A Medicare Newsletter for Region D DMEPOS Suppliers - A service of CIGNA Government Services

REGION D
DMERC DIALOGUE
DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

April 2006 (Spring) ***General Release 06-2***

Region D DME Benefit Integrity Support Center

Project Background

On September 30, 2005, the Centers for Medicare & Medicaid Services (CMS) awarded a new contract to EDS (Electronic Data Systems) and its subcontractor IntegriGuard, LLC, to establish the Region D Durable Medical Equipment Benefit Integrity Support Center (DME-BISC).

Region D consists of Alaska, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, Mariana Islands, and American Samoa.

This project is part of the CMS Medicare Integrity Program (MIP) to engage Program Safeguard Contractors (PSC) in 1) combating Medicare fraud, waste, and abuse, and 2) identifying erroneous claims submission and educating providers in correct billing and coverage practices. These are the Benefit Integrity (BI)/Medical Review (MR) functions currently performed by CIGNA Government Services (CGS), the Region D Durable Medical Equipment Regional Carrier (DMERC).

EDS assumes responsibility for the above functions from CGS effective March 1, 2006. As a PSC, EDS is generally responsible for data-analysis, investigation, and case development for the DME-BISC. IntegriGuard, acting as a subcontractor, performs medical reviews as well as education services for the DME-BISC.

The DME-BISC does not replace the Medicare program administration work performed by CGS. CGS will continue its current responsibilities including processing and paying claims (including Medicare Secondary Payer (MSP) and crossover), customer service, appeals, provider education and publications.

Project History

In accordance with Section 1834(1)(12) of the Social Security Act, CMS entered into contracts in 1992 with four DMERCs to perform all of the DMERC duties associated with processing claims for DME Prosthetics, Orthotics, and Supplies (DMEPOS) under Part B of the Medicare program. Traditionally, CMS has contracted with insurance companies to perform the tasks necessary to administer the Medicare program. The original four DMERCs were responsible for claim processing, customer service, provider education, medical review, MSP, medical policy, and fraud and abuse tasks within their given jurisdictions.

In recent years, CMS has been shifting its contracting approach away from a single general contractor to multiple specialist contractors who handle specific tasks within their given jurisdictions. Multiple contractors may work together to provide the full range of necessary services for a particular jurisdiction.

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Region D DME Benefit Integrity Support Center (cont'd)

Project Purpose

The DME-BISC will create a focused resource to detect and deter fraud in the Medicare DME program in the region. In this capacity, it will develop administrative solutions, investigations, and cases for referral to law enforcement, as well as provide ongoing support for those cases as needed. Additional responsibilities include coordination of BI activities in the region, and dissemination of relevant BI information to the related Affiliated Contractor (AC), providers, and beneficiaries.

The DME-BISC also has the responsibility to perform all Medical Review (MR) functions, including development and revision of DME Local Coverage Determinations (LCDs), provider education and training, and the review of medical record documentation for claim submission and correct payment. It will also serve as the Point of Contact (POC) for CMS' ongoing Comprehensive Error Rate Testing (CERT) activities.

Expected Outcomes

Through its work, the DME-BISC expects to identify situations of potential fraud, waste, and abuse in the Medicare program for case development and referral to law enforcement; perform timely and accurate resolution of complaints alleging fraud; and identify Medicare program weaknesses, vulnerabilities, and make recommendations for corrective actions, including prepayment reviews, overpayment recovery and provider education.

Medical Review Mailing Address

Beginning March 1, 2006, suppliers may send documentation requested for medical review and supporting documentation for Advance Determinations of Medicare Coverage (ADMCs) to:

Medical Review
IntegriGuard, LLC
2121 N. 117 Ave., Suite 200
Omaha, NE 68164

DME-BISC Contacts

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MEDICAL POLICY

Policies Revised

Listed below is a summary of updates to the Local Coverage Determinations (LCDs)/Policy Articles (PAs) effective for dates of service on or after January 1, 2006. Suppliers are reminded that these policy revisions are published in the split format of a local coverage determination and policy article. Both documents taken together constitute the "medical policy." Suppliers are strongly encouraged to read both the LCD and the policy article that accompanies the LCD for a full understanding of the coverage, coding and documentation requirements.

The policies are published on the DMERC Web site and are also available on the CMS Web site at www.cms.hhs.gov/mcd/indexes.asp.

Ankle-Foot/Knee-Ankle-Foot Orthosis

LCD – HCPCS CODES AND MODIFIERS: Added L2034 and L2387.

DOCUMENTATION REQUIREMENTS: Removed requirement for documentation to be attached to the claim.

PA – CODING GUIDELINES: Added L2034.

Canes and Crutches

LCD – HCPCS CODES: Description verbiage revised for E0116.

Commodes

LCD – INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Removed "Least Costly Alternative" statement for E0165. Revised statements related to E0165. Revised statements for commodes E0170 and E0171.

HCPCS CODES: Added E0170 and E0171. Deleted E0169.

DOCUMENTATION REQUIREMENTS: Added E0170, E0171 as requiring the KX modifier if criteria for seat lift mechanism is met. Removed requirement for documentation of weight to be submitted on claim with E0168.

PA – CODING GUIDELINES: Added E0170 and E0171 to Column I in the table. Added definition of E0170 and E0171.

Continuous Positive Airway Pressure System (CPAP)

LCD – HCPCS CODES: Added A4604. Revised A7032 and A7033.

INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Accessories: Added frequency guideline for A4604 and A7030. Added clarification regarding Full Face Mask Seals (A7031).

DOCUMENTATION: Revised requirements for documenting excess quantities of supplies.

APPENDICES: Revised definition of apnea-hypopnea index (AHI) to reflect NCD.

PA – CODING GUIDELINES: Added definitions for A4604, A7032 and A7033.

Epoetin

LCD – HCPCS CODES AND MODIFIERS: Added J0881, J0882, J0885, and J0886. Deleted Q0136, Q0137, Q4054, and Q4055.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Updated section with HCPCS code changes.

CODING GUIDELINES: Updated section with HCPCS code changes.

External Infusion Pumps

LCD – INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Added J2278 criteria.

HCPCS CODES AND MODIFIERS: Added J0133, J1265, J2278, and J3285. Deleted E0782, Q4075, Q4076, and Q4077.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Corrected error in implantable pump codes. Added bundling statement about batteries.

CODING GUIDELINES: Added statement about A4232.

Facial Prostheses

LCD – HCPCS CODES AND MODIFIERS: Added A5120. Deleted A5119.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added A5120. Deleted A5119.

CODING GUIDELINES: Added A5120. Deleted A5119.

Glucose Monitors

LCD – HCPCS CODES AND MODIFIERS: Added A4233, A4234, A4235, A4236, and A9275. Deleted A4254.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added non-coverage statement for home blood glucose disposable monitor.

Home Dialysis Supplies and Equipment

LCD – HCPCS CODES AND MODIFIERS: Added A4215. Revised verbiage for A4216. Deleted A4656.

DOCUMENTATION REQUIREMENTS: Removed requirement that medical necessity documentation be submitted with Not Otherwise Classified codes.

PA – NON-MEDICAL NECESSITY COVERAGE & PAYMENT RULES: Added A4215 and deleted A4656 from list of codes that would be denied as noncovered when billed without the AX modifier.

CODING GUIDELINES: Added A4215 and deleted A4656 from list of codes which must be submitted with an AX modifier.

Hospital Beds And Accessories

LCD – INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Added criteria for E0911 and E0912.

HCPCS CODES AND MODIFIERS: Added E0911 and E0912.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Clarified trapeze bars and added E0911.

Immunosuppressive Drugs

LCD – HCPCS CODES AND MODIFIERS: Added Q0510, Q0511 and Q0512. Deleted G0369 and G0370.

DOCUMENTATION REQUIREMENTS: Eliminated DMERC Information Form (DIF) completion requirement.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added Q0510, Q0511 and Q0512. Deleted G0369 and G0370. Added a definition for supply fee code Q0512.

Lower Limb Prostheses

LCD – INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Updated section with HCPCS code changes. Corrected code range for level 1 knee additions. Added functional level requirement for high activity knee control frame (L5930). HCPCS CODES: Added L5703, L5858, L5971 and L7600. Deleted K0670.

DOCUMENTATION REQUIREMENTS: Updated section with HCPCS code changes. Added L5930 to list of codes requiring a K modifier – effective for dates of service on or after 5/1/06.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added noncoverage statement for prosthetic donning sleeves. Added noncoverage statement for user-adjustable heel height.

CODING GUIDELINES: Updated section with HCPCS code changes. Added statement concerning prosthetic foot covers. Added statement concerning ultralightweight material.

Nebulizers

LCD – INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Inserted new HCPCS Codes A4216 and A4218 and deleted codes J7051 and J7699 where appropriately. Added coverage statement for code A7007. Added A7007 to the related code table for E0565. Added A7007 to usual maximum amount.

HCPCS CODES & MODIFIERS: Added HCPCS codes A4218, G0333, J7620, J7627, Q0513 and Q0514. Verbiage revision to description of HCPCS codes A4216 and J7626. Deleted HCPCS codes J7051, J7616, G0373 and G0374.

ICD-9 CODES THAT SUPPORT MEDICAL NECESSITY: Added J7620 and J7627 to the list of codes requiring ICD-9 code 491.0-508.9, deleted J7616. Added A7007 to the 5th paragraph of HCPCS codes requiring specific ICD-9 codes. Added A4216 and deleted A7051 from the 6th paragraph of HCPCS codes requiring specific ICD-9 codes.

DOCUMENTATION REQUIREMENTS: Revised E1399 and J7699 documentation requirements.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Deleted A7007 from statement that this code would be denied as a convenience item. Replaced deleted G0371 and G0374 with new dispensing fee HCPCS codes Q0513 and Q0514. Revised guidelines for dispensing fees.

CODING GUIDELINES: Added A7007 as equipment that would not be used with oxygen. Deleted J7616 and replaced with new HCPCS code J7620. Added A4118 to replace J7699 for metered dose dispenser of sterile saline or water.

Negative Pressure Wound Therapy Pumps

LCD – INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Removed deleted HCPCS code A6551 as requiring SADMERC verification. Deleted A6551 and inserted canister code A7000 as having a maximum of 10 canisters allowable per month.

HCPCS CODES AND MODIFIERS: Added A7000. Deleted A6551. Revised A6550.

PA – CODING GUIDELINES: Revised definitions for codes E2402 and A6550. Inserted the canister HCPCS code A7000 and removed the deleted canister coder A6551 where applicable. Added statement about Coding Verification Review for code E2402.

Oral Anticancer Drugs

LCD – HCPCS CODES AND MODIFIERS: Added Q0511, Q0512, J8498 and J8597. Deleted G0370, K0415 and K0416.

DOCUMENTATION REQUIREMENTS: Edited for code changes. Revised J8498, J8597 and J8999 instructions.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Edited for code changes. Revised instructions for Supply Fee.

CODING GUIDELINES: Added J8498 and J8597. Deleted K0415 and K0416.

Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

LCD – INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Added J8540. Deleted Q0181.

HCPCS CODES AND MODIFIERS: Added J8540, Q0511 and Q0512. Deleted G0370.

DOCUMENTATION REQUIREMENTS: Added J8540. Revised Q0181 requirements.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added J8540, Q0511 and Q0512. Revised Supply Fee instructions. Deleted Q0181 and G0370.

CODING GUIDELINES: Deleted dexamethasone example.

Orthopedic Footwear

LCD – HCPCS CODES AND MODIFIERS: Added L3031. Revised L3170, L3215, L3216, L3217, L3219, L3221, L3222 and L3230.

PA – CODING GUIDELINES: Eliminated guideline for L3215-L3230 because code narrative has been revised.

Ostomy Supplies

LCD – INDICATIONS AND LIMITATION OF COVERAGE AND/OR MEDICAL NECESSITY: Removed deleted HCPCS code A5119 from 6 month Usual Maximum Amount and added new HCPCS code A5120 to Usual Maximum Amount array.

HCPCS CODES & MODIFIERS: Added A4363, A4411, A4412 and A5120. Deleted A5119. Verbiage change to A4372.

PA – CODING GUIDELINES: Added A4412 to the statement regarding high output ostomy pouches and revised definition. Added statement regarding the billing of ostomy clamps with ostomy pouches and urinary pouches.

ICD-9 CODES THAT ARE NOT COVERED: Removed A5119 from array and added A5120 to array.

Oxygen and Oxygen Equipment

LCD – HCPCS CODES: Added E1392. Deleted K0671.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Udpated section with HCPCS code changes.

CODING GUIDELINES: Udpated section with HCPCS code changes.

Parenteral Nutrition

LCD – INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Moved statement about coverage in a SNF to Policy Article. Revised statement concerning the quantity of lipids requiring additional documentation.

HCPCS CODES AND MODIFIERS: Added B4185. Deleted B4184 and B4186.

DOCUMENTATION REUIREMENTS: Deleted paragraph referring to pre-1996 dates of service.

PA – CODING GUIDELINES: Added B4185. Deleted B4184 and B4186. Adding guideline for B4185 (lipids).

Respiratory Assist Devices

LCD – INDICATIONS AND LIMIITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Revised coverage criteria for central sleep apnea. Added frequency guidelines for A4604, A7030, and A7031.

HCPCS CODES: Added A4604. Revised A7032 and A7033.

DOCUMENTATION: Revised requirements for documenting excess quantities of supplies. APPENDICES: Added definitions for central sleep apnea and complex sleep apnea.

PA – CODING GUIDELINES: Added definitions for A4604, A7032 and A7033.

Seat Lift Mechanisms

LCD – HCPCS CODES AND MODIFIERS: Added E0172.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added coverage statement for E0172.

CODING GUIDELINES: Added definition of E0172.

Spinal Orthoses: TLSO and LSO

LCD – INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Updated section with HCPCS code changes.

HCPCS CODES: Added L0491, L0492 and L0625-L0640. Deleted K0618, K0619 and K0634-K0649.

PA – CODING GUIDELINES: Updated section with HCPCS code changes.

Suction Pumps

LCD – HCPCS CODES & MODIFIERS: Changed description for A4216.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised definition of A4216.

Surgical Dressings

LCD – HCPCS CODES: Added A6457, A6513 and A6530-A6549. Deleted K0620 and L8100-L8239.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Updated section with HCPCS code changes.

CODING GUIDELINES: Updated section with HCPCS code changes.

Therapeutic Shoes for Persons with Diabetes

LCD – HCPCS CODES AND MODIFIERS: Added A5512 and A5513. Deleted K0628 and K0629.

PA – CODING GUIDELINES: Added A5512 and A5513. Deleted K0628 and K0629. Revised requirements for Coding Verification Review by the SADMERC.

Motorized/Power Wheelchair Bases

LCD – INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Added the option of downcoding to a POV.

DOCUMENTATION REQUIREMENTS: Deleted requirements for dates of service prior to 10/25/05.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Deleted criteria for dates of service prior to 10/25/05.

CODING GUIDELINES: Eliminated mention of codes E1210-E1213.

Wheelchair Options/Accessories

LCD – HCPCS CODES AND MODIFIERS: Added E0705, E2207-E2226, E2371 and E2372. Revised E0971. Discontinued E0972, K0064, K0066-K0068, K0074-K0076, K0077, K0078, K0102, K0104, K0106 and K0452.

INDICATIONS AND LIMITATIONS OF COVERAGE AND/OR MEDICAL NECESSITY: Moved statement concerning orders for power wheelchair accessories to the Policy Article. Revised general coverage criteria to reflect changes in the NCD. Updated section with HCPCS code changes. Added coverage criteria for attendant control of power wheelchair. Added noncoverage statement for non-sealed batteries, effective 5/1/06. Revised coverage criteria form manual reclining back effective 5/1/06. Deleted noncoverage statement for a cane and crutch holder.

DOCUMENTATION REQUIREMENTS: Revised instructions for EY modifier. Eliminated use of the CMN. Revised documentation requirements for replacement items. Deleted instructions for billing E2399 and K0108.

PA – NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added requirement for a written order prior to delivery for power wheelchair accessories. Added statement concerning accessories for rollabout chair and transport chair. Revised the types of batteries that are separately payable with power wheelchairs. Revised noncoverage statement concerning attendant control for power wheelchairs. Updated section with HCPCS code changes.

CODING GUIDELINES: Updated section with HCPCS code changes. Added guidelines for accessories for rollabout and transport chairs. Added definitions for tires and wheels for manual wheelchairs. Added rollabout chairs and transport chairs to the correct coding table. Added E2212 and E2215 to the correct coding table as column I codes. Revised the Column II codes in the correct coding table for Column I codes for Manual Wheelchairs, Power Wheelchairs, K0069, K0070, K0071, K0072 and K0077.

COVERAGE AND BILLING

Durable Medical Equipment

Transport Chairs And Rollabout Chairs

Transport chairs (E1037-E1039) and rollabout chairs (E1031) are considered to be mobility assistive equipment and therefore subject to the national policy as defined in Pub. 100-03, *Medicare National Coverage Determinations Manual*, section 280.3. In general, patients who qualify for these devices would be those who are not able to use a cane or walker for ambulation, who are unable to self-propel a manual wheelchair, who are unable to operate a power-operated vehicle (scooter) or power wheelchair, and who have a caregiver who is willing and able to operate the transport/rollabout chair.

Proper Billing Of Zero-Pressure Tire Tube Inserts K0093 And K0097

Per the CMS Joint Signature Memorandum JSM-06172, K0011 power wheelchairs are delivered routinely with two foam-filled tires that are correctly coded using two units of K0093. In almost every case, a K0011 power wheelchair could not be legitimately coded with more than two tire tube inserts. Coding for more than two tire tube inserts represents coding and billing for a service not provided.

Claims submitted for K0011 power wheelchairs, two units of K0093 and two units of K0097, code K0097 will deny as services not provided.

Orthotics/Prosthetics

Therapeutic Shoes – Revision Of Requirement For Coding Verification Review

A revision of the medical policy on Therapeutic Shoes for Persons with Diabetes which posted on our site on December 1st, and also published in the January 2006 *DMERC Region D Supplier Manual* update, added a new requirement for Coding Verification Review by the SADMERC for shoes and inserts for claims with dates of service on or after 1/1/06. That requirement is being changed. The requirement for Coding Verification Review for therapeutic shoes (A5500) is being eliminated. The requirement for Coding Verification Review of inserts (new codes A5512 and A5513 in 2006) is being delayed and will be effective for claims with dates of service on or after July 1, 2006. A revision of the policy with this change is being published in this quarter's supplier manual update.

Pharmacy

Supplying Fee And Inhalation Drug Dispensing Fee Revisions And Clarifications

Medlearn Matters Article Number: MM3990

Related Change Request (CR) #: 3990
Related CR Release Date: November 10, 2005
Related CR Transmittal #: 754
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Note: This article was revised on December 19, 2005, to correct the language in the first bullet in the "Notes" box at the top of page 2. The original article included information that was not really related to this article and that information was deleted.

Provider Types Affected - Physicians, providers, and suppliers billing oral anti-cancer chemotherapeutic drugs, oral anti-emetic drugs, immunosuppressive drugs, or inhalation drugs to Medicare durable medical equipment regional carriers (DMERCs) or fiscal intermediaries (FIs).

Provider Action Needed

This article is based on information contained in Change Request (CR) 3990, which clarifies and revises the policies and fees related to the supply fee and dispensing fee, and outlines changes to Healthcare Common Procedure Coding System (HCPCS) codes used for those fees.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 303(e) (2)) authorized Medicare to pay a supplying fee for the following drugs:

- Immunosuppressive drugs,
- Oral anti-cancer chemotherapeutic drugs, and
- Oral anti-emetic drugs used as part of an anti-cancer chemotherapeutic regimen.

Supplying Fees

Effective January 1, 2006, Medicare will pay the following supplying fees to a pharmacy for each of the above listed drugs:

- **$24.00 for the first prescription** supplied to a beneficiary during a 30-day period. Each pharmacy that supplies the above listed drugs to a beneficiary during a 30-day period will be eligible for one $24 supplying fee in that period.
- **$16.00 for each subsequent prescription** of the above listed drugs supplied to a beneficiary in the same 30-day period.

Notes:

- For a refill prescription, Medicare will allow payment of a $24 supplying fee up to seven days before the end of the 30-day period for which the last $24 supplying fee was paid.

- A pharmacy will be limited to one $24 fee per 30-day period even if the pharmacy supplies more than one category of the above-mentioned drugs (for example, an oral anti-cancer drug and an oral anti-emetic drug) to a beneficiary. A supplier will not be allowed more than twelve $24 supplying fees per beneficiary per year.

- Medicare will pay a supplying fee for each prescription (including prescriptions for different strengths) of the same drug supplied on the same day. For example, Medicare will pay a supplying fee for both 1) a prescription for 100mg tablets and 2) a prescription for 5 mg tablets of the same drug supplied on the same day.

- This change does not alter the one-time $50 supply-

ing fee (code Q0510 – replacement code for G0369) for the first immunosuppressive prescription after a transplant.

Dispensing Fees

Medicare also pays a dispensing fee for inhalation drugs, in accordance with Section 1842(o)(2) of the Social Security Act. Effective January 1, 2006, Medicare will pay one dispensing fee to a pharmacy amounting to:

• **$57.00 for an initial dispensing fee** to a pharmacy for the initial 30-day period of inhalation drugs furnished through DME regardless of the number of shipments or drugs dispensed during that time and regardless of the number of pharmacies used by a beneficiary during that time;

• **One dispensing fee of $33.00 for a 30-day period of inhalation drugs** furnished through DME regardless of the number of shipments or drugs dispensed during that time; and

• **One dispensing fee of $66.00 for each dispensed 90-day period of inhalation drugs** furnished through DME regardless of the number of shipments or drugs dispensed during that time.

One Dispensing Fee Payment for 90-Day Period

Only one dispensing fee payment will be made for the 90-day period, regardless of the number of pharmacies used by a beneficiary. A supplier cannot be paid for more than one of the following for a beneficiary for the same period:

• An initial dispensing fee (G0333);
• A 30-day dispensing fee (Q0153); or
• A 90-day dispensing fee (Q0514.

Refill Prescriptions/Supply and Dispensing Fees

For a refill prescription, Medicare will allow payment of the dispensing fee no sooner than seven days before the end of usage for the current 30-day or 90-day script for which a dispensing fee was previously paid. An inhalation drug supplier will not be allowed more than 12 months of dispensing fees per beneficiary per year.

Note: The supply fee and dispensing fee must continue to be billed on the same claim as the drug supplied or dispensed. Also, note that a **supply fee and a dispensing fee is not appropriate for one drug** because:

• The supply fee is for immunosuppressives, oral anti-cancer drugs, and oral anti-emetic drugs; and
• The dispensing fee is for inhalation drugs only.

HCPCS Code Changes

Durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs) are instructed by CR3990 to recognize the following Healthcare Common Procedure Coding System (HCPCS) codes for:

• Supply fees for immunosuppressive, oral anti-cancer, and oral anti-emetic drugs:

• **Code Q0510** (replaces G0369) – First immunosuppressive prescription after a transplant. ($50.00)
• **Code Q0511** (replaces G0370) – Pharmacy supplying fee for immunosuppressive, oral-anticancer, and oral anti-emetic drugs, first prescription in a one-month period. Each pharmacy may receive this fee once in a 30-day period. ($24.00)
• **Code Q0512** (replaces G0370) – Pharmacy supplying fee for immunosuppressive, oral anticancer, and oral anti-emetic drugs – each subsequent prescription in a 30-day period. ($16.00)
• Dispensing fee for inhalation drugs(one per month) - Pay the first claim received for inhalation drugs:
• **Code G0333** - Pharmacy dispensing fee for initial inhalation drug(s); initial 30 day supply to a beneficiary
• **Code Q0513** (replaces G0371) - Pharmacy dispensing fee for inhalation drug(s); per 30-days. ($33.00)
• **Code Q0514** (replaces G0374) - Pharmacy dispensing fee for inhalation drugs(s); per 90-days. $66.00)

A supplier cannot be paid for more than one of the above fees (G0333, Q0513, Q0514) for a beneficiary for the same period.

Note: Effective January 1, 2006 Medicare will no longer recognize codes G0369, G0370, G0371, and G0374. Also, the Medicare DMERC or FI will downcode G0333 to Q0513 and pay on the basis of Q0513 if a prior claim has been paid to any supplier for that beneficiary for inhalation drugs. Similarly, Medicare will downcode Q0511 to Q0512 if more than one claim for Q0511 is received from the supplier for a beneficiary during the 30-day period (except allowing for the refill within seven days of the end of the 30-day period).

Implementation

The implementation date for the instruction is January 3, 2006.

Additional Information

For complete details, please see the official instruction

issued to your FI or DMERC regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR3990 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your DMERC or FI at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Supplies

A4253 (Blood Glucose/Reagent Strips) Reviews: Lessons Learned

Recent postpayment medical reviews, both supplier and code specific, corroborate findings from the Comprehensive Error Rate Testing (CERT) contractor regarding serious documentation problems with claims for diabetic monitors and supplies. Only 19 of the 100 files evaluated in a widespread probe review of claims from 91 suppliers contained documentation supporting that the claim met Medicare coverage criteria. Missing or incomplete documentation accounted for the majority of the errors. These errors included:

- Failure to submit any records for the review,
- Failure to obtain medical records,
- Missing or incomplete written order,
- Missing proof of delivery,
- Missing proof of previous/scheduled training in the use of the monitor and supplies, and
- Missing proof of competence in using test results to assure appropriate blood sugar control.

The *DMERC Region D Supplier Manual* provides the documentation requirements for glucose monitor and supply claims. While suppliers are not required to routinely submit documentation with claims, the manual explains that requisite documentation must be available upon request. Suppliers are also informed that the documentation request may specify that actual medical records need to be submitted.

> It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available to the DMERC upon request. (*DMERC Region D Supplier Manual* – Glucose Monitor Local Coverage Determination)

The Glucose Monitor LCD also informs suppliers that a supplier generated form, even if signed by the physician, is not sufficient proof of medical necessity if the Carrier or CERT contractor requests medical records.

> Suppliers are not prohibited from creating data collection forms in order to gather medical necessity information; however, the DMERC will not rely solely on those forms to prove the medical necessity of services provided. Suppliers must not attribute any self-generated forms or data collection requests to the Medicare Program, CMS, or the DMERCs. Physicians are not required to fill out additional forms from suppliers or to provide additional forms to suppliers or to provide additional information to suppliers unless specifically requested by the supplier per the DMERC. (*DMERC Region D Supplier Manual* – Glucose Monitor Local Coverage Determination)

Over 60% of the suppliers from the widespread probe were unable to provide proof of training and proof of competency. While suppliers are not required to provide actual training in the use of a home glucose monitor, they must obtain documentation that the training did or is scheduled to take place. A separate, but equally important, requirement is that the files must also include documentation that the patient (or caregiver) is capable of using the test results to assure appropriate blood sugar control. Examples of how these requirements can be met include, but are not limited to, signed beneficiary and/or physician statements and notations in the physician's progress notes or other medical records.

Claims for supply quantities above the normal policy allowances have additional documentation requirements. When extra supplies are ordered, the medical record must provide an individualized explanation as to why the beneficiary requires a testing frequency that exceeds utilization guidelines. These records must include the beneficiary's test log or other physician record documenting the frequency at which the patient actually tests and must be submitted upon request. Suppliers are reminded that new documentation to support supply quantities exceeding utilization guidelines have to be obtained every six months.

Finally, there appears to be some confusion regarding when to use modifier KX versus modifier KS. These modifiers do not designate whether the beneficiary is a Type I (IDDM) or Type II (NIDDM) diabetic. They should be used to indicate whether or not the beneficiary is being treated with insulin injections. The KX modifier must be added to the claim if the beneficiary is receiving insulin injections. Modifier KS specifies that the beneficiary is not being treated with insulin injections. Therefore, if a Type II (NIDDM) diabetic is receiving insulin injections, modifier KX ***not*** modifier KS is the correct choice.

Suppliers are encouraged to refer to the *DMERC Region D Supplier Manual* and the CIGNA Government Services Web site (www.cignagovernmentservices.com) for additional information regarding Medicare documentation requirements concerning home blood glucose monitors and supplies. The web resources include a Documentation Checklist (http://www.cignagovernmentservices.com/dmerc/mr/CERT/pdf/glucose.pdf) that suppliers can use to assure that their files contain all required documentation.

