Jurisdiction D News from Noridian Administrative Services, LLC.

Happenings

December 2006
Issue No. 1

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

Introducing Jurisdiction D Happenings

"Jurisdiction D Happenings" is the name of the Jurisdiction D DME Medicare Administrative Contract bulletin or newsletter. The bulletin will contain educational material, claim submissions reminders, reimbursement and coverage updates and much more for suppliers in Jurisdiction D. Jurisdiction D encompasses the states of Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, N. Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming.

Jurisdiction D Happenings will be available on our DME web site, www.noridianmedicare.com, in the News and Publications section approximately every six weeks in a PDF format. The bulletin will also include a Table of Contents that is both alphabetized and sorted by topic to allow for quick access to information.

Suppliers who have completed paperwork in the past to receive a hard-copy bulletin will continue to receive a hardcopy bulletin four times a year. At this time, NAS is not requiring new paperwork to be completed. The quarterly mailing will include two issues of Jurisdiction D Happenings.

We hope that you will find Jurisdiction D Happenings to be an informative and educational tool.

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Jurisdiction D DME MAC Supplier Contacts and Resources

Phone Numbers

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

Web site: www.noridianmedicare.com

Mailing Addresses

Claims, Redetermination Requests and Correspondence
Noridian Administrative Services
PO Box 6727
Fargo ND 58108-6727

Electronic Funds Transfer Forms
Noridian Administrative Services
PO Box 6728
Fargo ND 58108-6728

Administrative Simplification Compliance Act Exception Requests
Noridian Administrative Services
PO Box 6736
Fargo ND 58108-6737
Fax: 888-523-8449

Benefit Protection
Noridian Administrative Services
Benefit Protection – DME
PO Box 6736
Fargo ND 58108-6736

Electronic Data Interchange
CIGNA Government Services
Attn: DMERC EDI
PO Box 690
Nashville TN 37202

Program Safeguard Contractor
Medical Review
IntegriGuard, LLC
2121 N 117 Avenue Suite 200
Omaha NE 68164
Fax: 402-498-2306

Reconsiderations and Administrative Law Judge Requests

Qualified Independent Contractor

Mailing Address
River Trust Solutions, Inc
PO Box 180208
Chattanooga, TN 37401-7208

Courier Address
River Trust Solutions, Inc
801 Pine Street
Chattanooga, TN 37402

Other DME MACs

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

Other Resources

Statistical Analysis DMERC	1-877-735-1326	www.palmettobga.com
National Supplier Clearinghouse	1-866-238-9652	www.palmettogba.com
Centers for Medicare & Medicaid Services		www.cms.hhs.gov

Holiday Schedule

Holiday schedule remaining for 2006:

Christmas Day .....December 25, 2006

Holiday Schedule for 2007:

New Years Day .....January 1, 2007
Martin Luther King Day* .....January 15, 2007
Presidents Day* .....February 19, 2007
Good Friday.....April 6, 2007
Memorial Day.....May 28, 2007
Independence Day .....July 4, 2007
Labor Day ..... September 3, 2007
Columbus Day* .....October 8, 2007
Veterans Day*..... November 12 (Observed)
Thanksgiving .....November 22 and 23
Christmas Day .....December 24 and 25

* The Federal Holidays, noted with an * are days that our contact center will be closed for receiving incoming calls. The contact center staff will be attending internal training and it may be possible that our staff could contact you on these days in regards to claims processing or education issues.

Contractor Number for Jurisdiction D DME MAC

Effective September 30, 2006, the contractor number assigned to the Jurisdiction D DME Medicare Administrative Contractor workload is 19003. Claims for Jurisdiction D are processed by Noridian Administrative Services for the following states and territories: Alaska, American Samoa Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, N. Mariana Islands, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington and Wyoming.

Education regarding this change was provided through implementation newsletters and the transition page on our Web site, specifically for electronic transactions.

Source: Transmittal 237, Change Request 5279, dated September 15, 2006

CMS Strengthens Emergency Preparedness Communications

The CMS is working to strengthen its emergency preparedness communications infrastructure for the nation's health care providers. As part of this emphasis, CMS is encouraging all health care providers to subscribe to their contractor's listserv in order to remain informed in case of either a regional or national emergency.

The listserv subscription form for Jursidiction D DME suppliers is located at: www.noridianmedicare.com/secure/dme/list_dme_eform.html. This communication tool is an effective and rapid way to disseminate critical information in the case of a regional or national emergency. CMS also recommends that at least one alternate employee subscribes to this listserv as a backup.

Source: Transmittal 239, Change Request 5336, dated September 29, 2006

CMS Mailing Lists

The CMS electronic mailing lists can help you with your business! Also referred to as listservs, subscribing to these electronic mailing lists enables you to receive e-mails about the latest CMS Fee-for-Service (FFS) initiatives, regulations, and policy changes.

For additional information, visit the Medicare Learning Network (MLN) website (www.cms.hhs.gov/MLNGenInfo) for official CMS educational products and information for FFS Medicare providers. We encourage you to obtain copies of fact sheets/brochures from the MLN website to use as handouts at your association conferences, etc. Hardcopies can also be ordered by going to the MLN Products Ordering Page at: http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 and then click on the first item under "Informational Resources".

For more details about the CMS Electronic Mailing Lists, download the Fact Sheet from the following url: www.cms.hhs.gov/MLNProducts/downloads/MailingLists_FactSheet.pdf.

DMEPOS Competitive Bidding Implementation Contract Awarded

The Centers for Medicare & Medicaid Services recently announced the award of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Implementation Contract (CBIC) to Palmetto GBA. Awarding this contract is a key step in the timely implementation of the Medicare DMEPOS Competitive Bidding Program. Palmetto GBA will conduct certain functions related to the Medicare DMEPOS Competitive Bidding program, such as preparing the request for bids, performing bid evaluations, selecting qualified suppliers and setting payments for all competitive bidding areas. In addition, Palmetto GBA will be responsible for overseeing an education program for beneficiaries, suppliers and referral agents. Palmetto GBA will also assist CMS and its contractors in monitoring program effectiveness, access and quality.

The proposed rule on the Medicare DMEPOS Competitive Bidding Program was published in the May 1, 2006, Federal Register. The final rule is expected to be issued later this year. Also, the statute requires competition under the program to be phased in beginning in 2007.

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

Further information and instruction on how to submit a change of information may be found by visiting the NSC Web site, www.palmettogba.com/nsc, and by following this path: Supplier Enrollment/Change of Information/Change of Information Guide.

Suppliers with questions regarding changes of information should contact the NSC Customer Service Line at (866) 238-9652.

IVR User Guide

The Interactive Voice Response user guide has been posted to the Contact section of the NAS DME Web site. This guide can be viewed and printed by selecting the IVR User Guide link under the heading "Phone and Mail Contact Information". This guide provides details on how speak commands into the IVR system and enter commands using the telephone keypad. In addition, this guide outlines what information is needed to use the IVR system and what information can be obtained from this system.

Sources for "Jurisdiction D Happenings" Articles

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

Medicare Deductible, Coinsurance and Premium Rates for 2007

MLN Matters Number: MM5345
Related Change Request (CR) #: 5345
Related CR Release Date: October 27, 2006
Related CR Transmittal #: R41GI
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

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

Provider Action Needed
This article is based on Change Request (CR) 5345 which announces the 2007 Medicare rates and instructs your Medicare contractors to make necessary updates to their claims processing systems.

Background
There are beneficiary-related costs for using certain services under Parts A and B of Medicare, typically in the form of deductibles, co-payments, and/or premium payments. Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements. A beneficiary is 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 in a spell of illness.

When a beneficiary receives such services for **more than 60 days** 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.

An individual has 60 lifetime reserve days (LRDs) of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these LRDs is equal to one-half of the inpatient hospital deductible.

For Skilled Nursing Facility (SNF) services furnished during a spell of illness, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day.

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 occurs more than 12 months after the date a person is initial eligibility to enroll, a 10 percent penalty is assessed for 2 years for every year they could have enrolled and failed to enroll in Part A.

Under Supplementary Medical Insurance (SMI) or Part B,

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.

Medicare Part A for 2007
For Calendar Year (CY) 2007, the following rates are applicable for Medicare Part A Deductible, Coinsurance, and Premium amounts:

Deductible	$992.00 per benefit period

Coinsurance	$248.00 a day for days 61-90 in each period
	$496.00 a day for days 91-150 for each LRD used
	$124.00 a day in a SNF for days 21-100 in each benefit period

Premium	$410.00 per month for those who must pay a premium
	$451.00 per month for those who must pay both a premium and a 10 % increase
	$226.00 per month for those who have 30-39 quarters of coverage
	$248.60 per month for those who have 30-39 quarters of coverage and must pay a 10 % increase

Medicare Part B for 2007
For CY 2007, the following rates are applicable for Medicare Part B Deductible and Coinsurance :

Deductible	$131.00 per year
Coinsurance	20 percent

CMS updates the Part B premium each year. These adjustments are made according to formulas set by statute. By law, the monthly Part B premium must be sufficient to cover 25 percent of the program's costs, including the costs of maintaining a reserve against unexpected spending increases. The federal government pays the remaining 75 percent.

Below are the annual Part B premium amounts from Calendar Year (CY) 1996 to 2006. For these years, and years prior to 1996, the Part B premium is a single established rate for all beneficiaries.

Year	Part B Premium
1996	$42.50
1997	$43.80
1998	$43.80
1999	$45.50

Year	Part B Premium
2000	$45.50
2001	$50.00
2002	$54.00
2003	$58.70

Year	Part B Premium
2004	$66.60
2005	$78.20
2006	**$88.50**

Beginning on January 1, 2007, the Part B premium will be based on the income of the beneficiary. Below are the CY 2007 **Part B premium amounts based on beneficiary income parameters.**

Income Parameters for Determining Part B Premium		
Premium/month	**Individual Income**	**Combined Income (Married)**
$ 93.50	$ 80,000.00 or less	$160,000.00 or less
$105.80	$ 80,000.01 - $100,000.00	$160,000.01 - $200,000.00
$124.40	$100,000.01 - $150,000.00	$200,000.01 - $300,000.00
$142.90	$150,000.01 - $200,000.00	$300,000.01 - $400,000.00
$161.40	$200,000.01 or more	$400,000.01 or more

New Site for Medicare Provider Service Toll Free Numbers

MLN Matters Number: SE0655

Provider Types Affected
All Medicare physicians, providers, and suppliers

Impact on Providers
This article is mainly for informational purposes and discusses a new and more convenient web address and site that houses toll-free numbers that physicians, providers, and suppliers can use to contact their Medicare contractor (carriers, including durable medical equipment (DME) regional carriers and DME Medicare administrative contractors (DME MACs), and fiscal intermediaries, including regional home health intermediaries (RHHIs).

Background
The Centers for Medicare & Medicaid Services (CMS) is pleased to announce to all Medicare physicians, providers, and suppliers a new and improved web site for accessing Medicare Contractor Provider Call Center toll-free number information. The new site is located at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS web site.

This change is a result of replacing the previous "Provider Call Center Toll-Free Numbers Directory" (with map) document with an Excel® file that contains all of the information previously available plus many improvements.

The original document proved difficult to update and download while keeping the functionality of the map intact. The new Excel's smaller file size allows for a significantly faster download, and the improved functionality, provided by the pull-down menus, makes more targeted contact information available while filtering the displays appearing on the screen.

Additionally, a "Coverage Area" column has been added to the original four columns of information (i.e., State Served, Call Center, Program, and Toll-Free Number) and each column has a menu allowing users to filter the information displayed on the screen. Selecting the menus to "ALL" resets the spreadsheet to display all available information.

Many of the existing MLN Matters articles contain links to the previous map document, which was http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf on the CMS web site. As you can see, the new address is almost identical, except for the last three characters, "*pdf*," which are now "*zip*."

Please be aware that articles already housed on the MLN Matters pages will not be updated with the new link, except where such articles are revised in the future for other reasons. However, those providers who have been using the map document directory should already know where to find it within the CMS website and should, therefore, be able to locate the new document.

The directory is also prominent on all MLN pages and should be easy to find. In fact, now might be a good time to bookmark the new address or add it to your "Favorites" list: http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip.

The new spreadsheet directory will be updated approximately once every three months—more often if necessary.

As previously mentioned, you can access the new file from all major MLN web pages, including the main section pages at:
http://www.cms.hhs.gov/MLNGenInfo/
http://www.cms.hhs.gov/MLNProducts/
http://www.cms.hhs.gov/MLNMattersArticles/
http://www.cms.hhs.gov/MLNEdWebGuide/

The new file can be downloaded directly from http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS web site.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

MLN Matters Number: MM5212
Related Change Request (CR) #: 5212
Related CR Release Date: August 18, 2006
Related CR Transmittal #: R1031CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Provider Types Affected
Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), Medicare carriers, including durable medical equipment regional carriers (DMERCs) and Durable Medical Equipment Medicare Administrative Contracts (DME MACs).

Provider Action Needed
The November 2005 through February 2006 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes (RARCs) and the X12N 835 Health Care Claim Adjustment Reason codes (CARCs).

The Centers for Medicare & Medicaid Services (CMS) has developed a new web site located at http://www.cmsremarkcodes.info/ on the CMS website, to provide information and help navigate the RARC database more easily. A helpful search tool is provided at this site if you need to find a specific category of code. This new website does not replace the Washington Publishing Company (WPC) web site, http://www.wpc-edi.com/codes, as the official site where the most current RARC list resides. Use the list posted at the **WPC web site** if there are any discrepancies between code text listed either on the new web site or in this article, and the code text provided on the WPC web site.

Please refer to the *Background* section of this article for a summary of the RARC and CARC code text changes.

Background
Among the codes sets mentioned in the Implementation Guide for transaction 835 (Health Care Claim Payment/Advice), the following two code sets must be used to report payment adjustments and related information for transaction 835 and the standard paper remittance advice for Medicare:

- Claim Adjustment Reason Code (CARC); and
- Remittance Advice Remark Code (RARC).

Additionally, for the coordination of benefits (COB) transaction (837), the CARC must be used.

Both of these code sets are updated three times a year, and Medicare issues recurring Change Requests (CRs) that capture the changes in these code sets that have been approved in the previous four months.

Summary of Current Updates (November 1, 2005 – February 28, 2006 Changes)
Remark Code (RARC) Changes
New: The following code table reflects new remark codes:

New Code	Current Narrative
N365	This procedure code is not payable. It is for reporting/information purposes only.
N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.
N367	The claim information has been forwarded to a Health Savings Account processor for review.
N368	You must appeal the determination of the previously adjudicated claim.
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.

Modified: Remark Code **MA02** was modified effective December 29, 2005. Its modified narrative is:

"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."

This modification is effective January 1, 2006, and was implemented on or before May 17, 2006.

Deactivated: Code **MA03** was deactivated effective October 1, 2006. Remark code MA02 may be used instead.

Reason Code (CARC) Changes
New: The following table reflects new reason codes:

New Code	Current Narrative	New as of:
193	Original payment decision is being maintained. This claim was processed properly the first time.	February 2006
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician.	February 2006
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service	February 2006

Additional Information
CR5212 is the official instruction issued to your Medicare carrier/DMERC/FI/RHHI regarding changes mentioned in this article. CR5212 may be found at http://www.cms.hhs.gov/Transmittals/downloads/R1031CP.pdf on the CMS web site.

CMS Announces Part D Low Income Subsidy Redetermination Information

MLN Matters Number: SE0668

Provider Types Affected
Physicians, suppliers, providers, and their staff who serve Medicare beneficiaries.

Background
The purpose of this Special Edition (SE) article is to alert providers that Medicare and Social Security are making decisions about whether some people who qualify for extra help (also referred to as the low-income subsidy) in 2006 will continue to qualify in 2007. People affected by these changes will receive information from Medicare or Social Security. The information provided in this SE is intended to help you counsel your patients affected by these changes and help them understand their options for getting help paying for Medicare prescription drug coverage.

Key Points

CHANGES IN QUALIFYING FOR EXTRA HELP IN 2007

A person will no longer **automatically** qualify for extra help in 2007 if he or she no longer:

- Has both Medicare and Medicaid (full-benefit dual-eligible),
- Belongs to a Medicare Savings Program (partial dual-eligible), or
- Receives Supplemental Security Income (SSI) benefits.

People who will no longer automatically qualify for extra help in 2007 will receive a notice and an application for extra help in the mail from Medicare by the end of September.

If in the coming months a person's situation changes so that they again automatically qualify for extra help, Medicare will send them another notice letting them know that they qualify.

Medicare is also mailing notices to people who will continue to automatically qualify for extra help in 2007 but whose copayment levels will change as of January 1, 2007. Medicare will mail these notices by early October to let people know their new copayment level. A change in co-payment level could result when there is a change in someone's Medicaid eligibility.

For example, if someone with both Medicare and Medicaid no longer resides in a nursing home, then he or she will no longer qualify for a $0 co-payment effective January 1, 2007.

People with no changes who continue to automatically qualify for extra help as of January 1, 2007, will not receive a notice.

BENEFICIARIES MIGHT STILL SAVE ON THEIR MEDICARE PRESCRIPTION DRUG COVERAGE COSTS EVEN IF THEY DON'T QUALIFY FOR EXTRA HELP

The good news is, even if a person no longer automatically qualifies for extra help, they may still be able to save on Medicare prescription drug coverage costs. A person who no longer automatically qualifies may still qualify for extra help based on their income and resources, but will need to apply to Social Security or their State Medical Assistance (Medicaid) office to find out. Applying early is important so their extra help can be effective as early as January 1, 2007. Social Security's application for extra help and a self-addressed postage free envelope will be included in the mailing they receive. And if they don't qualify, there are still other ways to save on drug costs, as mentioned below.

A person should **apply and qualify** for extra help if

- Yearly income is less than $14,700 (single) or $19,800 (married and living with their spouse), and
- Resources are less than $11,500 (single) or $23,000 (married and living with their spouse). Resources include savings and stocks but not home or car.

