Standards.

When a supplier is accredited that does not automatically mean the supplier has met the requirements to bill Medicare as a DMEPOS supplier.

The NSC and the Accrediting Organizations are responsible for enforcing two separate sets of standards. Each set of standards relate to different aspects of a supplier's business. Therefore, the two processes are not interchangeable.

Being in compliance with one set of standards does not mean being in compliance with the other. A supplier may be accredited, which means the supplier is qualified to provide certain products and services, but the accreditation does not mean the supplier has met the requirements to bill Medicare. The supplier must show compliance with the DMEPOS supplier standards in order to obtain and retain billing privileges.

Another issue regarding accreditation that suppliers seem to be concerned about is site visits. Both the NSC and the Accrediting Organizations will conduct site visits or surveys to determine a supplier's compliance with the set of standards each entity is responsible for enforcing. Therefore, suppliers can expect to receive a site visit or survey from both the NSC and the Accrediting Organizations to verify compliance with the respective set of standards.

With regards to the accreditation process, the NSC's involvement will be limited to ensuring suppliers are properly accredited to provide the products and services listed on the supplier file and for collecting and maintaining information regarding supplier accreditation.

Please note the CMS has yet to establish a date when all suppliers must be accredited. Therefore, suppliers are not currently required to provide the NSC with accreditation information or complete Section 2F of the CMS 855S application form. The NSC will inform suppliers when this information is required.

Below is a breakdown of each entity's responsibilities, which should help in understanding the differences between the two processes.

**The NSC is responsible for:**

- The DMEPOS Enrollment Process
- Ensuring suppliers are in compliance with the DMEPOS supplier standards
- Maintaining information regarding supplier accreditation
- Performing site visits to ensure a supplier's compliance with the DMEPOS supplier standards

**The Accrediting Organizations are responsible for:**

- Accrediting suppliers based on the Quality Standards for specific products and services provided to Medicare beneficiaries
- Ensuring suppliers remain in compliance with the Quality Standards
- Conducting site surveys to ensure suppliers are in compliance with the Quality Standards

Again, the NSC and the Accrediting Organizations are enforcing two different sets of standards and being in compliance with one set does not mean the supplier is in compliance with the other.

For information regarding the DMEPOS enrollment process, please contact the NSC Customer Service Line at (866) 238-9652 or visit the NSC Web site.

For information regarding the accreditation process and the Quality Standards, please visit http://www.cms.hhs.gov/CompetitiveAcqforDMEPOS on the CMS Web site.

## FORMS

# New MSP Inquiry and Refund Form

NAS is pleased to introduce a new, interactive form dedicated to DME MSP inquiries and refunds. This new streamlined form will allow MSP inquiries and refunds to be processed more timely by our MSP department. Suppliers can type their information in the form, print and mail to NAS.

The interactive form also has features that allow you to highlight the fields so you can easily see where to enter the information and to highlight the required fields so that the form is complete and no key data is missing. The current Refunds to Medicare form has also been revised to allow for submission of only non-MSP refund requests. We encourage suppliers to utilize these new forms and to share this change with all affected staff in your office.

# Revised Jurisdiction D EDI Applications

The Jurisdiction D EDI Customer Profile and Jurisdiction D EDI Enrollment Form have been revised. The most current version has a revised date of August 20, 2007, on all pages.

## FORMS CONT'D

Applications received on or after October 1, 2007, must be submitted on the most current version with a revised date of August 20, 2007. Any applications received on or after October 1, 2007, not on the most current version will be returned.

The forms can be located at www.cignagovernmentservices.com/edi/dmerc/forms.html. If you have any questions, please contact the EDI Helpdesk at 866-224-3094.

## COVERAGE

# Nebulizers – Perforomist and Brovana – Coverage Criteria and Billing Instructions

Formoterol (Perforomist) is a long-acting beta-adrenergic agonist (LABA) drug, which recently has become available as an FDA-approved, non-compounded unit dose inhalation solution. It is covered for dates of service on or after the date of FDA approval, May 11, 2007.

**Coverage Criteria**

FDA-approved inhalation solutions of formoterol or arformoterol are covered when the following criteria are met:

1. It is medically necessary for the management of chronic obstructive pulmonary disease (diagnosis codes 491.0-492.8, 496); and

2. The patient has a documented history of routine use of at least four doses per day of an FDA-approved albuterol or metaproterenol inhalation solution or at least three doses per day of an FDA-approved levalbuterol inhalation solution.

If these criteria are not met, formoterol and arformoterol will be denied as not medically necessary.

These criteria represent a revision of those previously published for Brovana (arformoterol). The routine use requirement for levalbuterol has been changed from four doses per day to three doses per day since the standard dose of levalbuterol as noted in the FDA-approved indications is three times per day. These revised criteria are effective retroactively to the FDA approval date of Brovana, October 6, 2006.