Utilization Requirements For Diabetic Supplies

The Local Coverage Determination (LCD) for Home Glucose Monitors as found in Chapter 9 of the *DMERC Region D Supplier Manual* states the utilization guidelines for diabetic supplies. Insulin dependent diabetics may have up to 100 test strips and up to 100 lancets or one lens shield cartridge every month, and non insulin dependent may have up to 100 test strips and up to 100 lancets or one lens shield cartridge every 3 months.

The LCD also describes the coverage criteria for higher utilization. When more than the usual medical need is prescribed and billed, a narrative must accompany the claim. For example, "documentation on file for testing 5 times a day". The amount in excess will be denied as not medically necessary without this documentation. The actual documentation must be available to the DMERC upon request.

If criteria are not met, all testing supplies will be denied as not medically necessary. If quantities of testing supplies that exceed the utilization guidelines are provided and criteria are not met, the amount in excess will be denied as not medically necessary.

General

Annual Update Of HCPCS Codes Used For Home Health Consolidated Billing Enforcement

Medlearn Matters Article Number: MM4114
Related Change Request (CR) #: 4114
Related CR Release Date: October 14, 2005
Effective Date: January 1, 2006
Related CR Transmittal #: 710
Implementation Date: January 3, 2006

Provider Types Affected - All Medicare providers billing carriers, including durable medical equipment regional carriers (DMERCs), regional home health intermediaries (RHHIs), or fiscal intermediaries (FIs), for medical supply or therapy services.

Provider Action Needed - The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2006. Affected providers should be aware of these changes.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA.) As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes.

Services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physicians;
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare periodically publishes Routine Update Notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS

codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

Additional Information

CR4114 provides the annual HH consolidated billing update effective January 1, 2006. The following table describes the HCPCS codes and the specific changes to each that this notification is implementing on January 3, 2006:

Code	Description of Code	Type Change	Replacement Code or Code Being Replaced
Non-Routine Supplies			
A4656	Needle, any size each	Delete	Replacement code: A4215 with revised definition (code A4215 is already on HH CB list.)
A5119	Skin barrier wipes box pr	Delete	Replacement code: A5120
A6025	Gel sheet for dermal or epidermal application (e.g., silicone, hydrogel, other)	Delete	
A6457	Tubular dressing with or without elastic, any width, per linear yard	Add	
A4412	Ostomy pouch, drainable, high output, for use on a barrier with flange (two-piece system), without filter, each	Add	
A5120	Skin barrier, wipes or swabs, each	Add	Replaces code A5119
A4363	Ostomy clamp, any type, replacement only, each	Add	
A4411	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each	Add	
Therapies – No Update			

The last update to the HH consolidated billing was issued under Transmittal 340, CR3525. The related *Medlearn Matters* article, MM3525, may be found at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3525.pdf on the CMS web site.

For complete details, please see the official instruction issued to your carrier/DMERC/RHHI/intermediary regarding this change. That instruction may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4114 in the CR NUM column on the right, and click on the file for that CR.

A complete historical listing of codes subject to HH consolidated billing can be found at http://www.cms.hhs.gov/providers/hhapps/ on the CMS web site. The last bullet on this page contains a link to download the list. If you have any questions, please contact your carrier/DMERC/RHHI/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

April Quarterly Update To The 2006 Annual Update Of HCPCS Codes Used For Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

Medlearn Matters Article Number: MM4298
Related Change Request (CR) #: 4298
Related CR Release Date: February 1, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R826CP
Implementation Date: April 3, 2006

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), for services provided to Medicare beneficiaries in skilled nursing facilities (SNFs)

Provider Action Needed

Impact to You - This article is based on Change Request (CR) 4298, which provides updates to the lists of HCPCS codes that are subject to the Consolidated Billing (CB) provision of the SNF Prospective Payment System (PPS).

What You Need to Know - Services included on the SNF consolidated billing enforcement list will be paid to SNF Medicare providers only. Services excluded from the SNF consolidated billing enforcement list may be paid to Medicare providers other than SNFs. See *Background* and *Additional Information* sections for further explanation.

What You Need to Do - See the *Background* section of this article for further details regarding these changes.

Background - The Social Security Act (Section 1888, http://www.ssa.gov/OP_Home/ssact/title18/1883.htm) codifies both the SNF PPS and CB. The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes subject to the CB provision of the SNF PPS.

Services that appear on this HCPCS code list (that are submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs)) will not be paid by Medicare to providers (other than an SNF) when included in SNF CB.

For non-therapy services, SNF CB applies only when the services are furnished to an SNF resident during a covered Part A stay. However, SNF CB applies to the following services whenever they are furnished to an SNF resident, regardless of whether Part A covers the stay:

- Physical and occupational therapies; and
- Speech-language pathology.

Services for beneficiaries that are excluded from SNF PPS and CB may be paid to providers (other than SNFs) even when in an SNF stay. To assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

2006 Annual Update

Each January, CMS publishes a combined instruction for FIs and Carriers/DMERCs for the annual notice on SNF CB. The 2006 Annual Update file for FIs can be found at
http://www.cms.hhs.gov/SNFConsolidatedBilling/01a_SNFCBforFIs.asp#TopOfPage
on the CMS web site. This 2006 file will be updated with the changes addressed in CR4298 by March 1, 2006.

Information on the 2006 Annual Update for carriers can be found at http://cms.hhs.gov/SNFConsolidatedBilling/ on the CMS web site.

Note: Quarterly updates apply to FIs and carriers/DMERCs. The update provided by CR4298 affects claims with dates of service on or after the effective date of CR4298 unless otherwise indicated. The following HCPCS codes are listed as being added or removed from the Annual Update:

HCPCS Codes Added or Removed from Annual Update

Computerized Axial Tomography (CT) Scans (Major Category I, FI Annual Update, EXCLUSION)	
HCPCS Code REMOVED	**Descriptor**
76375	3D/holograph reconstr add-on
Radiation Therapy (Major Category I, FI Annual Update, EXCLUSION)	
C9722	KV imaging w/ir tracking
G0242	Lultisource photon ster plan
G0338	Linear accelerator stero pln
Angiography, Lymphatic, Venous (Major Category I, FI Annual Update, EXCLUSION)	
36598	Contrast injection, radiologic eval of existing cent venous access device **Note:** This code should be added to the SNF CB file effective April 1, 2006.
Outpatient Surgery and Related Procedures (Major Category I, FI Annual Update, INCLUSION)	
15810	Salabrasion
15811	Salabrasion
G0345	Intravenous infusion, hydration; initial, up to one hour
Ambulance Trips w/ Application to Major Category II (Major Category I, FI Annual Update, EXCLUSION)	
Q3019	ALS vehicle used, emergency transport, no ALS service furnished
Q3020	ALS vehicle used, non-emergency transport, no ALS service furnished
Dialysis Supplies (Major Category II, FI Annual Update, EXCLUSION)	
A4656	Needle, any size, for dialysis, each

Chemotherapy Administration (Major Category III, FI Annual Update, EXCLUSION)	
96408	Chemotherapy, push technique
96410	Chemotherapy,infusion method
96412	Chemo, infuse method add-on
96414	Chemo, infuse method add-on
96520	Pump refilling, maintenance
96530	Pump refilling, maintenance
G0357	Intravenous, push technique, single or initial substance/drug
G0358	Intravenous, push technique, each additional substance/drug
G0359	Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
G0360	Each additional hour, one to eight hours
G0361	Initiation of prolonged chemotherapy infusion (more than 8 hours)
G0362	Each additional sequential infusion (different substance /drug), up to one hour
96409	Chemo admin; IV, push; single/initial drug
96411	Chemo admin; IV, push; each add'l drug
96413	Chemo admin; IV, infusion; up to 1 hr; single/initial drug
96415	Chemo admin; IV, infusion; each add'l hr, 1-8 hrs
96416	Chemo admin; IV, infusion; initiation of prolonged chemo, requiring pump
96417	Chemo admin; IV infusion; each add'l sequential infusion, up to 1 hr
C8953	Chemo admin; IV, push
C8954	Chemo admin; IV, infusion; up to 1 hr
C8955	Chemo admin; IV, infusion; each add'l hr

Implementation

The implementation date for the instruction is April 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R826CP.pdf on the CMS web site.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

Eliminate The Use Of Surrogate Unique Physician Identification Numbers (UPINs) On Medicare Claims

Medlearn Matters Article Number: MM4177

Related Change Request (CR) #: 4177
Related CR Release Date: November 10, 2005
Effective Date: April 1, 2006
Related CR Transmittal #: 752
Implementation Date: April 3, 2006

Note: This article was revised on February 16, 2006, to remove a reference to FIs in the second bullet point on page 2.

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), using surrogate UPINs

Provider Action Needed

This article is based on Change Request (CR) 4177, which directs your carrier or DMERC to no longer accept the surrogate UPIN OTH000 to identify ordering or referring physicians on claims submitted by billers, suppliers, physicians, and non-physician practitioners. (Beneficiary submitted claims and mass immunization claims are excluded.)

Background

The Social Security Act (Section 1833(q)) requires that all physicians who meet the definition of a physician (Section 1861(r)) must have a UPIN, and that all claims for services ordered or referred by one of these physicians include the name and UPIN of the ordering/referring physician.

Currently, suppliers, physicians, and non-physician practitioners are allowed to bill for diagnostic, radiology, consultation services, and equipment with the use of Surrogate UPIN OTH000. Surrogate UPINs were intended to be used during an interim period when a UPIN has been requested but has not yet been received.

CR4177 announces that CMS will no longer accept the Surrogate UPIN OTH000 to identify the ordering or referring physicians on claims submitted by billers, suppliers, physicians, and non-physician practitioners, effective for dates of service April 1, 2006, and later: (Beneficiary submitted claims and mass immunization claims are excluded.)

• Durable medical equipment (DME) suppliers, physicians, non-physician practitioners, and billers must submit the UPIN assigned to the ordering or referring physician; and §Medicare carriers and DMERCs will return, as unprocessable, all claims submitted with Surrogate UPIN OTH000.

Implementation

The implementation date for this instruction is April 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site.

From that web page, look for CR 4177 in the CR NUM column on the right, and click on the file for that CR. If you need to obtain another physician's UPIN for billing purposes, you may find that UPIN by going to http://www.upinregistry.com. If you have any questions, please contact your carrier/DMERC at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

MMA - Enrolling Indian Health Service (IHS) Facilities As Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS) Suppliers

Medlearn Matters Article Number: MM3845

Related Change Request (CR) #: 3845
Related CR Release Date: November 18, 2005
Related CR Transmittal #: 133
Effective Date: January 1, 2005
Implementation Date: April 3, 2006

Provider Types Affected - Indian Health Services (IHS) facilities wishing to enroll as Medicare suppliers

Provider Action Needed

Impact to You - Section 630 of the Medicare Modernization Act (MMA) permits IHS facilities to directly bill for itemized DMEPOS as of January 1, 2005. Previously, IHS facilities could not directly bill Medicare for DMEPOS.

What You Need to Know - This article is based on information from Change Request (CR) 3845, which provides Medicare manual instructions describing how Indian Health Service (IHS) facilities
enroll as DMEPOS suppliers.

What You Need to Do - See the *Background* and *Additional Information* sections of this article to find out further details regarding these changes.

Background

The Medicare Modernization Act (MMA, Section 630) permits Indian Health Service (IHS) facilities to directly bill for itemized Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) as of January 1, 2005. Previously IHS facilities could not directly bill Medicare for DMEPOS. The MMA also provides for all Medicare Part B services to be billed including all preventive services.

To enable direct billing of DMEPOS, an IHS facility must enroll with the National Supplier Clearinghouse (NSC) and secure a Medicare supplier billing number. For enrollment purposes, Medicare recognizes two types of IHS facilities:

• Those facilities wholly owned and operated by the HIS; and
• Facilities that are owned by the IHS but tribally operated or totally owned and operated by a tribe.

The Application

To enroll, the IHS facility must complete a **Medicare Supplier Enrollment Application: CMS-855S** Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) **Suppliers** CMS-855S must be completed in accordance with its associated instructions, except as follows:

• Facilities that are totally owned and operated by the IHS are considered a governmental organization. An Area Director of the IHS must sign the Section 15 Certification Statement of the CMS – 855S, be listed in Section 6 of the form and sign the letter required by Section 5 of the form, which attests that the IHS will be legally and financially responsible in the event that there is any outstanding debt owed to CMS.

• Facilities that are tribally operated are considered tribal organizations. The Section 15 Certification Statement of the CMS – 855S must be signed by a tribal official who meets the definition of an authorized official in accordance with the page 2 definitions shown on the CMS – 855S. The same authorized official must be listed in Section 6 of the CMS – 855S and must sign the letter required by Section 5 of the form which attests that the tribe will be legally and financially responsible in the event that there is any outstanding debt owed to CMS.

Facility Requirements

IHS facility requirements include the following:

• **Site visits** will be required for all IHS facilities enrolling for DMEPOS. This includes all hospitals and pharmacies. All IHS facilities enrolled by the NSC must meet all required standards as verified by the review procedures for all other DMEPOS suppliers except as discussed in this article.

• All IHS facilities, whether operated by the IHS or a tribe, must be exempt from the comprehensive liability **insurance requirements** under 42 CFR Sec. 424.57(c)(10).

• All IHS facilities, whether operated by the IHS or a tribe, will be exempt from the requirement to provide any **state licenses** for their facility/business. For example, if the DMEPOS supplier indicates on its application that it will be providing hospital beds and is located in a state that requires a bedding license, such licensure is not required for Medicare enrollment.

However, if they provide a DMEPOS item that requires a licensed professional in order to properly provide the item, the IHS facility must provide a copy of the professional license. The licensed professional can be licensed in any state or have a federal license. For example, a pharmacy does not need a pharmacy license, but must have a licensed pharmacist.

Assignment of Specialty Codes and Appropriate Billings

Upon successful enrollment, the NSC will provide identifiers identifying IHS enrollments and IHS hospitals in order to facilitate proper reimbursement by durable medical equipment regional carriers (DMERCs).

The NSC will enroll all Indian Health Service (IHS) facilities including all hospitals and clinics (free standing or hospital based). This includes all facilities whether wholly owned and operated by the IHS or tribally owned and/or operated. For any IHS facility that enrolls, the NSC will issue a supplier number with:

• An A9 specialty code for newly enrolled IHS DMEPOS suppliers which are not hospitals; or

• An A9/A0 specialty code for newly enrolled IHS DMEPOS suppliers which are IHS/tribal hospitals and hospital based facilities to include Critical Access Hospitals (CAHs).

The specialty indicator will ensure that the claims are paid appropriately by either the FI or DMERC. IHS facilities with a specialty code of A9/A0 must submit claims for prosthetics, orthotics, and surgical dressings to their Medicare FI for payment and not to a DMERC.

Implementation

The implementation date for CR3845 is April 3, 2006.

Additional Information

IHS facilities that are tribally owned and/or operated are advised that their Medicare beneficiaries are not responsible for deductibles or coinsurance. However, Medicare still pays these IHS facilities a payment that is at 80

percent of the DMEPOS fee schedule. The remaining 20 percent will be shown as a CO denial on the remittance advice with an adjustment reason code of B6 indicating *"This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty."*

For further details, please see the official instruction issued to your DMERC/carrier/intermediary regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR3845 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your DMERC/carrier/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Medical Review Matching Of Electronic Claims And Additional Documentation In The Medical Review Process

Medlearn Matters Article Number: MM4052

Related Change Request (CR) #: 4052
Related CR Release Date: November 10, 2005
Related CR Transmittal #: 131
Effective Date: February 10, 2006
Implementation Date: February 10, 2006

Note: This article was revised on November 24, 2005, to show the correct effective and implementation dates to be February 10, 2006. The original article incorrectly showed 2005. All other information remains the same.

Region D Note: For electronically submitted claims, supporting paper documentation that is necessary for medical review may only be submitted in response to a letter that requests additional documentation (ADR). CIGNA DMERC does not employ a process that permits paper documentation to be matched with electronically submitted claims.

Provider Types Affected - All Medicare physicians, providers, and suppliers

Provider Action Needed

Impact to You - Other than certain limited exceptions, such as for providers that employ very few employees, the Centers for Medicare & Medicaid Services (CMS) currently instructs all initial claims to be filed electronically. This is true even when the claim will be subjected to prepayment medical review.

What You Need to Know - Generally, Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), cannot require or permit the voluntary submission of paper claims. If any supporting paper documentation is necessary for medical review, it can only be solicited by the contractor and submitted through the Additional Documentation Request (ADR) or alternate contractor process that permits matching. This supporting documentation must be submitted separately from an electronic claim, at the contractors' request. **Exception:** At their discretion, some contractors accept unsolicited paper supporting documentation, if they can match the electronic claim and paper documentation.

What You Need to Do - File initial claims electronically when subjected to prepayment medical review unless you are in an "excepted" category. Unless your contractor informs you that they accept supporting paper documentation with the electronic claim, submit all supporting documentation through the regular ADR process, or alternate contractor process that permits matching.

Background

Although Medicare contractors may use any information they deem necessary to make a prepayment or post-payment claim review determination, contractors may not require providers or suppliers to file initial claims on paper to Medicare when the claim requires additional documentation. The Administrative Simplification Compliance Act requires providers, with very few exceptions, to submit claims electronically.

Medicare contractors may not require or request of any provider the submission of supporting documentation with the initial claim(s) through contractor developed forms, local policies, or any other communication with providers. Medicare contractors may only request supporting documentation through the ADR process or alternate contractor process that enables matching of the documentation to the initial claim.

Additional Information

The *Medicare Claims Processing Manual,* Chapter 24, Section 90, contains information regarding the limited circumstances under which your contractor may request

paper claims. The manual is available at http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf on the CMS web site.

The official instruction issued to your carrier/intermediary/DMERC/RHHI regarding this change may be found by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4052 in the CR NUM column on the right, and click on the file for that CR.

You may also wish to refer to *Medlearn Matters* article MM3440 on the requirements to submit claims electronically. That article is available at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3440.pdf on the CMS web site.

If you have any questions, contact your carrier/DMERC/FI/RHHI at their toll free number, which is available at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Providing Accurate Information On Your Claims

As a participant in the Medicare program, you are required to keep accurate documentation and records of all claims that you submit. Delays in the payment of a claim can occur as a result of various factors. One way to ensure that your claims are processed in a timely fashion is to include the correct supplier number that corresponds with the name of your company and address that is on file with Medicare. Additionally, if you are including your Tax I.D. number, please remember that it also needs to match the records that are on file with Medicare. Failure to include a valid supplier number with an accurate, according to Medicare records, supplier name and address could result in the delay of claim payment. To verify or update your information please contact the National Supplier Clearinghouse (NSC) at 1.866.238.9652.

It is also very important to submit accurate information for individuals that receive the benefit of Medicare. Claims may be rejected or denied if the name on a claim does not match the Health Insurance Claim Number (HICN). Please make sure that information submitted on a claim is consistent with the information on the beneficiary's red, white, and blue Medicare card. Please avoid nicknames or alternate spellings.

The Administrative Simplification Compliance Act (ASCA) requires all expenses for items and services billed to the Medicare program be submitted electronically. Paper claims may be denied unless the supplier or provider meets one of the limited exceptions. The Medicare program offers free electronic billing software, as well as a list of approved vendors that have successfully tested and offer their software for a fee.

If you would like more information on billing electronically, please visit www.cignagovernmentservices.com or call our Electronic Data Interchange (EDI) department at: DMERC billers – 1.866.224.3094, option 1, 8am–5pm MST.

APPEALS

Appeals Of Claims Decisions: Redeterminations And Reconsiderations And Appeals Rights For Dismissals

Medlearn Matters Article Number: MM3939

Related Change Request (CR) #: 3939
Related CR Release Date: October 21, 2005
Related CR Transmittal #: 724

Effective Date: January 1, 2006, for appeals of initial determination of claims by Medicare carriers; May 1, 2005, for initial claim determinations by Medicare Fiscal Intermediaries (FIs)

Implementation Date: December 16, 2005, for FIs and January 1, 2006, for carriers

Provider Types Affected

Physicians, providers, and suppliers who appeal initial claims determinations by Medicare

Provider Action Needed

The purpose of CR3939 is to notify Medicare contractors (fiscal intermediaries (FIs) or carriers, including durable medical equipment regional carriers (DMERCs)) and Medicare providers about the upcoming transition to the new second level of the appeals process.

The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a "reconsideration." This new

"reconsideration" is different from the previous first level of appeal for Part A claims performed by FIs. Reconsiderations will be processed by Qualified Independent Contractors (QICs).

Rather than repeat the extensive details of CR3939 in this article, the Centers for Medicare & Medicaid Services (CMS) encourages physicians, providers, and suppliers who wish to appeal an initial determination of a Medicare claim made by a Medicare carrier or FI to review CR3939. The new/revised manual sections of Chapter 29 of the *Medicare Claims Processing Manual* that are attached to CR3939 contain many important details for those wishing to file claims determination appeals. You can find CR3939 by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site.

From that web page, look for CR3939 in the CR NUM column on the right, and click on the file for that CR.

The key new or revised sections contained in CR3939 include information on:

- Filing a request for redetermination;
- Appeal rights for dismissals of redetermination requests, including sample dismissal letters and notices;
- Filing requests for reconsiderations, the second level of appeal;
- Time limits for filing reconsideration requests; and
- How reconsideration decisions are effectuated.

If you bill a Medicare FI, you may also wish to review Medlearn Matters article MM3530 and/or CR3530. They are available as follows:

Medlearn Matters article MM3530 MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries (CR Title-"Appeals Transition – BIPA 521 Appeals") is available at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3530.pdf on the CMS web site. CR3530 Revisions to Medicare Appeals Process for Fiscal Intermediaries (CR Title-"Appeals Transition – BIPA 521 Appeals") is available at http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf on the CMS web site.

Please refer to your local FI, carrier, or DMERC if you have questions on this issue. To find their toll free phone numbers go to http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Appeals Of Claims Decisions: Redeterminations And Reconsiderations

Medlearn Matters Article Number: MM3944

Related Change Request (CR) #: 3944
Related CR Release Date: September 23, 2005
Related CR Transmittal #: 688

Effective Date: May 1, 2005, for appeals of claims submitted to Medicare intermediaries and January 1, 2006, for appeals of claims submitted to carriers

Implementation Date: December 16, 2005, for Medicare intermediaries and January 1, 2006, for Medicare carriers

Provider Types Affected - Physicians, providers, and suppliers who submit claims to Medicare for services

Provider Action Needed

Medicare providers who appeal claims decisions made by Medicare carriers and fiscal intermediaries (FIs), including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs), need to be aware of the new appeals processes.

Background

The purpose of CR3944 is to notify Medicare contractors (FIs or carriers, including DMERCs) and Medicare providers about the upcoming transition to the new second level of the appeals process.

The **"redetermination"** is the first level of appeal. It is a second look at the Part A or B claim and supporting documentation by an employee of the contractor (Medicare carrier or intermediary) who was not involved in the initial claim determination. In performing a redetermination of the services requested by the appellant, Medicare contractor personnel must examine all issues in the claim.

The Medicare claims appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new, second level in the administrative appeals process, called a **"reconsideration."** This new **"reconsideration"** is different from the previous first level of appeal for Part A claims performed by FIs. These

appeals are processed by Qualified Independent Contractors (QICs).

Additional Information

Rather than repeat the extensive details of CR3944 in this article, the Centers for Medicare & Medicaid Services (CMS) encourages physicians, providers, and suppliers who wish to appeal an initial determination of a Medicare claim made by a Medicare carrier or FI to review CR3944. The new/revised manual sections of Chapter 29 of the *Medicare Claims Processing Manual* that are attached to CR3944 contain many important details for those wishing to file claims determination appeals. You can find CR3944 by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR3944 in the CR NUM column on the right, and click on the file for that CR.

If you bill a Medicare FI, you may also wish to review Medlearn Matters article MM3530 and/or CR3530. They are available as follows:

Medlearn Matters article MM3530 MMA, "Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title-Appeals Transition – BIPA 521 Appeals), is available at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3530.pdf on the CMS web site.

CR3530, "Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title-Appeals Transition – BIPA 521 Appeals), is available at http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf on the CMS web site.

In addition, if your request for a redetermination is dismissed by the Medicare contractor, you may wish to understand your appeal rights with regard to that dismissal. These rights are discussed in CR3939, which can also be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. Once at that page, look for CR3944 in the CR NUM column on the right and click on the file for that CR.

Please refer to your local FI, carrier, or DMERC if you have questions on this issue. To find their toll-free phone numbers, go to http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

MMA – Changes To Chapter 29 – General Appeals Process In Initial Determinations

Medlearn Matters Article Number: MM4019

Related Change Request (CR) #: 4019
Related CR Release Date: October 7, 2005
Related CR Transmittal #: 695
Effective Date: May 1, 2005
Implementation Date: January 9, 2006

Provider Types Affected - Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. It is different from the previous first level of appeal for Part A claims performed by Fiscal Intermediaries (FIs). Reconsiderations will be processed by Qualified Independent Contractors (QICs).

CR4019 focuses on the general appeals process in Initial Determinations. CR4019 contains a considerable amount of information that is pertinent to the entire process of Medicare claims appeals, and focuses specifically on the additions of Sections 200 to 260 to Chapter 29 of the *Medicare Claims* Processing Manual.

Key Points

Centers for Medicare & Medicaid Services (CMS) Decisions Subject to the Administrative Appeals Process

The Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. These decisions are subject to appeal with the SSA.

Minor Errors and Omissions

Providers should be aware that there is no need to appeal a claim if the provider has made a minor error or omission in filing the claim, which, in turn, caused the claim to be denied. In the case where a minor error or omission is involved, the provider can request that the Medicare contractor reopen the claim so the error or

omission can be corrected, rather than having to go through the appeals process.

Who May Appeal

CR4019 (Additions to Chapter 29) defines and describes the individuals and entities who have the right to appeal a Medicare contractor's initial determination. (Medicare contractors are carriers, including Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs).) An individual who has a right to appeal is referred to as a "party."

Provider or Supplier Appeals When the Beneficiary Is Deceased

When a provider or supplier appeals on behalf of a deceased beneficiary, and the provider or supplier otherwise does not have the right to appeal, it is the contractor's responsibility to determine whether another party is available to appeal. CR4019 describes what must be done in this situation.

Parties to an Appeal - Any of the persons/entities who may appeal Medicare's decision to deny or reduce payment are parties to an appeal of a claim for items or services payable under Part A or Part B.

Steps in the Appeals Process: Overview

The process of appeal described in CR4019 is effective for all redeterminations issued on or after May 1, 2005, by Medicare FIs and all redeterminations issued on or after January 1, 2006, by carriers. The appeals process consists of five levels. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal. No appeal can be accepted until an initial determination has been made for the claim. The following chart outlines the steps in the Medicare appeal process:

The Medicare Fee-for-Service Appeals Process

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold to be Met or Amount in Controversy (AIC)
1. Redetermination			
• Performed by the Medicare Contractor	120 days from date of receipt of the notice initial determination (MSN or RA). (The notice of initial determination is presumed to be received five days from the date of the notice unless there is evidence to the contrary.)	Part A – FI (MAC) Part B – Carrier (MAC)	None
2. Reconsideration			
• Performed by QIC • Case file prepared by the Medicare contractor and forwarded to the QIC.** • Medicare contractor may have effectuation responsibilities for decisions made by the QIC.	180 days from date of receipt of the redetermination	Part A and B – QIC	None

3. Administrative Law Judge (ALJ) Hearing			
• Case file prepared by the QIC and forwarded to the HHS Office of Medicare Hearings and Appeals (OMHA). • Medicare contractor may have effectuation responsibilities for decisions made at the ALJ level.	60 days from the date of receipt of the reconsideration notice	Part A and B – HHS OMHA Field Office	At least $100 remains in controversy*** *For requests made on or after January 1, 2006, at least $110 remains in controversy*
4. Departmental Appeals Board (DAB) Review			
• Contractor may have effectuation responsibilities for decisions made at the DAB level.	60 days from the date of receipt of the ALJ hearing decision/dismissal	Part A and B – DAB or ALJ Hearing Office	None
5. Federal Court (Judicial) Review			
• Medicare contractor may have effectuation responsibilities for decisions made at the Federal Court level.	60 days from date of receipt of DAB decision or declination of review by DAB		At least $1,050 remains in controversy*** *For requests made on or after January 1, 2006, at least $1,090 remains in controversy*

*****Where to Appeal - Part A includes Part B claims filed with the FI.
****** In accordance with the appropriate manual section and the Joint Operating Agreement (JOA).
*******Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar Amount in Controversy (AIC) requirement will increase by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Where to Appeal

Where a party must file an appeal depends on the level of appeal. The above chart indicates where appellants should file appeal requests for each level of appeal.