The above amounts are for 2006 and may change in 2007. If a beneficiary lives in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

HOW TO APPLY FOR EXTRA HELP

Use the web, phone, mail, or in person but apply as soon as possible:

- Apply for extra help online through Social Security at: www.socialsecurity.gov/ on the web. To apply by phone, get a paper application mailed, or make an appointment at the local Social Security office, call 1-800-772-1213. TTY users should call 1-800-325-0778.
- To apply for extra help through the State Medical Assistance (Medicaid) office, visit www.medicare.gov/ or call 1-800-MEDICARE (1-800-633-4227) for their telephone number. TTY users should call 1-877-486-2048.
- Remind beneficiaries to apply or reapply for extra help if income and/or resources change.

If patients still don't qualify for extra help, encourage them to review the following options for lowering prescription drug coverage costs:

- The state may have programs that provide help paying prescription drug costs. The patient should contact their State Medical Assistance (Medicaid) office for more information. They can call 1-800-MEDICARE or visit www.medicare.gov/ for the Medicaid telephone number.
- There may be Medicare drug plans available in your area for 2007 with no premiums and no deductibles. Encourage patients to compare these plans to their current plan. New Medicare drug plans can begin advertising as of October 1. Beneficiaries have the opportunity to switch Medicare drug plans from November 15 through December 31 each year. New coverage would begin January 1 of the following year.

Encourage patients to enroll early. If they're switching plans, joining the new Medicare drug plan as soon as possible gives the plan time to mail a membership card, acknowledgement letter, and welcome package before the new coverage becomes effective.

People who applied and qualified for extra help in 2006

The Social Security Administration (SSA) is reviewing the eligibility of people who applied and qualified for extra help prior to May 2006. This review will ensure these people are still eligible and receiving the appropriate amount of extra help. SSA mailed these individuals a letter at the end of August telling them what Social Security's records show for their income, resources and household size. A cost of living increase in their Social Security benefit will not be considered a change in their situation.

- People who have no changes to their income, resources or household size should do nothing.
- People who have any changes to their income, resources, or household size will need to return a one-page letter (L1026) in the envelope enclosed with the mailing within 15 days. SSA will then mail them a form called "Social Security Administration Review of Your Eligibility for Extra Help" (Form 1026B). If these individuals fill out and return the form within 30 days, any change to the amount of extra help they qualify for will be effective in January 2007 unless their marital status changed. Changes in marital status may result in changes to the amount of extra help in the following month.

SSA will also send the eligibility review form (1026B) directly to some people to complete because SSA already has information about a change in their income, resources or household composition. The Medicare beneficiary needs to return that form to the SSA within 30 days.

SSA will review the eligibility review form (1026B) and send the person a letter explaining its decision. SSA may decide a person:

- Has no change in the amount of extra help they receive, or
- Has an increase in the amount of extra help they receive, or
- Has a decrease in the amount of extra help they receive, or
- No longer qualifies for extra help.

If a beneficiary believes that SSA's decision is incorrect, they have the right to appeal it. The decision letter will explain their appeal rights. The following web links at the SSA website provide more information:

- Fact Sheet— www.socialsecurity.gov/pubs/10111.html
- Mailing (L1026) www.ssa.gov/prescriptionhelp/L1026%20Passive%20Redetermination%20English%20SAMPLE%20_08-25-06%20Systems_.pdf on the Social Security website.
- "Social Security Administration Review of Your Eligibility for Extra Help" (1026B) www.ssa.gov/prescriptionhelp/SSA-1026B-OCR-SM-INST.pdf

Top Reasons for Education Status Letters

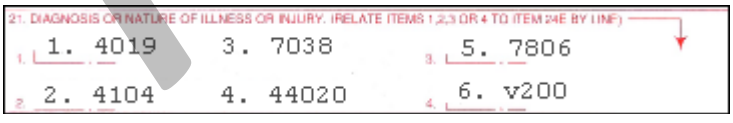
It is very important for suppliers to follow proper claim submission guidelines. NAS sends an Education Status letter for each unprocessable paper claim received. The letter provides the claim control number, the patient's name, Health Insurance Claim Number and the date(s) of service to identify which claim could not be processed. The original claim will not be returned.

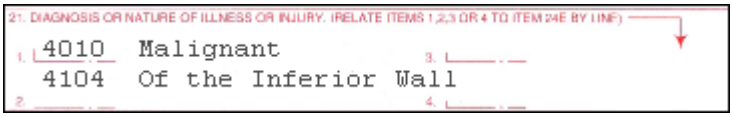
Below are the top four reasons Education Status letters are sent, along with helpful hints on ways to reduce or eliminate these top claim errors. Comprehensive CMS 1500 claim form instructions can be found in the Claims section of our website.

1. Description in Item 21-Diagnosis

- Enter the patient's diagnosis/condition. **Enter the diagnosis code only, not the description.**
- Enter up to four codes in priority order.

Below are examples of **incorrect** diagnosis placement in Item 21.



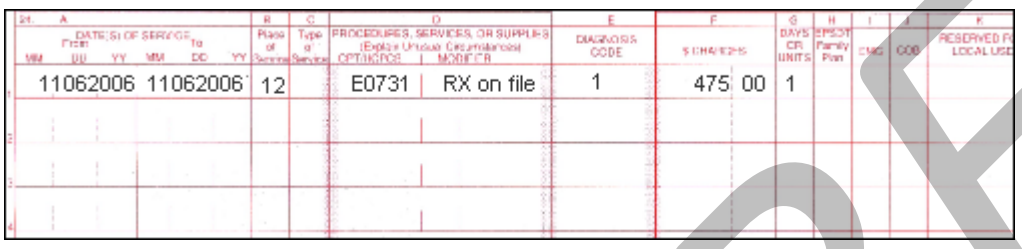


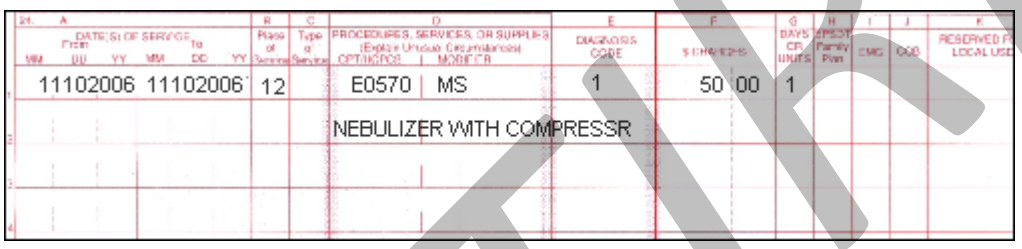
Below is an example of **correct** diagnosis code placement in Item 21.

2. Description in Item 24D-HCPCS/Modifier

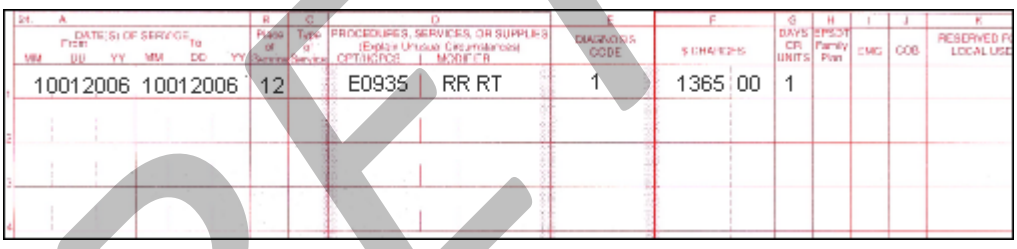
- Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code.
- Enter the specific procedure code **without** a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in Item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim.
- Modifiers must be two alpha/numeric characters. **Do not place extra narrative after or under the procedure code.**

Below are examples of **incorrect** reporting in Item 24D.





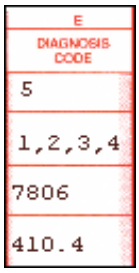
Below is an example of **correct** reporting in Item 24D.



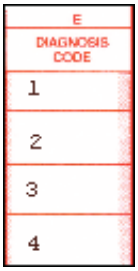
3. Diagnosis Pointer in Item 24E

- Enter the diagnosis code reference number as shown in Item 21 to relate the date of service and the procedures performed to the primary diagnosis. **Enter only one reference number per item.** When multiple services are performed, enter the primary reference number for each service, **either a 1, or a 2, or a 3, or a 4.**
- If a situation arises where two or more diagnoses are required for a procedure code, the supplier must reference only one of the diagnoses in Item 21.
- Place only a single diagnosis pointer on each line. The actual diagnosis should not be placed in this item. Diagnosis narrative should not be placed in this item.

Below is an example of **incorrect** reporting in Item 24E for the diagnosis pointer.



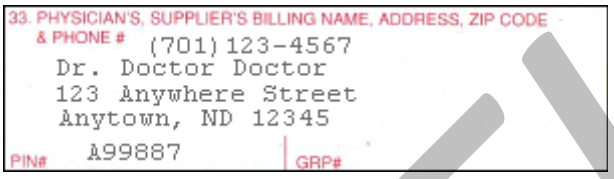
Below is an example of the **correct** reporting of the diagnosis pointer in Item 24E.



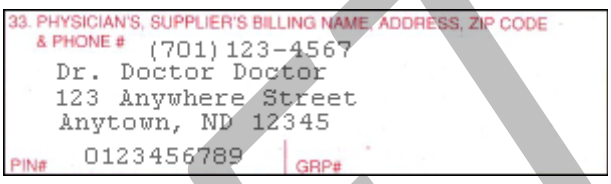
4. Supplier Number in Item 33-Incorrect Format

- Supplier numbers are ten digits as assigned by the National Supplier Clearinghouse. **Do not report an NPI or a UPIN in Item 33 or 24K.**

Below is an example of **incorrect** reporting of the supplier number in Item 33.



Below is an example of **correct** supplier number reporting in Item 33.



Website Satisfaction Survey

The Centers for Medicare & Medicaid Services has contracted with ForeSee Results to conduct web site satisfaction surveys on behalf of Medicare contractors. The surveys are intended to obtain feedback from users of the Noridian Administrative Services web site regarding content, usability, reliability and overall satisfaction.

The ForeSee Results web satisfaction survey will be implemented on the NAS DME web site on November 15, 2006. Following implementation, users navigating the NAS web site will be randomly selected to complete the survey. If you are selected, a pop-up window will appear. If this occurs, we would appreciate you taking a few minutes to provide your feedback. The feedback is anonymous and will help NAS evaluate how well we accomplished our objectives of creating a web site that meets the needs of suppliers.

New Skilled Nursing Facility Information Available

The *Skilled Nursing Facility Consolidated Billing Web-Based Training Course* is now available on the Centers for Medicare & Medicaid Services (CMS) *Medicare Learning Network (MLN)*. The course provides general information about Skilled Nursing Facilities (SNF), SNF Consolidated Billing, and "under arrangement" agreements between SNFs and other providers or suppliers. To access the course, visit www.cms.hhs.gov/mlngeninfo/01_overview.asp, scroll down to "Related Links Inside CMS" and select "Web-Based Training Modules."

The *Skilled Nursing Facility Prospective Payment System Fact Sheet*, which is the first in an upcoming series of payment fact sheets, is now available on the CMS MLN. To access the fact sheet, visit www.cms.hhs.gov/MLNProducts/downloads/snfprospaymtfctsht.pdf. The fact sheet will be available for ordering through the *MLN* in approximately six weeks.

EDUCATIONAL CONT'D.

Upcoming Ask the Contractor Teleconference

NAS will be conducting its final post-implementation Jurisdiction D DME Ask the Contractor Teleconference at 3 pm CT on **Thursday, December 14, 2006**.

During this call, suppliers will have the opportunity to speak directly to NAS on the topic of their choice. NAS will have staff available to listen and respond to supplier issues.

To participate in this ACT, dial 1-800-230-1074. For those suppliers who may need an international number (American Samoa, Guam and Northern Mariana Islands), dial 1-612-234-9959. You will be asked to provide the following:

Conference name (DME MAC Jurisdiction D Ask the Contractor)
Your name
Name of the organization you represent
State/territory from which you are calling

Note: The call will start promptly at 3 pm CT and will last one hour. Suppliers should call in ten-to-fifteen minutes prior to the start of the call. Suppliers do not need to register to attend this call.

CLAIM SUBMISSION

Administrative Simplification Compliance Act Enforcement

The Administrative Simplification Compliance Act (ASCA) prohibits payment of initial health care claims not sent electronically as of October 16, 2003, except in the following limited situations:

- Carrier small providers-To qualify, a supplier that bills Medicare must have fewer than 10 full time equivalent employees;
- Participants in a Medicare demonstration project where paper claim filing is required by that demonstration due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;
- Providers that submit claims to Medicare where more than one other insurer was liable for payment prior to Medicare;
- Providers of 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;
- Those few claims that may be submitted by Medicare beneficiaries;
- Providers that only furnish services outside of the United States;
- Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and
- Providers that can establish that an "unusual circumstance" exists that precludes submission of claims electronically. (An example of an unusual circumstance would be a provider that submits fewer than 10 claims per month to a Medicare contractor on average.)

Note: We have listed only the situations that may apply to DME suppliers. A complete list of situations that apply to all Medicare providers can be found in MLN Matters 3440.

Please note that some of these situations are temporary or apply only to certain claims. When the temporary situation expires or when billing other types of claims, providers must submit their claims or those other types of claims electronically and in the HIPAA standard.

NAS, as the DME Medicare Administrative Contractor for Jurisdiction D, is enforcing ASCA. In late June, over 2,000 Exhibit C (Request for Documentation) letters were sent to paper submitters advising them they either had to provide documentation allowing them to continue submitting paper claims or begin submitting claims electronically. If the supplier did not respond to the Exhibit C letter within 45 days of receipt, the supplier was notified via an Exhibit D letter that Medicare would deny any paper claims submitted ninety days after the date of the initial request letter.

If the supplier responded with information that established eligibility to submit paper claims, they were notified via the Exhibit F letter that they met one or more exception criteria to the ASCA requirements and that they were permitted to continue submitting paper claims.

NAS is currently implementing post-payment enforcement of ASCA by analyzing reports displaying the number of paper claims that all suppliers in Jurisdiction D submit each quarter. By the end of the month following the quarter, selected suppliers who have submitted the highest numbers of paper claims will be reviewed. If you are one of the selected suppliers with a large number of paper claims being submitted under your supplier number, you will receive an Exhibit C (Request for Documentation) letter.

The Exhibit C letter will ask you to respond within 30 days, if you intend to continue submitting paper claims, indicating which of the above-described situations (exceptions) is your basis for continuing to submit paper claims. Include with your response evidence to establish that you qualify for waiver of the electronic filing requirement. For instance, if you are a small supplier, evidence might consist of copies of payroll records for all of your employees that list the number of hours worked. Other examples of good documentation to meet this exception are quarterly worker's compensation or unemployment tax documents. If an office has no employees (sole proprietors), send a copy of the Schedule C used for federal income tax purposes. Identifying information, such as personal information or Social Security numbers, can be blacked out when submitting this documentation.

To apply for an ASCA exception waiver, fax your request and all supporting documentation to 701-433-3463. You can also mail your request to:
Noridian Administrative Services
PO Box 6737
Fargo, ND 58108-6737

If you cannot provide acceptable evidence to substantiate that you are eligible under ASCA guidelines to continue to submit paper claims to Medicare, NAS will begin to deny all paper claims you submit effective with the 91st calendar day after the date of the letter. This decision cannot be appealed.

If you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. The DME MAC can supply you with HIPAA-compliant free billing software for submission of Medicare claims or you can use commercial software that can be used to bill Medicare as well as other insurance companies. To learn more about electronic data interchange and how to get started billing claims electronically, go to the Jurisdiction D EDI web site, at www.cignamedicare.com/edi/dmerc/support.html.

Additional information regarding ASCA enforcement can be found in the Internet Only Manual, Publication 100-04, Chapter 24, Section 90.5 at www.cms.hhs.gov/manuals/downloads/clm104c24.pdf

Important Note: Suppliers do not need to send documentation to NAS proving that an ASCA exception is met until an Exhibit C letter is received. NAS will not accept such documentation until a supplier has been sent an Exhibit C letter.

Revised CMS-1500 Claim Form

MLN Matters Number: MM4293 Revised
Related Change Request (CR) #: 4293
Related CR Release Date: March 31, 2006
Effective Date: See Note below.
Related CR Transmittal #: R899CP
Implementation Date: October 2, 2006

Note: This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR5060, which is available at http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf.

Provider Types Affected
Physicians, providers, and suppliers who are excluded from the mandatory electronic claims submission requirements and submit claims to Medicare carriers using the CMS-1500 paper claim form

Important Points to Remember
CR4293 describes the claim form **CMS-1500 (12-90)** that is being revised to accommodate the reporting of the National Provider Identifier (NPI) and will then be named **CMS-1500 (08-05)**. The following timeline outlines the schedule for using the revised CMS-1500 claim form:

- October 1, 2006: Health plans, clearinghouses, and other information support vendors should be ready to handle and accept the revised CMS-1500 (08/05) claim form.
- October 1, 2006 – January 31, 2007: Providers can use either the current CMS-1500 (12/90) version or the revised CMS-1500 (08/05) version of the claim form.
- February 1, 2007: The current CMS-1500 (12/90) version of the claim form is discontinued; only the revised CMS-1500 (08/05) form is to be used. All rebilling of claims should use the revised CMS-1500 (08/05) form from this date forward, even though earlier submissions may have been on the current CMS-1500 (12/90) claim form.

Background
The Form CMS-1500 form answers the needs of many health insurers. It is the basic form prescribed by the Centers for Medicare & Medicaid Services (CMS) for the Medicare program and is accepted only from physicians and suppliers that are excluded from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32.

The CMS-1500 (12-90) claim form is being revised to accommodate the reporting of the National Provider Identifier (NPI). The intent of the new form is to best accommodate the NPI with minimal changes to the current claim form. The CMS-1500 (08-05) version will be effective October 1, 2006, but will not be mandated for use until February 1, 2007. Therefore, there will be a period when the current and the revised forms will both be acceptable.

The change log that lists the various changes made to the CMS-1500 (08-05) version can be viewed at the National Uniform Claim Committee (NUCC) web site at http://www.nucc.org/images/stories/PDF/change_log.pdf.