Formoterol and arformoterol are administered using a pneumatic compressor (E0570, E0571) and a small volume nebulizer (A7003, A7004, A7005).

A maximum of two vials of formoterol (20 micrograms each) or two vials of arformoterol (15 micrograms each) are covered per day.

Short-acting beta adrenergic agonists (SABAs) may be covered as rescue/supplemental medication in addition to formoterol or arformoterol. However, when formoterol or arformoterol is used, the maximum amount of SABA inhalation solutions that will be covered is an average of one dose per day (31 doses per month).

**Coding and Billing Guidelines**

When submitting claims for formoterol or arfomoterol, use code J7699 with a KO modifier. Enter the name of the drug in the narrative field of the electronic record or in Item 19 if the CMS-1500 (08-05) claim form. A KX modifier may be added to J7699KO only when:

(a) The drug being billed is Perforomist or Brovana; and,

(b) The coverage criteria stated above have been met.

There are no other drugs that may be billed using the KX modifier with code J7699.

When billing for Perforomist, 1 unit of service = 1 vial (20 micrograms).

When billing for Brovana, 1 unit of service = 1 vial (15 micrograms).

Refer to the Nebulizers LCD and Policy Article for additional information on coverage, coding, and billing of inhalation solutions. The Nebulizers policy will be revised to incorporate this information.

# Negative Pressure Wound Therapy – LCD Documentation

Recent reviews of Negative Pressure Wound Therapy (NPWT) claims have identified supplier deficiencies in their documentation of compliance with the Local Coverage Determination (LCD) coverage criteria. The NPWT LCD is a complex policy containing items that, in the event of an audit, would require submission of information from the beneficiary's medical record.

Elements of the LCD that require information from the medical record to justify coverage include:

- Complete description of the wound
- Description of prior care for the wound
- Complications with surgically created wounds
- Monthly monitoring of wound healing progress
- Need for more than four months therapy
- Need for a quantity of supplies that exceeds the expected amounts outlined in the LCD

Review the "Indications and Limitations of Coverage and/or Medical Necessity" section of the LCD for a complete discussion of coverage criteria.

The "Documentation Requirements" section provides substantial guidance on the type of information that may be requested.

*"Documentation of the history, previous treatment regimens (if applicable), and current wound management for which an NPWT pump is being billed must be present in the patient's medical record and be available for review if requested by the DMERC. This documentation must include such elements as length of sessions of use, dressing types and frequency of change, and changes in wound conditions, including precise measurements, quantity of exudates, presence of granulation and*

## COVERAGE CONT'D

*necrotic tissue and concurrent measures being addressed relevant to wound therapy (debridement, nutritional concerns, support surfaces in use, positioning, incontinence control, etc.).*

*Documentation of wound evaluation and treatment, recorded in the patient's medical record, must indicate regular evaluation and treatment of the patient's wounds, as detailed in the Indications and Limitations of Coverage Section. Documentation of quantitative measurements of wound characteristics including wound length and width (surface area), and depth, and amount of wound exudate (drainage), indicating progress of healing must be entered at least monthly. The supplier of the NPWT equipment and supplies must obtain from the treating clinician, an assessment of wound healing progress, based upon the wound measurement as documented in the patient's medical record, in order to determine whether the equipment and supplies continue to qualify for Medicare coverage. (The supplier need not view the medical records in order to bill for continued use of NPWT. Whether the supplier ascertains that wound healing is occurring from month to month via verbal or written communication is left to the discretion of the supplier. However, the patient's medical records may be requested by the DMERC in order to corroborate that wound healing is/was occurring as represented on the supplier's claims for reimbursement).*

*When NPWT therapy exceeds 4 months on the most recent wound and reimbursement ends, individual consideration for additional months may be sought using the appeals process. Documentation should be submitted with the appeal explaining the special circumstances necessitating the extended therapy time."*

Many suppliers create documents to facilitate their collection of information. In the event of an audit, forms that are developed by entities including but not limited to a supplier or a professional association are not sufficient, by themselves, to document that coverage criteria have been met. If forms are used, there must be documentation in the patient's medical record that corroborates the information on the forms and verifies that coverage criteria have been met.

Refer to the Jurisdiction D Supplier Manual, Chapter Three, Documentation Requirements, and Chapter Nine, LCDs and Policy Articles, for additional information on NPWT and other general documentation requirements.

## WHEELCHAIR/POWER MOBILITY DEVICE

**Group 34 Batteries**

Group 34 batteries should be billed using HCPCS K0108, Wheelchair component or accessory, not otherwise specified. In Item 19 on the CMS-1500 claim form or in the narrative field for electronic claims, report "Group 34 battery for PMD."

Group 34 batteries will be down-coded to HCPCS E2363, Power wheelchair accessory; group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat). This has been determined to be the most appropriate code as Group 34 batteries are not considered reasonable and necessary for a power wheelchair.

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