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

REGION D
DMERC DIALOGUE
DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

January 2006 (Winter) ***General Release 06-1***

CIGNA Government Services Welcomes New Medical Director

CIGNA Government Services is pleased to announce that Dr. Mark Pilley has accepted the position of Medical Director for DMERC Region D. Dr. Pilley has many years of experience, with specialized expertise in developing and applying medical guidelines and policies to Medicare reviews.

Dr. Pilley brings with him 7 years of Medicare experience, including that of Medical Director where he had ultimate accountability for the development and implementation of local medical review policies and local coverage decisions, medical review decision guidelines used in making medical review determinations, and monitoring of consistency and accuracy.

He has 23 years of experience as a family physician in private practice, providing primary care services to patients as well as independent medical examinations for Social Security disability.

Dr. Pilley is a Board Certified Family Physician in the American Academy of Family Physicians and completed a Family Medicine Program at the University of Arkansas Medical Sciences in Little Rock, AR. He is also certified in the American Board of Quality Assurance Utilization Review Physicians and the American Board of Independent Medical Examiners.

He is a Fellow in the American Academy of Disability Evaluating Physicians (AADEP), a member of the AADEP Board, and member of the AADEP educational faculty in teaching American Medical Association Guides for impairment ratings, prevention of long term disability, workforce management, and the AADEP International Congress.

Dr. Pilley holds an MD degree from the University of Missouri, Columbia; and a BS degree in Biology from the University of Missouri, Kansas City.

Dr. Pilley is a great addition to the Region D staff and we look forward to working with him.

Medicare Provider Satisfaction Survey

Beginning January 2006, the Centers for Medicare & Medicaid Services (CMS) will begin conducting the Contractor Provider Satisfaction Survey (MCPSS) to measure provider satisfaction of the key services provided by the 42 Medicare contractors, including CIGNA Government Services. This survey is just one of the tools CMS will use to carry out the measurement of satisfaction levels among providers, a requirement of the Medicare Modernization Act. The end goal is to influence the efficient administration of the Medicare program.

About 400 randomly selected DMERC suppliers in Region D will be selected to participate in the survey. The survey will take approximately 20 minutes to complete and will focus on six key areas of the provider-contractor interface, including provider communications, provider inquiries, claims processing, appeals, and medical review.

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Medicare Provider Satisfaction Survey (cont'd)

The selected providers will receive a packet of information that will include a letter from CIGNA Government Services, a letter from Westat, the company performing the survey, and instructions on how to access and complete the survey via a secure Internet Web site. The packet will also include contact information to request a paper copy of the survey instrument to submit responses by mail or fax. All responses are due by January 25, 2006.

Although CIGNA Government Services has conducted provider satisfaction surveys in the past, this is the first time that CMS has conducted a uniform, national mechanism for measuring provider satisfaction. Thank you in advance for your participation and support of this survey.

If you have any questions regarding the survey, please contact Westat at 1.800.863.3561, or mcpss@westat.com.

MEDICAL POLICY

Durable Medical Equipment

An Algorithmic Approach To Determine If Mobility Assistive Equipment Is Reasonable And Necessary For Medicare Beneficiaries With A Personal Mobility Deficit (CR3791 - Mobility Assistive Equipment (MAE))

Medlearn Matters Article Number: MM3791

Related Change Request (CR) #: 3791
Related CR Release Date: June 3, 2005
Related CR Transmittal #: 37 and 574
Effective Date: May 5, 2005
Implementation Date: July 5, 2005

Note: This article was revised on October 19, 2005, to include a reference to the web site for the single coverage wheelchair page. That link is https://www.cms.hhs.gov/coverage/wheelchairs.asp on the CMS web site. All other information remains the same.

Provider Types Affected

Providers billing Medicare durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs) for MAE

Provider Action Needed

Impact to You

This article includes information from Change Request (CR) 3791, in which the Centers for Medicare & Medicaid Services (CMS) addresses numerous items that it has termed Mobility Assistive Equipment (MAE).

What You Need to Know

MAE includes (but is not limited to) canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. CMS determines that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. Determination of the presence of a mobility deficit will be made by an algorithmic process (as outlined in the Clinical Criteria for MAE Coverage included in this article) to provide the appropriate MAE to correct the mobility deficit.

What You Need to Do

You should sequentially consider specific questions in CR3791 that provide clinical guidance for the coverage of equipment (of appropriate type and complexity) to restore the beneficiary's ability to participate in Mobility-Related Activities of Daily Living (MRADLs) (toileting, feeding, dressing, grooming, bathing, etc.) in customary locations in the home. These questions correspond to the numbered decision points on the *Clinical Criteria for MAE Coverage* flow chart in CR3791. That chart is also included in this article.

Background

Recently, considerable public interest has focused on the provision of wheelchairs under the Medicare benefit. The agency has responded with a multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them. One facet of this plan is the delineation of suggested clinical conditions of wheelchair coverage. CMS solicited public comment through a number of open-door forums and other methods. Many advocacy groups suggested that the agency adopt a function-based interpretation of its historical "bed- or chair- confined" criterion for wheelchair coverage.