Implementation
The implementation date for the instruction is October 2, 2006

Additional Information
The official instructions issued to your Intermediary regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R899CP.pdf on the CMS web site.

You may also wish to review MLN Matters articles:

- **SE0555**, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities" available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0555.pdf on the CMS web site; and/or
- **SE0528**, "CMS Announces the National Provider Identifier (NPI) Enumerator Contractor and Information on Obtaining NPIs" available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0528.pdf on the CMS web site.

Modification of National Provider Identifier Editing Requirements in CR4023 and an Attachment to CR4320

MLN Matters Number: MM5229
Related Change Request (CR) #: 5229
Related CR Release Date: August 18, 2006
Related CR Transmittal #: R234OTN
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Provider Types Affected
Providers, physicians, and suppliers who bill Medicare fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and Medicare carriers including durable medical equipment regional carriers (DMERCs) (or durable medical equipment Medicare administrative contractors (DME MACs) if appropriate)

Provider Action Needed
This article is based on CR5229, which corrects certain business requirements from CR4023 that relate to edits for National Provider Identifiers (NPIs) and provider legacy identifiers when reported on claims, particularly for **referring/ordering or other secondary providers**, effective October 1, 2006 and later. Additionally, CR5229 revises Attachment 1 to CR4320.

Some of those business requirements erroneously assumed that any provider for whom information is reported in a claim, including a referring/ordering or other secondary provider, would need to be enrolled in Medicare and therefore listed in the Medicare Provider Identifier Crosswalk. This is not always the case. CR5229 modifies those business requirements.

These modifications will enable correct processing of affected claims in October 2006 and later, and will avoid the unnecessary rejection of many claims that involve a referring/ordering or other secondary provider. Please refer to the *Background* section of this article and to CR5229 for additional important information regarding these modifications.

Background
The Medicare Learning Network (MLN) articles, MM4023 and MM4320 which are based on CR4023 and CR4320 respectively, contain important information about the stages of the NPI implementation process. Some of this information is updated in the current article. The links to these articles are located in the *Additional Information* section of this article.

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 online at https://nppes.cms.hhs.gov.

During Stage 2 of the NPI implementation process (October 2, 2006 - May 22, 2007), Medicare will utilize a Medicare Provider Identifier Crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and to report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions.

Primary and Secondary Providers
Providers, for NPI provider identifier editing purposes, are categorized as either "primary" or "secondary" providers. Primary providers include billing, pay-to, and rendering providers. Primary providers are required to be enrolled in Medicare for the claim to qualify for payment.

Secondary providers are all other providers for which data could be reported on an institutional (837-I) or professional (837-P), free billing software or direct data entry (DDE) claim, or on a revised CMS-1500 or a UB-04 (once those paper claims are accepted by Medicare). Since the UB-92, the currently used CMS-1500, and the HIPAA NCPDP format do not allow reporting of both NPIs and legacy identifiers, information on secondary providers in those claims is not included in the following requirements. **Secondary providers may be enrolled, but are not required to be enrolled in Medicare** (unless they plan to bill or be paid by Medicare for care rendered to Medicare beneficiaries).

Secondary Provider Claims
Claims Submitted with NPI and Medicare Legacy Identifier: During Stage 2, claim submitters should submit a provider's Medicare legacy identifier whenever reporting an NPI for a provider. Failure to report a Medicare legacy number for a provider enrolled in Medicare could result in a delay in processing of the claim. When an NPI and a legacy identifier are reported for a provider, Medicare contractors will apply the same edits to those numbers that would have been applied if that provider was a primary provider . (See MM4023.)

There are two exceptions:

1. A Medicare contractor cannot edit a surrogate Unique Provider Identification Number (sometimes called a dummy UPIN, such as OTN000). Despite its name, a surrogate is not actually unique for a specific provider.
2. Only a National Supplier Clearinghouse (NSC) identification number or a UPIN should ever be reported as the legacy numbers on a claim sent to a DMERC/DME MAC. If a carrier Provider Identification Number (PIN) is reported as a legacy identifier with an NPI, DMERCs/DME MACs will edit as if the NPI was the only provider identifier reported for that provider.

Claims Submitted with NPI Only:
The NPI is edited to determine if it meets with the physical requirements of the NPI (10 digits, begins with a 1, 2, 3, or 4, and the check digit in the 10th position is correct), and whether there is a Medicare Provider Identifier Crosswalk entry for that NPI.

If the NPI is located in the Crosswalk:

- The Taxpayer Identification Number (TIN) (Employer Identification Number (EIN) or Social Security Number (SSN) and legacy identifier will be sent to the trading partner in addition to the NPI if coordination of benefits (COB) applies.

- However, only the TIN will be forwarded to the COB payer if there is more than one legacy identifier associated with the same NPI in the Medicare Provider Identifier Crosswalk because it may be difficult to know which Medicare legacy identifier applies to that claim.

If the NPI is not located in the Crosswalk:

- No supplemental identifier can be reported to a COB payer.
- However, the claim **will not be rejected** if the NPI for a referring/ordering provider or another secondary provider cannot be located in the Medicare Provider Identifier Crosswalk, with one exception. Reporting of a Medicare legacy identifier other than a surrogate UPIN signifies a provider is enrolled in Medicare. If a Medicare legacy identifier is reported and cannot be located in the Crosswalk, the claim will be rejected, regardless of whether an NPI was reported for that provider.

Claims (including UB-92 or the current CMS-1500 paper claims) submitted with Medicare Legacy Identifier Only

- A Medicare contractor may, but is not required to check a legacy number against the Medicare Provider Identifier Crosswalk.
- As at present, claims will be rejected if any Medicare legacy identifier reported on a claim does not meet the physical requirements (length, if numeric or alphanumeric as applicable) for that type of Medicare provider identifier.

COB and Medigap Trading Partners
Legacy identifiers will not be reported to these trading partners for secondary providers if they are not submitted on the claim sent to Medicare, are surrogate UPINs or if the provider is not enrolled in Medicare. If not enrolled, a legacy identifier or a TIN cannot be sent for a"secondary" provider because Medicare would not have issued a legacy identifier to or collected a TIN from that provider.

837-I or 837-P version 4010A1 Claims
Attachment 1 to CR4320 which is being revised as part of CR5229 addresses (among other issues), the identification of secondary providers for which the 837-I or 837-P version 4010A1 implementation guides only require reporting of an NPI or other identifier "if known." Unless there is a pre-existing Medicare instruction that mandates the reporting of a specific identifier for those "if known" types of providers, there is no requirement for entry of any identifier for those entities/individuals. If there is no such requirement, claims received that lack an identifier for those types of providers will not be denied.

Note that "secondary" providers such as a referring/ordering physician are not required to be enrolled in Medicare as a **condition for payment** of the services or supplies they order, furnish, supervise delivery of, etc. for beneficiaries **when those services are billed, paid-to or rendered by "primary" providers.** For example, Medicare could pay**:**

- A hospital for services ordered for a patient for inpatient hospital care when the admitting or attending physician is not enrolled in Medicare;
- Hospital surgery costs when the surgeon is not enrolled in Medicare; or
- A hospital when services are purchased from another provider "under arrangements" even if that other provider is not enrolled in Medicare.

Additional Information
CR4320, issued February 1, 2006, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms" is located at http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf on the CMS web site.

The associated MLN article (with the same title) MM4320, can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf on the CMS web site.

CR4023, dated November 3, 2005, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms" is located at http://www.cms.hhs.gov/transmittals/downloads/R190OTN.pdf on the CMS web site. MM4023, the associated MLN article, is located at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf on the CMS web site.

CR5229 is the official instruction issued to your Medicare carrier/DMERC (DME MAC if appropriate), FI/RHHI regarding changes mentioned in this article. CR5229 may be found at http://ww.cms.hhs.gov/Transmittals/downloads/R234OTN.pdf on the CMS web site.

Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500

MLN Matters Number: MM5060 Revised
Related Change Request (CR) #: 5060
Related CR Release Date: September 15, 2006
Related CR Transmittal #: R1058CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Note: Page 3 of this article was revised on October 13, 2006, to reflect that the **appropriate NPI** must be entered in certain fields on Form CMS-1500. Previously, the article incorrectly stated the NPI of the billing provider. All other information remains the same.

Provider Types Affected
Physicians and suppliers who bill Medicare carriers including durable medical equipment regional carriers (DMERCs) for their services using the Form CMS-1500.

Key Points

- The Centers for Medicare & Medicaid Services (CMS) is implementing the revised Form CMS-1500, which accommodates the reporting of the National Provider Identifier (NPI).
- The Form CMS-1500 (08-05) version will be effective January 1, 2007, but will not be mandated for use until

April 2, 2007.

- During this transition time there will be a dual acceptability period of the current and the revised forms.
- A major difference between Form CMS-1500 (08-05) and the prior form CMS-1500 is the **split provider identifier fields**.
- The split fields will enable NPI reporting in the fields labeled as NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.
- There will be a period of time where both versions of the CMS-1500 will be accepted (08-05 and 12-90 versions). The dual acceptability timeline period for Form CMS-1500 is as follows:

January 2, 2007 – March 30, 2007	Providers can use either the current Form CMS-1500 (12-90) version or the revised Form CMS-1500 (08-05) version. **Note**: Health plans, clearinghouses, and other information support vendors should be able to handle and accept the revised Form CMS-1500 (08-05) by January 2, 2007.
April 2, 2007	The current Form CMS-1500 (12-90) version of the claim form is discontinued; only the revised Form CMS-1500 (08-05) is to be used. **Note**: All **rebilling** of claims should use the **revised** Form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the current Form CMS-1500 (12-90).

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

Note that a provision in the HIPAA legislation allows for an additional year for small health plans to comply with NPI guidelines. Thus, small plans may need to receive legacy provider numbers on coordination of benefits (COB) transactions through May 23, 2008. CMS will issue requirements for reporting legacy numbers in COB transactions after May 22, 2007.

In a related Change Request, CR4023, CMS required submitters of the Form CMS-1500 (12-90 version) to continue to report Provider Identification Numbers (PINs) and Unique Physician Identification Numbers (UPINs) as applicable.

There were no fields on that version of the form for reporting of NPIs in addition to those legacy identifiers. Change Request 4293 provided guidance for implementing the revised Form CMS-1500 (08-05). This article, based on CR 5060, provides additional Form CMS-1500 (08-05) information for Medicare carriers and DMERCs, related to validation edits and requirements.

Billing Guidelines

- When the NPI number is effective and required (May 23, 2007, although it can be reported starting January 1, 2007), claims will be **rejected** (in most cases with reason code 16 – "claim/service lacks information that is needed for adjudication") in tandem with the appropriate remark code that specifies the missing information,

if

- The appropriate **NPI is not entered** on Form CMS-1500 (08-05) in items:
  - **24J** (replacing item 24K, Form CMS-1500 (12-90));
  - **17B** (replacing item 17 or 17A, Form CMS-1500 (12-90));
  - **32a** (replacing item 32, Form CMS-1500 (12-90)); and
  - **33a** (replacing item 33, Form CMS-1500 (12-90)).

Additional Information
When the NPI Number is Effective and Required (May 23, 2007)
To enable proper processing of Form CMS-1500 (08-05) claims and to avoid claim rejections, please be sure to enter the correct identifying information for any numbers entered on the claim.

Legacy identifiers are pre-NPI provider identifiers such as:

- PINs (Provider Identification Numbers)
- UPINs (Unique Physician Identification Numbers)
- OSCARs (Online Survey Certification & Reporting System numbers)
- NSCs (National Supplier Clearinghouse numbers) for DMERC claims.

CLAIM SUBMISSION CONT'D.

Additional NPI-Related Information
Additional NPI-related information can be found at http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS web site.

The change log which lists the various changes made to the Form CMS-1500 (08-05) version can be viewed at the NUCC Web site at http://www.nucc.org/images/stories/PDF/change_log.pdf.

MLN Matters article MM4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions via Direct Data Entry Screen, or Paper Claim Forms," can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf on the CMS web site.

CR4293, Transmittal Number 899, "Revised Health Insurance Claim Form CMS-1500," provides contractor guidance for implementing the revised Form CMS-1500 (08-05). It can be found at http://www.cms.hhs.gov/transmittals/downloads/R899CP.pdf on the CMS web site.

MLN Matters article MM4023, "Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange (EDI) Transactions, via Direct Data Entry (DDE) Screens, or Paper Claim Forms," can be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4023.pdf on the CMS web site.

CR5060 is the official instruction issued to your carrier or DMERC regarding changes mentioned in this article, MM5060. CR 5060 may be found by going to http://www.cms.hhs.gov/Transmittals/downloads/R1058CP.pdf on the CMS web site.

Returning Paper Claims Received From Clearinghouses

MLN Matters Number: MM5341
Related Change Request (CR) #: 5341
Related CR Release Date: November 3, 2006
Related CR Transmittal #: R247OTN
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected
All Medicare providers who submit paper claims to clearinghouses for filing with Medicare

Provider Impact
If a clearinghouse submits claims for you on paper (rather than electronically) your payments may be affected. The Administrative Simplification Compliance Act (ASCA) requires that claims a clearinghouse submits to Medicare on your behalf must be submitted electronically. When your carrier or fiscal intermediary (FI) identifies that a clearinghouse has submitted a claim for you on paper, they will return the claim unprocessed to the clearinghouse.

Background
Section 3 of the **Administrative Simplification Compliance** Act (ASCA), PL 107-105; the implementing regulation at 42 CFR 424; and the *Medicare Claims Processing Manual* Chapter 24, Section 90-90.6 and its exhibits all require (except in limited situations) that you submit claims to Medicare electronically. And, while ASCA regulations do allow you (as a provider) to submit some, or all, claims on paper in very specific and limited instances; **HIPAA covered entities (other than providers) are not eligible for an exemption from these electronic Medicare claim submission requirements**

CR 5341, from which this article is taken, addresses claims that your clearinghouse submits to Medicare on your behalf. To be specific, if you contract with a clearinghouse to send claims to Medicare for you, they are required to submit these claims electronically.

But this being said, there is evidence that some clearinghouses are routinely submitting paper claims without the providers' knowledge. You should be aware that your carriers and FIs, having identified that a provider's clearinghouse has submitted your claims in paper form, will return them back to the clearinghouse without action.

Additional Information
The official instruction (CR5341) issued to your Medicare contractor (carriers, durable medical equipment regional carrier (DMERC), DME Medicare Administrative Contractor (DME MAC), fiscal intermediary (FI), or Part A/B Medicare Administrative Contractor (A/B MAC)) regarding paper claims that they receive from clearinghouses is located at www.cms.hhs.gov/Transmittals/downloads/R247OTN.pdf on the CMS website.

APPEALS

Telephone and Written Reopenings

Clerical errors or omissions can be addressed via the telephone or in writing as a reopening request. Clerical errors or omissions have been defined by the Centers for Medicare & Medicaid Services (CMS) as human or mechanical errors on part of the supplier or the DME MAC, such as:

- Mathematical or computational mistakes
- Transposed procedure or diagnosis codes
- Inaccurate data entry
- Misapplication of a fee schedule
- Computer errors

Examples of reopenings include (not an all inclusive list):

- Diagnosis changes/additions
- Date of service changes
- Procedure code changes
- CMN updates
- Certain modifier changes/additions (not an all inclusive list)
  - KH DMEPOS item, initial claim, purchase or first month rental
  - KI DMEPOS item, second or third month rental
  - KJ DMEPOS item, parenteral enteral nutrition (PEN) pump or capped rental, months four to fifteen

KX Specific required documentation on file.
RR Rental

Note: Modifiers GA (ABN on file) and GY (item or service statutorily excluded or does not meet the definition of any Medicare benefit) must be done as a written redetermination.

If the above changes will result in **reduction** of payment, these changes cannot be initiated via phone and must be sent as a refund request by completing the Refunds to Medicare form.

Disclaimer: If any of the above changes, upon research, are determined to be too complex, the phone representative will inform the caller that these need to be sent in writing with the appropriate documentation as a redetermination.

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

To initiate a telephone reopening, call the Supplier Contact Center at 1-866-243-7272. The following items should be readily available at the time of the call:

- Beneficiary Medicare health insurance claim (HIC) number (with alpha/numeric suffix)
- Beneficiary given name, first and last
- Beneficiary exact birth date
- Claim number being requested for review. The Claim Control Number (CCN) is located on the remittance advice.
- Date of service being reviewed
- Name of supplier of item in question
- Supplier Number
- Course of action being requested (e.g., diagnosis change, modifier addition, CMN update)

The timeframe to submit a reopening is:

- Within 12 months after the date of the initial determination
- After such 12-month period, but within four years after the date of the initial determination, for good cause. All requests for good cause must be submitted in writing.

The option to submit a reopening request in writing is also available. When submitting a written reopening request, the following items are not required, but may help expedite the process:

- NAS' redetermination request form available on our websie in the Forms section under Appeals or a letter identifying the specific reopening request
- Beneficiary name
- Medicare HIC number
- Name and address of supplier of item/service
- Date of services being reviewed
- Which items and/or services you want adjusted

Include a copy of the Medicare Remittance Advice and any

Redeterminations

Redeterminations are defined as a request to review a claim when there is dissatisfaction with the original determination. A redetermination is the first level of the appeals process and is an independent re-examination of an initial claim determination. A claim must be appealed within 120 days from the initial determination date. A redetermination, previously titled an appeal, can only be requested for services where an initial claim determination has been made which grants appeal rights and documentation is required for review. **Clerical errors or omissions should be handled as a reopening, not a redetermination.**

All redetermination requests must be submitted in writing. If available, documentation should be submitted with redetermination requests, along with the information listed below:

- CMS 20027 form, NAS' redetermination request form on our website in the Forms section under Appeals or a redetermination request letter
- Clearly state in your inquiry that you are requesting a redetermination
- Beneficiary name
- Medicare health insurance claim (HIC) number
- Name and address of supplier of item/service
- Date of services being reviewed
- Which items and/or services you want reviewed
- Any documentation to assist the reviewer in making an accurate decision such as invoices, CMNs, ABNs, orders, medical records, etc.