When to Appeal – Time Limits for Filing Appeals and Good Cause for Extension of the Time Limit for Filing Appeals

The time limits for filing appeals vary according to the type of appeal. The table above indicates the time limits for filing appeal requests for each level of appeal. These time limits may be extended if good cause for late filing is shown.

Good Cause - General Procedure to Establish Good Cause for Late Filing

Procedures to establish good cause are effective for all requests for redeterminations received by FIs on or after May 1, 2005, and all requests for redeterminations received by the carrier on or after January 1, 2006.

The new Section 240 of Chapter 29 of the *Medicare Claims Processing Manual* lists the general procedure for establishing good cause for late filing; when a favorable decision for good cause is made; and when an unfavorable

decision for good cause is made. A listing of conditions and examples that may establish good cause for late filing by beneficiaries, **or** by providers, physicians, and suppliers, can be found in Section 240, which is attached to CR4019.

Amount in Controversy (AIC) Requirements

The amount in controversy requirements apply only to the ALJ and Federal Court Levels. The chart above indicates the amount in controversy (AIC) as well as the method of calculating the AIC, for the Medicare appeals process.

Additional Information

The official instruction issued to your FI or carrier regarding this change may be found by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4019 in the CR NUM column on the right, and click on the file for that CR. All of the new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR4019. These sections provide excellent detail that explains the revised appeals process.

Please refer to your local FI or carrier for more information about this issue. To find their toll-free phone number, go to http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Submitting Additional Documentation With The Redetermination Request

CIGNA Government Services Redetermination Department makes every effort to provide a thorough analysis of every request we receive. It is important that we have ALL the facts available concerning the issues involved. If you submitted additional information with your original claim, please note this on your redetermination request or include that information with the redetermination request. All medical documentation must be signed and dated by a health care professional. If the beneficiary has signed an Advance Beneficiary Notice, please submit a copy along with your redetermination request. The following are examples of additional documentation that may be sent with the redetermination request:

Surgical Dressings

- A dated wound evaluation that gives the type of wound, location, drainage, size and depth of the wound. It should be dated within 30 days of the date of service in question.
- If you are billing a Not Otherwise Classified (NOC) code, please provide a detailed description of the item such as the product name and number.
- A detailed written order from the patient's physician that specify the type of dressing per wound, the size of the dressing (if appropriate), the number/amount to be used at one time per wound (if more than one), the frequency of dressings change, and expected duration of need.

Urologicals

- Nurses notes and patients daily care records. If the patient requires additional quantities of catheters, the reason for the need must be documented.
- Documentation from the patient's doctor providing information about the patient's medical condition including episodes of pyuria, fevers and/or urinary tract infections. Lab reports that would include urine culture with greater than 10,000 colony forming units of a urinary pathogen.

Wheelchair, POVs, Attachments and Accessories

Date of service prior to May 5, 2005

- A completed Certificate of Medical Necessity, sign and dated by the ordering physician.
- Physician's order.
- Documentation that shows coverage criteria has been met.

Date of service May 5, 2005 through October 24, 2005

- A Certificate of Medical Necessity (does not need to be reviewed, completed, or signed by the physician).
- Payment Authorization.
- Delivery slip.
- Verbal order (if item was dispensed based on a verbal order).
- Written order that includes beneficiary's name, detailed description of the item, list/description of all options and additional features, start date (if different than signature date). Clinician's signature and signature date.
- Documentation from the patient's physician providing information to support the medical need based on the National Coverage Determination.

Note: POVs require a written order.

Dates of service on or after October 25, 2005

- A Certificate of Medical Necessity (does not need to be reviewed, completed, or signed by the physician).
- Payment authorization.
- Delivery slip.
- Verbal order (if item was dispensed based on a verbal order).

• Written order that includes beneficiary's name, detailed description of the item, list/description of all options and additional features (accessories), date of completion of the face-to-face examination, pertinent diagnoses/conditions that relate to the need for the power mobility device, length of need, start date (if different than signature date), and clinician's signature and signature date.
• Face-to-face examination performed by the treating physician no more than 30 days prior to receipt of the written order.
• Documentation from the patient's physician providing information to support the medical need.

Note: POVs and power wheelchair cannot be delivered prior to a written order and face-to-face examination.

Attachments, Accessories and the ultra lightweight wheelchair (K0005)

• Medical records which explain the need for the wheelchair and each individual accessory.
• Manufacturer's name and product number, invoice/suggested retail price.
• Description of the patient's routine activities outside the home.
• For ultra lightweight wheelchair (K0005), describe features needed compared to the high strength lightweight wheelchair (K0004).
• If billing for K0108 (Wheelchair Component Or Accessory, Not Otherwise Specified), include description of the item, product name, product number, and medical necessity for the item.

Prosthetics and Replacement Sockets

• A new order signed by the doctor.
• Measurements of residual limb changes.
• Medical documentation that explains the need for socket replacements or new prosthetic. This information should include any weight changes, level of activity, length of time since amputation, number of sock plies used.

Orthotics

• Treatment plan from the doctor and supplier.
• Documentation about the patient's condition which explains the need for new or replacement orthotics.

Lymphedema Pumps

• The Certificate of Medical Necessity.
• Additional documentation that describes the location of the lesion(s), any other treatments tried or the reasons other treatments could not be tried.
• The diagnosis of CVI with venous stasis ulcers must include a six month trial of conservative therapy that has failed to heal.
• The diagnosis of Lymphedema must include a 4 week trial with no significant improvement.

Multiple Ventilators

• Medical records or documentation to demonstrate the medical need for more than one ventilator.

Tracheal Suction Catheters

• Documentation describing the patient's condition and that of the tracheostomy site.
• The medical reasons for any increase in catheter usage.

Enteral Formula (Category IV and V Nutrients)

• A Certificate of Medical Necessity.
• Lab results.
• Test results.
• Documentation that demonstrates the patient's condition on the Category I nutrient as opposed to the Category IV or V nutrient over a period of time.

Parenteral Formula

• Discharge Summaries.
• Operative reports.
• Fecal Fat tests.
• Evidence of failed tube trails and significant malnourishment.

Air Fluidized Beds

• A Certificate of Medical Necessity.
• Current wound evaluation that details the location of the ulcer, nutritional status, moisture control.
• Additional documentation that outlines patient's condition, description and duration of other treatments tried, pressure reducing support surfaces used within the last month, nutritional support, the level of bed confinement and the possibility of institutionalization in the absence of the bed.

Support Surfaces

• A signed and dated statement from the ordering physician.
• Documentation that shows the location of the ulcer.

Infusion Pumps for Dobutamine, Milrinone and Dopamine

• A Certificate of Medical Necessity.
• Physician's order.
• Hospital Discharge Summary.
• Inotropic data form (Supplier Manual, Chapter 9, EIP).
• Cardiac Catheterization report.

Same or Similar Equipment Denials

- A Certificate of Medical Necessity, if applicable.
- Physician's order.
- Signed pick up and delivery tickets.
- A detailed outline of events (who provided what and when) and the change in medical need.

Break In Service Denials

- A description of the patient's prior medical condition which necessitated the previous item;
- A statement explaining when and why the medical necessity for the previous item ended; and
- A statement explaining the patient's new or changed medical condition and when the new need began.

ELECTRONIC DATA INTERCHANGE (EDI)

Claim Status Category Code And Claim Status Code Update

Medlearn Matters Article Number: MM4256
Related Change Request (CR) #: 4256
Related CR Release Date: January 20, 2006
Effective Date: April 1, 2006
Related CR Transmittal #: R814CP
Implementation Date: April 3, 2006

Provider Types Affected - All providers submitting Health Care Claim Status Transactions to Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

Provider Action Needed

Impact to You - This article is based on Change Request (CR) 4256, which provides the April 2006 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHIs).

What You Need to Know - Medicare contractors are to use codes with the **"new as of 4/06"** designation and prior dates and inform affected providers of the new codes. CR 4256 applies to Chapter 31, 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.

What You Need to Do - See the *Background* section of this article for further details.

Background - Claim Status Category codes indicate the general category of a claim's status (accepted, rejected, additional information requested, etc.), which is then further detailed by the Claim Status Code(s). 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.

The Health Care Code Maintenance Committee maintains the Claim Status Category and Claim Status codes, and as previously mentioned, the Committee meets at the beginning of each X12 trimester meeting and makes decisions about additions, modifications, and retirement of existing codes.

Note: The updated list is posted three times a year (after each X12 trimester meeting) at the Washington Publishing Company web site at http://www.wpcedi.com/codes. Once at the Washington Publishing Company web site, select "Claim Status Codes" or "Claim Status Category Codes" to access the updated code list. Included in the code lists are specific details, including the date when a code was added, changed or deleted. All code changes approved in February 2006 are to be listed at this above web site approximately thirty (30) days after the meeting concludes. For this update, Medicare will begin using the codes in place as of 4/06.

Implementation - The implementation date for this instruction is April 3, 2006.

Additional Information - For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R814CP.pdf on the CMS web site.

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

EDI Billing For Wheelchair Options With LT RT Modifiers

The right (RT) and left (LT) modifiers must be used (when appropriate) for wheelchair options and/or accessories. When the same code for bilateral items (left and right) are billed electronically on the same date of service as

a purchase (NU or UE modifiers), bill both items on the same claim line using the LTRT modifiers and 2 units of service. When the same code for bilateral items are billed electronically on the same date of service as a rental (RR modifier), bill the items on two separate claim lines with the RT modifier on one line and the LT modifier on the other line.

Healthcare Provider Taxonomy Codes (HPTC) Update

Medlearn Matters Article Number: MM4254
Related Change Request (CR) #: 4254
Related CR Release Date: January 20, 2006
Effective Date: April 1, 2006
Related CR Transmittal #: R815CP
Implementation Date: April 3, 2006

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for Part A and Part B services.

Provider Action Needed

Impact to You - This article is based on Change Request (CR) 4254 which informs Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs) and regional home health intermediaries (RHHIs)) to obtain the most recent Healthcare Provider Taxonomy Codes (HPTC) and use it to update their internal HPTC tables.

What You Need to Know - HIPAA requires that submitted data, which is part of a named code set, be valid data from that code set. Claims accepted with invalid data are non-compliant. Because health care provider taxonomy is a named code set in the 837 Institutional and Professional implementation guides, Medicare must validate the inbound taxonomy codes against their internal HPTC tables.

What You Need to Do - See the *Background* section of this article for further details.

Background - The Healthcare Provider Taxonomy Codes (HPTC) set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment (specifically within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care claim transaction).

HPTCs are scheduled for update twice per year (April and October). The HPTC list is available from the Washington Publishing Company at http://www.wpcedi.com/codes/taxonomy in two forms:

- A free Adobe PDF download of the HPTC list; and
- An electronic representation of the list (available for purchase) which facilitates the automatic loading of the code set.

Note: Claims received with invalid data are non-compliant with HIPAA and will not be processed by Medicare.

Implementation - The implementation date for this instruction is April 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R815CP.pdf on the CMS web site.

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

Information Regarding Claim Submission With The Use Of The National Provider Identifier (NPI)

Beginning January 3, 2006, suppliers that have applied for and received an NPI number may start submitting claims with use of that number. Please be aware that a valid ***supplier number must also be present*** on the claim(s). Please note that the NPI number must be a total of ten digits, with the last containing a valid check digit. There will be an NPI validation routine in the Appendix of the DMERC EDI manual to help determine if the check digit being submitted is correct. This information will be updated in the EDI manual as of January 2006. If your proprietary software does not accommodate an NPI number you will need to contact your vendor.

If the claim(s) are submitted with an NPI number but no current supplier number, these claims will reject. For more information, please refer to the various Medlearn Matters articles that have been published regarding this topic.

Revision To Chapter 31 – Attestation Form For Conducting Real Time Eligibility Inquiries With Medicare

Medlearn Matters Number: MM4093
Revised Related Change Request (CR) #: 4093
Related CR Release Date: October 7, 2005
Effective Date: October 1, 2005
Related CR Transmittal #: 700
Implementation Date: November 7, 2005

Note: This article was revised on January 31, 2006, to change the effective date (shown above) from October 1, 2006, to October 1, 2005. All other information remains the same.

Provider Types Affected - Providers who access the 270/271 health care eligibility inquiry and response application in real time

Provider Action Needed

Impact to You

Beginning September 1, 2005, an on-line attestation form (*Trading Partner Agreement for Submission of 270s to Medicare on a Real-Time Basis)* must be completed by submitters authenticated by the Centers for Medicare & Medicaid Services (CMS) to conduct 270/271 transactions with CMS before providers may access the real-time 270/271 health care eligibility inquiry and response application.

What You Need to Know

Submitters requesting access to the Medicare beneficiary database must follow the procedure outlined in the *Additional Information* section below.

What You Need to Do

Please be sure to fill out this new agreement form located at http://www.cms.hhs.gov/it so you can conduct 270/271 transactions with Medicare.

Background

The purpose of Change Request (CR) 4093 is to alert Medicare providers to the revision in the *Medicare Claims Processing Manual*, Chapter 31 (ANSI X12N Formats Other than Claims or Remittance).

This revision addresses the standards for Medicare beneficiary eligibility inquiries, and creates the database and infrastructure needed to provide a real-time, centralized Health Insurance Portability and Accountability Act (HIPAA) compliant Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

Additional Information

Access Process for Clearinghouses/Provider

Beginning September 1, 2005:

- The Medicare Eligibility Integration Contractor (MEIC) will e-mail the on-line attestation form outlining security and privacy procedures for submitters already submitting authenticated 270 transactions on a real time basis.
- Each Submitter should complete the form in its entirety and transmit it back via e-mail to MCAREHD@emdeon.com.

Beginning October 1, 2005:

- Submitters will be able to access the appropriate forms for the CMS 270/271 Medicare Eligibility transaction at: http://www.cms.hhs.gov/AccessToDataApplication
- The submitter must provide the information requested on the form electronically and click on the appropriate assurances. If the submitter does not consent to the terms of the agreement, by appropriately completing the form, the access process will be terminated.
- A copy of the appropriately completed form must be electronically submitted to CMS. Once CMS has the completed form, it will be authenticated, at which time the submitter will then be directed to complete an Medicare Data Communications Network (MDCN) connectivity form and submit it electronically in order to be connected to the 270/271 eligibility database.

CMS staff will make sure that all of the necessary information is provided on the form, and will ensure the complete connectivity to the 270/271 application.

A CMS contractor known as the Medicare Eligibility Integration Contractor (MEIC) will contact the submitter in order to authenticate the accessing entity's identity.

Once authentication has been completed, the MEIC will provide the Clearinghouses, Providers, and Trading Partners with a submitter identification (ID) that must be used on all 270/271 transactions.

The MDCN extranet application is suitable for many providers that can create, send, and receive complete X12

eligibility transactions. CMS will soon offer a second solution for providers that desire to conduct the transaction using the Direct Data Entry (DDE) version. The DDE version will allow all approved providers to conduct eligibility transactions over the public internet at no cost to the provider.

Please note that in order to access the MDCN, an entity must obtain the necessary telecommunication software from the AT&T reseller on its own. AT&T Resellers and contact cumbers include the following:

• IVANS: http://www.ivans.com; Telephone: 1-800-548-2675
• McKesson: http://www.mckesson.com; Telephone: 1-800-782-7426; Key option 5, then key option 8

MEIC Helpdesk Support

You may also contact the MEIC help desk for connectivity issues on Monday through Friday, 7:00 a.m. - 9:00 p.m. EST; Telephone: 1-866-324-7315; E-mail address: MCARE@cms.hhs.gov.

Related Links

The official instruction issued to your fiscal intermediary (FI), regional home health intermediary (RHHI), carrier, or durable medical equipment regional carrier (DMERC) regarding this change may be found by going to http://www.cms.hhs.gov/Transmittals/downloads/R700CP.pdf on the CMS web site.

Please refer to your local FI, RHHI, Carrier or DMERC for more information about this issue. To find the toll free phone number, go to http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

Revision To Chapter 31 – Addition Of Hospice Data To HIPAA 270/271 Eligibility Inquiry And Response Transactions

Medlearn Matters Article Number: MM4193
Related Change Request (CR) #: 4193
Related CR Release Date: December 29, 2005
Effective Date: January 23, 2006
Related CR Transmittal #: R793CP
Implementation Date: January 23, 2006

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs) for Hospice services

Provider Action Needed

This article is based on Change Request (CR) 4193, which adds Hospice data to the Centers for Medicare & Medicaid Services (CMS) Health Insurance Portability and Accountability Act (HIPAA) Health Care Eligibility Benefit Inquiry and Response transaction (270/271). Hospice will be part of the core data elements returned on the 271 response.

Background

CMS is making changes to its Information Technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA) compliant 270/271 health care eligibility inquiry and response in real-time.

CMS is using a phased approach for providing this eligibility transaction on a real-time basis:

• **Extranet:** Clearinghouses, certain providers, and trading partners (as described below) will be permitted to submit 270s via the CMS AT&T communication Extranet (the Medicare Data Communication Network or MDCN). This Extranet is a secure closed private network currently used to transmit data between Medicare Fee-for-Service (FFS) contractors and CMS.
• **Internet:** CMS expects to provide limited internet access to the 270/271 transaction this year. Instructions on accessing eligibility data via this method will be provided prior to the time internet access becomes available.

All electronic 270 files will be processed at the CMS data center, and the CMS data center will use a single consolidated national eligibility database to respond to the eligibility inquiries.

CR4193 revises the *Medicare Claims Processing Manual* (Pub. 100-04) Chapter 31 (ANSI X12 Formats Other than Claims or Remittance), Section 10.2 (Eligibility Extranet Workflow), by adding the following Hospice data to the CMS HIPAA Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

271 Response Data Elements

If a service type code is submitted in a 270 that does

not trigger additional Medicare data elements, the following data elements will be returned in the 271 as applicable:

271 Information Returned	Loop	Segment	Element	Data Value
Hospice Data	2110C	EB DTP	EB01 EB03 EB04 EB06 DTP01 DTP02 DTP03	X 45 MA 26 292 D8 or RD8 Dates

Implementation - The implementation date for the instruction is January 23, 2006.

Additional Information

Medlearn Matters Article MM3883 provides information regarding the access process for beneficiary eligibility inquiries and replies (HIPAA 270 and 271 transactions, Extranet Only). It can be reviewed at http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3883.pdf on the CMS web site.

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R793CP.pdf on the CMS web site. If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/apps/contacts/on the CMS web site.

Shared Systems Medicare Secondary Payer (MSP) Balancing Edit And Administrative Simplification Compliance Act (ASCA) Enforcement Update

Medlearn Matters Number: MM4261
Related Change Request (CR) #: 4261
Related CR Release Date: February 2, 2006
Effective Date: July 1, 2006
Related CR Transmittal #: R831CP
Implementation Date: July 3, 2006

Provider Types Affected - Physicians, suppliers and providers billing MSP claims to Medicare carriers, fiscal intermediaries (FI), durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs)

Key Points for Providers

CR4261 makes two key changes to Medicare claims processing as follows:

• First, CR4261 states that inbound MSP claims will be rejected if the paid amounts and the adjusted amounts paid by the primary payer do not equal the billed amounts at the line level and if the claim lacks standard claim adjustment reason codes to identify adjustments performed.

While Medicare may be able to handle such a discrepancy because it does not always use this information, it may pass such claims to other payers. Such other payers may then reject the claims because they do not comply with the 837 version 4010A1 institutional and professional implementation guides. As a result, Medicare will not accept such claims in order to be fully compliant with HIPAA.

• Second, if a provider's paper claims have been denied due to ASCA electronic claims provision enforcement by Medicare contractors (carriers, FIs, RHHIs, and DMERCs), the provider may resubmit the paper claims if they submit appropriate documentation that establishes that they meet the criteria for submitting paper claims.

Providers have until the 91st day after the initial ASCA letter to submit documentation that proves eligibility for submission of paper claims. If a provider establishes eligibility later than the 91st day of the initial enforcement letter and then resubmits paper claims, payment will be denied for dates of service between the 91st day and the effective date for submission of claims.

Implementation - The implementation date for the instruction is July 3, 2006

Additional Information

For details of enforcement of the ASCA, please see related Medlearn Matters article MM3440, "Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims," at http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3440.pdf on the CMS web site.

The official instruction on this change, CR4261, may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R831CP.pdf on the CMS web site. If you have questions, please contact your carrier/intermediary/DMERC at their toll-free number which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

Stage 1 Use And Editing Of National Provider Identifier Numbers Received In Electronic Data Interchange Transactions, Via Direct Data Entry Screens, Or Paper Claim Forms

Effective January 2006, new edits were put into place to verify that an NPI and legacy Supplier Number are provided when submitting Medicare claims. If an NPI number is submitted without a legacy Supplier Number, the claims will reject. As a result, if you are submitting 276/277 batch claims, the following edits are in effect. If your claims reject as a result of these new edits, please correct the claims and resubmit.

50518	LEGACY PROVIDER NUMBER REQUIRED	NM108	The qualifier identifying the Legacy Provider number for this transaction is invalid. Valid Values: FI - Federal Taxpayer's Identification Number **SV - Service Provider Number**
50519	DUPLICATE QUALIFIERS NOT ALLOWED	NM108	There must be only one Provider name qualifier submitted with the Service Provider Level.

Furthermore, if you are submitting 837 claims, the following edits are in place to verify that an NPI number is in fact provided on the claims. Please remember: legacy Supplier Numbers must also be provided or the claim will reject. If your claims reject as a result of these new edits, please correct the claims and resubmit.

11358	EIN OR SSN REQ FOR NPI AT 2010AA LOOP	REF01	The qualifier submitted for the Billing/Pay-to-Provider indicates an NPI number has been submitted. Valid Values: EI = Employers Identification Number SY = Social Security Number
11359	EIN OR SSN REQ FOR NPI AT 2010AB LOOP	REF01	The qualifier submitted for the Pay-to-Provider indicates an NPI number has been submitted. Valid Values: EI = Employers Identification Number SY = Social Security Number
11360	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Referring Provider Secondary Identifier must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number
11361	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Rendering Provider Secondary Identifier must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number
11362	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Purchased Service Provider Secondary Identifier must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number
11363	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Supervising Provider Secondary Identifier must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number

11364	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Rendering Provider Secondary Identifier must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number
11365	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Purchased Service Provider Secondary Identifier must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number
11366	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Supervising Provider Secondary Identifier must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number
11367	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Ordering Provider Secondary Identifier must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number
11368	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Referring Provider Secondary Identifier must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number
11369	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Billing Provider must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number
11370	VALID EIN OR SSN REQUIRED IF NPI	REF02	The SSN/EIN submitted for the Pay-to- Provider must be 9 numbers. Valid Values: EI = Employers Identification Number SY = Social Security Number
20309	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Billing Provider indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20310	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20311	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20312	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number

20313	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20314	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20315	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20316	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20317	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20318	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20319	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20320	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number
20321	PROVIDER NUMBER REQ IF NPI	REF01	The qualifier submitted for the Reference Identification indicates an NPI number has been submitted. Valid Values: 1C = Medicare Provider Number 1G = Provider UPIN Number

Stage 2 Requirements For Use And Editing Of National Provider Identifier (NPI) Numbers Received In Electronic Data Interchange Transactions, Via Direct Data Entry Screens Or Paper Claim Forms

Medlearn Matters Article Number: MM4023

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

Note: This article was revised on November 29, 2005, to clarify that the end date of the transition period for the revised CMS-1500 form is February 1, 2007. (See the paper claims form section.)

Provider Types Affected

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

Provider Action Needed

The requirements for Stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are not based on the date of receipt of a transaction, unless otherwise stated in a business requirement. Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the NPI in Stage 2 is October 1, 2006.

Background

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414). To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005. Applications can be made by mail and also online at https://nppes.cms.hhs.gov.

NPI and Legacy Identifiers

The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. **Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers**.

Legacy provider identifiers include:

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

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

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

Primary and Secondary Providers

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

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

Crosswalk

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

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

NPI Transition Plans for Medicare FFS Providers

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

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

Claim Rejection

Claims will be rejected if:

- The NPI included in a claim or claim status request does not meet the content criteria requirements for a valid NPI; this affects:
  - X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only);
  - National Council of Prescription Drug Plan (NCPDP) claims (submitted to
  - Medicare DMERCs only);
  - Claims submitted using Medicare's free billing software;
  - Electronic claim status request received via X12 276 or DDE screen; and
  - Non-X12 electronic claim status queries;

- An NPI reported cannot be located in Medicare files;

• The NPI is located, but a legacy identifier reported for the same provider in the transaction does not match the legacy identifier in the Medicare file for that NPI;

• Claims include the NPI but do not have a taxpayer identification number (TIN) reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare's free billing software.

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

X12 837 Incoming Claims and COB

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

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

National Council of Prescription Drug Plans (NCPDP) Claims

The NCPDP format was designed to permit a prescription drug claim to be submitted with either **an NPI or a legacy identifier, but not more than one identifier** for the same retail pharmacy or prescribing physician. The NCPDP did provide qualifiers, including one for NPIs, to be used to identify the type of provider identifier being reported.

• For Stage 1, retail pharmacies were directed to continue filing their NCPDP claims with their individual NSC number and to report the UPIN of the prescribing physician.

• During Stage 2, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have the prescribing physician's NPI) in their claims.

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

Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006 and end February 1, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007.

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

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

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

Standard Paper Remits (SPRs)

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

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

Remit Print Software

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

Free Billing Software

Medicare will ensure that this software is changed as needed by October 2, 2006, to enable reporting of both

an NPI and a Medicare legacy identifier for each provider for which data is furnished in a claim, and to identify whether an entered identifier is an NPI or a legacy identifier.

In-Depth Information

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

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

CR4023, the official instruction issued to your FI/ regional home health intermediary (RHHI) or carrier/durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4023 in the CR NUM column on the right, and click on the file for that CR.

You may also wish to review *Medlearn Matters* article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition *Medlearn Matters* Articles on NPI-Related Activities," which is available at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0555.pdf on the CMS web site. This article contains further details on the NPI and how to obtain one.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find their toll free phone number, go to http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

HIPAA

Termination Of The Medicare Health Insurance Portability & Accountability Act (HIPAA) Incoming Claim Contingency Plan, Addition Of A Self-Assessable Unusual Circumstance, Modification Of The "Obligated To Accept As Payment In Full"(OTAF) Exception, And Modification Of Administrative Simplification Compliance Act (ASCA) Exhibit Letters A, B And C

Medlearn Matters Article Number: MM4119
Related Change Request (CR) #: 4119
Related CR Release Date: December 30, 2005
Effective Date: April 1, 2006
Related CR Transmittal #: R802CP
Implementation Date: April 3, 2006

Provider Types Affected - Physicians, providers, and suppliers who submit claims to the Centers for Medicare & Medicaid Services (CMS) Medicare contractors (carriers, fiscal intermediaries (FIs), durable medical equipment regional carriers (DMERCs) or regional home health intermediaries (RHHIs))

Background

This article, based on CR4119, summarizes some of the key revisions to electronic data interchange (EDI) requirements contained in the *Medicare Claims Processing Manual*, Chapter 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims). Some of these changes have already been reported in earlier Medlearn Matters articles and are mentioned here only as reminders.

The EDI policy revisions are necessary for:

- HIPAA compliancy, including contingency plan termination, and free claim software changes;
- Administrative Simplification Compliance Act (ASCA) compliancy, including unusual circumstance, "Obligated to Accept as Payment in Full" (OTAF) modification, and modified ASCA letters.

Medicare providers must adhere to these electronic data interchange requirements. Electronic transactions that do not fully comply with the implementation guide requirements for these formats will be rejected.