The mailing address for redeterminations is:
DME Medicare Administrative Contractor (MAC)
PO Box 6727
Fargo ND 58108-6727

Reopenings and Revisions of Claim Determinations and Decisions

MLN Matters Number: MM4147
Related Change Request (CR) #: 4147
Related CR Release Date: September 29, 2006
Related CR Transmittal #: R1069CP
Effective Date: November 29, 2006
Implementation Date: November 29, 2006

Provider Types Affected
Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare contractors (fiscal intermediaries (FIs) including regional home health intermediaries (RHHIs) and carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare Administrative Contractors (DME MACs) for payment.

Provider Action Needed
This article, based on Change Request (CR) 4147, notifies you about changes to the Medicare Claims Processing Manual, which ensure that claims with **clerical errors** (**which**

include minor errors and omissions) should be processed as "**reopenings**" and not as "**appeals**."

All reopenings are conducted at the discretion of your Medicare contractor and are therefore not appealable. Your Part A Medicare contractor may continue to handle some errors through the claim adjustment process. The Centers for Medicare & Medicaid Services (CMS) has added "Missing data items, such as provider number or missing date of service" to the definition of clerical errors. Note that clerical errors are limited to errors in form and content, and that omissions do not include failure to bill for certain items or services. Please note that third party payor errors DO NOT constitute clerical errors.

Please refer to the *Additional Information* section of this article and to the information in the manual attachment to CR4147 (Pub. 100-04, *The Medicare Claims Processing Manual*, Chapter 34, Section 10) for detailed and updated information regarding reopenings. Please note also that this information replaces what was previously found in Chapter 29, Section 90 of *The Medicare Claims Processing Manual*.

Background
The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), and by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Section 937 of MMA requires the establishment of a process for the correction of minor errors and omissions that do not necessitate the use of the formal appeals process.

Additional Information
"A reopening is a remedial action taken to change a final determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record." (Pub. 100-04, *The Medicare Claims Processing Manual*, Chapter 34, Section 10)If your reopening request is denied, you may not appeal the contractor's refusal to reopen but you can appeal the original claim denial as long as the timeframe to request an appeal has not expired. **Requesting a reopening does not toll the timeframe to request an appeal**. If a reopening results in a revised determination, new appeal rights will be afforded on that revised determination. Not all reopenings result in a revised determination. Some important points to note about reopenings as a result of these changes are as follows:

- Medicare contractors will not use reopenings as an appeal when a formal appeal is not available.
- Medicare contractors may conduct a reopening to revise an initial determination or redetermination. Medicare Secondary Payer (MSP) beneficiary or provider/supplier recovery claims are not reopening actions except where the recovery claim is a MSP provider/supplier recovery claim. All other MSP beneficiary or provider /supplier recovery claims are initial determinations.
- If a claim is suspended for medical review, a request for additional documentation (ADR) may be required to make a determination. If no response is received within the specified timeframes, the medical review department will likely deny the service as not reasonable and necessary based on lack of documentation. In such cases, if appealed with the requested documentation, the Medicare contractor will perform a reopening instead of an appeal. The reopenings will be performed by the medical review department.
- For Part A Medicare, there are a limited number of clerical errors that can be corrected through the reopening process. Many FIs are handling the correction of errors through the submission of an adjustment or corrected claim. FIs who are handling errors through adjustments will continue to do so.
- Medicare contractors will accept reopening requests only if they are made in writing or over the telephone. Please note that the telephone reopenings process is not required for fiscal intermediaries.
- Medicare contractors will ask the providers or suppliers to fax in the proof to support changes and error correction, when necessary.
- In cases where the issue is: (1) too complex to be handled over the phone or (2) there is a need for additional medical documents, the Medicare contractor will inform the party that their request cannot be processed over the phone. In such instances, the contractor will advise the requestor to file their request in writing.
- Medicare contractors will require the following three items from the caller, prior to conducting a telephone reopening: (1) provider/ physician/supplier name & ID # or NSC #; (2) Beneficiary last name & first initial; and (3) Medicare HICN. **NOTE: Items must match exactly**.

CR4147 is the official instruction issued to your FI/RHHI, carrier, DMERC, or DME MAC regarding changes mentioned in this article. CR 4147 may be found by going to http://www.cms.hhs.gov/Transmittals/downloads/R1069CP.pdf on the CMS website.

For additional information relating to the Medicare appeals process, you may wish to refer to Chapter 29 of the *Medicare Claims Processing Manual*, which is available at http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf .

New Qualified Independent Contractor for DME Reconsiderations

On October 11, 2006, the Centers for Medicare & Medicaid Services notified contractors of the restructured Part B QIC jurisdictions. Effective December 1, 2006, RiverTrust Solutions will be the contractor responsible for the reconsideration process for DME nationwide. Beginning November 20, 2006, you will notice a change in your Medicare Redetermination Notices. At that time you will be directed to send your requests for reconsideration to:
RiverTrust Solutions, Inc
PO Box 180208
Chattanooga TN 37401-7208

Courier Address
RiverTrust Solutions, Inc
801 Pine Street
Chattanooga TN 37402

APPEALS CONT'D.

Reconsideration requests must be made in writing and can be submitted on the CMS 20033 form (available in the Forms section of our website or at www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf) or via a letter. The reconsideration request letter must contain the following items:

- Beneficiary name,
- Medicare health insurance claim number,
- Specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service,
- Name and signature of the party or representative of the party requesting the reconsideration, and
- Name of the contractor that made the redetermination.

NOTE: To aid in the processing of your request and to avoid significant delays, a copy of the redetermination notice should accompany your reconsideration request.

Any additional documentation, new information or medical evidence that may assist the QIC in reevaluating the claim(s) should be attached to the written reconsideration request. If no additional information is submitted, a decision will be made based on the documentation contained in the DME MAC/DMERC redetermination case file.

ERA

Medicare Remit Easy Print New Version Available

Medicare Remit Easy Print (MREP) Version 1.9 is now available for download! Version 1.9 includes many improvements, including the latest version of the Claim Adjustment Reason Codes and the Remittance Advice Remark Codes, as well as:

- The MREP Remittance Advice has been modified to accommodate the presence of an NPI value at the 2110 loop and when the submitted (2110.SVC07) and paid units (2110.SVC05) of service are present and differ. Also, when claim line Remittance Advice Remark Code(s) (RARC) are present, they display further into the right on the second line of the claim line.
- The MREP Remittance Advice that is printed from the Claim Detail tab has been modified so that heading information is printed on multiple pages (when multiple pages are present).
- The user has the option to print or suppress the glossary of Remittance Advice Remark Codes (RARCs) and Claim Adjustment Reason Codes (CARCs) involved with a particular MREP Remittance Advice, when printed from the Claim Detail tab. **Note:** When the user elects to print the glossary of RARCs and CARCs, they will continue to print on a separate page from the remittance advice.
- An MREP Help online system has been incorporated into the MREP software to give the user the opportunity to look up information regarding the functionality (i.e., reports, search function, etc.) of the software rather than referring to the MREP User Guide.
- A user has the capability to automatically import 835v4010A1 remit files when the MREP application is invoked.
- The list of Remittance Advices that display in the top half portion of the MREP main screen has been modified to include a new field, Payee ID (1000B.N104).
- The Search Tab has been modified to allow the user to search on a Rendering NPI value (2110.REF02 value when 2110.REF01 = HPI).
- The following reports are new or have been updated:
    - **Other Adjustments Report**: This **new** report displays claims that have Late filing and Interest, and the remittance advices that have Withholding and Forwarding Balances.
    - **Non-COB Claims Report:** This **new** report displays claims that did not cross over. These claims do not have the value of 19, 20 or 21 in the 2100.CLP02 data field.
    - **Coinsurance Report**: This **new** report only displays those claim lines that have coinsurance dollar amounts greater than zero. It also displays either the Rendering NPI or the Rendering Provider Number.
    - **Adjusted Service Line(s), Deductible Service Line(s), Coinsurance Service Line(s), Deductible/ Co-Insurance Service Line(s) and Denied Service Line(s) Reports:** These existing reports have been modified to display either the Rendering NPI or the Rendering Provider Number.

Corrected Issues

- The MREP software has been updated so that when a user chooses to resize his/her screen, the screen resizes correctly.
- The MREP software is being updated to correctly account for the dollar amounts in the claim and remit total adjustments when a CR and/or PR group code is present.

In addition, there are changes to the MREP User Guide including a "*What's New*" section with the improvements included in this version. After this October update, annual MREP updates are anticipated to be every July. Remember you can save time and money by taking advantage of **FREE** Medicare Remit Easy Print software available to view and print the HIPAA compliant 835!"

End of Contingency for Electronic Remittance Advice – Action

MLN Matters Number: SE0656

Provider Types Affected
Providers and physicians who bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and carriers, including durable medical equipment regional carriers (DMERCs)

Background
The purpose of this Special Edition article is to clarify for providers the information issued by the Centers for Medicare & Medicaid (CMS) regarding the date to end the contingency plan for ERAs.

Key Points

ERA CONT'D.

Effective October 1, 2006, Medicare will only generate Health Insurance Portability and Accountability Act (HIPAA) compliant remittance advice – transaction 835 version 004010A1 – to all electronic remittance advice receivers. In addition, CMS issued instructions in Change Request (CR) 5047 that required a one-time hold of Medicare payments for the period of September 22, 2006, to September 30, 2006, for claims that would have been paid during the last 9 business days of fiscal year 2006. (See the *MLN Matters* article on CR5047 at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5047.pdf on the CMS web site.)

CMS has further instructed that on or after October 1, 2006:

- Any ERA for claims that would be held per CR5047 or for any other reason shall be created in the HIPAA compliant format.
- Any duplicate remittance advice per provider request shall be created in the HIPAA compliant, if electronic, or paper format.

Current figures indicate that 99% of all ERA receivers (providers and other entities that receive the ERA on behalf of providers) are receiving a HIPAA compliant ERA format and they are unaffected by the end of the contingency plan. The remaining **1% of legacy ERA receivers need to transition to a HIPAA compliant ERA format** between now and October 1, 2006. The following are the **options available** to you as a legacy ERA receiver:

- Start receiving HIPAA compliant ERAs beginning on October 1, 2006.
- Request to switch to Standard Paper Remittance (SPR) advice.
    - If you are already receiving an SPR, and do not want to receive the HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier to stop sending any ERA.
    - If providers are not currently receiving SPR, and do not wish to switch to HIPAA compliant ERA, notify your Medicare FI, DMERC, RHHI, or carrier that you would like to start receiving SPR and not receive any ERA.

There are tools available to providers to view and print the remittance advice information using free Medicare software (PC Print for institutional providers and Medicare Remit Easy Print (MREP) for professional providers and suppliers). These free software packages are 835 version 004010A1 compatible and will not work with any legacy ERA. Both software packages have important advantages over the SPR. Both packages can also be used to generate a hard copy remittance to be sent for secondary/tertiary billing, and for accounts receivable reconciliation. See the additional information section of this article for MREP details.

Additional Information
To learn about more MREP benefits, download the brochure available at www.cms.hhs.gov/MLNProducts/downloads/remit_easy_print.pdf on the CMS web site. Or, you can view Special Edition MLN Matters article SE0611 at www.cms.hhs.gov/MLNMattersArticles/downloads/SE0611.pdf or a related MLN Matters article (MM4376) at www.cms.hhs.gov/MLNMattersArticles/downloads/MM4376.pdf on the CMS web site.

For more information about the MREP software and how to receive the HIPAA 835, please contact your FI, RHHI, carrier/DMERC. Medicare Part B Electronic Data Interchange (EDI) helpline phone numbers are available at www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartBEDIHelpline.pdf on the CMS web site. Those billing for Part A services can find the appropriate toll free number at www.cms.hhs.gov/ElectronicBillingEDITrans/Downloads/MedicarePartAEDIHelpline.pdf on the CMS web site.

Ending the Contingency Plan for Remittance Advice and Charging for PC Print, Medicare Remit Easy Print and Duplicate RAs

MLN Matters Number: MM 5308
Related Change Request (CR) #: CR 5308
Related CR Release Date: September 22, 2006
Related CR Transmittal #: R1063CP
Effective Date: October 1, 2006
Implementation Date: October 23, 2006

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

Impact on Providers
This Change Request (CR) updates the *Medicare Claims Processing Manual* (Publication 100-04) for ending the contingency plan for Electronic Remittance Advice (ERA), and instructs contractors about charging for PC Print, Medicare Remit Easy Print (MREP), and duplicate Remittance Advice (RA).

Background
This article is based on Change Request (CR) 5308 which

- Updates the *Medicare Claims Processing Manual* (Chapters 22 and 24) to include the end of the contingency period for Electronic Remittance Advice (ERA) effective October 1, 2006; and
- Provides instructions to Medicare contractors (A/B MACs, carriers, DMERCs, DME MACs, FIs, and RHHIs) regarding charging for:
    - Generating and mailing provider requested duplicate remittance advices (RAs). There is no current CMS instruction for contractors to charge for generating duplicate remittance advice (when provider has already been sent a remittance advice – either in electronic or paper format) and mailing in case of paper remittance advice. Therefore, CR 5308 informs Medicare Contractors that they are now allowed to charge to recoup their cost to generate a duplicate RA if the request comes from a provider or any entity working on behalf of the provider.

ERA CONT'D.

- Making PC Print or Medicare Remit Easy Print software available to providers by CD/DVD or any other means when the requested software is available for free to download. Contractors may charge up to $25.00 for each mailing to cover their cost(s).

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, an ERA sent to a provider **on or after October 16, 2003** is required to be a standard HIPAA compliant ERA, and the ERA standard adopted under HIPAA was ANSI ASC X12N transaction 835, Version 004010A1.

CMS implemented a contingency plan (as of October 16, 2003) to continue to accept and send HIPAA-compliant and non HIPAA-compliant transactions from/to trading partners beyond October 16, 2003, for a limited time.

CMS ended the contingency period for claims in October 2005, and in a Joint Signature Memorandum (JSM/TDL-06518) issued on June 28, 2006, CMS instructed Medicare contractors that it **is ending the contingency period for ERAs** on **September 30, 2006**.

CR 5308 instructs Medicare Contractors that, on or after October 1, 2006, all ERAs must be provided in the standard HIPAA (ANSI ASC X12N 835 version 004010A1) format.

EFT

Announcing Release of the Revised EFT Agreement

On August 31, 2006, the Centers for Medicare & Medicaid Services (CMS) issued revisions to the CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement. This revised form is available at www.cms.hhs.gov/CMSForms/CMSForms/list.asp.

Contractors shall continue to accept either the 09/2003 or the 08/2006 version of the EFT Authorization Agreement through November 30, 2006. Effective December 1, 2006, contractors shall only accept the 08/2006 version of the EFT Authorization Agreement.

CERT

New Schedule of CERT Calls and Medical Request Letters

Effective November 1, 2006, the Comprehensive Error Rating Testing contractor will follow the schedule listed below when requesting medical record documentation from DME suppliers for claims pulled for review under the CERT program guidelines.

Day 0 Initial Call/Letter (date claim chosen for review)
Day 30 Second Call/ Letter
Day 45 Third Call/ Letter
Day 60 OIG Letter
Day 76 Claim scored in error (when documentation is not returned)

Please note these new timeframes and ensure that all applicable staff in your office are made aware of this revised schedule. It is important that suppliers respond to all medical records requests, including those relating to CERT, immediately upon receipt.

CERT Documentation

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

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

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

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

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

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

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

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

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

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

IHS

CR5230 - Clarifications and Additions to Chapter 19, Indian Health Services

(NOTE: Transmittal 1027, CR 5230, dated August 11, 2006 is rescinded and replaced with Transmittal 1040 CR 5230. This CR is a complete rewrite of Chapter 19, however the deletion of the subsections of sections 30, 50 and 70 were erroneously omitted from the transmittal page. All other information remains the same.)

Background: This change request (CR) includes new sections and clarifications to previously released sections of Chapter 19, Indian Health Services (IHS) in the Medicare Claims Processing Manual. This update to Chapter 19 includes documentation pertinent to the fiscal intermediary (FI), carrier and Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for IHS and should be reviewed in its entirety. Documentation for all CMS approved transmittals issued prior to this CR is included in this revision.

Policy: There are no policy changes or system changes associated with this revision to Chapter 19. All policy and system changes were implemented based upon the implementation dates associated with the specific CRs previously released.

For complete details, please see the official instruction regarding this change. That instruction may be viewed at www.cms.hhs.gov/Transmittals/downloads/R1040CP.pdf on the CMS web site.

MSP

MSP Records Incorrect

It has recently been discovered that approximately 11,000 beneficiary records have been set up incorrectly in the Common Working File (CWF) affecting the following health plans:

- Premera Blue Cross
- Premera Blue Cross Blue Shield of Alaska
- LifeWise Health Plan of Oregon
- LifeWise Health Plan of Arizona
- LifeWise Health Plan of Washington

The error in the Medicare records has caused claims for these beneficiaries to deny stating Medicare is not the primary payor. This error will potentially affect claims for Medicare Part A, Medicare Part B and DME. CMS is aware of this situation and is actively seeking resolution. Estimated correction of all records in CWF is November 17, 2006.

If your records show a member from one of the above health plans has Medicare as the primary payor, but the claim was denied stating they are secondary, please resubmit the claim to Medicare on/after November 20, 2006.

If you have a question regarding a claim denial related to primary coverage, you may contact the appropriate health plan by calling the Customer Service number referenced on the back of the member identification card.

EDI

EDI Media Changes

The Jurisdiction D EDI department will reject any EDI claims received via fax-imaging, diskette, tape or other similar storage media after March 31, 2007. More information on this change can be found at www.cms.hhs.gov/transmittals/downloads/R1081CP.pdf.

Deletion Notification for Inactive CSI and/or Beneficiary Eligibility User IDs

As a Medicare contractor, we are required by the Center for Medicare & Medicaid Services to verify all identification numbers and passwords are secured on a regular basis. During our last system review, we determined several User ID numbers for accessing the Claims Status Inquiry (CSI) and/or Beneficiary Eligibility systems had not been used within the last six-month period.

In order to maintain the highest level of security and ensure only active accounts are allowed access to the system, we have deleted those ID numbers. The ID number was only used to access the CSI and/or Beneficiary Eligibility systems and will not affect your ability to transmit claims and download information using the Stratus network.

If you are still interested in using the electronic CSI and/or Beneficiary Eligibility systems, you will need to re-apply by sending in a new Jurisdiction D EDI Customer Profile form. The Jurisdiction D EDI Customer Profile form can be downloaded from www.cignagovernmentservices.com/edi/dmerc/forms.html.

All complete applications are processed within 21 business days from the date of receipt. A new User ID will be issued to you at that time. If you have any questions, please contact the EDI Help Desk at 866-224-3094.

National Council for Prescription Drug Programs Coordination of Benefits Companion Document Update

MLN Matters Number: MM5080
Related Change Request (CR) #: 5080
Related CR Release Date: May 26, 2006
Related CR Transmittal #: R227OTN
Effective Date: June 26, 2006
Implementation Date: August 28, 2006

Provider Types Affected
Suppliers who submit claims to Medicare durable medical equipment regional carriers (DMERCs) and Medicare trading partners for prescription drugs provided to Medicare beneficiaries for coordination of benefits.

EDI CONT'D.

Background
This article and Change Request 5080 provide a One-Time Notification to DMERCs with a revised NCPDP companion document. Most current trading partners cannot accept the NCPDP version 5.1 batch standard 1.1 for COB crossover purposes due to a lack of data elements they consider essential within the transaction. The revised companion document provides workaround instructions to give current trading partners these data elements.

Key Points
The following information is important for trading partners regarding the instructions in the companion document for the workaround of the NCPDP version 5.1 batch standard 1.1 for COB crossover purposes:

- The 15-digit Internal Control Number (ICN)/Claim Control Number (CCN) that identifies a Medicare processed claim will appear in field 330-CW- (Alternate ID) within the "Claim Segment" portion of the NCPDP COB file. (Note: Bytes Page 1 of 3 16-19 will contain spaces.) The ICN will enable the trading partner to determine that an adjustment to an original claim occurred, since adjustments necessitate a change to the ICN.
- A Patient Assignment of Benefits Indicator default value of "Y" will be included in field 330-CW (Alternate ID) in byte 20.
- Per CMS regulations, drugs will always be paid by Medicare as mandatory assignment.
- The HICN will always be passed in "Patient ID" (field 332-CY with a "99-other" qualifier in field 331-CX Patient Id qualifier). The "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's policy number; on claim based Medigap crossovers; that was sent on the inbound transaction in the Alternate-Id (field 330-CW carried within the "Claim Segment").
- For non-claim based Medigap crossovers, the "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's policy number as submitted on the carrier's eligibility file.
- For Medicaid crossovers, the "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's Medicaid policy number as submitted on the carrier's eligibility file.
- If the beneficiary's policy number is not available, the "Cardholder ID" (field 302-C2 carried within the "Insurance Segment") will contain the beneficiary's HICN.
- The retail pharmacy's (supplier) name and address will be populated in lieu of the Facility Name and Address in the 500-byte-free formatted field when the 'Patient Location' field (307-C7) equals "1" (home).
- Values have been added to the Prior Authorization Segment Supporting Documentation Field 498-PP (Medicare Mapping)

Additional Information
The official instructions issued to your Medicare DMERC regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R227OTN.pdf on the CMS web site. The companion document to supplement the NCPDP Version 5.1 Batch Transaction Standard1.1 Billing Request for exchanges with Medicare DMERCs is attached to CR5080.

Note that the missing data elements in the NCPDP version 5.1 batch standard 1.1 were addressed in CR4290. To view the MLN Matters article related to CR4290 go to http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4290.zip on the CMS web site.

FRAUD AND ABUSE

Fraud and Abuse Fact Sheet

The Centers for Medicare and Medicaid Services (CMS) has developed a new Medicare Fraud & Abuse fact sheet that directs you, as a Medicare supplier, to a number of sources of information pertaining to Medicare fraud and abuse and helps you to understand what to do if you suspect or become aware of incidents of potential Medicare fraud or abuse. This fact sheet is available in a downloadable format at www.cms.hhs.gov/MLNProducts/downloads/081606_Medicare_Fraud_and_Abuse_brochure.pdf on the MLN products web page. Hard copies can be ordered at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 through the MLN Product Ordering Page on the CMS website.

Interactive Forms

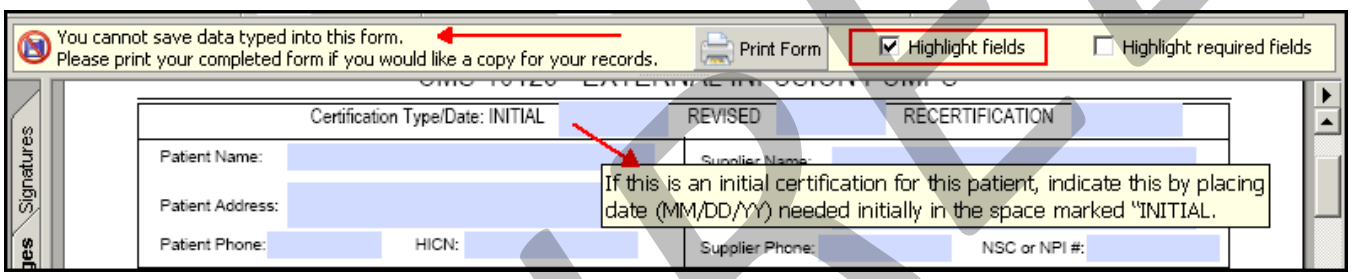
Several interactive forms are available to DME suppliers on the NAS Web site. These forms are designed for easier completion and to increase processing accuracy. The following interactive forms are currently available:

- Refunds to Medicare
- Inquiries/Redetermination
- CMS 854 CMN - "Section C" Continuation Form
- CMS 10125 DIF - External Infusion Pumps
- CMS 10126 DIF - Enteral and Parenteral Nutrition

Information entered into these forms can be printed but not saved. These interactive forms require Adobe Reader 6.0 or higher to use, which can be downloaded from the Web site.

To determine which fields are available for completion within a form, select "Highlight fields" in the upper right corner. Select "Highlight required fields" to view only the required fields. Users may select both options at the same time.

To access instructions about a particular section of a form, simply move the mouse or cursor over the designated field and detailed instructions are displayed. CMS supplied instructions are also included with most forms.



Enteral and Parenteral Nutrition DME MAC Information Form Reminder

Although CMS has recently adopted the new CMN and DIFs, the completion of the Enteral and Parenteral Nutrition DIF10.03 form will remain the same for electronic claims. When multiple products are billed, you must continue to submit a separate DIF for each line item with the answer to questions 3A (HCPCS) and 4A (calories per day) corresponding to the individual line item on the claim.

For example, when submitting a claim for B4150 and B4152, the electronic claim would show the following:

- Line 1 – B4150 Attach the DIF 10.03 with 3A equal to B4150 and 4A reported as 2000
- Line 2 – B4152 Attach the DIF 10.03 with 3A reported as B4152 and 4A submitted as 1000

Please contact the Jurisdiction D EDI Helpdesk if you have any questions at 1-866-224-3094.

Certificate of Medical Necessity and DMERC/DME MAC Information Form Changes

Update with New Oxygen CMN Form Number Entry Method

The Centers for Medicare & Medicaid Services (CMS) has developed improved CMNs and DIFs. As a result, there are changes that will be necessary in the software being provided to EDI trading partners to accommodate these new forms.

Software must be updated to allow for the new form numbers as well as the modified question sets corresponding with the changes on the new forms. In addition, a significant change to how the Oxygen CMN (new form 484.3) is mapped will be necessary. With the current form, all responses to the oxygen questions as well as the form identifier are mapped from the loops and segments in the 2400 loop. With the new form, the LQ segment will be used to identify the new form number 484.3 (2440. LQ02= 48403) and question 2 on the Oxygen form will be answered by using the 2440 FRM segment (2440.FRM03). All other responses to the questions on the Oxygen CMN will be reported as they are today.

As a reminder, to address a question with multiple responses, an alpha character will need to be added after the question number in 2440.FRM01 to show which part of the question is being answered. The alpha characters should be listed in order as they appear on the forms.

As a reference, the segment/field definitions are provided below:

ANSI X12N 837 Reference	ANSI Reference Description	Definition	Valid Values
2440.LQ01	Code list qualifier code	CMN Form	UT-CMS DMERC CMN
2440.LQ02	Industry Code	New CMN form numbers	Identifier Used to report CMN form number. Must be a valid OMB approved CMN form number excluding alpha characters and period. For the new oxygen form, enter the form number as 48403.
2440.FRM01	Assigned Identification	Question number on CMN form	Must include both number and letter together in FRM01.
2440.FRM02	Yes/No Condition	Question response - Y, N, W	Used to report responses to any CMN question, requiring a Yes/No response.
2440.FRM03	Reference Identification	Question response - Text For Oxygen CMN (form 484.3) value must = 1, 2, or 3	Used to provide responses to any CMN question, requiring a text or uncodified response.
2440.FRM04	Date	Question Response - Date	Use to provide responses to any CMN requiring a date. Enter CCYYMMDD format
2440.FRM05	Percent	Question Response - Percentage	Use to provide responses to any CMN question. Must be in a 99(V)9 format.

There will be a transition period for claims submitted from October 1, 2006 through December 31, 2006; during this time claims for items requiring a CMN or DIF will be accepted with either the old or the new forms. As of January 1, 2007, only the new forms will be accepted for all dates of service. The new forms can be obtained from the CMS Web site at: www.cms.hhs.gov/cmsforms/cmsforms/list.asp#topofpage.

If you have any questions, please contact EDI Support at 866-224-3094.

CMN and DIF Changes-Supplement to MM4296

The Centers for Medicare & Medicaid (CMS) has revised the Certificates of Medical Necessity forms and DMERC Information Forms (DIFs). Suppliers can begin using the new forms on October 1, 2006, however, for claims submitted on/after January 1, 2007 that require a CMN or DIF, the new form must be submitted. Suppliers can submit either version between October 1, 2006 and December 31, 2006.

For more information on these changes, please see the MLN Matters article MM4296. Below is an overview of what is different on the new forms:

Home Oxygen Therapy
Previous Form: CMS-484, version 484.2
New Form: Oxygen, CMS-484, version 484.03
Differences: Question 2 has been revised. Answer 1, 2 or 3 will be populated in the 2440 Loop.

2440 Loop
LQ*UT*48403~
FRM*2___ (___is the answer to Question 2)**

Question 4, Facility, is no longer required. Questions 5 – 10 were renumbered to become Questions 4 – 9. The questions have the same verbiage version and map to the same location in the 4010A1 format.

Hospital Bed
Previous Form: CMS-841, version 01.02A
New Form: None. No longer required for claims on or after October 1, 2006.

Support Surfaces
Previous Form: CMS-841, version 01.02B
New Form: None. No longer required for claims on or after October 1, 2006.

Lymphadema Pumps
Previous Form: CMS-846, version 04.03B
New Form: **Pneumatic Compression Device**, CMS-846, version 04.04B
Differences: CMN name changed from Lymphadema Pumps to Pneumatic Compression Device. All questions have changed, however, responses will still populate in the 2440 Loop.

2440 Loop
LQ*UT*0404~
FRM*1*___ (Enter the Y or N response in the ____)
FRM*2*___ (Enter the Y or N response in the ____)
FRM*3*___ (Enter the Y or N response in the ____)
FRM*4*___ (Enter the Y or N response in the ____)
FRM*5*___ (Enter the Y or N response in the ____)

Osteogensis Stimulators
Previous Form: CMS-847, version 04.03C
New Form: CMS-847, version 04.04C
Differences: Wording has changed for Questions 6 (no longer 6a and 6b), 9a, 10a and 11 (no longer 11a and 11b). There is a new question 12. Responses will populate in the 2440 Loop.

2440 Loop
LQ*UT*0404~
FRM*6*_____ (Enter the Y or N response in the ____)
FRM*7A* ___ (Enter the Y or N response in the ____)
FRM*7B___ (Enter the number of months response in the ____)**
FRM*8*_____ (Enter the Y or N response in the ____)
FRM*9A* ___ (Enter the Y or N response in the ____)
FRM*9B___ (Enter the number of months response in the ____)**
FRM*10A* __ (Enter the Y or N response in the ____)
FRM*10B _ (Enter the number of months response in the ____)**
FRM*10C _ (Enter the number of months response in the ____)**
FRM*11*____ (Enter the Y or N response in the ____)
FRM*12*____ (Enter the Y or N response in the ____)

Transcutaneous Electronic Nerve Stimulators (TENS)
Previous Form: CMS-848, version 06.02B
New Form: CMS-848, version 06.03B
Difference: All questions are new. Responses will populate in the 2440 Loop.

2440 Loop
LQ*UT*0603~
FRM*1*_____ (Enter the Y or N response in the ____)
FRM*2____ (Enter the number of months response in the ____)**
FRM*3____ (Enter the number for the condition response in the ____)**
FRM*4*_____ (Enter the Y or N response in the ____)
FRM*5*_____ (Enter the Y or N response in the ____)
FRM*6*___ (Enter the date response in the ____)**

Seat Lift Mechanism
Previous Form: CMS-849, version 07.02A
New Form: CMS-849, version 07.03A
Difference: No change to questions. Responses will populate in the 2440 Loop.

2440 Loop
LQ*UT*0703~

External Infusion Pump
Previous Form: CMS-851, version 09.02
New Form: CMS-10125, version 09.03
Differences: Questions 1 and 2 are new. Question 4 becomes Question 3. Question 5 becomes Question 4. Reponses will populate in the 2440 Loop.

2440 Loop
LQ*UT*0903~
FRM*1A___(Enter the HCPCS code in the ____)**
FRM*1B___(Enter the HCPCS code in the ____)**
FRM*1C___(Enter the HCPCS code in the ____)**
FRM*2A___(Enter the drug name for the NOC HCPCS in the ____)**
FRM*2B___(Enter the drug name for the NOC HCPCS in the ____)**
FRM*2C___(Enter the drug name for the NOC HCPCS in the ____)**
FRM*3___ (Enter the number for the route of administration in the ____)**
FRM*4___ (Enter the number for the method of administration in the ____)**

CMN/DIF CONT'D.

Parenteral Nutrition
Previous Form: CMS-852, version 10.02A
Enteral Nutrition
Previous Form: CMS-853, version 10.02B
New Form: Enteral and Parenteral Nutrition, CMS-10126, version 10.03
Difference: Combines old Enteral Nutrition CMN and Parenteral Nutrition CMN.

2440 Loop
LQ*UT*1003~
FRM*1*_____ (Enter the Y or N response in the ____)
FRM*2*_____ (Enter the Y or N response in the ____)
FRM*3A___ (Enter the HCPCS code in the ____)**
FRM*3B___ (Enter the HCPCS code in the ____)**
FRM*4A___ (Enter the calories per day in the ____)**
FRM*4B___ (Enter the calories per day in the ____)**
FRM*5____ (Enter the number for the method of administration response in the ____)**
FRM*6____ (Enter the number of days per week response in the ____)**
FRM*7*_____ (Enter the Y or N response in the ____)
FRM*8A___ (Enter the amino acid ml response in the ____**
FRM*8B**_ (Enter the amino acid concentration response in the ____)**
FRM*8C __ (Enter the amino acid gms protein response in the ____)**
FRM*8D___ (Enter the dextrose ml response in the ____)**
FRM*8E**_ (Enter the dextrose concentration response in the ____)**
FRM*8F___ (Enter the lipids ml response in the ____)**
FRM*8G __ (Enter the lipids days/week response in the ____)**
FRM*8H** (Enter the lipids concentration response in the ____)**
FRM*9____ (Enter the route of administration response ____)**

Please contact the Jurisdiction D EDI Help Desk at 1-866-224-3094 with any questions on submitting the CMN/DIF forms electronically.

New DMEPOS CMNs and DIFs for Claims Processing

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

Note: This article was revised on October 28, 2006, to reflect changes made to CR4296. The key change is that the CR4296 applies to claims based on dates of service rather than dates of receipt. In addition, the CR release date, transmittal number, and Web address for accessing CR4296 were changed. All other information remains the same.

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

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

There is a transition period for claims for dates of service from October 1, 2006, through December 31, 2006, where claims for items requiring a CMN or DIF will be accepted with either the old or the new form. The improved forms also permit the use of a signature and date stamp.

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

Background
CMNs provide a mechanism for suppliers of durable medical equipment (defined in 42 U.S.C. § 1395x(n)) and medical equipment and supplies (defined in 42 U.S.C. § 1395j(5)) to demonstrate that the item they provide meets the minimal criteria for Medicare coverage. Medicare DMERCs review the documentation provided by physicians, suppliers, and providers on the CMNs and DME Information Forms (DIFs) and determine if the medical necessity and applicable coverage criteria for selected DMEPOS were met.

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

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

Claims Accepted During Transition Period

The following table identifies the CMNs for claims for services provided during the transition period from October 1, 2006, through December 31, 2006. (For services on or after January 1, 2007, the old forms will no longer be accepted.)

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

Newly Revised CMNs Accepted During Transition Period

The following table identifies the newly revised CMNs that will be accepted for services provided during the transition period for claims from October 1, 2006, through December 31, 2006. For services on or after January 1, 2007, these forms will become effective for claims for items requiring a CMN.

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

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

New DIFs Accepted During Transition Period

The following table identifies the new DIFs that will also be accepted during the transition period for claims for services provided from October 1, 2006, through December 31, 2006. For services on or after January 1, 2007, the new forms will become effective for claims for items requiring a DIF.