Key Points

Medicare HIPAA Incoming Claim Contingency Plan

The Medicare HIPAA incoming claim contingency plan has been terminated. **All electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the National Council for Prescription Drug Program (NCPDP) Telecommunication Standard requirements and the Batch Standard 5.1 (DMERCs only) will be rejected.** Please refer to the *Additional Information* section of this article for more information.

Until the Medicare contingency plan for **HIPAA mandated transaction types other than claims sent to Medicare is terminated**, Medicare contractors **will support** the pre-HIPAA electronic transaction formats listed in the *Medicare Claims Processing Manual*, Chapter 24, Section 40.2 (attached to CR 4119). Please refer to the *Additional Information* section of this article for more information.

NCPDP Claims

NCPDP claims submitted to DMERCs may contain modifiers for compound drugs in the **narrative portion** in the prior authorization segment on the NCPDP standard since it does not currently support reporting modifiers in the compound segment. Please refer to the attachment to CR4119, *Medicare Claims Processing Manual,* Chapter 24, Section 40.2 – B, for further instructions and a list of the modifiers.

Currently Coordination of Benefits (COB) trading partners are not able to accept NCPDP format transmissions for **secondary payment**. CMS is working with the NCPDP to develop a "workaround" to resolve this problem, however, until then, NCPDP claims will not be crossed over to other payers. **Retail pharmacies will need to bill secondary payers directly to collect supplemental benefits that may be due for those claims.** Transmission of pre-HIPAA electronic format claims to other payers under a COB agreement will end when (the earliest of the date) a trading partner completes successful testing on the use of the X12 837 version 4010A1 and /or the HIPAA NCPDP format (as appropriate); or the Medicare HIPAA COB contingency plan ends.

Other Issues

Medicare secondary payer claims may be submitted **non-electronically** when a primary payer has made an "Obligated to Accept as Payment in Full" (OTAF) adjustment, **and there is more than one primary payer.** Providers have been directed to report OTAF adjustments in a CN1 segment of a claim, but it is not possible to either identify which primary payer owns a reported OTAF adjustment, or to report more than one OTAF adjustment in the event they apply to each primary payer.

The free billing software (from your Medicare contractor) should be able to **identify when Medicare is a secondary payer**. It should also be able to collect standard claim adjustment reason codes and adjustment amounts made by a primary payer when Medicare is the secondary payer. If it is not collecting this information, the software must be modified to enable this requirement.

Unusual Circumstances

Certain "unusual circumstances" are automatically waived from the electronic claim submission requirement for either the indicated claim type, or for the period when an "unusual situation" exists. CMS has added a circumstance to the selfassessable Unusual Circumstance list in which **paper claim submission is permitted**. **Home oxygen therapy claims** for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO2 is more than 60 mmHg but a combination of factors necessitates use of oxygen. The X12 work group responsible for development of the version 4010A1 implementation guide recognizes that there is a deficiency in the guide pertaining to home oxygen therapy claims. This will be corrected in a later version of that implementation guide, but in the interim, covered entities are bound by the existing version 4010A1 requirements. As result, CMS will permit claims that meet this situation to be submitted on paper.

Modified examples of ASCA exhibit letters A, B, and C can be found in the manual attachment to CR4119(*Medicare Claims Processing Manual*, Chapter 24, Exhibits of Form Letters). Your Medicare contractor will send these revised letters, as appropriate.

- Exhibit A—Response to a non- "unusual circumstance" waiver request
- Exhibit B—Denial of an "unusual circumstance" waiver request
- Exhibit C—Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper

Additional Information

Medicare HIPAA Incoming Claim Contingency Plan Termination

All electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the NCPDP requirements will be rejected. The Medicare contingency plan for the X12 835, 276/277 (version 4010 support will need to be terminated), 837 claims that Medicare sends to another payer as provided for in a trading partner agreement, and the 270/271 version 4010A1 transactions remain in effect pending further notice. CMS will issue advance notice to the health care industry when a decision is reached to terminate the remaining Medicare contingency plans.

HIPAA Mandated Transaction Types Other Than Claims Sent to Medicare

Until the Medicare contingency plan (mentioned above) is terminated, Medicare contractors will support the pre-HIPAA electronic transaction formats listed in the *Medicare Claims Processing Manual*, Chapter 24, Section 40.2. These include for claims submitted to:

- All Medicare contractors – UB – 92 version 6.0 claims for coordination of benefits (COB) sent to other payers under trading partner agreements; proprietary format for eligibility data responses using the CMS standard eligibility data set; and X12 276/277 version 4010.
- FIs – X12 837 institutional version 4010 and 3051; X12 835 versions 3030Ma, 3051.3A, and 3051.4A for remittance advice.
- Carriers and DMERCs – X12 837 professional version 4010 and 3051; National Standard Format (NSF) version 3.01; X12 835 IG versions 3030Mb, 3051.3B, and 3051.4B for remittance advice; and NSF version 3.01.
- Carriers only - X12 270/271 IG version 3051 for eligibility query and response.
- Please note - Specifications for each of these transactions can be found the Washington Publishing Company web site at http://www.wpcedi.com/HIPAA for those X12 IGs (other than the NCPDP) adopted as national standards under HIPAA.

The official instruction, CR4119, issued to your FI/RHHI, or carrier/ DMERC, regarding this change may be found by going to http://www.cms.hhs.gov/Transmittals/downloads/R802CP.pdf. Attached to CR4119, you will find the revised portions of the *Medicare Claims Processing Manual* referenced in this article.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find the toll-free phone number, go to http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

FEE SCHEDULE

Fee Schedule Update For 2006 For Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

Medlearn Matters Number: MM4194
Related Change Request (CR) #: 4194
Related CR Release Date: December 2, 2005
Effective Date: January 1, 2006
Related CR Transmittal #: 770
Implementation Date: January 3, 2006

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services paid under the DMEPOS Fee Schedule

Provider Action Needed

This article is based on Change Request (CR) 4194, and it provides specific information regarding the annual update for the 2006 DMEPOS Fee Schedule.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to:

- Implement fee schedule amounts for new codes; and
- Revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for:

- Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)); and
- Parenteral and Enteral Nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

Note: DMERCs will use the 2006 PEN fee schedule payment amounts to pay claims for items furnished from January 1, 2006 through December 31, 2006.

The 2006 DMEPOS Fee Schedule Update factors for Health Care Common Procedure Codes (HCPCS) items furnished from January 1, 2006, through December 31, 2006, and are as follows:

HCPCS Codes	Notes
A5120	Modifier "AV" is added for billing items furnished for facial prosthetics. Modifier "AU" is added for billing items furnished for urological supplies.
L2005	Is being revised effective January 1, 2006, to ensure that the code's allowable amount is representative of a full knee, ankle, foot orthosis (KAFO), including the joint component.
L8609 and L8685 through L8689	Describe items that are subject to the fee schedule for prosthetics and orthotics (PO) and are being added to the HCPCS effective January 1, 2006. These codes fall under the jurisdiction of the local carriers rather than the DMERCs. The Centers for Medicare & Medicaid Services (CMS) will be calculating the fee schedule amounts for these items using the standard gap-filling process. The description for these codes can be obtained from the 2006 HCPCS file as soon as it becomes available at http://www.cms.hhs.gov/ HCPCS ReleaseCodeSets/ANHCPCS/list.asp#TopOfPage on the CMS web site.

The following codes are being deleted from the HCPCS, effective January 1, 2006, and are therefore being removed from the DMEPOS and PEN fee schedule files:

A4254	E0996	K0075	K0670	L8140
A4643 thru A4647	E1000	K0076	K0671	L8150
A5119	E1001	K0078	K0731	L8160
A5509	E1019	K0102	K0732	L8170
A5511	E1021	K0104	L0860	L8180
B4184	E1025 thru E1027	K0106	L1750	L8190
B4186	E1210 thru E1213	K0415	L3963	L8195
E0169	E1239	K0416	L8100	L8200
E0752	K0064	K0452	L8110	L8230
E0754 thru E0759	K0066	K0600	L8120	L8239
E0953	K0067	K0618 thru K0620	L8130	L8620
E0954	K0068	K0628 thru K0649		
E0972	K0074			

The HCPCS codes listed below are being added to the HCPCS on January 1, 2006:

A4218	B4185	E2212 thru E2226	L3961
A4233 thru A4236	E0170 thru	E2371	L3967
A4363	E0172	E2372	L3971
A4411	E0485	L0491	L3973
A4412	E0486	L0492	L3975 thru L3978
A4604	E0641	L0621 thru L0640	L5703
A5120	E0642	L0859	L5858
A5512	E0705	L2034	L5971
A5513	E0762	L2387	L6621
A6457	E0764	L3671 thru L3673	L6677
A6513	E0911	L3702	L6883 thru L6885
A6530	E0912	L3763 thru L3766	L7400 thru L7405
A6531	E1392	L3905	L7600
A6532	E1812	L3913	L8609
A6533 thru A6544	E2207 thru	L3919	L8623
A6549	E2210	L3921	L8624
A9275	E2211	L3933	L8680 thru L8689
A9281	E2212	L3935	
A9282			

The Medicare DMERCs will gap-fill base fee schedule amounts for each state in their region for the following new HCPCS codes that will be subject to the DMEPOS fee schedules in 2006:

HCPCS Codes	Notes
A4363, A4411, A4412	Ostomy, Tracheostomy, or Urological Supplies (OS)
A4233, A4234, A4235, A4236, A4604, E0485, E0486, E2216, E2217,E2218, E2222, E2223, E2225, E2226, E2371, E2372	Inexpensive or Routinely Purchased DME (IN)
E0170, E0171, E0911, E0912, E1812	Capped Rental DME (CR)
L0624, L0629, L0632, L0634, L2034, L2387, L3671, L3672, L3673, L3702, L3763, L3764, L3765, L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975, L3976, L3977, L3978, L5703, L5971, L6621, L6677, L6883, L6884, L6885, L7400, L7401, L7402, L7403, L7404, L7405	Prosthetics and Orthotics (PO)
A6513	Surgical Dressings (SD)

Suppliers should remember to add HCPCS modifier AV when billing code A5120 for facial prosthetic items only when furnished in conjunction with a facial prosthesis. Also, add modifier AU when billing code A5120 for urological items only when furnished in conjunction with urological supplies.

Implementation - The implementation date for the instruction is January 3, 2006

Additional Information - The official instruction issued to your carrier, intermediary, or DMERC regarding this change, can be found at http://new.cms.hhs.gov/transmittals/downloads/R770CP.pdf on the CMS web site. If you have questions regarding this issue, you may also contact your carrier, FI, or DMERC at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

January 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective January 1, 2006, And Revisions To January 2005, April 2005, July 2005, And October 2005 Quarterly ASP Medicare Part B Drug Pricing Files

Medlearn Matters Article Number: MM4140

Revised Related Change Request (CR) #: 4140
Related CR Release Date: November 4, 2005
Effective Date: January 1, 2005
Related CR Transmittal #: 746
Implementation Date: January 3, 2006

Note: This article was revised on November 17, 2005, to change the phrase “Not Otherwise Clarified” to “Not Otherwise Classified” in the “What You Need to Know” section. All other information remains the same.

Provider Types Affected - All Medicare providers who bill Medicare for Part B drugs

Provider Action Needed

Impact to You

CR4140 provides notice of the updated payment allowance limits in the January 2006, January 2005, April 2005, July 2005, and October 2005 drug pricing files.

What You Need to Know

Be aware that certain Medicare Part B drug payment limits have been revised and that CMS updates the payment allowance on a quarterly basis. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to this document.

What You Need to Do

Make certain that your billing staffs are aware of these changes.

Background

According to Section 303 (c) of the Medicare Modernization Act of 2003 (MMA), the Centers for Medicare & Medicaid Services (CMS) will update the payment allowances for Medicare Part B drugs on a quarterly basis. Beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the average sales price (ASP).

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis and each quarter, CMS will update your carrier/FI payment allowance limits with the ASP files. On or after December 19, 2005, revised January 2005, April 2005, July 2005, and October 2005 ASP and NOC payment files and the January 2006 ASP and NOC files will be available for download.

- The revised January 2005 payment allowance limits apply to dates of service January 1, 2005 through March 31, 2005.
- The revised April 2005 payment allowance limits apply to dates of service April 1, 2005 through June 30, 2005.
- The revised July 2005 payment allowance limits apply to dates of service July 1, 2005 through September 30, 2005.
- The revised October 2005 payment allowance limits apply to dates of service October 1, 2005 through December 31, 2005.
- The January 2006 payment allowance limits apply to dates of service January 1, 2006 through March 31, 2006.

Exceptions

There are, however, exceptions to the general rule and they were summarized in MM3846, effective July 1, 2005, and may be viewed at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3783.pdf on the CMS web site.

Implementation

The implementation date for the instruction is January 3, 2006.

Additional Information

The official instruction issued to your carrier/intermediary regarding this change may be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4140 in the CR NUM column on the right and click on the file for that CR.

CMS will also update the Microsoft Excel files on the CMS web site to reflect these revised payment limits. Those files can be found at http://www.cms.hhs.gov/providers/drugs/asp.asp on the CMS web site.

If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Reasonable Charge Update For 2006 For Splints, Casts, Dialysis Supplies, Dialysis Equipment, And Certain Ocular Lenses

Medlearn Matters Article Number: MM4131

Related Change Request (CR) #: 4131
Related CR Release Date: November 8, 2005
Effective Date: January 1, 2006
Related CR Transmittal #: 749
Implementation Date: January 3, 2006

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) for services/supplies related to splints, casts, dialysis supplies and equipment, and certain intraocular lenses

Provider Action Needed

This article is based on Change Request (CR) 4131, which provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in Calendar Year (CY) 2006. The 2006 payment limits for splints and casts will be based on the 2005 limits, increased by 2.5 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2005.

Background

Payment continues to be made on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses in CY 2006 as required by regulations contained in 42 CFR 405.501, which can be reviewed at http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr405_02.html.

For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. The CPT codes should be used as indicated in the CPT section "Application of Casts and Strapping" for the specified CPT procedure codes in the 29XXX series.

For dialysis supplies, Healthcare Common Procedure Coding System (HCPCS) codes A4215, A6216, and A6402 have been added to the dialysis supplies that require an AX modifier for payment. Therefore, suppliers must attach the AX modifier to these codes when they are used to bill for dialysis supplies. HCPCS codes A6216 and A6402, when billed with the HCPCS modifier AX, should be reported as type of service (TOS) "L." HCPCS codes A4215, A6216, and A6402, when billed without the HCPCS modifier AX, should be reported as TOS "S."

HCPCS Code/Modifier Description	HCPCS Code/Modifier Description
Code A4215	Needle, sterile, any size, each
Code A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border
Code A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border
Modifier AX	Item furnished in conjunction with home dialysis services

For intraocular lenses, dialysis supplies, and dialysis equipment, the 2006 customary and prevailing charges will be computed using actual charge data from July 1, 2004, through June 30, 2005.

Remember that for intraocular lenses, payment is made only on a reasonable charge basis for lenses implanted while the patient is in a physician's office.

Implementation - The implementation date for this instruction is January 3, 2006.

Additional Information - For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4131 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your carrier/DMERC at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

HCPCS UPDATES

Change In The Long Descriptor For HCPCS Code Q4080

Medlearn Matters Article Number: MM4324
Related Change Request (CR) #: 4324
Related CR Release Date: February 10, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R209OTN
Implementation Date: March 13, 2006

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services related to ILOPROST inhalation treatment of Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 4324, which provides information on the revised code dosage descriptor for Q4080. This is a non-systems change CR.

Background - The Centers for Medicare & Medicaid Services (CMS) established Healthcare Common Procedure Coding System (HCPCS) code Q4080 that was effective July 1, 2005, with a code descriptor that read:

"ILOPROST, INHALATION SOLUTION, ADMINISTERED THROUGH DME**, 20 MICROGRAMS."**

Effective January 1, 2006, the long code descriptor for HCPCS code Q4080 will read:

"ILOPROST, INHALATION SOLUTION, ADMINISTERED THROUGH DME**, UP TO 20 MCG."**

The short descriptor for HCPCS code Q4080 will continue to read:

"Iloprost inhalation solution."

CR4324 provides clarification on the change in the long descriptor for HCPCS code Q4080 effective January 1, 2006.

Region D Note: When either 10mcg/1ml or the 20mcg/2ml ampule size is furnished, only one unit of Q4080 should be billed.

Implementation - The implementation date for the instruction is March 13, 2006.

Additional Information - For complete details, please see the official instruction issued to your carrier/DMERC/intermediary/RHHI regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/Transmittals/downloads/R209OTN.pdf on the CMS web site.

If you have any questions, please contact your carrier/DMERC/intermediary/RHHI at their toll-free number, which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

New Temporary Codes For Adjustable Wheelchair Cushions

Medlearn Matters Article Number: MM4267
Related Change Request (CR) #: 4267
Related CR Release Date: February 3, 2006
Effective Date: July 1, 2006
Related CR Transmittal #: R835CP
Implementation Date: July 3, 2006

Provider Types Affected - Durable medical equipment (DME) suppliers, and providers who order wheelchair services for Medicare beneficiaries

Provider Action Needed

Impact to You

Medicare may not reimburse you correctly for ordering or supplying wheelchair cushions for your Medicare patients if you don't use the correct codes on your claim.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has established four new "K" codes for adjustable wheelchair cushions, effective July 1, 2006.

What You Need to Do

Make sure that your billing staffs are aware of these new "K" codes for wheelchair cushions.

Background

CMS has established four new "K" codes for adjustable wheelchair cushions, effective for services provided on or after July 1, 2006. These new codes are displayed in the following table:

"K" Codes for Adjustable Wheelchair Cushions, Effective July 1, 2006

Code	Description
K0734	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth
K0735	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
K0736	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth
K0737	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth

Additional Information

You can find more information about the four new "K" codes for adjustable wheelchair cushions at http://www.cms.hhs.gov/Transmittals/downloads/R835CP.pdf on the CMS web site.

Should you have any questions concerning these codes, you may contact your Medicare DME regional carrier or fiscal intermediary (FI) at their toll-free number, which you can find at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

MEDICARE SECONDARY PAYER (MSP)

Full Replacement Of And Rescinding Change Request (CR) 3504 - Modification To Online Medicare Secondary Payer Questionnaire

Medlearn Matters Article Number: MM4098

Related Change Request (CR) #: 4098
Related CR Release Date: October 21, 2005
Effective Date: January 21, 2006
Related CR Transmittal #: 41
Implementation Date: January 21, 2006

Provider Types Affected - Medicare providers who, upon inpatient or outpatient admissions of Medicare beneficiaries, use a questionnaire to determine other insurance coverage that may be primary to Medicare.

Provider Action Needed

Impact to You

CR4098 clarifies recent changes made to the "Medicare Secondary Payer Questionnaire."

What You Need to Know

This CR identifies all of the changes that were made to CR3504 ***and*** makes additional changes to the model questionnaire. These changes will assist providers in identifying other payers that may be primary to Medicare.

What You Need to Do

Please refer to the *Background* and *Additional Information* sections of this article and make certain that, if there are other payers, these situations are identified.

Background

The Centers for Medicare & Medicaid Services (CMS) received information that a prior instruction (CR3504) did not specifically mention all of the changes that were made to the "Medicare Secondary Payer (MSP) Questionnaire." CR4098 identifies all of the changes made as part of CR3504 and makes additional changes to the model questionnaire.

The *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1, available as an attachment to CR4098, provides a model: "Admission Questions to Ask Medicare Beneficiaries." The model contains questions that may be printed out and used as a guide to help identify other payers. (The website for accessing CR4098 is provided in the *Additional Information* section of this article.)

The following bullets identify the changes within the model MSP Questionnaire:

- **Parts IV** and **V** of the model questionnaire adds the response: "No, Never Employed."

- In **Parts IV, V, and VI** of the model questionnaire, providers should use "Policy Identification Number" to mean a number that is sometimes referred to as the health insurance benefit package number.

- **Parts IV, V, VI** of the model questionnaire adds "Membership Number" and it refers to the unique identifier assigned to the policyholder/patient.

- **Part V**, question 2 of the model questionnaire uses "spouse" instead of "family member."

- **Part V**, question 4 changes the model questionnaire to read*: Are you covered under the group health plan of a family member other than your spouse? _____Yes _____No. Name and address of your family member's employer:_____*

- **Part V** of the old question 4 is changed to ask whether the beneficiary is covered under a group health plan (GHP) and a question number 5 is added to gather the pertinent information about the GHP.

- In **Part VI,** question 6 now reads: "Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?"

Providers who use the model questionnaire to elicit MSP information from their Medicare patients should take special note of these changes. The implementation date for the instruction is January 21, 2006.

The official instructions issued to your Medicare carrier or intermediary regarding this change and the model questionnaire can be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. On the above page, scroll down the CR NUM column on the right to find the links for CR4098. Click

on the links to open and view the files for this CR.

If you have questions, please contact your carrier/intermediary at their toll-free number which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

MISCELLANEOUS

Announcement Of Redesigned National Provider Identifier (NPI) Web Page

Announcing the redesigned CMS web page dedicated to providing all the latest NPI news for health care providers! Visit http://www.cms.hhs.gov/NationalProvIdentStand/ on the web. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A new fact sheet with answers to questions that health care providers may have regarding the NPI is now available on the web page; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative website at http://www.wedi.org/npioi/index.shtml on the web.

Centers For Medicare & Medicaid Services (CMS) Seeks Provider Input On Satisfaction With Medicare Fee-For-Service Contractor Services

Medlearn Matters Article Number: SE0602
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: January 3, 2006
Related CR Transmittal #: N/A
Implementation Date: January 3, 2006

Note: This article was revised on January 20, 2006, to show the effective and implementation dates (see above) as January 3, 2006.

Provider Types Affected - Sample of 25,000 Medicare providers served by 42 Medicare Fee-for-Service FFS) Contractors, including fiscal intermediaries (FIs), carriers, durable medical equipment regional carriers (DMERCs), and rural home health intermediaries (RHHIs)

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS) would like to provide a channel for you to voice your opinions about the services you receive from your Fee-for-Service (FFS) Contractors. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to garner quantifiable data on provider satisfaction with the performance of FFS contractors. The MCPSS is one of the tools CMS will use to carry out the measurement of provider satisfaction levels, a requirement of the Medicare Modernization Act (MMA). Specifically, the survey will enable CMS to gauge provider satisfaction with key services performed by the 42 contractors that process and pay the more than $280 billion in Medicare claims each year. Those Medicare contractors will use the results to improve service. CMS will use the results to improve its oversight of and increase the efficiency of the administration of the Medicare program.

What You Need to Know

The first national implementation of the MCPSS will begin January 3, 2006. If you have been selected, you will receive a notification packet in the mail with background information about the survey, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet website. The letter will also include a phone number that you can call to request a paper copy of the survey instrument to submit your responses by mail or fax, if you prefer to do so.

What You Need to Do

Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the time to complete and submit your survey responses as soon as possible. The data collection period will continue through January 25, 2006.

Background

The 2006 survey will query approximately 25,000 randomly selected providers – those physicians, healthcare practitioners, and facilities that serve Medicare beneficiaries across the country – on the seven key areas of the provider-contractor interface:

- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment

- Medical review
- Provider audit and reimbursement

It contains a total of 76 questions and takes approximately 21 minutes to complete. The deadline for survey submission is January 25, 2006. CMS will analyze the data and release a summary report in July that will be made available on the Internet. Each contractor will also receive an individual report on their performance in June. The MCPSS will be conducted on an annual basis.

CMS has awarded a contract to Westat, a survey research firm, to administer the MCPSS.

Additional Information

For questions or additional information about the MCPSS, please visit http://www.cms.hhs.gov/MCPSS/ on the CMS web site.

Change Payment Floor Date For Paper Claims

Medlearn Matters Article Number: MM4284
Related Change Request (CR) #: 4284
Related CR Release Date: February 10, 2006
Effective Date: January 1, 2006
Related CR Transmittal #: R850CP
Implementation Date: March 13, 2006

Provider Types Affected

Physicians, providers, and suppliers who use paper claims to bill Medicare carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)

Important Points to Remember

• CR4284 changes the payment floor date for paper claims from the 27th day to the 29th date after receipt of a claim.

• Effective January 1, 2006, Medicare carriers, DMERCs, FIs, and RHHIs will not pay paper claims prior to the 29th day after receipt of the claim.

Background

The Social Security Act Section 1816b (c) (3) (B) (ii) and Section 1842 (c) (3) (B) (ii) provides for payment waiting periods for Medicare claims before a claim is paid by the Medicare contractor. Congress has amended the Social Security Act to extend the waiting period for paper claims from 27 to 29 days, effective January 1, 2006.

Implementation

The implementation date for this instruction is March 13, 2006.

Additional Information

The official instructions issued to your carrier regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R850CP.pdf on the CMS web site.

If you have questions, please contact your Medicare carrier, DMERC, FI, or RHHI at their toll-free number which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

Correction To Chapter 17, Section 80.2.3 Of The Medicare Claims Processing Manual Regarding MSN/ANSI X12 Denial Messages For Anti-Emetic Drugs

Medlearn Matters Article Number: MM4001
Related Change Request (CR) #: 4001
Related CR Release Date: September 23, 2005
Effective Date: December 23, 2005
Related CR Transmittal #: 684
Implementation Date: December 23, 2005

Provider Types Affected

Providers and suppliers billing Medicare carriers or durable medical equipment regional carriers (DMERCs) for anti-emetic drugs

Provider Action Needed

This article is provided for your information only.

Background

CR4001 corrects an error in the *Medicare Claims Processing Manual* (Pub. 100-4), Chapter 17, Section 80.2.3 (MSN /ANSI X12N Denial Messages for Anti-Emetic Drugs).

The text incorrectly cites Medicare Summary Notice (MSN) 6.3 as a valid MSN denial message for anti-emetic drugs. In response to this correction, your carriers and DMERCs will not use *MSN 6.3: Payment cannot be made for oral drugs that do not have the same active ingredients as they would have if given by injection when an anti-emetic drug is denied*.

Rather, if the anti-emetic drug is denied because the Food and Drug Administration (FDA) did not approve it or because the drug is not being used as part of an anti-cancer chemotherapeutic regimen, carriers and DMERCs will use either:

• *MSN 6.2: Drugs not specifically classified as effective by the Food and Drug Administration are not covered* (ANSI X12 Adjustment Code 114); or

• *MSN 6.4: Medicare does not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours after administration of a Medicare covered chemotherapy drug* (ANSI X12 Group Code PR 96 with Remark Code M100)).

Additional Information

You can find more information about Denial Messages for Anti-Emetic Drugs by going to http://www.cms.hhs.gov/transmittals/downloads/R684CP.pdf on the CMS web site.

Finally, if you have any questions, please contact your carrier/DMERC at their tollfree number, which may be found at http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

Electronic Funds Transfer

Considering that **Electronic Funds Transfer (EFT) may be required of all Medicare providers/suppliers**, please enroll now for this free service to avoid potential future claim payment delay.

Similar to direct deposit programs, CIGNA Government Services deposits payments directly to your business' checking or savings account. Your money is not "en route" or waiting in the mail or at the office; it is instead reflected as a positive balance in your business account.

You do it for the benefit of making your personal life more convenient, why not for business too?

To Enroll

Simply complete an EFT Enrollment Form with the original signature of an authorized company representative. Attach a voided check, or account and routing information on bank letterhead. Forms and enrollment tips are available at www.cignagovernementservices.com/eft, or through Customer Service.

Once complete, mail the form with the original signature to:

For DMERC:

CIGNA Government Services
Attn: EFT Enrollment
P.O. Box 690
Nashville, TN 37202

For questions, please call us at: 877.320.0390

For Part B:

CIGNA Government Services
Attn: EFT Enrollment
P.O. Box 25226
Nashville, TN 37202

For questions, please call us at: 615.782.4509

Enrollment is Free

The program costs nothing, and is available to both paper and electronic billers.

Payment is Faster

Once payment is processed typical turnaround for electronic transfer to your account is two days, eliminating time spent waiting for the mail or manually depositing checks at the bank.

Multi-Handling Risks are Reduced

Payment is made directly from CIGNA's bank to yours, reducing the risk of human intervention error.

Lost or Delayed Checks are Prevented

Payments are made electronically, eliminating the risk of potential loss in the mail.

FAQ's

Once CIGNA Government Services deposits money into my business account, can it also be removed?

Only if it has been deposited into the wrong account. If an over-or-under payment has been made, payments will be adjusted over future claims payments.