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

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

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

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

CMNs Eliminated

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

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

Transcutaneous Electrical Nerve Stimulator CMN for Purchases

The Centers for Medicare & Medicaid Services has recently developed improved CMNs. The revised TENS CMN (CMS Form 848, OMB#0938-0679) will only apply to purchases. **As of January 1, 2007, contractors shall not require a CMN for TENS rentals.**

For rental of TENS with a date of service on **or after October 1, 2006, through December 31, 2006, suppliers must use the old CMN form (DMERC 06.02B), unsigned and partially completed as follows**:

Section A:	Enter the date of service (i.e., the delivery date) in the "Initial" date field
	Enter all currently required information
Section B:	Enter 99 in the "Est. Length of Need" field
	Enter the primary diagnosis in the "Diagnosis Codes" field
	Enter "D" as the answer to questions 1, 3 and 6. Enter "5" as the answer to question 5. You may leave the answer to questions 2 and 4 blank
Section C:	May leave blank
Section D:	Enter a "yes" in the "Physician's Signature" field. Enter the delivery date in the "Signature Date" field
Paper CMNs:	For hard copy CMNs, only complete section A. All other sections of the CMN should be left blank

Contractors will not edit on this partially completed TENS CMN. Claims tied to a TENS CMN will be accepted and processed based on the format of the CMN.

Although a CMN is not required for the rental of a TENS, all other documentation requirements still apply:

- A written order prior to delivery of the TENS must be kept on file and available upon request.
- Code E0731 requires the brand name and model number within the narrative section of the claim and documentation supporting medical necessity within the suppliers file. The KX modifier must be added to this code if coverage requirements per the Local Coverage Determination have been met.
- Over utilization of supplies exceeding the usual maximum amounts as described in the Local Coverage Determination must be clearly documented in the patient's medical record corroborating the medical necessity and available upon request.
- Refer to Chapter 3 of the Jurisdiction D Supplier Manual for more information on documentation requirements.

For more information, see MLN Matters article MM5107, located at: www.cms.hhs.gov/MLNMattersArticles/downloads/MM5107.pdf

New DMEPOS Transcutaneous Electrical Nerve Stimulators Certificate of Medical Necessity for Purchases

MLN Matters Number: MM5107 Revised
Related Change Request (CR) #: 5107
Related CR Release Date: October 31, 2006
Related CR Transmittal #: R168PI
Effective Date: October 2, 2006
Implementation Date: January 2, 2007

Note: This article was revised on November 1, 2006, to reflect changes CMS made to CR5107 to clarify the transition period. In addition, the article has some specific information for completing CMNs during this transition period.

Provider Types Affected
Providers and suppliers using CMNs when billing Medicare durable medical equipment regional carriers (DMERCs) or DME Medicare Administrative Contractors (DME MACs) for the purchase of TENS.

Background
The Centers for Medicare & Medicaid Services (CMS) has recently developed improved CMNs that were approved by the Office of Management and Budget (OMB). The OMB approved form number for the CMS-848 is OMB# 0938-0679.

Key Points of CR 5107

The revised Transcutaneous Electrical Nerve Stimulators (TENS) CMN will **only apply to purchases**.

Beginning January 1, 2007, **CMNs for TENS rentals will not be required.** DMERCs and DME MACs will allow suppliers to submit a partially-completed unsigned TENS CMN for claims submitted on or after October 2, 2006, and ending on December 31, 2006.

For more information regarding the revised CMN forms, see the MLN Matters article MM4296, which is available on the CMS website at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4296.pdf. Note that you must use the old CMN forms for this transition period (dates of service on or after October 1, 2006, and ending on

CMN/DIF CONT'D.

December 31, 2006). Also, note the following:

- Enter the date of service (i.e., the delivery date) in the "initial" date field in Section A of the CMN.
- Enter all other information in Section A fields that are required currently.
- Enter 99 in the "Est. Length of Need" field in Section B.
- Enter the primary diagnosis in the "diagnosis Codes" field in CMN Section B.
- Enter "D" as the answer to questions 1, 3, and 6 of Section B of the CMN.
- Enter "5" as the answer to question 5 of Section B.
- The answers to questions 2 and 4 of Section B may be left blank.
- You may leave section C as blank.
- In Section D of the CMN, enter a "yes" in the "Physician's Signature" field and enter the delivery date in the "Signature Date" field.
- For hardcopy CMNs, only complete Section A and leave other sections blank.

Additional Information
The official instructions, CR 5107, issued to your Medicare DMERC/DME MAC regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R168PI.pdf on the CMS website.

The new CMN form is available at http://www.cms.hhs.gov/cmsforms/downloads/CMS848.pdf on the CMS site.

NPI

NPI: Get It. Share It. Use It.

Over 1.4 million National Provider Identifiers (NPIs) have been issued. Do you have yours?

Think you don't need an NPI? Think again and be sure. If you are a healthcare provider who bills for services, you probably do need an NPI. If you bill Medicare for services, you definitely do!

The bad news is that as of November 23, 2006, **only six months** remain until the NPI compliance date. The implementation of the NPI is a complex process that will impact all business functions of your practice, office, or institution including: billing, reporting, and payment. This is why providers are urged to get, share, and use their NPI **NOW** to avoid a **disruption in cash flow**.

If you don't have an NPI, get one. If you have one, start the testing process with your health plan and use it on your claims and other transactions.

CMS continues to urge providers to include legacy identifiers on their NPI applications. This information is critical for health plans and healthcare clearinghouses in the development of crosswalks to aid in the transition to the NPI.

Key NPI Facts
The Centers for Medicare & Medicaid Services (CMS) along with the Workgroup for Electronic Data Interchange (WEDI) and other industry health plans would like to remind providers of the following key NPI facts:

- Every covered healthcare provider must get and use the NPI; and even if a healthcare provider is an individual and is not conducting electronic transactions and is, therefore, not a covered provider, he or she may be required by health plans or employers to obtain an NPI.
- The NPI is not just a number. It does affect internal and external business and systems operations and can affect the appropriate payment of claims in a timely manner.
- It is estimated that use of the NPI can require a transition period of no less than 120 days.
- Providers should begin to test and use their NPIs in electronic healthcare transactions no later than January 31, 2007.
- May 23, 2007, is not when the process starts but when the process must be completed.
- Providers may be requested to communicate their NPIs to health plans, clearinghouses, and other providers well before the compliance date.
- A healthcare provider who is a sole proprietor is considered an individual and can only have ONE NPI.

Sharing NPIs
Once providers have received their NPIs, they should share their NPIs with other providers with whom they do business and with health plans that request it. In fact, as outlined in current regulation, all providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes—including designation of ordering or referring physician. Providers should also consider letting health plans, or institutions for whom they work, share their numbers for them.

NPIs are Free
Healthcare providers should know that getting an NPI is free. You do not need to pay an outside source to obtain your NPI for you. All CMS education on the NPI is also free. CMS does not charge for its education or materials.

NPI Questions
CMS continues to update our Frequently Asked Questions (FAQs) to answer many of the NPI questions we receive on a daily basis. Visit the following link to view all NPI FAQs: http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=Qjr3YRYh&p_lva=&p_li=&p_page=1&p_cv=&p_pv=&p_prods=0&p_cats=&p_hidden_prods=&prod_lvl1=0&p_search_text=NPI&p_new_search=1&p_search_type=answers.search_nl

Providers should remember that the NPI Enumerator can only answer/address the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter
- Trouble accessing NPPES

- Forgotten password/User ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203.

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

Important Information for Medicare Providers

Communicating NPIs to Medicare

Medicare providers should know that there is no "special process" or need to call to communicate NPIs to the Medicare program. NPIs can be shared with the Medicare program in three different ways as part of the following standard procedures:

- Medicare providers should use their NPI, along with appropriate legacy identifiers, on their Medicare claims
- For new Medicare providers, an NPI must be included on the CMS-855 enrollment application
- Existing Medicare providers must provide their NPIs when making any changes to their Medicare enrollment information

Still Confused?
Not sure what an NPI is and how you can get it? As always, more information and education on the NPI can be found at the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand on the CMS website. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203.

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

NPI Claim Submission

As noted in previous announcements by the Agency and our contractors, the Centers for Medicare & Medicaid Services (CMS) plans to begin testing the new software that has been developed to use the National Provider Identifier (NPI) in the existing Medicare fee-for-service claims processing systems. Providers have until May 23, 2007, before you are required to submit claims with only an NPI.

Until testing is complete within the Medicare processing systems, CMS urges providers to continue submitting Medicare fee-for-service claims in one of two ways:

- **Use your legacy number**, such as your Provider Identification Number (PIN), NSC number, OSCAR number or UPIN; or
- Use **both** your NPI **and** your legacy number.

Until testing of the new software that uses the NPI in the Medicare systems is complete and until further notice from CMS, the following may occur if you submit Medicare claims with only an NPI:

- Claims may be processed and paid, or
- Claims for which Medicare systems are unable to properly match the incoming NPI with a legacy number (e.g., PIN, OSCAR number) **may** be rejected to the provider, and then you will need to resubmit the claim with the appropriate legacy number.

As always, more information and education on the NPI can be found at the CMS NPI page www.cms.hhs.gov/NationalProvIdentStand. Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203.

Important Guidance Regarding National Provider Identifier Usage in Medicare Claims

MLN Matters Number: SE0659

Provider Types Affected
Physicians, providers, and suppliers who conduct HIPAA standard transactions, such as claims and eligibility inquiries

Provider Action Needed
You must report your NPI correctly on all electronic data interchange (EDI) transactions that you submit, as well as on paper claims you send to Medicare and telephone Interactive Voice Response (IVR) queries by no later than May 23, 2007, or your transactions will be rejected.

Carriers have reported errors on claims (see Background, below) that will impact your payment when you begin to submit NPIs. Although not mandated until May 23, 2007, providers are currently allowed to submit NPIs in Medicare transactions other than paper claims. NPI will be accepted on the revised paper claim CMS-1500 (0805) and UB-04 forms early in 2007.

Make sure that your billing staffs are using your NPI correctly when they submit your claims for services provided to Medicare beneficiaries or submit electronic beneficiary or claim status queries to Medicare.

Background
All HIPAA covered healthcare providers who would either bill Medicare; render care to Medicare beneficiaries; order durable medical equipment, supplies, or services for beneficiaries; refer beneficiaries for other health care services; act as an attending physician when a beneficiary is hospitalized; prescribe covered retail prescription drugs for beneficiaries; operate on beneficiaries; or could otherwise be identified on a claim submitted to Medicare for payment must obtain an NPI. This applies whether providers are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) **or organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, managed care organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to

identify themselves in HIPAA standard transactions.

Although the NPI requirement applies by law to covered entities such as healthcare providers, healthcare clearinghouses, and health plans in the U.S. when exchanging electronic transactions for which a national standard has been adopted under HIPAA, HIPAA permits healthcare plans to elect to require reporting of NPIs in paper claims and for non-HIPAA transaction purposes. Medicare will also require NPIs for identification of all providers listed on the UB-04 institutional paper claim form and of physicians and suppliers listed on the revised CMS-1500 (08-05) professional paper claim form by May 23, 2007.

Medicare will reject paper claims received after May 22, 2007 that do not identify each provider, physician or supplier listed on a paper or electronic claim with an NPI. Medicare will also begin to require an NPI in Interactive Voice Response (IVR) queries effective May 23, 2007.

Retail pharmacies are required to use the NCPDP format adopted as a HIPAA standard for submission of prescription drug claims to Medicare. Since that format permits entry of only one provider identifier each for a pharmacy and the physician who prescribed the medication, retail pharmacies that use the NCPDP HIPAA format can use either their National Supplier Clearinghouse (NSC) number or their NPI to identify themselves, and either the Unique Provider Identification Number (UPIN) or the NPI to identify the prescribing physician prior to May 23, 2007.

May 23, 2007 and later, only an NPI may be reported for identification of pharmacies and prescribing physicians. NCPDP claims received by Medicare after May 22, 2007 that lack an NPI for either the pharmacy or the prescribing physician will be rejected.

This being said, Medicare carriers and fiscal intermediaries (FIs) have reported receiving X12 837-P (professional) and X12-837–I (institutional) claims containing errors that will result in claim rejection, and/or processing delays, if they continue to occur once NPI reporting begins.

Incorrect information in the 2010A/A Billing Provider Loop in X12 837-P Claims
Prior to May 23, 2007, carriers will reject claims when the NPI in a loop does not belong to the owner of the Provider Identification Number (PIN) or UPIN that should also be reported in REF02 of the same loop, or if the name and address of the provider in that loop do not correlate with either the NPI, PIN or UPIN in the same loop. The same edits will also be applied to NPIs when received on paper claims prior to May 23, 2007.

Carriers have also detected claims where the rendering physician's or supplier's NPI is reported in the 2010A/A NM1 segment when the claim was submitted by a group to which the physician belongs or the home office of a chain to which a supplier belongs. The 2010A/A loop of an 837-P claim must contain the identifier that applies to the groups/chains (NPI entity 2) that submitted the claims. This rule also applies to identification of the billing provider on a paper claim. Information concerning a billing agent or a healthcare clearinghouse may never be reported in the billing provider loop for a Medicare claim.

To prevent this error, you must report the rendering physician's or supplier's NPI in the NM109 data element in the rendering provider claim level loop (2310B), unless multiple services were furnished by different members of the group/chain. If multiple rendering providers were involved, the information for each must be reported in the service level 2420A loop along with the service(s) each of them rendered. To facilitate claim processing prior to May 23, 2007, you should also report the rendering provider(s) PIN(s) as the REF02 data element with 1C in REF01 in that same rendering provider loop (2310B for the claim or 2420A for individual services, as applicable).

Reporting of the Pay-to Address in the Billing Provider (2010A/A) Loop
Once NPI reporting begins, carriers will reject claims when the pay-to-address, if different than the actual practice location address, is in the 2010A/A (billing provider) loop, rather than in the 2010A/B (pay-to-provider) loop.

When groups or organizations submit claims, and the billing and the pay-to providers are different individuals or entities, the pay-to information must always be reported in the 2010A/B loop and the billing provider information in the 2010A/A loop.

Reporting of the Name and Address of a Billing Provider in the 2010A/A Loop of an X12 837-I (Institutional) Electronic Claim
FIs will reject claims in which the billing provider and the rendering provider are different entities, and you report the billing provider's name and address in the 2010A/A loop of an X12 837-I (institutional) electronic claim, and the OSCAR number of the rendering provider in that same loop.

If the home office of a chain has obtained one NPI for all facilities it owns, or one of a chain's facilities bills for all (or other) facilities owned by that chain, or a hospital bills for its special units, the home office, hospital or other facility submitting those claims is considered a form of billing agent for Medicare purposes.

In this instance, you must identify the specific provider, for whom the claim is being submitted, as the billing provider for that claim. If a provider that furnished the care had a separate OSCAR number than the entity submitting its claims, the provider that furnished the care must be identified in the billing provider loop. You must also report the name of the facility for whom the claim is being submitted, that facility's address, and should report applicable NPI (when obtained prior to May 23, 2007), as well as the Medicare OSCAR number assigned to that provider in the 2010A/A (billing provider) loop of the claim.

If the home office, hospital or other entity that prepared the claim is to be sent payment for the claim, you must report the name and address, and should report the NPI if issued, and the applicable OSCAR number associated with that entity in the 2010A/B (pay-to-provider) loop prior to May 23, 2007.

However, you should note that Medicare will not issue payment to a third party for a provider solely as result of completion of the 2010A/B loop of an electronic claim. The facility that furnished the care, or the established owner of that facility, must have indicated on their 855 provider enrollment form filed when that facility enrolled in Medicare (or via a

subsequent 855 used to update enrollment information) that payments for that facility are to be issued to that home office, hospital, other facility or an alternate third party.

Additional Information
For those providers still permitted to submit any paper claims under the restrictions imposed by the Administrative Simplification Compliance Act, Medicare plans to begin accepting paper claims on the revised CMS-1500 (08-05 version) beginning January 2, 2007 (allowing you to report a provider's NPI as well as the applicable PIN or UPIN); and on the revised UB-04 (CMS-1450) form beginning March 1, 2007 (allowing you to report a provider's NPI as well as the applicable OSCAR or UPIN). Medicare carriers plan to reject "old" CMS-1500 forms received after March 31, 2007, and FIs plan to reject UB-92 forms received after April 30, 2007. **Note**: Medicare does not accept NPIs on the "old" versions of the CMS-1500 or UB-92 forms. There are no fields on those forms designed for NPI reporting.

CMS highly recommends that for electronic or paper Medicare claims that you submit during the transition period to full NPI implementation on May 23, 2007, you include both the NPI and the Medicare legacy identifier of each provider for whom you report information.

- When you report an NPI on a claim sent to a carrier for a referring, ordering, purchased service or supervising physician, or for a provider listed in the service facility locator loop, use a UPIN as the Medicare legacy identifier. Furthermore, if any of those physicians are not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007, you should report OTH000 as the UPIN.
- When you report an NPI on a claim sent to an FI for an attending, operating or other physician, or in the service facility locator loop (when those loops apply), you should also report the provider's UPIN. And as above, you may report OTH000 as the surrogate UPIN if any of those providers is not enrolled in Medicare, and the claim is being submitted prior to May 23, 2007.
- Finally, when you report an NPI for a billing, pay-to, or rendering provider identified on a claim sent to a carrier, you should also report the valid Medicare PIN that applies to that physician or supplier. Additionally, you should always report an OSCAR number for each billing, pay-to, or possibly a service facility locator loop provider identified on a claim sent to an FI, as well as the NPI if issued to each of those providers, prior to May 23, 2007.

Remember that failure to report information as described here may result in delayed processing or rejection of your claims.

Stage 2 Requirements for Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens or Paper Claim Forms

MLN Matters Number: MM4023 Revised
Related Change Request (CR) #: 4023
Related CR Release Date: November 3, 2005
Related CR Transmittal #: 190
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

Note: This article was revised on August 25, 2006, by adding this statement directing readers to view article MM5060 at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5060.pdf for more current information on the effective dates for using Form CMS-1500 (08/05). The dates in the MM5060 article supersede the dates in this article and MM5060 conforms with CR5060, which is available at http://www.cms.hhs.gov/transmittals/downloads/R1010CP.pdf.

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/NPPES/Welcome.do.

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); National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only);
    - Claims submitted using Medicare's free billing software; Claims submitted using Medicare's free billing software;
    - Electronic claim status request received via X12 276 or DDE screen; and Electronic claim status request received via X12 276 or DDE screen; and
    - Non-X12 electronic claim status queries; 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.