How many forms should I submit for our group?

For Part B, both individual and group numbers are assigned. If you are part of a group practice, only one application is required for the entire group and all providers under that group number will be automatically set up for EFT. If you are not part of a group practice, than you need your own application. For DMERC, submit an application for each supplier number that your office currently bills for, and for which you currently receive Medicare claims payments.

How long after I submit my enrollment form will I begin receiving electronic payments?

Once your authorization has been processed, you will begin to receive electronic payments within 10 to 15 days. If the information you submit is inaccurate or incomplete, you will continue to receive paper checks until CIGNA Government Services receives the appropriate information.

How will I be notified of payment? Will I still receive remittance advices?

You may opt for Electronic Remittance Notices (ERNs). The advantage to opting for the ERN is that your remittances are available to you sooner, and there is now free software available to you through CMS (Medicare Remit Easy Print – MREP) to download them. If you take advantage of the ERN option, your paper remittances will be discontinued after 45 days. You may also take advantage of the variety of services that software vendors can provide, including auto-post to individual provider accounts, auto-post to individual patient accounts and more; as well as the individual statements your bank provides.

What if my bank merges or I close my account?

All changes to EFT accounts must be done through the EFT Enrollment Form. CIGNA cannot accept phone calls or faxes. If an account closes, the bank notifies the CIGNA Finance Department that the EFT account has been cancelled and paper checks are then issued. A letter is then sent to you letting you know that your EFT account has been closed. You must re-apply with your new account information in order to be set up again for this service.

Who do I call if I have a question?

If the payment you receive is not what you expected for the services rendered, contact our Customer Service line to discuss the claims in question. If your bookkeeping records reflect a skipped or misstated entry, your bank will help you reconcile the records.

Be proactive and sign up for EFT today to begin receiving payments faster and to avoid Medicare claims payment delays!

MMA – Erroneous Guidance – Basis To Waive Penalty

Medlearn Matters Article Number: MM3898

Related Change Request (CR) #: 3898
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Related CR Transmittal #: 739
Implementation Date: January 19, 2006

Provider Types Affected - Physicians, suppliers, and providers who bill Medicare and who face penalties as a result of such billings

Provider Action Needed

Impact to You

Providers and suppliers may not be subject to a penalty if the basis for the penalty that would have otherwise been applicable was that the provider acted in accordance with erroneous guidance from the Medicare program.

What You Need to Know

Medicare can grant a waiver of a penalty when **ALL of the following conditions are present:**

- The guidance was erroneous.
- The guidance was issued by the Secretary of the Department of Health and Human Services or was issued by a Medicare contractor (carrier, fiscal intermediary, durable medical equipment regional carrier (DMERC) or regional home health

intermediary (RHHI)) acting within the scope of the contractor's Medicare contract authority.

- The guidance was in writing.
- The guidance related to the furnishing of an item or service or to the submission of a claim for benefits for furnishing such item or service with respect to the provider or supplier submitting such claim.
- The guidance was issued timely.
- The provider or supplier accurately and fully presented the circumstances relating to such items, services, and claim to the Medicare contactor or to the Centers for Medicare & Medicaid Services (CMS), and did so in writing.
- The provider or supplier followed the guidance provided by the Medicare contractor (or by CMS).

What You Need to Do

Review CR3898 if you feel you are being subjected to a penalty for acting in accordance with erroneous guidance from the Medicare program.

Background

Section 903 © of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to as MMA, establishes a basis for waiving penalties and interest charges levied on providers and suppliers who incurred such penalties and/or interest as a result of following Medicare guidance, which turned out to be erroneous. **CR3898 details the conditions under which a provider or supplier may seek a waiver of a penalty due to such erroneous guidance. CR3898 does not address the waiver of interest charges.**

Additional Information

Full details of the process for seeking and obtaining a waiver can be found in Chapter 33 (Miscellaneous Hold Harmless Provisions), Section 10 (Erroneous Program Guidance: Basis to Waive Penalty) of the *Medicare Claims Processing Manual.* That material is attached to CR3898, which can be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web site, look for CR3898 in the CR NUM column on the right, and click on the file for that CR.

For additional information relating to this issue, please refer to your local carrier or intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Explanation Of Systems Used By Medicare To Process Your Claims

Medlearn Matters Article Number: SE0605
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Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected

All physicians, providers, and suppliers who submit claims to Medicare

Introduction

This Special Edition article provides a high-level overview of the software systems Medicare uses to process your claims. Frequently, *Medlearn Matters* articles reference Medicare systems and this article will help explain briefly what those systems are.

Sometimes, you may see documents from the Centers for Medicare & Medicaid Services (CMS) that reference the "Shared Systems," or system acronyms, such as FISS, MCS, or CWF. The purpose of this Special Edition article is to provide you with some understanding of these systems and how they are used to process your claims.

Overview

When a beneficiary visits a physician, hospital, or other supplier of health care services, a claim is sent by the provider of the service to a Medicare fiscal intermediary (FI) or carrier, including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs). Collectively, the carriers and FIs, DMERCs, and RHHIs are referred to as Medicare contractors.

Using certain systems, known within CMS as "Shared Systems," the Medicare contractors perform traditional claims processing services, and send claims to another Medicare system, known as the Common Working File (CWF) System for verification, validation, and payment authorization.

Responses are returned from the CWF concerning payments to the FI, RHHI, DMERC, or carrier, who subsequently pays for the service, if appropriate. Only CMS and the Medicare contractors have direct communication with the CWF System. CWF provides an interface between CMS and its contractors.

The Medicare Claims Flow Diagram on the last page of this article illustrates the claims processing flow. In brief, the various systems that process Medicare claims are described as follows:

Shared Systems

There are three "Shared Systems" that process Medicare claims:

- One processes Medicare claims submitted to FIs and RHHIs;
- Another processes claims submitted to carriers; and
- The third processes claims submitted to DMERCs.

All three of the "Shared Systems" interface with the CWF, which is addressed below. These systems apply certain edits to claims received. Claims that do not pass those edits are returned to the provider (RTP) and are often referred to as RTP claims. Examples of claims that may be RTP'ed include those where an invalid health insurance claim number (HICN) or an invalid provider number is supplied on the initial claim.

Fiscal Intermediary Standard System (FISS)

FISS is a mainframe system that FIs and RHHIs use to process Medicare Part A claims nationwide, including outpatient claims submitted under Part B. Within FISS, claims are entered, corrected, adjusted, or canceled. Inquiries for status of claims**,** for additional development requests, or for eligibility and various codes are processed.

Multi-Carrier System (MCS)

MCS is a mainframe system that Medicare Part B carriers use to process Medicare Part B Claims nationwide. It processes claims for physician care, durable medical equipment, and other outpatient services. Like its Part A counterpart, claims are entered, corrected, adjusted, or canceled. Inquiries for status of claims**,** for additional development requests, or for eligibility and various codes are processed.

VMS Shared System

This system has some of the same characteristics as the MCS, but processes claims submitted by suppliers to the Medicare DMERCs.

CMS-Supplied Modules and Pricing/Coding Files

In addition to the "Shared Systems," CMS supplies other uniform modules to FIs, RHHIs, DMERCs, and carriers, and these modules are used by the shared systems in processing Medicare claims. By and large, these modules establish rates (or prices) and processing logic according to type of service.

These modules or programs include the following:

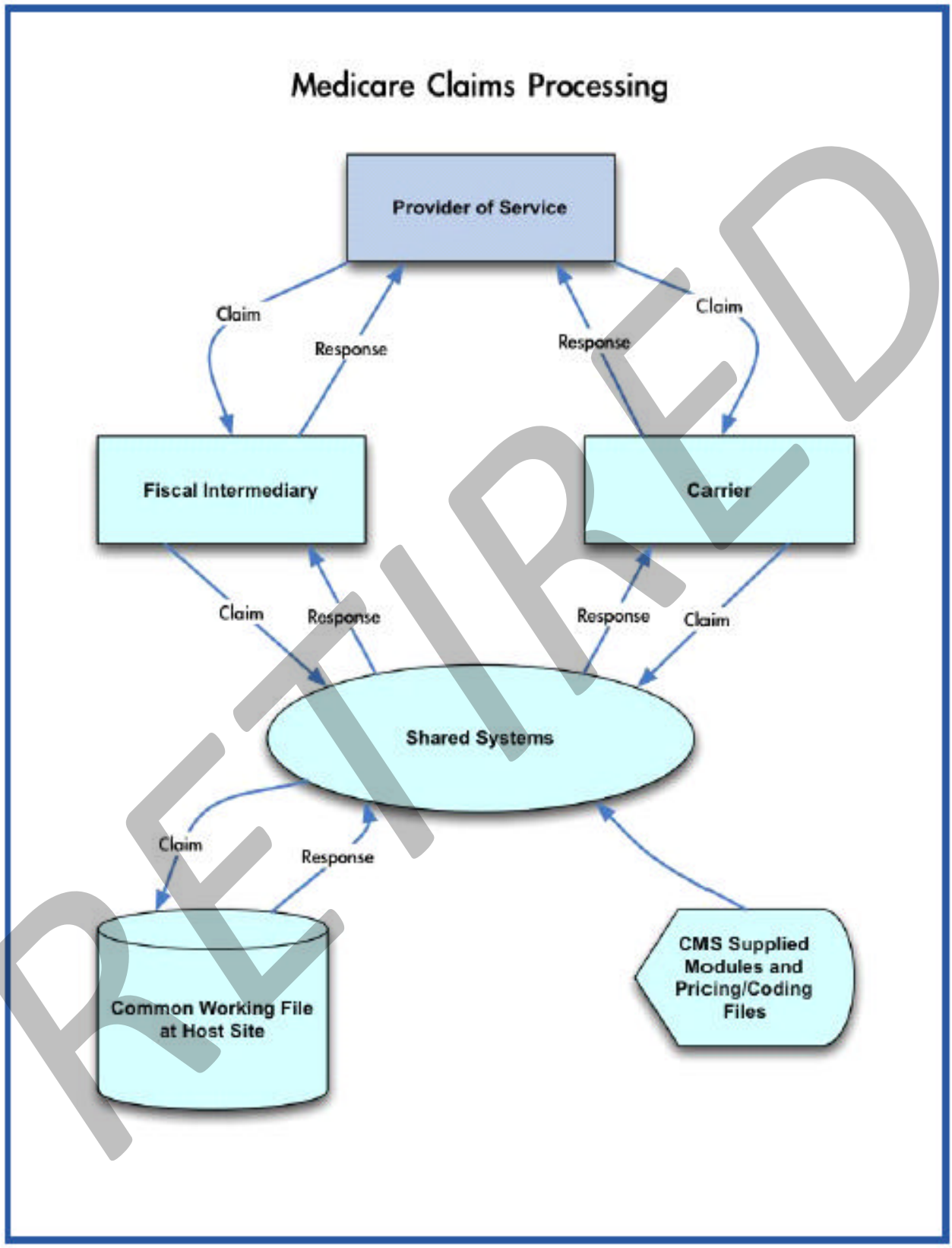
- Those referred to as the PRICERs (there are several PRICERs, such as an inpatient PRICER, an outpatient PRICER, and so on);
- OCE (Outpatient Code Editor);
- MCE (Inpatient Code Editor); and
- GROUPER, which translates variables such as age, diagnosis, and surgical codes into a diagnosis related group (DRG).

In addition, fee schedules and codes are supplied by CMS in the form of downloadable files which are used by the shared systems in processing Medicare claims.

Some of these files include: MPFSDB (Medicare Physician Fee Schedule) and its various forms; DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Schedule); Ambulance Fee Schedule; and HCPCS (Health Care Common Procedure Codes).

Common Working File (CWF)

The CWF contains information about all Medicare beneficiaries. The shared systems interface with the CWF to verify beneficiaries' entitlement to Medicare, deductible status, and benefits available, such as lifetime reserve days. The CWF actually approves payment of each claim. Under CWF, Part A and Part B data for each beneficiary is combined into a single, common working file.


Medicare Claims Processing
Provider of Service
Claim
Response
Response
Claim
Fiscal Intermediary
Carrier
Claim
Response
Response
Claim
Shared Systems
Claim
Response
Common Working File at Host Site
CMS Supplied Modules and Pricing/Coding Files

Hurricanes Katrina And Rita – Transportation Of Evacuees With Medical Needs

Medlearn Matters Article Number: SE0579

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Related CR Release Date: N/A
Effective Date: N/A
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Implementation Date: N/A

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for transportation services provided to evacuees of Hurricanes Katrina and Rita

Provider Action Needed

Impact to You - This Special Edition article provides a summary of the Department of Health and Human Services (DHHS) Fact Sheet regarding the transportation of Hurricanes Katrina and Rita evacuees with medical needs.

What You Need to Know - If you made your own medical transportation arrangements, prior to or after the DHHS established the HHS Medical Travel Center services contract, then the normal Medicare coverage rules apply.

What You Need to Do - As you receive inquiries from providers or beneficiaries seeking to discharge a patient (or to help those patients return home), you should provide them with the information contained in this special edition article. Please review the questions and answers at the end of this special edition article, and take appropriate action to use the instructions in your claims submissions.

Background

The Centers for Medicare & Medicaid Services (CMS) is providing this Special Edition article to give you important information regarding the transportation of Hurricanes Katrina and Rita evacuees with medical needs. This special edition article:

- Explains the HHS Medical Travel Center services;
- Defines which individuals are eligible for medical transportation;
- Provides information for beneficiaries;
- Defines the role of the Discharge Planner;
- Describes the different types of transfers; and
- Provides a list of transportation-related Questions and Answers directed to patients, providers, Medicare carriers and FIs, and Discharge Planners.

Hurricane Evacuation

Because of Hurricanes Katrina and Rita, many people were forced to evacuate their homes and healthcare facilities in Texas, Mississippi, and Louisiana. Evacuees included many Medicare beneficiaries, including some with serious and/or ongoing medical needs, and assisting theses evacuees has included dealing with significant difficulties and has raised questions regarding:

- The logistics of transporting the patients back to their home states, and
- The costs and billing for these medical transportation services.

In response to these and many more questions, DHHS created a Fact Sheet to provide information and answer frequently asked questions regarding certain issues resulting from Hurricanes Katrina and Rita.

The DHHS Fact Sheet provides instructions and answers questions pertaining to the provision of transportation for evacuees from Texas, Louisiana, and Mississippi who:

- Are currently patients in healthcare facilities,
- Have out-patient/on-going medical needs, or
- Were evacuated by air lift out of their home state.

Note: The DHHS Fact Sheet may be viewed at http://www.hhs.gov/katrina/factsheet.html on the DHHS web site.

In many counties and parishes in Texas, Mississippi, and Louisiana, the healthcare infrastructure will not support the return of evacuees with medical needs. Evacuees may need to continue to shelter in their host state, or travel to an interim location to be closer to friends and family until Texas, Mississippi, and Louisiana can support their return.

Texas is currently accepting the return of patients and those evacuees with ongoing medical needs to select counties in Texas.

Mississippi is currently accepting the return of patients and those evacuees with ongoing medical needs to select counties in Mississippi.

Louisiana is:

• Accepting the return of evacuees who are currently patients in healthcare facilities on a case-by-case basis only. All healthcare facilities in Louisiana are responsible for gaining approval from the Louisiana Department of Health and Hospitals before accepting the transfer of evacuees into the state. If there is not a receiving facility available, the evacuee may access transportation to an interim location in another state where family and friends may reside.
• NOT accepting the return of evacuees with medical needs who are not patients at healthcare facilities. When Louisiana determines it is able to support the return of evacuees with out-patient/on-going medical needs, additional guidance will be disseminated.

HHS Medical Travel Center

The DHHS established a transportation program to support the return of evacuees with medical needs from Texas, Mississippi and Louisiana. The HHS Medical Travel Center is under contract with HHS to arrange transportation for evacuees who require en-route medical care and/or medical transport to include a non-medical attendant to an institution or to a private residence, as appropriate.

If the evacuee's originating medical facility is not available in their home state or if their residence and community medical infrastructure is not suitable, evacuees will be allowed to travel to an interim location in the continental United States. The HHS Medical Travel Center will then return the evacuee to their home of record when a medical facility there is available, or they can return to a safe community/home environment.

The HHS Medical Travel Center provides transportation services without cost to providers. Providers (and patients) who use the HHS Medical Travel Center services will not incur any charge, and they should not bill Medicare. The HHS Medical Travel Center will be paid directly by HHS as per its contract.

The HHS Medical Travel Center can be reached at 1-866-753-9344. The phone lines are open everyday 7:00 a.m. to 5:00 p.m. Central Daylight Time (CDT).

Before contacting the HHS Medical Travel Center or their home state, all medical evacuees must register with the Federal Emergency Management Agency (FEMA) and obtain a Disaster Registration Number from the FEMA Registration Center at 1-800-621-FEMA. This phone line is operational 24 hours a day, 7 days a week.

Important Information for Discharge Planners

For evacuees in health care facilities or special needs shelters with a discharge planner, the discharge planners are responsible for:

• Determining if an evacuee must be transferred to a receiving facility or can be discharged to a private residence;
• Identifying a receiving facility/residence in the evacuee's home state or an interim state if necessary;
• Determining the evacuee's medical requirements during transport; and
• Arranging for a FEMA registration number for the evacuee and any non-medical assistants.

Facility to Facility Transfer

Once the discharge planner has completed these tasks, they may contact the HHS Medical Travel Center to arrange for medical transportation. In order to complete the transportation process, discharge planners must complete and submit a Documentation of Medical Necessity form provided by the HHS Medical Travel Center. This form will be provided planners when they call the HHS Medical Travel Center, and it is available at http://www.hhs.gov/katrina on the HHS web site.

Facility to Non-Facility Transfer

If the discharge planner determines that the evacuee can be discharged to a residence, the discharge planner must call the evacuee's home state, which will be acting as a receiving point of contact. Please see below for information on how to contact the evacuee's home state.

Evacuees in a Shelter, Hotel, or Private Home

Evacuees should call their home state to access transportation if they:

• Have medical needs, and
• Are sheltering in a hotel, private residence, or other facility that **cannot provide discharge planning**.

Guidance from the Home State

The evacuee's home state will determine if the evacuee can ride commercial transportation and if their state medical system can support their ongoing medical needs. If the state medical system cannot support the evacuee's ongoing medical needs, the home state will help the evacuee find an interim location in another state, if appropriate.

Texas

Texas evacuees with medical needs may contact the 2-1-1 telephone service (if calling within Texas) or 1-888-312-4567 (if out-of-state) to initiate access to appropriate transportation and receive an evaluation of the community medical infrastructure to support the return. The Texas phone lines are open everyday 8:00 a.m. to 5 p.m., Central Daylight Time (CDT).

Mississippi Department of Health

Mississippi evacuees with medical needs may contact the Mississippi State Health Department at 601-576-7300 to initiate access to appropriate transportation. The Mississippi phone lines are open Monday to Friday 8:00 a.m. to 5 p.m., Central Daylight Time (CDT).

Louisiana Department of Health and Hospitals

Louisiana is not currently accepting the return of evacuees with out-patient and/or ongoing medical needs. Evacuees from Louisiana with medical needs sheltering in a hotel, residence or other facility that cannot provide discharge planning must have their current medical attendant or family member contact the HHS Medical Travel Center to initiate access to appropriate transportation.

The evacuee's medical attendant must complete and submit a Documentation of Medical Necessity form provided by the HHS Medical Travel Center to complete the transportation process. This form will be provided for the evacuee's medical attendant when they call the HHS Medical Travel Center or is available online at http://www.hhs.gov/katrina on the HHS web site. If a family member is completing this form for the patient, it must be signed by the patient's current local healthcare provider.

Questions and Answers (Q&As)

Below are frequently asked questions about the transportation of Hurricane Katrina and Rita evacuees. CMS will be posting these Q & As at http://www.cms.hhs.gov/hki on the CMS web site:

Q1. What is the first step in the process no matter what category of evacuee I am?

A1. Register for Disaster Assistance and obtain a FEMA Disaster Registration number via 1- 800-621-FEMA.

Q2. What if the evacuee or patient I am arranging care for doesn't have a FEMA Disaster Registration number?

A2. Call the FEMA Registration Center at 1-800-621-FEMA to register for Disaster Assistance and obtain a FEMA Disaster Registration number.

Q3. Will this travel system arrange transportation for National Disaster Medical System (NDMS) patients as well as those persons who became patients in similar facilities after evacuating?

A3. Yes, the HHS Medical Travel Center will arrange transportation for all evacuees that currently require enroute medical care and/or medical transport, back to their home state or to an interim state. Discharge planners at medical facilities/shelters should contact the HHS Medical Travel Center to arrange for transportation of their evacuees.

Evacuees from Texas and Mississippi with medical needs who do not have a discharge planner should contact their home state. Evacuees from Louisiana with medical needs who do not have a discharge planner should contact the HHS Medical Travel Center and will need their healthcare provider to complete the forms.

Q4. Will evacuees or medical facilities incur any transportation costs using this travel system?

A4. The HHS Medical Travel Center covers all transportation costs; **there will be neither bills nor co-pays and no insurance forms will be necessary.**

Evacuees who can travel via commercial transportation must make their own arrangements to the airport or station.

Q5. Can a healthcare facility be reimbursed by the HHS Medical Travel Center for transportation arrangements already made? Can a healthcare facility make transportation arrangements for evacuees in the future and be reimbursed by the HHS Medical Travel Center?

A5. No. The HHS Medical Center will not reimburse facilities or states that have already made transportation arrangements for evacuees. All future transportation arrangements for evacuees should be made through the HHS Medical Travel Center or appropriate state system.

Q6. What are the criteria for deciding if an evacuee needs enroute medical care and/or medical transportation, and who makes this determination?

A6: If the evacuee is currently a patient at a medical facility and has a discharge planner coordinating their

transportation, the healthcare facility discharge planner will determine if the evacuee requires medical transportation.

If the evacuee is not sheltering at a facility with discharge planning, the evacuee's home state or, in the case of Louisiana, the evacuee's medical attendant or accompanying family member, will determine if the evacuee is able to travel via commercial air or ground transportation.

Commercial airlines are very flexible in accepting people with such medical needs as oxygen and wheelchairs. If that is all that is required, a routine commercial flight will be arranged by FEMA for the evacuee and their family members if the evacuee meets the necessary qualifications.

Q7. Will the HHS Medical Travel Center perform discharge planning or provide clinical validation of evacuees?

A7. No. The discharge planners in the healthcare facilities and/or the evacuee's home state will provide that function PRIOR to movement. The HHS Medical Travel Center will provide safe, efficient, and effective medical transport en-route.

Q8. Who arranges for the discharge planning of evacuees, including destination, special medical equipment required, or other relevant transportation concerns?

A8. The discharge planners of the healthcare facility in which the evacuee resides should coordinate all arrangements for the evacuee with the receiving institution. This includes working with the evacuee's home state, hospital, and/or nursing home to identify a receiving institution if the originating facility is not able to receive patients. Evacuees without discharge planners will need to contact their home state for assistance.

Q9. What if an evacuee requires en-route medical care and/or medical transport and has multiple accompanying family members (who are also evacuees) who must return with the evacuee?

A9. The HHS Medical Travel Center will provide a medical attendant to support en-route medical care if required. The HHS Medical Travel Center will make all reasonable efforts to accommodate at least one family member during medical transport. If the HHS Medical Travel Center is unable to do so, a separate transportation program will attempt to ensure family members will travel to the destination along a similar schedule. Both of these systems require all travelers to have a FEMA Disaster Registration Number.

Q10. If an evacuee is living in a hotel or a home (and therefore does not have a discharge planner) and has medical needs (e.g., requires oxygen or stabilized transport), how does the evacuee arrange for travel home?

A10. With the exception of Louisiana citizens, evacuees can call their home state to access travel arrangements. Their home state will act as their discharge planner and will determine if the evacuee can travel via commercial air or ground transportation and work with the evacuee to ensure that the medical infrastructure in their home community is ready to accept them. If the evacuee's home state determines that they can travel via commercial means, a separate transportation program will arrange their transportation. If the evacuee cannot travel by commercial means, the HHS Medical Travel Center will arrange for their transportation.

If the evacuee is a citizen of Louisiana and is living in a hotel or a home in a host state, he or she will not be able to return to Louisiana at this time. If their medical attendant or a family member determines that they can travel via commercial means, a separate transportation program will arrange their travel to an interim state. If the evacuee cannot travel by commercial means, the HHS Medical Travel Center will arrange for their transportation to an interim state and the evacuee's medical attendant should complete the necessary paperwork for the travel.

Q11. What if the evacuee wants to return to his or her original healthcare facility and that facility is not able to receive patients?

A11. There are three potential options if the originating facility is not able to receive patients:

- The evacuee's discharge planner can identify another facility within the evacuee's home state. Transportation will be provided to another suitable facility within the home state with final transportation to the originating facility to be arranged by the HHS Medical Travel Center when the originating facility is able to receive patients;

- The evacuee's discharge planner can identify a facility in an interim state where family members or other relatives or relations of the evacuee reside. The HHS Medical Travel Center will provide transportation to the interim state facility with final transportation to the originating facility to be arranged when it is able to receive patients; or

• The evacuee must continue to be cared for by the current host state with final transportation to the originating facility to be arranged by the HHS Medical Transport Center when the originating facility is able to receive patients.

Q12. As a discharge planner, do I have to arrange for transportation from my healthcare facility to the airfield (if aeromedical transportation is being used)?

A12. No, the HHS Medical Travel Center provides door-to-door service. See question Q4.

Q13. As a discharge planner, do I need to fill out and submit a particular discharge planning form when making travel arrangements for my patient evacuee?

A13. Yes. The HHS Medical Travel Center will fax or email you a Documentation of Medical Necessity form to complete. The information you provide on this form will help the HHS Medical Travel Center provide the necessary medical care enroute for your evacuee. This form is also available at http://www.hhs.gov/katrina on the HHS web site.

Q14. What if a discharge planner needs to move an evacuee within the state? Do these travel systems arrange that transportation?

A14. Yes, all of these travel systems arrange for intra- and inter-state transportation.

Q15. How will hospitals and other providers be reimbursed for the medical care they provided to evacuees?

A15. Remember, with the use of the HHS Medical Travel System, there are no transportation costs associated with the return of evacuees to their home state or an interim state. However, there are many ways for providers to be reimbursed for services provided to evacuees:

Existing Health Care Insurance

Many evacuees have existing health insurance coverage. Providers should bill an evacuee's private health insurer, if one exists;

Medicare

Many evacuees are covered under the Medicare program. Providers should contact their local Medicare carrier or fiscal intermediary, if they have questions regarding Medicare reimbursement for evacuee health care.

On January 1, 2006, the Medicare prescription drug benefit begins. CMS will work closely with evacuees and those who provide insurance counseling to the elderly to ensure that those evacuees who want to enroll in a drug plan will be able to do so. We are also taking steps to let those elderly evacuees who qualify for extra help in paying for their drug costs know about the availability of this program.

National Disaster Medical System (NDMS)

Some evacuees received medical treatment via the NDMS. At the request of FEMA, CMS and DHHS is developing payment mechanisms for those patients who entered NDMS hospitals via the Federal Coordinating Centers as part of the NDMS evacuation. Specifics about how to submit claims for these patients will be made available on the CMS web site (http://www.cms.gov).

Medicaid

Many evacuees will qualify for Medicaid, either because they were eligible in their home state, or because they are now eligible because of a loss of income and/or resources. CMS has approved Medicaid waivers for many states. Under these waivers, effective retroactively to August 24, 2005, evacuees who have been displaced from their home as a result of Hurricane Katrina will be provided the opportunity to enroll through a streamlined process to receive services under the Medicaid or SCHIP programs in whatever state they are now physically present. Medicaid and SCHIP providers should work with their states to submit claims and receive payment. States are putting in place modifications to their current claims processing systems to accept such claims, and all payments for Medicaid and SCHIP eligible persons will be handled through the states.

Uncompensated Care

Through the waiver process mentioned above, CMS is working with states with large numbers of evacuees to put in place processes for handling those claims which would otherwise have been uncompensated. Providers should contact their state for information on how those claims will be submitted and how payments will be processed.

CMS will be providing information on these payment mechanisms on the CMS web site (http://www.cms.hhs.gov/emergency/). CMS will also be sharing information with provider and patient-based national and state trade and professional associations, and the states via the state Emergency Operations Centers.