Additional Information

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/transmittals/downloads/R190OTN.pdf on the CMS web site.

You may also wish to review MLN Matters article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition MLN Matters Articles on NPI-Related Activities," which is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/se0555.pdf on the CMS web site. This article contains further details on the NPI and how to obtain one.

Correction of Business Requirement 4320.19 as Contained in CR4320 Regarding National Provider Identifier Information

MLN Matters Number: MM5217
Related Change Request (CR) #: 5217
Related CR Release Date: August 18, 2006
Related CR Transmittal #: R235OTN
Effective Date: January 1, 2006
Implementation Date: November 20, 2006

Provider Types Affected
Physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs) and DME Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs))

Impact on Providers
This article is based on change request CR5217, which instructs your Medicare carrier/DMERC/DME MAC, or FI/RHHI to provide specific National Provider Identifiers (NPIs) for those providers identified in electronic claims, such as a billing, pay-to, rendering or other provider, that have already obtained NPIs.

Prior to May 23, 2007, providers should report the Medicare legacy identifiers of those providers enrolled to submit claims to Medicare, as well as their NPI.

Note: Pending Medicare implementation of the UB-04 and the revised CMS-1500, providers are not to report NPIs on the current paper claim forms.

If not already available, the following information will be posted on your local Medicare contractor's web site, or included in provider newsletters from your local Medicare contractor:

- Adjustments to edits to be applied when an NPI is included in an electronic data interchange (EDI) transaction; and
- Actions that can be taken by claim and 276 submitters to avoid rejection of their transactions as result of these edits, and information about how to correct and resubmit a transaction if the transactions are rejected as result of these edits.

Additional Information
CR4320, "Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or on Paper Claim Forms" can be located at http://www.cms.hhs.gov/transmittals/downloads/R204OTN.pdf on the CMS web site.

MM4320, the similarly titled Medicare Learning Network (MLN) article associated with CR4320, is found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4320.pdf on the CMS web site.

CR5217 is the official instruction issued to your Medicare carrier/DMERC/DME MAC/FI/RHHI regarding changes mentioned in this article. CR5217 may be found at http://www.cms.hhs.gov/Transmittals/downloads/R235OTN.pdf on the CMS web site.

2006 Fourth Quarter Update for DMEPOS Fee Schedule

New Code

K0738 is a new code used for billing and payment for oxygen transfilling equipment used in the beneficiary's home to fill portable gaseous oxygen cylinders. The fee schedule amounts for this code are equal to the current add-on fee schedule amounts for portable oxygen equipment. This code is effective for dates of service on/after October 1, 2006.

Code	Description
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing

DMEPOS Fee Schedule Changes

Below are the fee schedule changes effective for various dates of service as referenced in the tables below.

Note: To reference the fee schedule amounts for all other DMEPOS, see the 2006 third quarter fees. The DMEPOS fee schedules are posted in the News and Publications section of the NAS DME Web site, www.noridianmedicare.com. Look for the section titled Publications and then select the heading Fee Schedules.

Alaska through **Montana**

Procedure	Category	AK	AZ	CA	HI	IA	ID	KS	MO	MT
L2232*	PO	78.20	78.20	78.20	78.20	78.20	78.20	78.20	78.20	78.20
E2620NU**	IN	547.70	547.70	547.70	547.70	547.70	547.70	547.70	547.70	547.70
E2620RR**	IN	54.77	54.77	54.77	54.77	54.77	54.77	54.77	54.77	54.77
E2620UE**	IN	410.79	410.79	410.79	410.79	410.79	410.79	410.79	410.79	410.79
E2621NU**	IN	574.76	574.76	574.46	574.46	574.46	574.46	574.46	574.46	574.46
E2621RR**	IN	57.47	57.47	57.47	57.47	57.47	57.47	57.47	57.47	57.47
E2621UE**	IN	431.08	431.08	431.08	431.08	431.08	431.08	431.08	431.08	431.08
K0738RR***	OX	32.08	32.07	32.07	32.08	32.07	32.08	31.06	32.08	30.57

North Dakota through **Wyoming**

Procedure	Category	ND	NE	NV	OR	SD	UT	WA	WY
L2232*	PO	78.20	78.20	78.20	78.20	78.20	78.20	78.20	78.20
E2620NU**	IN	547.70	547.70	547.70	547.70	547.70	547.70	547.70	547.70
E2620RR**	IN	54.77	54.77	54.77	54.77	54.77	54.77	54.77	54.77
E2620UE**	IN	410.79	410.79	410.79	410.79	410.79	410.79	410.79	410.79
E2621NU**	IN	574.46	574.46	574.46	574.46	574.46	574.46	574.46	574.46
E2621RR**	IN	57.47	57.47	57.47	57.47	57.47	57.47	57.47	57.47
E2621UE**	IN	431.08	431.08	431.08	431.08	431.08	431.08	431.08	431.08
K0738RR***	OX	30.57	32.07	32.07	32.08	30.57	32.08	32.07	30.57

*Effective for new claims with dates of service on/after January 1, 2005
**Effective for dates of service on/after January 1, 2006
***Effective for dates of service on/after October 1, 2006

Power Mobility Device Fee Schedule- Effective November 15, 2006

Below are the fees for dates of service on/after November 15, 2006 for HCPCS codes K0813 thru K0899 for power mobility devices.

The fee schedule amounts for codes K0868-K0891 (Group 4 wheelchairs with no power options) have been removed from the fee schedule since these are items that will rarely be covered under Medicare.

The fees shown are the rental fees for the first three months. The rental fee is reduced by 25% for months 4-13. In addition, these fees apply to all areas within the continental United States.

Proc	Mod	Mod	Fee
K0813	RR		$222.83
K0814	RR		$280.76
K0815	RR		$344.91
K0816	RR		$329.21
K0820	RR		$250.96
K0821	RR		$315.76
K0822	RR		$391.30
K0823	RR		$394.85
K0824	RR		$475.90
K0825	RR		$395.20
K0826	RR		$618.57
K0827	RR		$472.57
K0828	RR		$682.44
K0829	RR		$562.38
K0830	RR		$442.59
K0831	RR		$442.59
K0835	RR		$404.98
K0836	RR		$412.40
K0837	RR		$475.90
K0838	RR		$429.46
K0839	RR		$618.57
K0840	RR		$835.06
K0841	RR		$455.15
K0842	RR		$455.15
K0843	RR		$508.82
K0848	RR		$517.31
K0849	RR		$497.21
K0850	RR		$574.21
K0851	RR		$551.92
K0852	RR		$697.10
K0853	RR		$716.40
K0854	RR		$911.56
K0855	RR		$852.53
K0856	RR		$556.13
K0857	RR		$518.64
K0858	RR		$692.62
K0859	RR		$648.28
K0860	RR		$973.41
K0861	RR		$557.01
K0861	RR	KF	$602.17
K0862	RR		$692.62
K0863	RR		$973.41
K0864	RR		$1,158.33

October Quarterly Update for 2006 DMEPOS Fee Schedule

MLN Matters Number: MM5255
Related Change Request (CR) #: 5255
Related CR Release Date: August 25, 2006
Related CR Transmittal #: R1037CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

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

Background
This article and related CR5255 provide specific information regarding the quarterly update for the October 2006 DMEPOS Fee Schedule.

Key Points
Quarterly Update
The DMEPOS fee schedules are updated on a quarterly basis to:

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

Required Payment
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).

Codes Added to HCPCS
The following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) on October 1, 2006, and are effective for claims with dates of service on or after October 1, 2006:

- Code K0738 (Portable Gaseous Oxygen System, Rental; Home Compressor Used To Fill Portable Oxygen Cylinders; Includes Portable Containers, Regulator, Flow meter, Humidifier, Cannula Or Mask, And Tubing) This code is to be used for billing and payment for oxygen transfilling equipment used in the beneficiary's home to fill portable gaseous oxygen cylinders.
- HCPCS codes K0800 through K0802, K0806 through K0808, K0812 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891, K0898 and K0899, as appropriate, for related Power Mobility Device claims.

The descriptions for these codes and other codes in this article may be found in CR5255 at http://www.cms.hhs.gov/Transmittals/downloads/R1037.pdf on the CMS web site.

For power wheelchairs furnished on a rental basis with dates of service prior to October 1, 2006, use codes K0010, K0011, K0012, and K0014 as appropriate.

Claims for K0010, K0011, K0012 and K0014 with dates of service on or after October 1, 2006, if the claims are for purchase of initial rental of the item, will be rejected.

The fee schedules for HCPCS code E1238 (Wheelchair, Pediatric Size, Folding, Adjustable, Without Seating System) are being revised as part of this update to correct errors in calculation and are effective for dates of service on or after January 1, 2006.

Fee schedule amounts for codes E2620 and E2621 are being revised to correct fee schedule assignment errors for claims with dates of service on or after January 1, 2006.

The fee schedules for HCPCS code A7043 (Vacuum drainage bottle and tubing for use with implanted catheter) are being revised as part of this update to correct calculation errors and will be effective for dates of service on or after January 1, 2006.

Previously processed claims for codes E2620, E2621, A7043 and E1238 with dates of service on or after January 1, 2006, will be adjusted if they are resubmitted as adjustments.

The fee schedule for HCPCS code L8689 (External recharging system for implanted neurostimulator, replacement only) was revised. FIs and carriers will adjust previously processed claims for code L8689 with dates of service on or after January 1, 2006, if they are resubmitted as adjustments.

HCPCS code L8689 should only be used for external systems that recharge implanted batteries (i.e., external recharging of batteries that area inside the patient). Claims for replacements for other types of implanted neurostimulator battery charging systems should be submitted using L8699.

The fee schedules for HCPCS code L2232 (Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only) are added to the fee schedule file on October 1, 2006, and are effective for new claims with dates of service on or after January 1, 2005.

Codes H0049 (Alcohol And/Or Drug Screening) and H0050 (Alcohol And/Or Drug Services, Brief Intervention, Per 15 Minutes) are being added to the HCPCS on June 30, 2006, and will be available on January 1, 2007, for assignment by insurers in accordance with their programs and policies.

Additional Information
For complete details, please see the official instruction issued to your Medicare carrier, FI, RHHI, DMERC, or DME/MAC regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/Transmittals/downloads/R1037CP.pdf on the CMS web site.

October 2006 Quarterly Average Sales Price Medicare Part B Drug Pricing File, Effective October 1, 2006, and Revisions to April 2006 and July 2006 Quarterly ASP Medicare Part B Drug Pricing Files

MLN Matters Number: MM5270
Related Change Request (CR) #: 5270
Related CR Release Date: September 22, 2006
Related CR Transmittal #: R1066CP
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Note: This article was revised on September 25, 2006, to reflect changes to CR5270, which CMS re-issued on September 22, 2006. The article was revised, as was CR5270, to remove references to the revised January 2006 file. The CR transmittal number, release date, and Web address for accessing CR5270 were also changed. All other information remains the same.

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

Provider Action Needed
Change Request (CR) 5270, upon which this article is based, provides notice of the updated payment allowance limits effective October 1, 2006, and revisions to the April 2006 and July 2006 quarterly drug pricing files.

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.

Background
CR5270, upon which this article is based, provides the quarterly average sales price (ASP) Medicare Part B drug

pricing file update for October 1, 2006, and also provides revisions to the April 2006 and July 2006 quarterly files.

Section 303(c) of the Medicare Modernization Act of 2003 (MMA) revised the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis; and mandated that since January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis be paid based on the average sales price (ASP) methodology.

In the same way in 2006, all ESRD drugs furnished by both independent and hospital-based ESRD facilities; specified, covered outpatient drugs; and drugs and biologicals with pass-through status under the OPPS will be paid according to this ASP methodology, which is based on quarterly data submitted to CMS by manufacturers.

Note that MMA also requires CMS to update the payment allowance limits quarterly, which CR5270 does.

Beginning January 1, 2005, Part B drugs that are not paid on a cost or prospective payment basis) have been paid based on **106%** of the average sales price (ASP). Additionally, Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on **106%** of the ASP.

There are exceptions to this general rule as summarized below.

1. Blood and Blood Products
Blood and blood products furnished in the hospital outpatient department are paid under the outpatient prospective payment system (OPPS) at the amount specified for the APC to which the product is assigned. Conversely, for blood and blood products, not paid on a prospective payment basis (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner used to determine them on October 1, 2003.

The payment allowance limits for blood and blood products are 95% of the Average Wholesale Price (AWP) as reflected in the published compendia. These payment allowance limits will be updated on a quarterly basis, along with the others.

2. Infusion Drugs
The payment allowance limits for infusion drugs, furnished through a covered item of durable medical equipment, on or after January 1, 2005, will continue to be 95% of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. The payment allowance limits were not updated in 2006.

The payment allowance limits for infusion drugs (unless compounded), furnished through a covered item of durable medical equipment, that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95% of the first published AWP.

3. Influenza, Pneumococcal and Hepatitis B vaccines
The payment allowance limits for influenza, Pneumococcal and Hepatitis B vaccines are 95% of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. In this latter instance, the vaccine is paid at reasonable cost.

4. Drugs not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File
The payment allowance limits for drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File (other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration) are based on the published wholesale acquisition cost (WAC) or invoice pricing.

In determining the payment limit based on WAC, Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries, including regional home health intermediaries (RHHIs)) follow the methodology in the *Medicare Claims Processing Manual* specified for calculating the AWP, but substitute WAC for AWP. (See Publication 100-04, Chapter 17, Drugs and Biologicals at http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf on the CMS web site.)

The payment limit is 100% of the lesser of the lowest brand or median generic WAC. And note that for 2006, when the blood clotting factor is not included on the ASP file, the blood clotting furnishing factor of $0.146 per I.U. is added to the blood clotting factor payment amount.

Your Medicare contractor may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting contractor or will post them in an MS Excel file on the CMS web site. If the payment limit is available from CMS, contractors will substitute the CMS-provided payment limits for pricing based on WAC or invoice pricing.

1. New Drugs
The payment allowance limits for new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106% of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005. As mentioned above, for 2006, the blood clotting furnishing factor of $0.146 per I.U. is added to the payment amount for a new blood clotting factor when a new blood clotting factor is not included on the ASP file.

2. Radiopharmaceuticals
The payment allowance limits for radiopharmaceuticals are not subject to ASP. Radiopharmaceuticals furnished in the hospital outpatient department are paid charges reduced to cost by the hospital's overall cost to charge ratio. And your carrier/FI will determine payment limits for radiopharmaceuticals not furnished in the hospital outpatient department based on the methodology in place as of November 2003.

3. Drugs Furnished During Filling or Refilling an Implantable Pump or Reservoir
CR 5270 clarifies that payment for drugs furnished incident to the filling or refilling of an implantable pump or reservoir is determined under the ASP methodology, as described above. Your carrier or FI will develop the pricing for compounded drugs.

REIMBURSEMENT CONT'D.

Physicians (or a practitioner described in Section 1842(b)(18)(C)) may be paid for filling or refilling an implantable pump or reservoir when it is medically necessary for them to perform the service. Your carrier/FI must find the use of the implantable pump or reservoir medically reasonable and necessary in order to allow payment for: 1) The professional service of filling or refilling the implantable pump or reservoir; and 2) For drugs furnished incident to the professional service.

If a physician (or other practitioner) is prescribing medication for a patient with an implantable pump, a nurse may refill the pump if: 1) The medication administered is accepted as a safe and effective treatment of the patient's illness or injury; 2) There is a medical reason that the medication cannot be taken orally; and 3) The nurse's skills are needed to infuse the medication safely and effectively.

Here are some important things you should remember.

- The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.
- Pricing for compounded drugs is performed by your carrier/FI.
- The presence or absence or of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.
- The October 2006 and revised April 2006 and July 2006 ASP drug pricing files for Medicare Part B drugs will be available via the CMS Data Center (CDC) for your carriers/FIs to download on or after September 19, 2006.
- You can also view the October 2006 and revised April 2006, and July 2006 ASP NOC drug pricing files for Medicare Part B drugs (on or after September 22, 2006) at http://www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/02_aspfiles.asp#TopOfPage on the CMS web site.

Note that:

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

Additional Information

You can find the official instructions issued to your carrier/FI/RHHI/DMERC regarding this change by going to CR5270, located at http://www.cms.hhs.gov/Transmittals/downloads/R1066CP.pdf on the CMS web site.

CODING

Improved Access to Product Classifications

The SADMERC responds to requests for product reviews, primarily received from manufacturers. Results of product review coding decisions are posted in the SADMERC DMEPOS Product Classification Lists. The SADMERC has improved access to the Product Classification Lists. The Product Classification lists are now accessed through the Durable Medical Equipment Online Coding System (DMECS). This enhancement to DMECS provides you with a user-friendly look-up for products.

You may view and use DMECS on the SADMERC pages of the Palmetto GBA web site. From www.palmettogba.com, select SADMERC from the Quick Links section. Select the link to DMECS in the Topics section.

In DMECS, select "Search for Codes or Fees" from the menu on the left. Scroll down to the section titled "Search DMEPOS Product Classification List". You may search for products by entering search criteria. All criteria entered are treated as wild cards so you may search by a whole word or part of a word. You may search on all or one of the following:

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

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

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

Correction to Skilled Nursing Facility Consolidated Billing Coding File

MLN Matters Number: MM5103
Related Change Request (CR) #: 5103
Related CR Release Date: August 18, 2006
Related CR Transmittal #: R1032CP
Effective Date: April 1, 2001
Implementation Date: September 18, 2006

Provider Types Affected
Physicians and providers billing Medicare carriers for SNF services to Medicare beneficiaries

What You Need to Know
Because claims for the procedure codes in Table 1 below have been processing incorrectly, carriers will begin reopen and reprocess affected claims, when brought to their attention.

Background
CMS has become aware that claims for the procedure codes listed below, have not been processing correctly. In order to ensure that you receive payment for these procedure codes, CR 5103, from which this article is taken, instructs Medicare carriers to reopen and reprocess these claims, when brought to the carrier's attention.