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

Additional Information

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Important Information About Medicare Coverage Of Drugs Under Part B And The New Medicare Prescription Drug Coverage (Part D), And Vaccines Administered In A Physician's Office – The Ninth In The Medlearn Matters Series On The New Prescription Drug Plans

Medlearn Matters Article Number: SE0570

Related Change Request (CR) #: N/A
Related CR Release Date: N/A

Provider Types Affected - Physicians, healthcare professionals, providers, suppliers, and their staff

Key Points to Remember

• Drugs covered under Fee-For-Service (FFS) Medicare Parts A/B that are paid to institutional providers (hospitals, SNFs, etc.) as part of a bundled payment are paid by fiscal intermediaries (FIs).
• Drugs covered under FFS Medicare Part B that are billed by physicians and suppliers are paid by carriers (including DMERCs).
• FIs and carriers do not, and will not, pay claims for Part D drugs. Providers should not submit claims for Part D covered drugs to FIs or carriers.
• Drugs covered under Part D are paid by Medicare Part D Drug Plans, such as Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs), for enrolled beneficiaries.
• Providers must have a contractual relationship with a Medicare Part D Drug Plan to bill these plans for drugs provided to enrolled beneficiaries. A state specific list of Medicare Part D Drug Plans can be found at http://www.medicare.gov/medicarereform/map.asp on the CMS web site.

Highlights

This article highlights the differences in how drugs are covered and which drugs are covered by Medicare Part B and the new Medicare prescription drug coverage (Part D). It also offers additional guidance on the effect of Part D on vaccines given to Medicare patients in a physician's office. Those currently billing Medicare Part B for drugs or for vaccines may wish to pay particular attention to this article.

Drugs Covered Under Part B and Part D

Part A/B Covered Drugs Set by Statute

Traditional Part A/B Medicare does not cover most outpatient prescription drugs. Under Part A, Medicare bundled payments made to hospitals and skilled nursing facilities (SNFs) generally cover all drugs provided during a covered Part A stay. (An exception is clotting factor supplied during a stay, which is paid separately from the bundled payment.)

Medicare also makes payments under Part B to physicians for drugs or biologicals that are **not** usually self-administered. Coverage is usually limited to drugs or biologicals **administered by infusion or injection**. If the injection is self-administered (e.g., Imitrex), it is not covered.

Physicians, healthcare professionals, providers, and suppliers may also bill Medicare Part B for other limited types of drugs as follows:

Durable Medical Equipment (DME) Supply Drugs

These are drugs that require administration by the use of a piece of covered DME (e.g., a nebulizer, or external or implantable pump). The statute does not explicitly cover DME drugs; they are covered as a supply necessary for the DME to perform its function.

The largest Medicare expenditures for drugs furnished as a DME supply are for inhalation drugs, (e.g., albuterol sulfate, ipratropium bromide) which are administered in the home through the use of a nebulizer. The other category of drugs Medicare covers as a DME supply are drugs for which administration with an infusion pump in the home is medically necessary (e.g., some chemotherapeutic agents).

Immunosuppressive Drugs

These include drugs used in immunosuppressive therapy (such as cyclosporine) for a beneficiary who has received a Medicare covered organ transplant.

Hemophilia Clotting Factors

These include hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision, and items related to the administration of such factors.

Oral Anti-Cancer Drugs

These are drugs taken orally during cancer chemotherapy, provided they have the same active ingredients and are used for the same indications as are chemotherapy drugs that would be covered if they were not self-administered but were administered instead as incident to a physician's professional service.

Oral Anti-emetic Drugs

These are oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen as a full therapeutic replacement for an intravenous anti-emetic drug within 24 or 48 hours of chemotherapy administration depending on the drug.

Pneumococcoccal Vaccine

This refers to the vaccine and its administration to a beneficiary if ordered by a physician.

Hepatitis B Vaccine

This includes the vaccine and its administration to a beneficiary who is at high or intermediate risk of contracting Hepatitis B. High risk groups include the following:

- Individuals with ESRD;
- Individuals with hemophilia who received Factor VIII or IX concentrates;
- Clients of institutions for mentally handicapped individuals;
- Persons who live in the same household as a Hepatitis B Virus (HBV) carrier;
- Homosexual men; and
- Illicit injectable drug abusers.

Intermediate risk groups include staff in institutions for the mentally handicapped and workers in healthcare professions who have frequent contact with blood or blood-derived body fluids during routine work.

Influenza Vaccine

This refers to the vaccine and its administration when furnished in compliance with any applicable state law. The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Antigens

These are prepared by a physician (usually an allergist) for a specific patient. The physician or physician's nurse generally administers them in the physician's office. In some cases, the physician prepares antigens and furnishes them to a patient who has been taught to self-administer them at home.

Erythropoietin (EPO)

EPO is used for treating anemia in persons with chronic renal failure who are on dialysis.

Parenteral Nutrition

Parenteral nutrients are covered under the prosthetic benefit. They are available to beneficiaries who cannot absorb nutrition through their intestinal tract. Parenteral nutrition is administered intravenously and is regulated as a drug by the FDA.

Intravenous Immune Globulin Provided in the Home

The MMA created a benefit for the provision of intravenous immune globulin (IVIG) for beneficiaries with a diagnosis of primary immune deficiency disease. Coverage is provided if a physician determines that the administration of IVIG in the patient's home is medically appropriate. Payment is limited to that for the IVIG itself and does not cover items and services related to administration of the product.

Part B Covered Drugs in the Context of a Professional Service

Drugs Furnished "Incident to" a Physician's Service

These are injectable or intravenous drugs that are administered predominantly by a physician or under a physician's direct supervision as "incident to" a physician's professional service. The statute limits coverage to drugs that are not usually self-administered. (If a drug is not self-administered by more than 50 percent of Medicare beneficiaries, it is considered "not usually self-administered.")

Separately Billable ESRD Drugs

Most drugs furnished by dialysis facilities are separately billable. The largest Medicare expenditures for such drugs are for erythropoietin (EPO), which is covered for dialysis beneficiaries when it is furnished by independent and hospital-based ESRD facilities, as well as when it is furnished by physicians.

Separately Billable Drugs Provided in Hospital Outpatient Departments

For Calendar Year 2005, Medicare continues to pay separately for drugs, biologicals, and radiopharmaceuticals whose median cost per administration exceeds $50, while packaging the cost of drugs, biologicals, and radiopharmaceuticals whose median cost per administration is less than $50 into the procedures with which they are billed.

Drugs Covered as Supplies or – "Integral to a Procedure"

Some drugs are covered as supplies that are an integral part of a procedure that is a diagnostic or therapeutic service, including radiopharmaceuticals (both diagnostic and therapeutic) and low osmolar contrast media. Other examples of drugs covered under the "integral to a procedure" provision include eye drops administered before cataract surgery.

Blood

Medicare does make separate payment for blood and blood products and these products are regulated as biological agents by the Food and Drug Administration (FDA).

Drugs Furnished as a Part of a Service in Provider Settings

Also covered are drugs furnished as a part of a service in the following provider settings:

• Drugs packaged under the Hospital Outpatient Prospective Payment System;
• Drugs furnished by ESRD facilities and included in Medicare's ESRD composite rate;
• Osteoporosis drugs provided by home health agencies under certain conditions;
• Drugs furnished by critical access hospitals' (CAH) outpatient departments;
• Drugs furnished by a Rural Health Clinic (RHC);
• Drugs furnished by Federally Qualified Health Centers (FQHC);
• Drugs furnished by Community Mental Health Centers (CMHC);
• Drugs furnished by ambulances; and
• Separately billable drugs provided in Comprehensive Outpatient Rehabilitation Facilities (CORF).

Part D Covered Drugs

Definition of a Part D Covered Drug

A Part D covered drug is a drug that is:

• Available only by prescription;
• Approved by the FDA (or is a drug described under section 1927(k)(2)(A)(ii) or (iii) of the Social Security Act);
• Used and sold in the United States; and
• Used for a medically accepted indication (as defined in section 1927(k)(6) of the Act).

A covered Part D drug includes prescription drugs, biological products, insulin as described in specified paragraphs of Section 1927(k) of the Act, and vaccines licensed under Section 351 of the Public Health Service Act. The definition also includes "medical supplies associated with the injection of insulin (as defined in regulations of the Secretary)." CMS defines those medical supplies to include syringes, needles, alcohol swabs, and gauze.

Part D Excluded Drugs

The definition of a covered Part D drug excludes any drug for which, as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual, even though a deductible may apply.

In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Medicaid under section 1927(d)(2) of the Act, with the exception of smoking cessation agents.

The drugs or classes of drugs that may currently be otherwise restricted under Medicaid include the following:

• Agents when used for anorexia, weight loss, or weight gain;
• Agents when used to promote fertility;
• Agents when used for cosmetic purposes or hair growth;
• Agents when used for the symptomatic relief of cough and colds;

• Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
• Nonprescription drugs;
• Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale;
• Barbiturates; and
• Benzodiazepines.

While these drugs or uses are excluded from basic Part D coverage, Medicare Part D drug plan sponsors can generally include them as part of supplemental benefits, provided they otherwise meet the definition of a Part D drug.

Because non-prescription drugs do not otherwise meet the definition of a Part D drug, the Part D drug plans may not include such drugs as part of supplemental benefits; however, under certain conditions as part of a plan utilization management program (including a step-therapy program), non-prescription drugs can be provided at no cost to enrollees. The cost of these drugs to the plan would be treated as administrative costs under such programs.

For more detailed information about Part B drugs and Part D coverage, please refer to the report at http://www.cms.hhs.gov/pdps/PartBandPartDdoc-revised7-27-05.pdf on the CMS web site. This report provides excellent detail on the overall issue of Part B and Part D drugs. For example, this report discusses the following:

• Situations in which a billing entity would have to decide whether, for a given drug, to bill Part B or Part D, based on characteristics of the beneficiary or medical use of the drug;
• Situations where the form of the drug determines where it is covered; and
• Situations where Part B coverage is in the context of another service.

Vaccines Administered in a Physician's Office

This section discusses the vaccines currently covered by Medicare Part B, and includes a few commonly asked questions regarding vaccine coverage under Medicare Part B and Part D. Basically, if a vaccine is currently covered under Part B, the vaccine will remain covered under Part B when the new Part D goes into effect on January 1, 2006.

Medicare Part B currently covers the following immunizations (as discussed earlier in this article):

• Pneumococcal pneumonia vaccine;
• Hepatitis B vaccine;
• Influenza virus vaccine; and
• Other vaccines (e.g., tetanus toxiod) when directly related to the treatment of an injury or direct exposure to a disease or condition.

Key Questions

Will All Vaccines be Covered under Part D, Effective January 1, 2006?

No. As just mentioned, if a vaccine was previously covered under Part B, it will continue to be covered under Part B. If it was previously **not** covered, then it will need to be covered under Part D. Pneumococcal and influenza vaccines are not covered under Part D because of Part B coverage.

Hepatitis B vaccine is covered under Part B for individuals at high or intermediate risk; for all other individuals, it would be covered under a Part D benefit. All other currently available vaccines and all future vaccines would be covered under Part D, but could be subject to plan prior authorization requirements to determine medical necessity.

If a Company That Offers Medicare Part D Drug Plans Determines, Through a Prior Authorization Program, that a Hepatitis B Vaccine is Going to be Administered by a Physician, Can This Company Deny the Claim Based on Part B Coverage in the Setting?

No. Since the Part B benefit for Hepatitis B vaccine is separate from the "incident to" benefit, the determination about whether it is a Part D drug depends solely on characteristics of the beneficiary.

However, if the plan sponsor determines based on Medicare Part B guidelines that the individual is at high or medium risk for Hepatitis B, the company should deny the claim.

For all other individuals, the vaccine would be a "Part D drug," and would be covered unless the plan had otherwise established medical necessity criteria for the vaccine as part of its approved prior authorization program. In this case, only low risk individuals who meet the plan's criteria would be eligible to receive the vaccine.

Additional Information

Web sites for Part B and Part D Coverage Information

• *Medicare Claims Processing Manual* - http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp
• *Medicare Benefit Policy Manual* - http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp
• Medicare Coverage Database - http://www.cms.hhs.gov/mcd/search.asp
• Carrier, DMERC, and Fiscal Intermediary Contacts by Region - http://www.cms.hhs.gov/medlearn/tollnums.asp
• Medicare Drug Information Resource - http://www.cms.hhs.gov/providers/drugs/default.asp
• Hospital Outpatient Prospective Payment System 2005 - http://www.cms.hhs.gov/providers/hopps/fr2005.asp
• Palmetto GBA - http://www.palmettogba.com
• AdminaStar - http://www.adminastar.com
• CIGNA - http://www.cignamedicare.com
• National/Local Coverage Determinations - http://www.cms.hhs.gov/coverage
• Medicare Part B versus Part D Coverage Issues - http://www.cms.hhs.gov/pdps/PartBandPartDdoc-revised7-27-05.pdf
• Medicare Prescription Drug CoverageInformation for Providers - http://www.cms.hhs.gov/medlearn/drugcoverage.asp
• Prescription Drug Plans -http://www.cms.hhs.gov/pdps/

Important Message To Nursing Home Administrators About Medicare Prescription Drug Coverage – The Tenth In The Medlearn Matters Series

Medlearn Matters Number: SE0575

Revised Related Change Request (CR) #: N/A
Related CR Release Date: N/A Effective Date: N/A
Related CR Transmittal #: N/A Implementation Date: N/A

Note: This article was revised on November 15, 2005, to provide a new web address on page 2 for viewing a copy of the letter sent by CMS to nursing home residents who are Medicare beneficiaries who also have full Medicaid coverage.

Provider Types Affected - Skilled nursing facilities (SNFs) and nursing homes with Medicare residents

Impact on Providers

This article contains information on Medicare prescription drug coverage as it applies to nursing home residents. The Centers for Medicare & Medicaid Services (CMS) will continue to use *Medlearn Matters* articles, where appropriate, to supplement the Minimum Data Set (MDS) channel to communicate important information and recommended action steps.

The goal is to ensure that the long term care population has a seamless transition to Medicare prescription drug coverage beginning January 2006.

Important Points to Remember

Key points to remember about the new Medicare prescription drug coverage include the following:

• On January 1, 2006, new prescription drug coverage, also known as Part D, will be available to all of your Medicare residents. It will cover brand name and generic drugs.
• Everyone with Medicare is eligible to join a Medicare drug plan in their area.
• Your residents can first enroll in a Medicare drug plan from November 15, 2005 – May 15, 2006.
• This new drug coverage requires all persons with Medicare to make a decision this fall. As a trusted source, your residents may turn to you for information about this new coverage.
• Please encourage your Medicare residents to learn more about this new coverage because it may save them money on prescription drugs.
• There is extra help for people with limited income and resources.

If your Medicare residents ask you questions about the new coverage, you can refer them to http://www.medicare.gov and 1-800-MEDICARE for additional information and assistance.

Background

At the end of October 2005, CMS mailed a letter to nursing home residents with Medicare and full Medicaid coverage (full-benefit dually eligible beneficiaries). This letter explained that Medicare, instead of Medicaid, will start paying for their prescription drugs beginning January 1, 2006.

The letter explained that if they don't enroll in a plan by December 31, 2005, Medicare will enroll them in a plan to make sure they don't miss a day of coverage. The letter provided the name and contact information for the plan in which Medicare would enroll them.

A sample copy of this letter can be found at: http://www.cms.hhs.gov/medicarereform/Enrollment-Q&A-10-20-05-withcover-sheet.pdf on the CMS web site.

Generally, residents with full Medicaid coverage who are enrolled in a Medicare Advantage plan or the Program of All-Inclusive Care for the Elderly (PACE) will receive their Medicare drug coverage through that plan.

CMS is establishing a web-based system through which nursing homes can access residents' plan enrollment information. This will enable the nursing facility, with the resident's permission, to identify the Medicare drug plan in which the resident is enrolled.

Everyone with Medicare is eligible to join a Medicare drug plan in their area. Many of your residents may want to join a plan to help with the high costs of medications. Your residents can first enroll in a Medicare prescription drug plan from November 15, 2005 – May 15, 2006.

Action Item

Residents with limited income and resources can apply for extra help paying for their prescription drugs. They can apply for this extra help through the Social Security Administration or their State Medical Assistance Office.

For more information on who can get extra help with prescription drug costs and how your residents can apply for that help, call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also find this information at http://www.socialsecurity.gov/ on the web.

Remember, your facility may request applications for the extra help and help residents who may qualify apply. It is important to submit applications for the extra help for new residents who are "Medicaid pending." Residents who have Medicare and full Medicaid coverage, get help from Medicaid paying their Medicare premiums, or receive Supplemental Security Income (SSI) benefits, automatically qualify for extra help and **do not need to apply** for it.

Additional Information

More information concerning Medicare prescription drug coverage and the nursing home population will continue to be supplied through articles such as these and through the MDS channel. Additional information and resources are available at http://www.cms.hhs.gov/medicarereform/pdbma/ on the CMS web site.

Key Medicare News For 2006 For Physicians And Other Health Care Professionals

Medlearn Matters Special Edition Article Number: SE0543
Related Change Release (CR) Date: N/A

Provider Types Affected - Physicians and health care professionals and their billing staffs billing Medicare carriers

Introduction

This Special Edition article is being provided to help you, the Medicare physician and health care professional, keep informed about important Medicare initiatives and additional new Medicare benefits available in Calendar Year (CY) 2006.

As you once again make your decision to enroll in or terminate enrollment in the Medicare participation program, the Centers for Medicare & Medicaid Services (CMS) would like to take this opportunity to review some important news, especially upcoming news for 2006.

CMS believes this information provides significant benefits to providers and their Medicare patients, and it will encourage providers to enroll in, or stay in, the Medicare participation program in order to take full advantage of the upcoming changes.

Information You Need to Know

Ending the Medicare HIPAA Contingency Plan

Based on the progress made by the health care community in implementing the administrative simplification standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) since October 2003, CMS ended the *Medicare HIPAA Contingency Plan* for incoming claims as of October 1, 2005.

October 16, 2003, was the deadline for compliance with the electronic transaction and code set standards of HIPAA. While the vast majority of Medicare providers are in compliance with the HIPAA standards, more work remains to be done to get all electronic billing Medicare providers into compliance. To be in compliance with the law, every Medicare electronic billing provider must submit HIPAA-compliant claims.

To ensure that you stay informed about HIPAA issues, CMS encourages you to visit the following web pages

for the latest news affecting you. To access the national educational articles distributed as part of the *Medlearn Matters* process, visit http://www.cms.hhs.gov/medlearn/matters/ on the CMS web site. Take special note of *Medlearn Matters* article MM3956. To access a variety of issues related to HIPAA policies affecting Medicare providers, visit http://www.cms.hhs.gov/providers/edi/ on the CMS web site.

Release of HIPAA Security Rule

By April 21, 2005, all covered entities under HIPAA (except small health plans) were required to ensure the security of electronic protected health information. Small health plans have until April 21, 2006, to meet the *HIPAA Security Compliance Deadline.*

CMS has released the HIPAA Security Rule, which outlines the administrative, physical, and technical safeguards that a covered entity must implement to be in compliance with the HIPAA security standards. A copy of the rule may be downloaded from https://www.cms.hhs.gov/hipaa/hipaa2 on the CMS web site.

CMS is eager to help you understand and implement the strategies for complying with the Security Rule and has developed educational materials that are available at http://www.cms.hhs.gov/hipaa/hipaa2 on the CMS web site. In addition, there are a number of professional and standards-setting organizations that offer listservs, white papers, and other helpful resources on security implementation.

National Provider Identifier

Health care providers who are covered entities under HIPAA are required by law to apply for a *National Provider Identifier (NPI)*. The NPI will replace health care provider identifiers in use today in standard health care transactions. The health plans with which you do business will instruct you as to when you may begin using the NPI in standard transactions. All HIPAA-covered entities except small health plans must begin using their NPI in standard electronic transactions by May 23, 2007; small health plans have until May 23, 2008.

To apply online, visit https://nppes.cms.hhs.gov, or call 1-800-465-3203 to request a paper application.

Also, visit http://www.cms.hhs.gov/hipaa/hipaa2 for the latest information regarding the NPI, including a transcript from CMS's recent National Provider Identifier Roundtable conference call.

Therapy Services

Therapy Services are defined as outpatient physical therapy, occupational therapy, and speech-language pathology. These services were limited through the Balanced Budget Act of 1997. Limits have been imposed twice, once in 1999 and for a few months in 2003. These limits are scheduled to be implemented again on January 1, 2006. Therapy services will be limited for each beneficiary for the year.

The allowable amount is estimated to be $1,750, but this may change based on the Medicare Economic Index at the end of the year. The amount applies for physical therapy and speech-language pathology combined, and for occupational therapy alone.

Therapy services performed in a physician's office must follow the standards and conditions listed in the manuals and must be identified with a modifier for physical therapy, occupational therapy, or speech-language pathology.

Those services identified as outpatient "therapy" are listed in the *Medicare Claims Processing Manual* (Pub 100-04), Chapter 5, Section 20. The benefit policies are in the *Medicare Benefit Policy Manual* (Pub 100-02), Chapter 15, Sections 220 and 230.

Medicare Contracting Reform

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 911) requires CMS to take the necessary steps between now and October 2011, to implement *Medicare Contracting Reform.* Although health care delivery in the United States has evolved through four decades of advances in medicine and technology, the contracting portion of Medicare's fee-for-service administrative structure has not.

Medicare Contracting Reform will bring standard contracting principles to Medicare, such as competition and performance incentives that the government has long applied to other federal programs under the Federal Acquisition Regulation.

Medicare Administrative Contractor (MAC) Authority

CMS is required to replace the current contracting authority with the new *Medicare Administrative Contractor (MAC)* authority. The law directs CMS to conduct full and open competitions for these new MACs. A/B MACs will administer both the Part A and Part B work

currently being handled by Fiscal Intermediaries (FI) and carriers in 15 designated geographical jurisdictions.

Home health/hospice MACs will perform work currently performed by Regional Home Health Intermediaries (RHHIs) in four designated geographical jurisdictions, while Durable Medical Equipment (DME) MACs will perform the work of the current Durable Medical Equipment Regional Carriers (DMERCs) in four designated geographical jurisdictions that correspond to the jurisdictions of the home health/hospice MACs.

Start-Up Acquisition and Transition Cycles

CMS plans to begin to compete these workloads with a start-up acquisition and transition cycle. This startup cycle is the competition of the current DMERC workloads and the A/B workload for Jurisdiction 3, a first step that focuses on a small discrete workload. The start-up cycle is currently ongoing. The procurement schedule anticipates the DME workload will be awarded in December 2005 and the Part A/Part B workload for Jurisdiction 3 will be awarded in June 2006.

That start-up cycle will be followed by MAC acquisition and transition Cycles One and Two. CMS anticipates each of these acquisition cycles will take approximately 9 to 12 months, from solicitation to award. CMS expects to award the Cycle One procurement in September 2007 and Cycle Two in September 2008. The subsequent transition of workload from the existing contractors to the new MACs will last from approximately 7 to 13 months. Under this schedule, the full fee-for-service workload will be transitioned to MACs by October 2009.

For the most current information available, including the acquisition schedule for each MAC jurisdiction, visit the Medicare Contracting Reform web site at http://www.cms.hhs.gov/medicarereform/contractingreform/ on the CMS web site.

New Benefits for People with Medicare

The 2006 calendar year introduces new health benefits for people with Medicare, resulting from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The full text of this Act can be found at http://www.cms.hhs.gov/medicarereform/MMAactFullText.pdf on the CMS web site.

Preventive Services Benefits

This MMA initiative was implemented in 2005. This is a **reminder** to you that newly covered preventive services include diabetes screening tests for seniors at risk for diabetes and blood tests to screen for cardiovascular disease. Also beginning in 2005, people enrolling in Medicare for the first time were eligible for an initial preventive physical exam, including an exam and an electrocardiogram, in addition to the other preventive and screening services that were already available: adult immunizations; electrocardiograms; pelvic exams; pap smears; mammograms; screenings for prostate and colorectal cancer, glaucoma, diabetes, and cardiovascular disease; and other preventive services.

Visit http://www.cms.hhs.gov/partnerships/tools/2005preventive/default.asp on the CMS web site to access educational materials about these benefits for you, your staff, and Medicare patients.

Medicare Prescription Drug Coverage

Beginning January 1, 2006, Medicare Prescription Drug Coverage will be available to all people with Medicare. Insurance companies and other private companies will be working with Medicare to offer drug plans and negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards that phase out by May 15, 2006 (or when a beneficiary's enrollment in a Medicare prescription drug plan takes effect, if earlier). Where the cards offered discounts, the plans will offer insurance coverage for prescription drugs. Visit http://www.cms.hhs.gov/medlearn/drugcoverage.asp to access educational materials about this proposed benefit for you, your staff, and Medicare patients.

The Medicare Chronic Care Improvement Initiative ("Medicare Health Support")

This initiative, which currently consists of eight regional pilot programs, is the first large-scale chronic care improvement initiative for targeted groups of beneficiaries under the Medicare Fee-For-Service (FFS) program. CMS selected Medicare Health Support Organizations (MHSOs) that offer self-care guidance and support to chronically ill beneficiaries. MHSOs help beneficiaries manage their health, adhere to their physicians' plans of care, and ensure that they seek or obtain medical care that they need to reduce their health risks. The pilot programs all have the following features:

• Initially, the programs are focused on beneficiaries who have Congestive Heart Failure (CHF) and/or Complex Diabetes, because these beneficiaries have heavy self-care burdens and high risks of experiencing poor clinical and financial outcomes. Approximately 20,000 beneficiaries have been invited to participate in each pilot program.

• The new programs are **not** single-disease focused. They are to help participants manage **all** their health problems.

• Participation is voluntary. Eligible beneficiaries do not have to change plans or providers or pay extra to participate. Their Medicare benefits remain unchanged.

• The pilot programs are currently available in 6 areas of the United States; another two programs will be operational by January 1, 2006.

For an overview of the initiative, download the fact sheet that describes "Medicare Health Support" at http://www.cms.hhs.gov/medicarereform/ccip/ on the CMS web site. Also, an informative *Medlearn Matters* article is available on this program at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3953.pdf, also on the CMS web site.

Payment Information

Competitive Acquisition Program

The MMA requires the implementation of a *Competitive Acquisition Program (CAP)* for Medicare Part B drugs and biologicals not paid on a cost or prospective payment system basis. Under the new program, scheduled to be implemented by July 1, 2006, physicians will be given a choice between buying and billing these drugs under the Average Sales Price (ASP) system, or selecting a Medicare-approved CAP vendor that will supply these drugs.

If the physician elects to obtain drugs through the CAP, the vendor will bill Medicare for the drug. The vendor will also bill the beneficiary for any applicable coinsurance and deductible. Physician enrollment in the program is anticipated to begin in the spring of 2006 for July through December 2006, and will then be conducted annually, in the fall of each year, for the following calendar year.

To access MMA, Section 303(d), go to http://www.cms.hhs.gov/providers/drugs/compbid/303d.pdf on the CMS web site. More information about the ASP system can be found at http://www.cms.hhs.gov/providers/drugs/asp.asp on the CMS web site. The following web site is meant to keep physicians informed about enrollment procedures, approved drug vendors, and drugs that may be obtained through the program: http://www.cms.hhs.gov/providers/drugs/compbid. In addition, a full press release and fact sheet can be viewed at: http://www.cms.hhs.gov/media/press/release. asp? Counter=1490 on the CMS web site.

Geographic Discrepancies and Scarcity Bonus Payments

Starting in 2004 and continuing through 2006, the MMA required that the geographic practice costs indices (GPCIs) applied to the physician work portion of the physician fee schedule may not be below 1.0. This provision increases payment rates in 57 of the country's 89 payment localities, and payments will go up for services provided up to the national average rate in areas that were previously below the national average.

Starting in 2005 and continuing through 2007, *Scarcity Bonus Payments* (a five percent (5%) bonus payment) will be paid to primary care and specialists providing care to Medicare beneficiaries in newly defined shortage areas. The new shortage areas are those counties with the lowest ratio of primary care/specialist physicians to Medicare beneficiaries and which represent an aggregate total of twenty percent (20%) of the total Medicare beneficiaries in the county.

Within the official instructions issued by CMS are detailed instructions regarding services eligible for Health Professional Shortage Areas (HPSA) and Physician Scarcity Area (PSA) bonus payments, HPSA incentive payments for services rendered in a critical access hospital (CAH), as well as HPSA designations and information regarding zip codes.

The official instruction issued to your carrier and intermediary regarding this change in the HPSA modifier may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site.

From that web page, look for CR3935 in the CR NUM column on the right, and click on the file for the desired CR. A *Medlearn Matters* article is also available related to this transmittal at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3935.pdf on the CMS web site. Additional information on the PSA bonus can be found in *The Guide for Using the HPSA/PSA Web Page*, at http://www.cms.hhs.gov/providers/bonuspayment/guide.pdf on the CMS web site.

Medicare Incentive Payment Program

Also beginning in 2005, the MMA modified the bonus payment program, which provides ten percent (10%) bonus payments to physicians in HPSAs. The bonus payments will be automatic for physicians practicing in counties that qualify as full HPSAs.

The PSA bonus payment was established in 2005 and per the MMA is currently scheduled to continue through

2007. This five percent (5%) bonus payment is paid to primary care physicians and specialists providing care to Medicare beneficiaries in PSA shortage areas. The PSA shortage areas are those counties with the lowest ratio of primary care/specialist physicians to Medicare beneficiaries and which represent an aggregate total of twenty percent (20%) of the total Medicare beneficiaries in the country. Additional information for physicians to use to determine whether the location where they provide a service is eligible for a bonus payment and how they should code their claims to receive that payment can be found at http://www.cms.hhs.gov/providers/bonuspayment on the CMS web site.

Medicare Payment for Insertion of Presbyopia-Correcting Intraocular Lenses Following Cataract Surgery

An Administrative Ruling on the *Requirements for Determining Medicare Payment for Insertion of Presbyopia-Correcting Intraocular Lenses following Cataract Surgery* was announced in 2005. For more information, see the CMS web site at http://www.cms.hhs.gov/spotlight-technology.asp. The CMS Ruling (No. 05-01) can be found at http://www.cms.hhs.gov/rulings/ on the CMS web site.

Payment for Influenza and Pneumococcal Vaccines

CMS has increased the Medicare payment rate for *Influenza* and *Pneumococcal* vaccines. The 2005 influenza vaccine payment increased to $12.056 and the pneumococcal vaccine payment increased to $24.57. As always, CMS urges you to place your vaccine orders early to ensure timely receipt.

Education Updates

The Medicare Learning Network

The Medicare Learning Network (MLN), the brand name for official CMS provider educational products, is designed to promote national consistency in Medicare provider information developed for CMS initiatives. The MLN products available on the Medlearn web page provide easy access to web-based training courses, comprehensive training guides, brochures, fact sheets, CD-ROMs, videos, educational web guides, electronic listservs, and links to other important Medicare Program information.

All educational products are available free of charge and can be ordered and/or downloaded from the Medlearn web page located at http://www.cms.hhs.gov/medlearn on the CMS web site. As always, CMS welcomes your comments and suggestions for Medicare educational products. Some of the information on the Medlearn web page is described in the table below.

New and Revised Brochures and Fact Sheets

Click on any of the following titles to link to information on Medlearn:

The Medicare Appeals Process: Five Levels to Protect Physicians and Other Suppliers - Brochure (October 2004) (232Kb) Updated May 2005 (http://www.cms.hhs.gov/medlearn/appeals_broch_1004.pdf)

The CMS Online Manual System: A Web-based Manual System for Providers, Contractors, and State Agencies – Twosided trifold brochure Updated July 2005 (3Mb) (http://www.cms.hhs.gov/medlearn/online_brochure.pdf)

The Medicare-Medicaid Relationship - Brochure (June 2005) (3.8Mb) Please note file size before downloading. (http://www.cms.hhs.gov/medlearn/relationship_brochure.pdf)

Quick Reference Information: Medicare Preventive Services (May 2005) - This two-sided job aid provides a quick reference to Medicare's preventive services and screenings, identifying coding requirements, eligibility, frequency parameters, and copayment/coinsurance and deductible information for each benefit. (42Kb) (http://www.cms.hhs.gov/medlearn/qr_prevent_serv.pdf)

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals - This guide provides information on Medicare's preventive benefits including coverage, frequency, risk factors, billing, and reimbursement. (2MB) Update May 2005 (http://www.cms.hhs.gov/medlearn/preventive/psguide.asp)

Expanded Benefits - This two-sided tri-fold brochure provides a basic overview of Medicare's three new preventive benefits: the Initial Preventive Physical Examination (IPPE); cardiovascular screening blood tests; and diabetes screening tests. (January 2005) (123KB) Revised May 2005 (http://www.cms.hhs.gov/medlearn/expanded_benefits_06-08-05.pdf)

Bone Mass Measurements - This two-sided tri-fold brochure provides a basic overview of Medicare's bone mass measurements (bone density studies) benefit. (January 2005) (168KB) Revised May 2005 (http://www.cms.hhs.gov/medlearn/bone_mass_06-08-05.pdf)

Cancer Screenings - This two-sided tri-fold brochure provides a basic overview of Medicare's mammography screening, screening Pap test, pelvic screening examination, colorectal cancer screening, and prostate cancer screening benefits. (January 2005) (162KB) Revised May 2005 (http://www.cms.hhs.gov/medlearn/cancer_screening_06-08-05.pdf)

Glaucoma Screening - This two-sided tri-fold brochure provides a basic overview of Medicare's glaucoma screening benefit. (January 2005) (154Kb) Revised May 2005 (http://www.cms.hhs.gov/medlearn/glaucoma_06-08-05.pdf)

Adult Immunizations – This brochure provides a basic overview of Medicare's Influenza Vaccine, Pneumococcal Polysaccharide Vaccine (PPV), and Hepatitis B Vaccine benefits. (January 2005) (137KB) Revised May 2005 (http://www.cms.hhs.gov/medlearn/adult_immunization_06-08-05.pdf)

Glaucoma Awareness Brochure - If you have questions about glaucoma and Medicare, this brochure may have the answers. (15 Kb) (http://www.cms.hhs.gov/medlearn/glaucoma_awareness.pdf)

Information and Education Resources for Medicare Providers, Suppliers, and Physicians (Adobe pdf 73Kb) Updated June 29, 2005 (http://www.cms.hhs.gov/medlearn/enroll_article.pdf)

ESRD Composite Payment Rate System - Fact Sheet (January 2005) (212Kb) (http://www.cms.hhs.gov/medlearn/ESRDCompRate PaymentSys.pdf)

Reimbursement for Kidney Transplant - Recipient, Donor, and Lab Tests (44Kb) (http://www.cms.hhs.gov/medlearn/Kidneydocweb.pdf)

Physician's Guide to Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (1.65MB) (http://www.cms.hhs.gov/medlearn/Book_Kidney_Dialysis-Final.pdf)

CERT Fact Sheet: Comprehensive Error Rate Testing Program (215Kb) (http://www.cms.hhs.gov/medlearn/certfactsheetv1-3.pdf)

Medicare Learning Network Products Catalog - This catalog provides a list of all available Medicare Learning Network products and a description of each product. (zip file 12MB) (http://www.cms.hhs.gov/medlearn/MedlearnCatalog705.pdf)

Remittance Advice

CMS is also pleased to announce the release of a national educational guide for Medicare Fee-for-Service providers, physicians, suppliers, and their billing staff to help increase their understanding of the *Remittance Advice (RA)*. This guide should help the provider community better understand the components of the RA, including the Claim Adjustment Reason Codes and Remittance Advice Remark Codes. The guide, titled *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers*, is now available for download on the Medicare Learning Network's (Medlearn) web page at http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf on the CMS web site.

Medicare Remit Easy Print

Also coming soon is *Medicare Remit Easy Print (MREP)*. With MREP, providers can view and print Standard Paper Remittances (SPRs) from their own personal computers. Benefits include the following:

- No more waiting for SPRs to arrive in the mail;
- The capability to print an individual's claim to send to other insurers; and
- The capability to create reports on Denied, Adjusted, and Deductible Claims.

In addition, MREP is easy to use and is free. CMS will provide more information on MREP soon.

For Physicians

As a reminder, the very popular *Medicare Resident & New Physician Training (MRNPT) Program Facilitator's Kit* is still available from the Medlearn web site. To order a copy, go to the Medlearn Product Ordering page at http://www.cms.hhs.gov/medlearn and select *Medicare Learning Network Products Catalog* at the link above.

Don't forget to check the *Medicare Physician Web Page*, which is designed to meet the Medicare information needs of physicians. The page is available on the CMS web site at http://cms.hhs.gov/physicians/ and includes links to general information on enrollment, billing, conditions of participation, publications, education, data, and statistics. A special feature link on the page is the Medicare Physician Fee Schedule Look-up, an application that enables users to look up physician service information regarding fee schedule amounts and geographic practice cost indices for every carrier and locality.

Advocacy Resources for Physicians

The *Physicians Regulatory Issues Team (PRIT)* is a team of CMS subject matter experts who work to reduce the regulatory burden on physicians who participate in the Medicare Program. Physicians play the central role in our health care system; they not only care for the health of individual patients, but also help to shape the broad health care delivery system.

As the federal agency that manages the Medicare program, CMS is committed to helping physicians focus on quality patient care by being their best business partner. The Medicare program and physicians share a common mission: providing high-quality medical care to patients. CMS encourages you to share your suggestions on how to improve the Medicare program by contacting the PRIT at 202-690-5907, or by sending an email to PRIT@cms.hhs.gov. That web site can be found at http://www.cms.hhs.gov/physicians/prit/

The PRIT is not the only advocate physicians have at Medicare. The *Physicians and Allied Health Open Door Forum* initiative is a monthly conference call with CMS policy experts and CMS senior staff.

Physicians and their office staff are encouraged to participate. They can ask questions about Medicare issues or simply listen to stay current on Medicare policy. For the date and time of the next Open Door Forum, visit the Open Door web site at http://www.cms.hhs.gov/opendoor/schedule.asp on the CMS web site.

Beneficiary Related News

Medicare and You 2006

The national edition of *Medicare and You 2006* is available for order. Call 1-800-MEDICARE (1-800-633-4227) to request up to 25 copies, or fax an order to 410-786-1905 for more than 25 copies.

BenefitsCheckUpRx

A new *web-based service* will help Medicare beneficiaries of limited income and resources gain access to the extra help available to them through the Medicare Modernization Act of 2003. The service, which will also help them enroll in other health care and prescription drug assistance programs, was developed by the Administration on Aging (AoA) with the assistance of CMS and the National Council on the Aging (NCOA).

The new service is a special version of *BenefitsCheck UpRx,* updated for the extra help with Medicare drug coverage. It is available at http://www.BenefitsCheckUp.org/rx. BenefitsCheckUpRx will help older adults and the advocates who work with them take advantage of the Medicare low-income subsidy, the comprehensive extra help that covers 95 percent of drug costs on average for people with Medicare who have limited means.

Applications are available now and, all together, about one in three Medicare beneficiaries are eligible for the extra help. A press release describing the service can be found at http://www.cms.hhs.gov/media/press/release.asp?Counter=1502 on the CMS web site.

Hospital Compare

CMS launched *Hospital Compare* nationally on its web site on April 1, 2005. For the first time, consumers are better able to compare the quality of care in nearly all of the nation's hospitals using quality information now available from CMS and the Hospital Quality Alliance (HQA). The new information provides consumers with standardized assessments of the care that nearly 4,200 hospitals across the country provide to all adult patients, based on valid and reliable measures that have been shown to reflect quality of care. Hospital Compare is available on the Internet at http://www.hospitalcompare.hhs.gov or http://www.medicare.gov.

New Beneficiary Publications

The following beneficiary publications are available at http://pubordering.cms.hhs.gov/mailinglist:

• 10969-S "Medicare and Home Health Care" (Spanish), located on Drop Down Menu, Option-Beneficiary-Misc;

• 02154 "Medicare Hospice Benefits" located on Drop Down Menu, Option-Beneficiary-Misc; and

• 11115 "Spreading the Word About Medicare's New Preventive Services (Tool Kit)."

Additional Information

If you have any questions, please contact your carrier at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Medicare Prescription Drug Coverage: Essential Information And Resources For Prescribing Health Care Professionals – The Eleventh In The Medlearn Matters Series On The New Prescription Drug Plans

Medlearn Matters Article Number: SE0603
Related Change Request (CR) #: N/A

Note: This article was revised on February 6, 2006, to reflect revised CMS policy that now provides for a 90 day supply of transitional prescription medicine. (See page 4.)

Provider Types Affected - All health care professionals who prescribe prescription medications for Medicare beneficiaries

Impact on Providers - The new Medicare prescription drug coverage began on January 1st. Already, pharmacists have filled millions of prescriptions for people with Medicare. During this important transition period to the new prescription drug coverage, the Centers for Medicare & Medicaid Services (CMS) understands that there is much that prescribing health care professionals need to know about this new coverage in order to help their Medicare patients.

Essential Information for Prescribing Health Care Professionals

CMS has compiled a list of information, resources, and tools that will allow health care professionals and their support staff to help their Medicare patients during this transition period.

Finding Formulary Information

CMS has a formulary finder that provides direct access to all plan websites at http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp on the web. In addition, we have worked with Epocrates to provide free software which makes the formulary selection process very simple. You can load this program into your PDA or run the software on a desktop. This tool is available at http://www.epocrates.com/ on the web.

Coverage Determination

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug.

An exception request is a type of coverage determination request. Through the exceptions process, an enrollee can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement).

CMS does not have the authority to mandate a standard exception process for each Medicare drug plan or MA-PD; however, the Agency is working to simplify the exceptions process. Like typical commercial payers, health care professionals may occasionally need to help a patient file a prior authorization for a medication or appeal a medication's tier. CMS is working with medical specialty societies to address these issues.

A form has been created by a coalition of medical societies and advocacy groups that can be faxed to your office by a pharmacist when he or she is given a prescription that is either not on the formulary or on a higher tier.

This form streamlines communication between the pharmacist and the physician and reduces the need for time consuming telephone calls to the doctor's office.

The form is located at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartDPharmacyFaxForm.pdf on the CMS web site, as well as at several medical society websites.

Expedited Review Process

There is an expedited review process that CMS has outlined to ensure that drug plans can move an appeal quickly, i.e., within a 24-hour turnaround time, to provide medicines to patients with an immediate need. Beyond this expedited review process, the standard appeals process to challenge a plan's coverage determination has five levels:

- Redetermination by the plan;
- Reconsideration by a Medicare drug coverage qualified independent contractor (QIC);
- An Administrative Law Judge (ALJ) hearing;
- Review by the Medicare Appeals Council; and
- Review by federal district court.

Visit http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp for a list of plan contacts you

can use to query your patient's plan should you need to pursue an appeal or require clarification on an issue.

Part B Drugs vs. Drugs Covered under Medicare Prescription Drug Coverage (Part D)

A previous Medlearn Matters article explains the difference between drugs covered under Part B versus those covered under Part D.

This article can be found at http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0570.pdf on the CMS web site. Additionally, a chart explaining specific drugs can be found at http://www.cms.hhs.gov/pharmacy/downloads/partsbdcoverageissues.pdf on the CMS web site.

Verifying Beneficiary Enrollment in a Medicare Drug Plan

Office staff can use the Medicare Prescription Drug Plan Finder, located at http://www.medicare.gov, to verify a beneficiary's enrollment in a Medicare drug plan. By entering all information provided on a beneficiary's Medicare card, the Plan Finder will identify the plan in which the beneficiary is enrolled.

Pharmacists have access to a new computer tool called "E1" that provides real time enrollment and eligibility information. This tool provides both eligibility and billing information at the point of sale and is constantly updated by CMS.

Obtaining Prior Authorizations

A prior authorization can only be obtained by calling the drug plan directly. 1-800-MEDICARE cannot process a prior authorization.

Ensuring Coverage for a Dual Eligible Beneficiary Who Needs to be Enrolled in a Plan

CMS has ensured that people with Medicare and full Medicaid benefits (full dual) will have drug coverage by enabling customer service representatives at 1-800-MEDICARE to enroll these beneficiaries in WellPoint, a national plan.

If these beneficiaries have **immediate prescription needs**, they should visit their local pharmacies. The pharmacist can enroll them in WellPoint at the pharmacy. To find out more about what happens with Medicare prescription drug coverage in certain situations, visit http://www.cms.hhs.gov/Pharmacy/Downloads/whatif.pdf on the CMS web site.

Providing a 90-day Supply of Transitional Prescription Medication

CMS has instructed all Medicare-approved plans to extend the original 30-day transitional coverage period by an additional 60 days. This means that a Part D beneficiary will be able to get a 90 day supply of all of his or her medications when they enroll in Part D, even if some of the medications are not on formulary. This 90 day period will give the patient's doctor and pharmacist time to adjust the patient's drug regimen, or request exceptions to the plan's formulary, so that the next refill of medications will be consistent with the plan's coverage rules. Beneficiaries who enroll after March 31st will get a 30 day transitional fill so that they have time to adjust their medication regimen to the plan formulary.

Important Contact Information to Report Problems with Medicare Prescription Drug Coverage

Health Care Professionals: E-mail prit@cms.hhs.gov with problems and issues encountered. Please take advantage of CMS' regular conference call at 2PM EST every Tuesday. This call gives health care professionals an opportunity to ask questions of CMS staff. Call 1-800-619-2457; Passcode: RBDML.

Pharmacists: Call 1-866-835-7595, a CMS dedicated line designed to help answer questions regarding billing and beneficiary enrollment information.

Additional Information

Health care professionals can visit http://www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage on the CMS web site. The redesigned web page contains all the latest information on Medicare prescription drug coverage.

Medicare System Edits For Respiratory Assist Devices (RADs) With Bi-Level Capability And A Back-Up Rate

Medlearn Matters Article Number: MM4223
Related Change Request (CR) #: 4223
Related CR Release Date: February 1, 2006
Effective Date: April 1, 2006
Related CR Transmittal #: R825CP
Implementation Date: April 3, 2006

Provider Types Affected - Providers and suppliers who bill Medicare regional home health intermediaries

(RHHIs) or durable medical equipment regional carriers (DMERCs) for Respiratory Assist Devices (RADs)

Provider Action Needed - Please be aware of this payment change for RADs with bi-level capability and a back-up rate.

Key Points

• The Final Rule, CMS-1167-F, *Payment for Respiratory Assist Devices (RADs) with Bi-Level Capability and a Back-Up Rate*, states that RADs with bi-level capability and a back-up rate must be paid as capped rental (CR) items or durable medical equipment (DME) under the Medicare program.
• RADs should not be paid as items requiring frequent and substantial servicing (FSS), as defined in section 1834(a)(3) of the Social Security Act.
• Effective April 1, 2006, Medicare will move the HCPCS codes E0471 and E0472 from the FSS category to the capped rental (CR) category.

Additional Information

The first claim received for each beneficiary for these codes with a date of service on or after April 1, 2006, will be counted as the first rental month in the cap rental period. Suppliers should begin submitting cap rental modifiers KH, KI or KJ, as appropriate, with all rental claims for these codes with dates of service on or after April 1, 2006.

The official instruction issued to your regional home health intermediary (RHHI) or durable medical equipment regional carrier (DMERC) regarding this change may be found by going to http://www.cms.hhs.gov/Transmittals/downloads/R825CP.pdf on the CMS web site.

Please refer to your local RHHI or DMERC if you have any questions. To find their toll free phone number, go to http://www.cms.hhs.gov/apps/contacts/ on the CMS web site.

Quarterly Provider Update

Medlearn Matters Article Number: SE0303

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

• Inform providers about new developments in the Medicare program;
• Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
• Ensure that providers have time to react and prepare for new requirements;
• Announce new or changing Medicare requirements on a predictable schedule; and
• Communicate the specific days that CMS business will be published in the Federal Register.

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update list-serv (electronic mailing list) at: http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1.

The Quarterly Provider Update can be accessed at http://www.cms.gov/providerupdate. We encourage you to bookmark this Web site and visit it often for this valuable information.

Remittance Advice Remark Code And Claim Adjustment Reason Code Update Provider Types Affected

Medlearn Matters Article Number: MM4123

Related Change Request (CR) #: 4123
Related CR Release Date: November 4, 2005
Effective Date: January 1, 2006
Related CR Transmittal #: 743
Implementation Date: January 3, 2006

Note: This article was revised January 11, 2006, to correct CMS web references. All other information remains the same.

Region D Note: Since this article was published, the description for MA02 has been updated as follows: "If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days."

Provider Types Affected - Physicians, providers, and suppliers who submit claims to Medicare contractors

(carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs)) for services

Provider Action Needed

Impact to You - The complete list, including changes made from March 1, 2005 through June 30, 2005, of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 Health Care Claim Adjustment Reason Codes can be found at http://www.wpc-edi.com/codes.

What You Need to Know - Please refer to the *Additional Information* section of this article for remark and reason code changes approved June 30, 2005.

What You Need to Do - Be sure your staff is aware of these changes.

Background

Two code sets—the reason and remark code sets—must be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination of benefits transactions.

The remittance advice remark code list is maintained by CMS, and used by all payers. Additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities. This list is updated three times a year, and posted at http://wpc-edi.com/codes.

The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets three times a year when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes. This updated list is posted three times per year.

Additional Information

The following lists summarize changes made from March 1, 2005 through June 30, 2005:

Remittance Advice Remark Code Changes

Code	New/ Modified/ Deactivated/ Retired	Current Narrative	Comment
N348	New	You chose that this service/supply/drug would be rendered/supplies and billed by a different practitioner/supplier.	Medicare Initiated
N349	New	The administration method and drug must be reported to adjudicate this service.	Not Medicare Initiated
N350	New	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure.	Not Medicare Initiated
N351	New	Service date outside of the approved treatment plan service dates.	Not Medicare Initiated
N352	New	There are no scheduled payments for this service. Submit a claim for each patient visit.	Not Medicare Initiated
N353	New	Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim.	Not Medicare Initiated
N354	New	Incomplete/invalid invoice.	Not Medicare Initiated

N355	New	The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days.	Medicare Initiated
N356	New	This service is not covered when performed with, or subsequent to, a non-covered service.	Not Medicare Initiated
N21	Modified	Your line item has been separated into multiple lines to expedite handling.	Modified effective August 1, 2005

M25	Modified	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	Modified effective August 1, 2005
M26	Modified	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	Modified effective August 1, 2005
M27	Modified	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified effective August 1, 2005

MA01	Modified	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.	Modified effective August 1, 2005
MA02	Modified	The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.	Modified effective August 1, 2005
MA03	Modified	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time. At the reconsideration, you must present any new evidence which could affect our decision.	Modified effective August 1, 2005
MA83	Modified	Did not indicate whether we are the primary or secondary payer.	Modified effective August 1, 2005
MA94	Modified	Did not enter the statement "Attending physician not hospice employee" on the claim form to certify that the rendering physician is not an employee of the hospice.	Modified effective August 1, 2005
N122	Modified	Add-on code cannot be billed by itself.	Modified effective August 1, 2005
N125	Modified	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The requirements for a refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.	Modified effective August 1, 2005

N29	Modified	Missing documentation/orders/notes/ summary/report/chart.	Modified effective August 1, 2005
N225	Modified	Modify N225 - Incomplete/invalid documentation/orders/notes/summary/report/ chart.	Modified effective August 1, 2005
M23	Modified	Missing invoice.	Modified effective August 1, 2005
167	New	This (these) diagnosis(es) is (are) not covered.	New as of June, 2005
168	New	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	New as of June, 2005
169	New	Payment adjusted because an alternate benefit has been provided.	New as of June, 2005
170	New	Payment is denied when performed/billed by this type of provider.	New as of June, 2005
171	New	Payment is denied when performed/billed by this type of provider in this type of facility.	New as of June, 2005
172	New	Payment is adjusted when performed/billed by a provider of this specialty.	New as of June, 2005
173	New	Payment adjusted because this service was not prescribed by a physician.	New as of June, 2005
174	New	Payment denied because this service was not prescribed prior to delivery.	New as of June, 2005
175	New	Payment denied because the prescription is incomplete.	New as of June, 2005
176	New	Payment denied because the prescription is not current.	New as of June, 2005
177	New	Payment denied because the patient has not met the required eligibility requirements.	New as of June, 2005
178	New	Payment adjusted because the patient has not met the required spend-down requirements.	New as of June, 2005
179	New	Payment adjusted because the patient has not met the required waiting requirements.	New as of June, 2005
180	New	Payment adjusted because the patient has not met the required residency requirements.	New as of June, 2005
181	New	Payment adjusted because this procedure code was invalid on the date of service.	New as of June, 2005
182	New	Payment adjusted because the procedure modifier was invalid on the date of service.	New as of June, 2005
183	New	The referring provider is not eligible to refer the service billed.	New as of June
184	New	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	New as of June, 2005
185	New	The rendering provider is not eligible to perform the service billed.	New as of June, 2005
186	New	Payment adjusted since the level of care changed.	New as of June, 2005

187	New	Health Savings account payments.	New as of June, 2005
188	New	This product/procedure is only covered when used according to FDA recommendations.	New as of June, 2005
189	New	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	New as of June, 2005
D21	New	This (these) diagnosis(es) is (are) missing or are invalid.	New as of June, 2005
23	Modified	Payment Adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.	Modified June, 2005
47	Retired	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	Inactive as of February, 2006
30	Retired	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	Inactive as of February, 2006
B6	Retired	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	Inactive as of February, 2006

In September, 2005, the Claim Adjustment Status Code Maintenance Committee approved a new reason code of 192 (Non-standard adjustment code from paper remittance advice), effective January 1, 2006. Reason Code 192 will be used by providers who must submit claims electronically under the Administrative Simplification Compliance Act when:

- Medicare is not the primary payer; and
- Providers have received paper remittance advice containing proprietary codes from the previous payer(s).

For additional information about Remittance Advice, please refer to *Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers* at http://www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf on the CMS web site.

The official instruction issued to your FI/carrier/DMERC/RHHI regarding this change may be found by going to http://www.cms.hhs.gov/Transmittals/downloads/R743CP.pdf on the CMS web site. From that web page, look for CR4123 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your FI/carrier/DMERC/RHHI at their toll-free number, which may be found at http://www.cms.hhs.gov/apps/contacts on the CMS web site.

Requirements For Voided, Canceled, And Deleted Claims

Medlearn Matters Article Number: MM3627

Related Change Request (CR) #: 3627
Related CR Release Date: June 17, 2005
Related CR Transmittal #: 159
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

Note: This article was revised on November 10, 2005, to clarify language in item 4 under "Acceptable Claims Deletions" on page 2. All other information remains the same.

Provider Types Affected - All Medicare physicians, providers, and suppliers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs)

Provider Action Needed

This Medlearn Matters article is based on information contained in Change Request (CR) 3627, which describes new Centers for Medicare & Medicaid Services (CMS) procedures and specific instructions to Medicare contractors (carriers, intermediaries, and DMERCs) for voiding, canceling, and deleting claims. As a result of these changes, providers should note that some claims they were able to delete in the past will no longer be deleted from Medicare's systems, but will instead become denied claims.

Background

The Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) has verified instances in which Medicare claims have been voided, canceled, or deleted by Medicare carriers, DMERCs, and FIs. Further, the Medicare contractors have not traditionally maintained an audit trail for the voided, canceled, or deleted claims. The OIG has indicated that Medicare must maintain an audit trail for voided, canceled, and deleted claims.

CMS is therefore implementing requirements for Medicare contractors (carriers/FIs, including DMERCs and regional home health intermediaries (RHHIs)) to:

• Deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons;

• Cancel, void, or delete claims that are unprocessable for acceptable reasons;

• Return as unprocessable claims that meet conditions mentioned below for the return of unprocessable claims; and

• Maintain an audit trail for all canceled, voided, or deleted claims that Medicare systems have processed far enough to have assigned a Claim Control Number (CCN) or Document Control Number (DCN).

Note: CR3627 requires that Medicare carriers, intermediaries, and DMERCs keep an audit trail on these claims once a CCN or DCN has been assigned to the claim.

Acceptable Claims Deletions

Below is a list of acceptable reasons a Medicare contractor may cancel, delete, or void a claim:

1. The current CMS 1500 form or the current CMS 1450 form is not used.

2. The front and back of the CMS 1500 (12/90) claim form are required on the same sheet and are not submitted that way (claims submitted to carriers only).