Table 1, shown below, displays the procedure codes (and applicable claim dates of service) subject to the overriding of the SNF consolidated billing edit. When brought to their attention, carriers will use the SNF consolidated billing override code to bypass the edits and adjust claims (claims with the dates of service as shown, and **processed prior to July 3, 2006**) to pay appropriately for these procedure codes.

Table 1 Procedure Codes Subject Reopening and Reprocessing*		
Code		Date of Service
54150 90471 90472	92977 93790	On or after April 1, 2001
0019T		On or after January 1, 2002
90871 90918 90919	90920 90921 92617	On or after January 1, 2003
G0345 J9395 L6697 L6698 L7181	36818 44137 90467 90468	On or after January 1, 2005
G0375 G0376		On or after March 22, 2005
G0372		On or after October 25, 2005

*All processed prior to July 3, 2006

Additional Information
You can find more information about the correction to the skilled nursing facility (SNF) consolidated billing (CB) coding file by going to CR5103, located at http://www.cms.hhs.gov/Transmittals/downloads/R1032CP.pdf on the CMS web site.

2007 Annual Update of HCPCS Codes for Skilled Nursing Facility Consolidated Billing

MLN Matters Number: MM5283
Related Change Request (CR) #: 5283
Related CR Release Date: September 29, 2006
Related CR Transmittal #: R1068CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected
Physicians, providers, and suppliers submitting claims to Medicare carriers, durable medical equipment regional carriers (DMERCs) or DME Medicare Administrative Contractors (DME MACs), and fiscal intermediaries (FIs) for services provided to Medicare beneficiaries in SNFs

Provider Action Needed
This article is based on Change Request (CR) 5283, which provides the 2007 annual update of HCPCS Codes for SNF CB and how the updates affect edits in Medicare claims processing systems.

CR5283 provides updated to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with policy for SNF CB in the *Medicare Claims Processing Manua*l (Publication 100-04), Chapter 6, Section 110.4.1 for carriers and Chapter 6, Section 20.6 for FIs.

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

- **For physicians and providers billing carriers**: By the first week in December 2006, new code files will be posted at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS web site.
- **For those providers billing FIs**: By the first week in December 2006, new Excel® and PDF files will be posted at http://www.cms.hhs.gov/SNFConsolidatedBilling/ on the CMS web site.

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

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

MLN Matters Number: MM5356
Related Change Request (CR) #: 5356
Related CR Release Date: October 27, 2006
Related CR Transmittal #: R1082CP
Effective Date: January 1, 2007
Implementation Date: January 2, 2007

Provider Types Affected
Physicians, suppliers, and providers who bill Medicare contractors (Fiscal Intermediaries (FIs), Carriers, Durable Medical Equipment Regional Carriers (DMERC), regional home health intermediaries (RHHIs), and DME Medicare Administrative Contractors (DME MACs) and Part A/B Medicare Administrative Contractors (A/B MACs)) for medical supply or therapy services.

Provider Action Needed
The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Codes System (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, 2007. Affected providers may note the changes in the table listed within this article or consult the instruction issued to the Medicare contractors as listed in the *Additional*

information section of this article.

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.

Key Points
CR5356 provides the annual HH consolidated billing update effective January 1, 2007. The following tables describe the HCPCS codes and the specific changes to each that this notification is implementing on January 2, 2007.

Table 1: Non Routine Supplies

Code	Description	Action	Replacement Code or Code being Replaced
A4213	Syringe, Sterile, 20 CC or Greater	Add	
A4215	Needle, Sterile, Any Size, Each	Add	
A4348	Male External Catheter with Integral Collection Compartment, Extended Wear, Each (e.g., 2 per month)	Delete	
A4359	Urinary Suspensory without Leg Bag	Delete	
A4244	Alcohol or Peroxide, per Pint	Add	
A4245	Alcohol Wipes, per Box	Add	
A4246	Betadine or Phisohex Solution, per Pint	Add	
A4247	Betadine or Iodine Swabs/Wipes, per Box	Add	
A4461	Surgical Dressing Holder, Non-reusable, Each	Add	Replaces code: A4462
A4462	Abdominal Dressing Holder, Each	Delete	Replacement code: A4461 and A4463
A4463	Surgical Dressing Holder, Reusable, Each	Add	Replaces code: A4462
A4932	Rectal Thermometer, Reusable, Any Type, Each	Add	
A6412	Eye Patch, Occlusive, Each	Add	

Table 2: Therapies

Code	Description	Action	Replacement Code or Code being Replaced
97020	Application Microwave	Delete	Replacement Code: 97024
97024	Application of a Modality to One or More Areas: Diathermy (e.g., Microwave)	Redefine	Replaces code: 97020
97504	Orthotic(s) Fitting and Training, Upper Extremity(ies), Lower Extremity(ies), and/or Trunk, Each 15 Minutes	Delete	Replacement code: 97760
97520	Prosthetic Training, Upper and/or Lower Extremity(ies), Each 15 Minutes	Delete	Replacement code: 97761
97703	Checkout for Orthotic/Prosthetic Use, Established Patient, Each 15 Minutes	Delete	Replacement code: 97762

97760	Orthotic(s) Management and Training (Including Assessment and Fitting when not Otherwise Reported), Upper Extremity(s), Lower Extremity(s) and/or Trunk, Each 15 Minutes	Add	Replaces code: 97504
97761	Prosthetic Training, Upper and/or Lower Extremity(s), Each 15 Minutes	Add	Replaces code: 97520
97762	Checkout for Orthotic/Prosthetic Use, Established Patient, Each 15 Minutes	Add	Replaces code: 97703

COVERAGE

Medicare Part B versus Part D Drug Coverage Determinations

MLN Matters Number: SE0652

Provider Types Affected
Physicians, pharmacists, providers, health care professionals, suppliers, and their staff

Impact on Providers
This Special Edition article is being provided by the Centers for Medicare & Medicaid Services (CMS) to assist physicians, providers, other prescribers, and pharmacists to understand the CMS' recommended approach to simplifying and expediting the coverage determination process for Medicare Part B versus Part D.

Affected physicians, pharmacists, providers, and their staff may also wish to review MLN Matters article number SE0570, which provides a good summary of Medicare's drug coverage under Parts A, B, and D of Medicare. That article is available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0570.pdf on the CMS web site.

Background
Part B — Medical Insurance
Medicare Part B covers drugs that are:

- Not usually self-administered; and
- Furnished and administered as part of a physician service.

Medicare Part B covers other selected drugs, such as the following:

- Drugs requiring administration via a piece of covered durable medical equipment (DME), such as a nebulizer or infusion pump in the home (because the law specifies "in the home" this coverage is generally not available in nursing facilities);
- Immunosuppressive drugs for people who had a Medicare covered transplant;
- Hemophilia clotting factors;
- Antigens;
- Intravenous immune globulin provided in the home;
- Certain oral anti-cancer and oral anti-emetic drugs;
- Erythropoietin for people with end stage renal disease (ESRD);
- Certain vaccines [Influenza, Pneumococcal, and (for intermediate- to high-risk individuals) Hepatitis B]; and
- Parenteral nutrition for people with a permanent dysfunction of their digestive tract.

Regional differences in Part B drug coverage policies can occur in the absence of a national coverage decision. For more information on local coverage determinations, go to http://www.cms.hhs.gov/coverage on the CMS web site.

Part D — Prescription Drug Insurance
Part D-covered drugs are defined as:

- Drugs available only by prescription, approved by the FDA, and used for a medically accepted indication which are not covered under part B (or Part A)

Certain drugs or classes of drugs (or their medical uses) are excluded by law from Part D coverage. These exclusions include the following:

- Benzodiazepines;
- Barbiturates;
- Drugs for anorexia, weight loss, or weight gain;
- Drugs used to promote fertility;
- Drugs used for cosmetic purposes or for hair growth;
- Drugs used for symptomatic relief of cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparation products;
- Non-prescription drugs; and Non-prescription drugs; and
- Drugs for which the manufacturer seeks to require as a condition of purchase that associated tests and monitoring services be purchased exclusively from the manufacturer or its designee.
- Drugs for the treatment of sexual or erectile dysfunction (beginning in 2007 for Medicare Part D beneficiaries)

COVERAGE CONT'D.

For more detailed information about Part B drugs and Part D coverage, please refer MLN Matters article SE0570 or to the detailed report at http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/BvsDCoverage_07.27.05.pdf on the CMS web site. This report provides excellent detail on the overall issue of Part B and Part D drugs. .

Recommended Process to Expedite Part B versus Part D Coverage Determinations

Plans may rely on physician information included with the prescription, such as diagnosis information (e.g., to determine if the prescription is related to a Medicare covered transplant) or location of administration (e.g., to determine if the prescription is being dispensed for a beneficiary in a nursing home) to the same extent they rely on similar information acquired through documentation from physicians on prior authorization forms. Assuming the indication on the script is sufficient to make the coverage determination, there is no need in such cases to require additional information to be obtained from the physician.

To the extent that the plan requires their contracted pharmacies to report the information provided on the prescription to assist in the determination of Part B versus Part D coverage, the plan may rely on the pharmacist's report of appropriate information to make the coverage determination under Part D. For example, for cases in which prednisone is prescribed for a condition other than immunosuppression secondary to a Medicare-covered transplant, and this is indicated on the prescription, a plan may authorize the pharmacy to dispense the drug under Part D without seeking further information from the prescribing physician.

PDPs are prohibited from paying for drugs that are covered under Part B. Certain drugs such as prednisone are covered under Part B when they are used to prevent organ rejection for a patient who has had a Medicare covered transplant. When a plan gets a prescription for prednisone, they must have a process by which they can verify that the prednisone is being used for a disease which would not trigger Part B coverage. Initially the plans instituted cumbersome prior authorizations procedures which required that the prescriber fill out a prior authorization form and send the form to the plan. In order to simplify the process CMS has instructed the plans that if a prescription is written for a B/D drug and the prescription has written on it the words "Part D" and a part D diagnosis such as "contact dermatitis" the prescription should be filled.

CMS is not requiring physicians to fill out prescriptions in the manner described below; instead, it is suggested as a way to save time and bypass what may be a burdensome process of completing a prior authorization form and faxing it back.

For example, prednisone used for immunosuppression following Medicare covered transplants or methotrexate used for cancer would be Part B drugs for these diagnoses, but they would be Part D drugs if they were used to treat rheumatoid arthritis.

Using the CMS guidance outlined above, if prednisone is prescribed for rheumatoid arthritis:

- The Diagnosis is "Rheumatoid Arthritis;"
- The Statement of Status is "for Part D."

The information recommended by CMS for inclusion on the written prescription for prednisone prescribed for Rheumatoid Arthritis is "Rheumatoid Arthritis for Part D.

Note: This clarification should not be construed to indicate that a Part D plan may not impose prior authorization or other procedures to ensure appropriate coverage under the Medicare drug benefit.

The Part D Plan is ultimately responsible for making the Part D coverage determination. However, CMS believes that the Part D plan will have met appropriate due diligence standards without further contacting a physician if:

- Necessary and sufficient information is provided on the prescription; and
- The contracted pharmacy is able to communicate this information to the plan in order to make the coverage determination.

CMS is preparing additional guidance to assist plans, pharmacies, and physicians in operationalizing these Part B versus Part D coverage determinations.

This Special Edition information does not supersede any existing guidance concerning documentation for Part B prescriptions.

Additional Information

For more detailed information on Part B versus Part D coverage, see the following CMS web sites: http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0570.pdf

http://www.cms.hhs.gov/PrescriptionDrugCovContra/downloads/DueDiligenceQA_03.24.06.pdf

http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf

ADMC

New Power Mobility Device HCPCS Codes Eligible for ADMC

Effective for dates of service on or after November 15, 2006, the following Power Mobility Device HCPCS codes will be eligible for Advanced Determination of Medicare Coverage (ADMC):

Group 2 - Power wheelchairs with single power option
K0835
K0836
K0837
K0838
K0839
K0840

Group 2 - Power wheelchairs with multiple power options
K0841
K0842
K0843

Group 3 - Power wheelchairs with no power options
K0848
K0849
K0850
K0851
K0852
K0853
K0854
K0855

Group 3 - Power wheelchairs with single power option
K0856
K0857
K0858
K0859
K0860

Group 3 - Power wheelchairs with multiple power options
K0861
K0862
K0863
K0864

Group 4 - Wheelchairs with no power options
K0868
K0869
K0870
K0871

Group 4 - Power wheelchairs with single power option
K0877
K0878
K0879
K0880

Group 4 - Power wheelchairs with multiple power options
K0884
K0885
K0886

Group 5 - (Pediatric) power wheelchair with single power option
K0890

Group 5 - (Pediatric) power wheelchair with multiple power options
K0891

Billing reminder: Claims with dates of service on or after November 15, 2006 billed with HPCPS codes K0011 or K0014 will be rejected by the system regardless of whether or not the supplier has received a prior affirmative ADMC from the DME PSC.

If the supplier has obtained an affirmative ADMC but does not deliver the equipment prior to November 15, 2006, the supplier may choose to resubmit the ADMC to the DME PSC with the newly eligible HCPCS codes. When resubmitting an ADMC request, please send the entire medical record including an updated physician order and the original ADMC decision. Prior approval of equipment does not guarantee coverage under the new eligible codes. Documentation must support medical necessity.

WHEELCHAIR/POWER MOBILITY DEVICE

Implementation of New HCPCS and Fee Schedule Amounts for Power Mobility Devices

A recurring update notification regarding the October quarterly update for the 2006 Durable Medical Equipment Prosthetic, Orthotics and Supplies (DMEPOS) fee schedule was issued on August 25, 2006 (Transmittal 1037, Change Request 5255). This transmittal included instructions for implementation on October 1, 2006, of HCPCS codes K0800 thru K0812 for power operated vehicles and K0813 thru K0899 for power wheelchairs and corresponding fee schedule amounts if applicable. The effective date for implementation of these codes and fee schedule amounts is being changed to November 15, 2006, to allow additional time for suppliers to prepare for these changes. Therefore, the instructions below replace those instructions listed in the policy section and business requirements of Transmittal 1037.

The following codes are being added to the HCPCS on November 15, 2006, and are effective for claims with dates of service on or after November 15, 2006:

Power Operated Vehicles

K0800	K0807
K0801	K0808
K0802	K0812
K0806	

Power Wheelchairs

K0813	K0828	K0843	K0859	K0879
K0814	K0829	K0848	K0860	K0880
K0815	K0830	K0849	K0861	K0884
K0816	K0831	K0850	K0862	K0885
K0820	K0835	K0851	K0863	K0886
K0821	K0836	K0852	K0864	K0890
K0822	K0837	K0853	K0868	K0891
K0823	K0838	K0854	K0869	K0898
K0824	K0839	K0855	K0870	K0899
K0825	K0839	K0856	K0871	
K0826	K0841	K0857	K0877	
K0827	K0842	K0858	K0878	

The Centers for Medicare & Medicaid Services (CMS) is in the process of calculating fee schedule amounts for the above codes, where applicable, and these fee schedule amounts will be transmitted to contractors in addendum DMEPOS fee schedule files in the near future.

Suppliers should use the above HCPCS codes for all new PMD claims with dates of service on or after November, 15, 2006. For power operated vehicles furnished on a rental basis with dates of service prior to November 15, 2006, suppliers should continue to use code E1230. For power wheelchairs furnished on a rental basis prior to November 15, 2006, suppliers should continue to use codes K0010 thru K0014, as appropriate.

Suppliers should begin submitting HCPCS codes K0800 through K0802, K0806 through K0808, K0812 through K0816, K0820 through K0831, K0835 through K0843, K0848 through K0864, K0868 through K0871, K0877 through K0880, K0884 through K0886, K0890, K0891, K0898 and K0899, as appropriate, for all Power Mobility Device claims with dates of service on or after November 15, 2006.

Power mobility device claims with dates of service prior to November 15, 2006, shall use E1230, K0010, K0011, K0012 and K0014 as appropriate.

Revised Power Mobility Devices Policy

As a result of continued discussions with manufacturers, suppliers and clinicians, a decision has been made to further revise the Power Mobility Devices policy. The effective date for the new codes and the policy remains unchanged, i.e., claims with dates of service on or after November 15, 2006. To view the revised policy and the corresponding policy documents, select the links below.

Power Mobility Devices - LCD

Power Mobility Devices - Policy Article

Power Mobility Devices - Policy Revision

Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle Claims

MLN Matters Number: MM5128 Revised
Related Change Request (CR) #: 5128
Related CR Release Date: August 25, 2006
Related CR Transmittal #: R157PI
Effective Date: June 5, 2006
Implementation Date: October 16, 2006

Note: This article was revised on November 1, 2006 to change the reference made to the Medicare Program Integrity Manual. This should have reference **Section 5.9** and not Section 5.8. All other information remains the same.

Provider Types Affected
Providers prescribing Power Mobility Devices (PMDs) and suppliers billing Medicare durable medical equipment regional carriers (DMERCs) for PMDs

Background
This Change Request (CR) is a supplement to CR 3952. When CR 3952 was developed and issued, the final regulation had not been published. The final rule was published in the Federal Register on April 5, 2006, and was effective on June 5, 2006. CR5128 contains updated changes based on the final regulation that differ from CR 3952. The key points below outline the changes based on the final regulations that differ from CR 3952. (The web address for the MLN Matters article, MM3952, related to CR3952 is http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3952.pdf on the CMS web site.)

Key Points
This article and CR5128 provide an update to Section 5.9 Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims of the Medicare Program Integrity Manual.

- Upon review, a written prescription for the PMD must be received by the supplier **within 45 days** after the face-to-face examination.
- For those instances of a recently hospitalized beneficiary, the written prescription must be received by the supplier **within 45 days** after the date of discharge from the hospital.
- The CMN for wheelchairs (signed or unsigned) is no longer needed for claims with a date of service on/after May 5, 2005 that are received on or after April 1, 2006.

Additional Information
The official instructions, CR5128, issued to your Medicare DMERC regarding this change can be found at http://www.cms.hhs.gov/Transmittals/downloads/R157PI.pdf on the CMS web site. The revised **Section 5.9 Evidence of Medical Necessity: Wheelchair and Power Operated Vehicle (POV) Claims** of the Medicare Program Integrity Manual is attached to CR5128.

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