3. A breakdown of charges is not provided, i.e., an itemized receipt is missing.

4. Only six line items may be submitted on each CMS 1500 claim form (Part B only).

5. The patient's address is missing.

6. An internal clerical error was made.

7. The Certificate of Medical Necessity (CMN) was not with the claim (Part B only).

8. The CMN form is incomplete or invalid (Part B only).

9. The name of the store is not on the receipt that includes the price of the item (Part B only).

Note: The Medicare contractor must keep an audit trail for all claims in the above "Acceptable Claims Deletions" category if a CCN or a DCN was assigned to the claim.

Unacceptable Claims Deletions

The following are unacceptable reasons for Medicare contractors to void, cancel, or delete claims:

1. A provider notifies the Medicare contractor that

claim(s) were billed in error and requests the claim be deleted (carrier claims only).

2. The provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (Type of Bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review. (FI claims only)

3. The patient's name does not match any Health Insurance Claim Number (HICN).

4. A claim meets the criteria to be returned as unprocessable under the incomplete or invalid claims instructions in the *Medicare Claims Processing Manual*, Chapter 1, Section 80.3.2.ff, which is available at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the CMS web site.

Medicare contractors must deny or reject claims in the above "Unacceptable Claims Deletions" category.

Return as Unprocessable Claims

Medicare contractors may return a claim as unprocessable for the following reasons:

1. Valid procedure codes were not used and/or services are not described (e.g., block 24D of the CMS 1500) Part B only).

2. The patient's HICN is missing, incomplete, or invalid (e.g., block 1A of the CMS 1500).

3. The provider number is missing or incomplete.

4. No services are identified on the claim.

5. Block 11 (insured policy group or FECA Number) of the CMS 1500 is not completed to indicate whether an insurer primary to Medicare exists (Part B only).

6. The beneficiary's signature information is missing (Part B only).

7. The ordering physician's name and/or UPIN are missing/invalid (blocks 17 and 17A of the CMS 1500).

8. The place of service code is missing or invalid (block 24B of the CMS 1500 – Part B only).

9. A charge for each listed service is missing (e.g., block 24F of the CMS 1500).

10. The days or units are missing (e.g., block 24G of the CMS 1500).

11. The signature is missing from block 31 of the CMS 1500 (Part B only).

12. Dates of service are missing or incomplete (block 24A of the CMS 1500).

13. A valid HICN is on the claim, but the patient's name does not match the name of the person assigned that HICN.

Summary

In summary, CMS believes the following:

• The problems listed under the "Acceptable Claims Deletions" heading are valid reasons to void/delete/cancel a claim if the Medicare contractor maintains an audit trail; and

• Claims with problems listed under the "Unacceptable Claims Deletions" heading should be denied or rejected by Medicare, and the decision to deny/reject the claim should be recorded in the Medicare contractor's claims processing system history file.

If a Medicare contractor determines that a claim is unprocessable before the claim enters that contractor's claims processing system (i.e., the claim processing system **did not assign a CCN or DCN** to the claim):

• The claim may be denied; and

• The contractor does not have to keep a record of the claim or the deletion.

If a Medicare contractor determines that a claim is unprocessable after the claim enters their claims processing system (i.e., the claim processing system **did assign a CCN or DCN** to the claim):

• The denied or rejected claim will not be totally deleted from Medicare's claims processing system. The Medicare contractor must maintain an audit trail for all deleted claims that have entered the claims processing system (i.e., the system assigned a CCN or DCN to the claim).

Implementation

The implementation date for the instruction is October 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR3627 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Termination Of The Existing Eligibility File-Based Crossover Process At All Medicare Contractors

Medlearn Matters Article Number: MM4231
Related Change Request (CR) #: 4231
Related CR Release Date: December 9, 2005
Effective Date: January 9, 2006
Related CR Transmittal #: 198
Implementation Date: January 9, 2006

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services to Medicare beneficiaries

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4231, which informs Medicare contractors (carriers, DMERCs, FIs, and RHHIs) about their responsibilities regarding the discontinuance of the current eligibility file-based crossover process effective January 3, 2006. **The impact of CR4231 is primarily** on CMS trading partners as defined later in this article. The article is primarily informational for providers.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) will discontinue the current eligibility file-based crossover process effective January 3, 2006, and CR 4231 outlines the processes that Medicare contractors must follow when trading partners request a waiver to enable them to move into crossover production with the CMS Coordination of Benefits Contractor (COBC) beyond January 3, 2006.

What You Need to Do

This article is informational only for providers, so they may be aware of the potential for changes in how their claims are forwarded to CMS trading partners for coordination of benefits activities. See the Background Section of this article for further details regarding the termination of the existing eligibility file-based crossover process.

CMS has been testing its national Coordination of Benefits Agreement (COBA) consolidated crossover process with over 120 trading partners starting in July 2004. During this time, CMS and its Coordination of Benefits Contractor (COBC) have brought the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 Coordination of Benefits (COB) claim files into high degrees of compliancy with the Version 4010-A1 837 Institutional and Professional Claim Implementation Guides. Starting in June 2005, CMS has been moving trading partners into crossover production with the COBC, and this trend has recently been accelerating.

Note: "Trading Partner" is defined as an issuer of an insurance policy that supplements Medicare or a State agency responsible for administration of Title XIX of the Social Security Act. It is also defined as a federal agency, or contractor thereof, that administers and provides health care benefits for its eligible beneficiaries or an entity working under contract with a self-insured employer plan or an insurer to adjudicate claims and perform other insurance functions. A trading partner does not include entities that merely receive, route, and/or translate files, such as health care clearinghouses, network service vendors, data transmission services, and billing services. CMS and its COBC may, however, transmit crossover claims to trading partners through one of these entities.

CMS recently provided guidance to all Medicare contractors (carriers, DMERCs, FIs, and RHHIs) regarding the discontinuance of the existing eligibility file-based crossover process effective December 31, 2005 (JSM-06026), and described a waiver process that trading partners who will not be moving into COBA crossover production by December 31, 2005, must follow.

In addition, CR4231 is being issued to:

- Clarify all Medicare contractor requirements as they

relate to the discontinuance of the existing eligibility file-based crossover process; and

• Update the end date for the existing Medicare eligibility file-based crossover process to January 3, 2006, for Medicare contractor purposes.

This will enable the Medicare contractors to initiate the termination process for those trading partners **that have not moved** to COBA production by December 31, 2005.

Note: The "eligibility file" is the data file provided by the Trading Partner containing the records required to identify Medicare beneficiaries for purposes of receiving Medicare Part A and B crossover claims and reporting existing prescription drug coverage by the trading partner.

CMS Medicare contractors will not cross claims over to trading partners beyond January 3, 2006, pursuant to signed crossover agreements and the submission of COB eligibility files. As of January 3, 2006, CMS' COBC will exclusively cross over all claims to trading partners in the HIPAA ANSI X12-N 837 COB (version 4010-A1) formats via the COBA eligibility file-based crossover process, unless:

1. Medicare contractors have submitted waiver requests to CMS on behalf of their current trading partners no later than December 16, 2005 (Note: Trading partners would need to have submitted these requests to the Medicare contractors no later than December 7, 2005), and

2. CMS has approved the trading partners' waiver requests in advance of January 3, 2006. (**Note:** CMS plans to reach a decision on all waiver requests no later than December 21, 2005, unless late waiver requests must be addressed.)

Termination Process Notifications to Trading Partners That Have Not Requested a Waiver

All Medicare contractors will begin the termination of the existing eligibility file-based crossover process with each individual trading partner that has not requested and received a waiver no sooner than January 3, 2006.

Impact on Mandatory Medigap ("Claim-Based") Crossovers

The January 3, 2006, end date **does not apply** to mandatory Medigap ("claim-based") crossovers, which are authorized by the Omnibus Budget Reconciliation Act of 1987 [Public Law 100-203, Section 4081(a)(B)], and currently supported by Part B and DMERC contractors.

Implementation

The implementation date for this instruction is January 9, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at http://new.cms.hhs.gov/transmittals/downloads/R198OTN.pdf on the CMS web site.

If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnims.asp on the CMS web site.

Unsolicited/Voluntary Refunds

Medlearn Matters Article Number: MM3274

Related Change Request (CR) #: 3274
Related CR Release Date: July 30, 2004
Related CR Transmittal #: 50
Effective Date: October 1, 2004/January 1, 2005
Implementation Date: October 1, 2004/January 3, 2005
Provider Types Affected - All Medicare providers

Provider Action Needed

Providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Background

Medicare carriers and intermediaries receive unsolicited/voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related CR 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such

refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.

Additional Information

If you have any questions regarding this issue, contact your carrier or intermediary at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Update To Medicare Deductible, Coinsurance, And Premium Rates For 2006

Medlearn Matters Article Number: MM4132
Related Change Request (CR) #: 4132
Related CR Release Date: November 4, 2005
Effective Date: January 1, 2006
Related CR Transmittal #: 31
Implementation Date: January 3, 2006

Provider Types Affected - Physicians, suppliers, and providers billing Part A and Part B services to Medicare carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)

Provider Action Needed

This article is based on Change Request (CR) 4132, which updates the Centers for Medicare & Medicaid Services (CMS) claims processing systems and the *Medicare General Information, Eligibility, and Entitlement Manual* (Pub.100-01) with the new 2006 Medicare deductible, coinsurance, and premium rates for 2006.

Background

Medicare beneficiaries using covered Part A services (inpatient hospital services, skilled nursing facilities (SNFs), home health services, and hospice care) and Part B services (physician services, outpatient hospital services, medical equipment and supplies, and other health services and supplies) may be subject to deductible and coinsurance requirements.

Beneficiaries are responsible for an inpatient hospital deductible amount (which is deducted from the amount payable by the Medicare program to the hospital) for inpatient hospital services furnished during a spell of illness.

After the 60th day that a beneficiary receives inpatient hospital services (during a spell of illness), he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per day for the **61st-90th day** spent in the hospital.

After the 90th day spent in the hospital during a spell of illness, the beneficiary may elect to use his or her 60 lifetime reserve days of coverage. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

For SNF services furnished during a spell of illness, the beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the **21st-100th day in an SNF.**

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment.

The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll but are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 10 percent penalty is assessed for two years for every year they could have enrolled and failed to enroll in Part A.

Under Supplementary Medical Insurance (SMI), all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute.

When SMI enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll. The following includes Medicare Part A and Part B deductible, coinsurance, and premium amounts for 2006:

A. Medicare Part A Deductible, Coinsurance, and Premium Amounts for 2006:

- **Deductible:** $952.00 per benefit period or spell of illness;

- **Coinsurance:**
  - $238.00 a day for days 61-90 in each period;
  - $476.00 a day for days 91-150 for each "Lifetime Reserve" day used; and
  - $119.00 a day in an SNF for days 21-100 in each benefit period; and
- **Premium:**
  - $393.00 per month for those who must pay a premium;
  - $432.30 per month for those who must pay a premium **and** must pay a 10 percent increase;
  - $216.00 per month for those who have 30-39 quarters of coverage; and
  - $237.60 per month for those who have 30-39 quarters of coverage **and** must pay a 10 percent increase.

The table below compares deductible and coinsurance amounts for 2005 and 2006:

Year	Inpatient Hospital Deductible, 1st 60 Days	Inpatient Hospital Coinsurance, 61st-90th Days	60 Lifetime Reserve Days Coinsurance	SNF Co-insurance
2005	$912	$228	$456	$114
2006	$952	$238	$476	$119

B. Medicare Part B Deductible, Coinsurance, and Premium Amounts for 2006:

- **Deductible:** $124.00 per year;
- **Coinsurance:** 20 percent; and
- **Premium:** $88.50 per month.

Implementation

The implementation date for the instruction is January 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4132 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC/intermediary at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Frequently Asked Questions

1. May I submit additional medical documentation to an Administrative Law Judge if I disagree with the Reconsideration determination?

   ANSWER: Effective 01/01/2006 all medical documentation must be submitted with the Reconsideration request. If documentation is not submitted, it cannot be submitted at the Administrative Law Judge (ALJ) level. ("Upcoming Changes To The Medicare Appeals Process", Winter 2006 *DMERC Dialogue)*

2. If a beneficiary uses two pharmacies for their inhalation drugs will both receive a dispensing fee?

   ANSWER: No. Refer to the Medlearn Matters Article # MM3990 entitled "Supplying Fee And Inhalation Drug Dispensing Fee Revisions And Clarifications" posted on our Web site on 12/21/2005 and included in this issue in the "Coverage and Billing" section.

3. What does the CO group code on my Remittance Advice mean?

   ANSWER: You may not hold a beneficiary financially responsible for any adjustments identified with a group code CO (contractual obligation). CO is always used to identify excess amounts for which the law prohibits Medicare payment and absolves the beneficiary of any financial liability, such as participation agreement violation amounts, limiting charge violations, late filing penalties, or amounts for services not considered reasonable and necessary.

4. If the quantity of testing supplies ordered by a physician exceeds the utilization guidelines in the Glucose Monitor Local Coverage Determination (LCD) what must I have on file to support medical necessity.

   ANSWER:
   a) Coverage criteria for a glucose monitor are met.
   b) The order from the treating physician.
   c) Previously dispensed supplies have nearly been exhausted.
   d) The treating physician has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the patient's medical record the specific reason for the additional materials for that particular patient.
   e) The treating physician has seen the patient and has evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets, or lens shield cartridges that exceed the utilization guidelines.
   f) documentation in the physician's records (e.g., a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the supplier's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every six months.

5. Does a supplier need to ask a Medicare beneficiary whether or not they have primary other insurance?

   ANSWER: Yes. Following is an excerpt regarding Medicare Secondary Payer (MSP) from the CMS Web site (http://www.cms.hhs.gov/MedicareSecondPayerandYou/):

   "Responsibilities of Providers Under MSP

   As a Part B provider (i.e. physicians and suppliers)
   - Follow the proper claim rules to obtain MSP information such as group health coverage through employment or non-group health coverage resulting from an injury or illness;

Frequently Asked Questions (cont'd)

- Inquire with the beneficiary at the time of the visit if he/she is taking legal action in conjunction with the services performed; and,
- Submit an Explanation of Benefits (EOB) form with all appropriate MSP information to the designated carrier. If submitting an electronic claim, provide the necessary fields, loops, and segments needed to process an MSP claim."

In addition, CMS provides a Medicare Secondary Payer Questionnaire (available in the *DMERC Region D Supplier Manual*, Chapter 11) that suppliers may use to collect information from the beneficiary.

6. What is an Additional Development Request (ADR) letter?

   ANSWER: To get a more complete picture of a beneficiary's condition, Medical Review may request additional documentation regarding a particular Medicare claim. A supplier should respond to an ADR within 30 days.

7. Can a supplier help the beneficiary enter the demographic information into the palm pilot device of the sleep oximeter device?

   ANSWER: No. CMS precludes any involvement by the supplier. "The Independent Diagnostic Testing Facility (IDTF) provides clear, written instructions to the beneficiary on the proper operation of the test equipment and the beneficiary has access to the IDTF in case other questions arise." (CMS Transmittal Pub. 100-20, Rev. 166, Change Request 3751, "Overnight Oximetery Testing")

8. The Continuous Positive Airway Pressure (CPAP) device requires the beneficiary to have a polysomnography. Must the results of that study score apneas and hypopneas separately from other sleep disturbances such as leg movement, snoring, respiratory event related arousals (RERAs) and other sleep disturbances to be acceptable?

   ANSWER: The Apnea-Hypopnea Index (AHI) is the key element of the coverage criteria for CPAP devices. It is the average number of apneas and hypopneas per hour. Other sleep disturbances that may be included by some polysomnographic facilities are not considered to meet the AHI definition in the LCD. Claims for items based upon an index that does not score apneas and hypopneas separately from other sleep disturbance events, will be denied as not medically necessary. (CPAP AND Respiratory Assist Devices - Apnea/Hypopnea Index", Spring 2003 *DMERC Dialogue)*

9. Can a mail order pharmacy ship a beneficiary's nebulizer drugs prior to the end of their utilization period?

   ANSWER: Yes, the claim processing department take into account that an order may be shipped before the date by which the prior order should be used up, up to 7 days, to make sure the patient has the refill before their supply is exhausted.

10. If a supplier has a prescription for a nebulizer with a length of need of lifetime does the supplier need to obtain a new order every twelve months?

    ANSWER: A new order is required: 1) When there is a change in the order for the accessory, supply, drug etc.; 2) On a regular basis (even if there is no change in the order) only if it is so specified in the Documentation section of a particular medical policy; 3) When an item is replaced; and 4) When there is a change of supplier.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

Reason for Submission:
- ❑ New EFT Authorization
- ❑ Revision to Current Authorization *(i.e. account or bank changes)*
- ❑ EFT Termination Request

Chain Home Office:
- ❑ Check here if EFT payment is being made to the Home Office of Chain Organization *(Attach letter Authorizing EFT payment to Chain Home Office)*

Physician/Provider/Supplier Information

Physician's Name _____

Provider/Supplier Legal Business Name _____

_____

Chain Organization Name _____

Home Office Legal Business Name *(if different from Chain Organization Name)* _____

_____

Tax ID Number: *(Designate SSN* ❑ *or EIN* ❑*)* __ __ __ __ __ __ __ __ __

Doing Business As Name _____

Medicare Identification Number *(OSCAR, UPIN, or NSC only)* _____

Depository Information (Financial Institution)

Depository Name _____

Account Holder's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number *(nine digit)* __ __ __ __ __ __ __ __ __

Depositor Account Number _____

Type of Account *(check one)* ❑ Checking Account ❑ Savings Account

Please include a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead with this agreement for verification of your account number.

Authorization

I hereby authorize the Medicare contractor, _____, hereinafter called the COMPANY, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the said Physician/Provider/Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

FORM CMS-588 (09/03)

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it. The COMPANY will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the COMPANY an updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name *(Print)* _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature _____ Date _____

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

Furnishing information is voluntary, but without it we will not be able to process your electronic funds transfer.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

Instructions for Completing the Authorization Agreement for EFT

The following instructions will guide you through the EFT Authorization process. If you are submitting multiple requests, a separate Authorization Agreement must be completed for each provider identification number (OSCAR, UPIN, or NSC). All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made. In the meantime, all payments will be mailed via hard copy checks directly to the "Pay To" address that the Medicare contractor currently has on file. Please contact the Provider Enrollment Unit to verify the "Pay To" address. This agreement must be completely filled out. Omission of any information will delay the processing of your request. If you have any questions, please contact your Medicare contractor. For a list of contractors see www.cms.hhs.gov/providers/enrollment/contacts/.

Please indicate your reason for completing this form: New EFT authorization; Change to your account information; or Termination of your EFT authorization.

If you are authorizing EFT payments to the Home Office of a Chain Organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the Home Office of the Chain Organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

Enter the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier as reported to the Internal Revenue Service (IRS). The account to which EFT payments are made must exclusively bear the Name of the Physician or Individual Practitioner, or the Legal Business Name of the person or entity enrolled with Medicare.

For EFT payments to the Home Office of a Chain Organization, the depository account must be established in the legal business name of the Home Office, and must match the Home Office name provided above on this form, as well as the Home Office name provided in the appropriate sections of the relevant Form CMS-855 (Provider/Supplier Enrollment Application).

Enter your Tax Identification Number as reported to the IRS. If the business is a corporation, provide the Federal Employer Identification Number (EIN), otherwise provide your SSN.

Enter your Medicare Identification Number. If you are a Part A Provider, or certified Supplier this will be your 6-digit OSCAR number. If you are enrolled as an individual practitioner or a group practice this will be the 6-position alphanumeric UPIN. If you are enrolled as a supplier of durable medical equipment, this will be the 10-digit National Supplier Clearinghouse number.

Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds), address, name of a contact person, and contact person's telephone number.

Enter your electronic Routing Transit Number, Account Number, and the type of account in which deposits will be made (Checking or Saving). Attach a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead for verification of your account number. The documentation on bank letterhead should confirm the name on the account, electronic routing transit number, account number and type, and the bank officer's name and signature.

If you do not submit this information, your EFT Authorization Agreement will be returned without further processing.

Read the Authorization carefully. By your signature on this form you are certifying:

1. That the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier;
2. The Physician/Provider/Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions;
3. That all arrangements between the depository and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions;
4. The effective date of the EFT authorization; and
5. That you will notify the Medicare contractor regarding any changes in the account in sufficient time to allow the contractor and the depository to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on Form CMS-855 which the Medicare contractor has on file.

Mail this form with the original signature (no Fax signatures can be accepted) to the Medicare Contractor that services your geographical area. For a listing of contractors, see www.cms.hhs.gov/providers/enrollment/contacts/.

DMERC Region D Publications Designation Form

DMERC Region D quarterly publications are distributed via Internet (www.cignamedicare.com) and CD-ROM. The CD-ROM includes the *DMERC Dialogue*, *DMERC Region D Supplier Manual* and update and various other supplier resources. Suppliers may choose to receive a paper copy of the *DMERC Dialogue* only in lieu of a CD-ROM.

Suppliers with multiple sites and supplier numbers may choose to eliminate publication distribution to some or all of the sites by designating that one CD-ROM be mailed to the supplier's corporate address. The CD-ROM will be mailed to the designated "Mail To" address for the corporate office on the supplier's enrollment application.

Complete the applicable section(s) below to **change** the method of publications distribution preferred. You may also submit your request in writing on your company letterhead to: CIGNA Government Services, Communications Department, Two Vantage Way, Nashville, TN 37228 or by fax: 615.782.4445.

Request for Paper Copy – DMERC Dialogue (Opt-Out of CD-ROM distribution)

_____
SUPPLIER NUMBER

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

Reason for requesting paper version:
- ☐ No personal computer
- ☐ No CD-ROM drive
- ☐ Prefer paper copy
- ☐ Other _____

(List additional supplier numbers to be included in this request on the back of this form.)

Request for CD-ROM (Opt-In or return to CD-ROM distribution)

_____
SUPPLIER NUMBER

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

(List additional supplier numbers to be included in this request on the back of this form.)

Request for elimination of CD-ROM distribution to multiple sites-Corporate address designation

_____
SUPPLIER NUMBER TO REMAIN ON PUBLICATIONS MAIL LIST

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

- ☐ Eliminate CD-ROM for all supplier numbers with the same "mail to" address shown on this form. [When this option is selected all newly assigned supplier numbers will be included in this request.]
- ☐ Eliminate CD-ROM only for the supplier numbers listed on the back of this form.

(List supplier numbers to be excluded from the publications mail list on the back of this form.)

DMERC Region D Publications Designation Form (cont'd)

List additional supplier numbers to be included in the request on the front of this form.

SUPPLIER NUMBER(S):

SUPPLIER NUMBER(S):

The privacy of our customers is important to CIGNA Government Services. Personally identifying information that is collected will be used only in connection with the specified request. CIGNA Government Services will protect all personally identifying information, sensitive and non-sensitive, that you share with us.

DMERC Region D Publication Order Form

Name:

Company Name:

Address:

City:	**State:**	**Zip:**

Email:

Note: Government agencies, state associations, CMS, CIGNA employees and other insurance companies do not need to submit payment.

Subscription (4 quarterly publications) $40.00

Region D *DMERC Dialogue*_____ (quantity) ***Subtotal*** **$_____**

CD-ROM _____ (quantity) (Includes *DMERC Dialogue*, *DMERC Region D Supplier Manual* and updates and various other materials.) ***Subtotal*** **$_____**

Individual Publication Requests

Region D *DMERC Dialogue** **($10.00 each issue)** (*Previous issues may include the supplier manual update.)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

CD-ROM ($10.00 each)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

DMERC Region D Supplier Manual
$40.00 per manual _____(quantity) ***Subtotal*** **$_____**

DMERC Region D Supplier Manual Update* **($10.00 each)** (*Previous updates may include the *DMERC Dialogue*.)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

NOTE: Beginning Spring 2003, hardcopies of supplier manual updates are no longer mailed and must be downloaded from our Web site at http://www.cignagovernmentservices.com/dmerc/dmsm/index.html. (Also, hardcopies are not available for the Summer and Fall 2002 updates, please download from the Web.)

DMERC DMEPOS Fee Schedule* ($10.00 each) (*DMERC DMEPOS suppliers do not need to submit payment for the fee schedule unless ordering more than one copy.)

Quantity_____ Year _____ ***Subtotal*** **$_____**

Total Amount Due **$_____**

Payment/Order Information

Checks or money orders should be made payable to CIGNA Government Services. Send completed order form and payment to:

Connecticut General Life Insurance Company
Attn: DMERC Publication Fulfillment Center
P. O. Box 360295
Pittsburgh, PA 15251-0295

If your order does not require a payment, send the completed order form to:

CIGNA Government Services
Attn: DMERC Region D Publications
P. O. Box 690
Nashville, TN 37202

If you have not billed CIGNA Government Services within the last 12 months, you will not be included on the current publication mailing list and will not receive your complementary CD-ROM or hardcopy *DMERC Dialogue*. Region D publications are available at http://www.cignagovernmentservices.com/dmerc/index.html.

(Rev. 07/2005)

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Customer Service Available

Telephone Inquiries—Customer Service Agents are available from 8:00 am to 5:30 pm CST, Monday through Friday. The Interactive Voice Response (IVR) System is available any time as long as the mainframe system is functional.

IVR System*:* 877.320.0390 ***Supplier Help Line****:* 866.243.7272 ***Beneficiary Help Line****:* 1-800-MEDICARE (1-800-633-4227, Ask for Medical Supplies)

Paper Claim Submission & Written Inquiries:
CIGNA Government Services
DMERC Region D
PO Box 690
Nashville TN 37202

Review Requests:
CIGNA Government Services
DMERC Reviews
PO Box 22995
Nashville TN 37202

Hearing Requests:
CIGNA Government Services
DMERC Hearings
PO Box 22263
Nashville TN 37202

Local Medical Review Policies (LMRPs), Local Coverage Determinations (LCDs), and Policy Articles

LMRPs, LCDs and Policy Articles are available to view and download on the CIGNA Government Services Web site (http://www.cignagovernmentservices.com/dmerc/lmrp_lcd/index.html) and the Centers for Medicare & Medicaid Services (CMS) Web site (http://www.cms.hhs.gov/coverage). Region D maintains paper copies of current, previously revised, or retired policies. Paper copies of policies are available upon request by writing to: CIGNA Government Services, DMERC Region D, ATTN: Elesha Campbell, P.O. Box 690, Nashville, TN 37202; or call 866.243.7272.

Requests may also be made by contacting the CIGNA Government Services Online Help Center at http://www.cignagovernmentservices.com/dmerc/resource.html. Requests for retired policies must include the name of the policy and the date the desired policy was in effect. In addition, you must provide a contact name, phone number and an address to which the policy may be mailed. CIGNA Government Services regrets we will not be able to fax or e-mail copies of the retired policies to the requester.

Supplier Application Packages and Changes of Address—If you need a supplier number application package or if you have questions concerning supplier number requirements, contact the National Supplier Clearinghouse (NSC) at the following: National Supplier Clearinghouse, PO Box 100142, Columbia SC 29202-3142, Phone: 866.238.9652, Web site: www.palmettogba.com.

Also, remember that no checks will be issued if the address on file with the NSC is different than any forwarding order on file with the U.S. Postal Service. Please notify the NSC if you have an address change or are planning to move in the near future.

EDI—For information on implementing electronic claim transmission, including testing procedures, call our EDI representatives at 866.224.3094, or send us e-mail at www.cignagovernmentservices.com/customer_service.

Coding Questions—The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) answers coding questions. Call 877.735.1326.

Overpayments/Refunds—When refunding a check, make it payable to CGLIC - Medicare and send it to:

CIGNA Federal Insurance Benefits—DMERC
PO Box 10927
Newark NJ 07193–0927

DMERC Dialogue *...a service of*

CIGNA Government Services
DMERC Region D
PO Box 690
Nashville TN 37202

Region D DMERC Serves. . .

Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

The *DMERC Dialogue*, together with occasional special releases, serves as legal notice to suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

CIGNA Government Services does not review or control the content and accuracy of Web sites referenced in this newsletter (except the CIGNA Government Services Web site) and is therefore not responsible for their content and accuracy.