CMS believes that an algorithmic process that sequentially considers the appropriate "Mobility Assistive Equipment" (MAE) that corrects the mobility deficit is the appropriate process to follow in covering MAEs. CMS believes that the Clinical Criteria for MAE Coverage, in Section 280.3, Chapter 1, of Medicare Publication 100-03 (*Medicare National Coverage Determinations*), sufficiently describes this process. Using such a process will ensure that the beneficiary (or caregiver) is able to maintain as much independence as physically and mentally possible, thereby ensuring that the beneficiary's Mobility-Related Activities of Daily Living (MRADLs) are maintained.

Mobility Assistive Equipment Coverage

CMS is extending national coverage regarding MAE for beneficiaries who have a personal mobility deficit sufficient to impair their participation in MRADLs, such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. Determining the presence of a mobility deficit will be made by an algorithmic process, as outlined in the Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit.

MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. CR3791 instructs Medicare carriers, DMERCs, and RHHIs to:

• Disregard the "bed- or chair-confined" criterion that has been historically used to determine if a wheelchair is reasonable and necessary as defined by the Social Security Act (Section 1862(A)(1)(a)).

• Use the algorithmic approach as outlined in the *Medicare National Coverage Determinations Manual* (Pub. 100-03, Section 280.3), Clinical Criteria for MAE Coverage (and included below) to determine coverage eligibility of MAE.

As in other cases, if data analysis indicates potentially aberrant billing, Medicare DMERCs and FIs will use these standards when performing medical review of claims.

Medicare beneficiaries may require mobility assistance for a variety of reasons and for varying durations because the etiology of the disability may be due to a congenital cause, injury, or disease. Thus, some beneficiaries experiencing temporary disability may need mobility assistance on a short-term basis, while in con-

trast, those living with chronic conditions or enduring disabilities will require mobility assistance on a permanent basis.

In addition, Medicare beneficiaries who depend upon mobility assistance are found in varied living situations. Some may live alone and independently while others may live with a caregiver or in a care facility. The beneficiary's environment is relevant to the determination of the appropriate form of mobility assistance that should be employed.

For many patients, a device of some sort is compensation for the mobility deficit. However, some beneficiaries experience co-morbid conditions that can impact their ability to safely use MAE independently or to successfully regain independent function even with mobility assistance.

The functional limitation (as experienced by a beneficiary) depends on:

• The beneficiary's physical and psychological function;

• The availability of other support; and

• The beneficiary's living environment.

A few examples include muscular spasticity, cognitive deficits, the availability of a caregiver, and the physical layout, surfaces, and obstacles that exist in the beneficiary's living environment.

Nationally Covered Indications

Effective May 5, 2005, CMS finds that the evidence is adequate to determine that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their performance of Mobility-Related Activities of Daily Living (MRADL) such as toileting, feeding, dressing, grooming, and bathing in customary areas in the home. **Determination of the presence of a mobility deficit will be made by an algorithmic process, *Clinical Criteria for MAE Coverage*, to provide the appropriate MAE to correct the mobility deficit.**

Clinical Criteria for MAE Coverage

The beneficiary, the beneficiary's family or other caregiver, or a clinician, will usually initiate the discussion and consideration of MAE use. Sequential consideration of the questions below provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the beneficiary's ability to participate in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. These questions correspond to the numbered decision points on the accompanying flow chart below.

1. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs in the home?

A mobility limitation is one that:

• Prevents the beneficiary from accomplishing the MRADLs entirely; or

• Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs; or

• Prevents the beneficiary from completing the MRADLs within a reasonable time frame.

2. Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?

• Some examples are significant impairment of cognition or judgment and/or vision.

• For these beneficiaries, the provision of MAE might not enable them to participate in MRADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with MAE.

3. If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?

• A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.

• If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate

amelioration or compensation for the appropriate use of MAE.

4. Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?

• Safety considerations include personal risk to the beneficiary as well as risk to others.

• The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.

• A history of unsafe behavior in other venues may be considered.

5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?

• The cane or walker should be appropriately fitted to the beneficiary for this evaluation.

• Assess the beneficiary's ability to safely use a cane or walker.

6. Does the beneficiary's typical environment support the use of wheelchairs, including scooters/power-operated vehicles (POVs)?

• Determine whether the beneficiary's environment will support the use of these types of MAE.

• Keep in mind such factors as the home's physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home.

7. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day?

• The manual wheelchair should be optimally configured (seating options, wheelbase, device weight, and other appropriate accessories) for this determination. Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.

• A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. lightweight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.

• The beneficiary's home should provide adequate access, maneuvering space, and surfaces for the operation of a manual wheelchair.

• Assess the beneficiary's ability to safely use a manual wheelchair.

Note: If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.

8. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?

• A POV is a 3- or 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation.

• The beneficiary's home should provide adequate access, maneuvering space, and surfaces for the operation of a POV.

• Assess the beneficiary's ability to safely use a POV/scooter.

9. Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?

• The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.

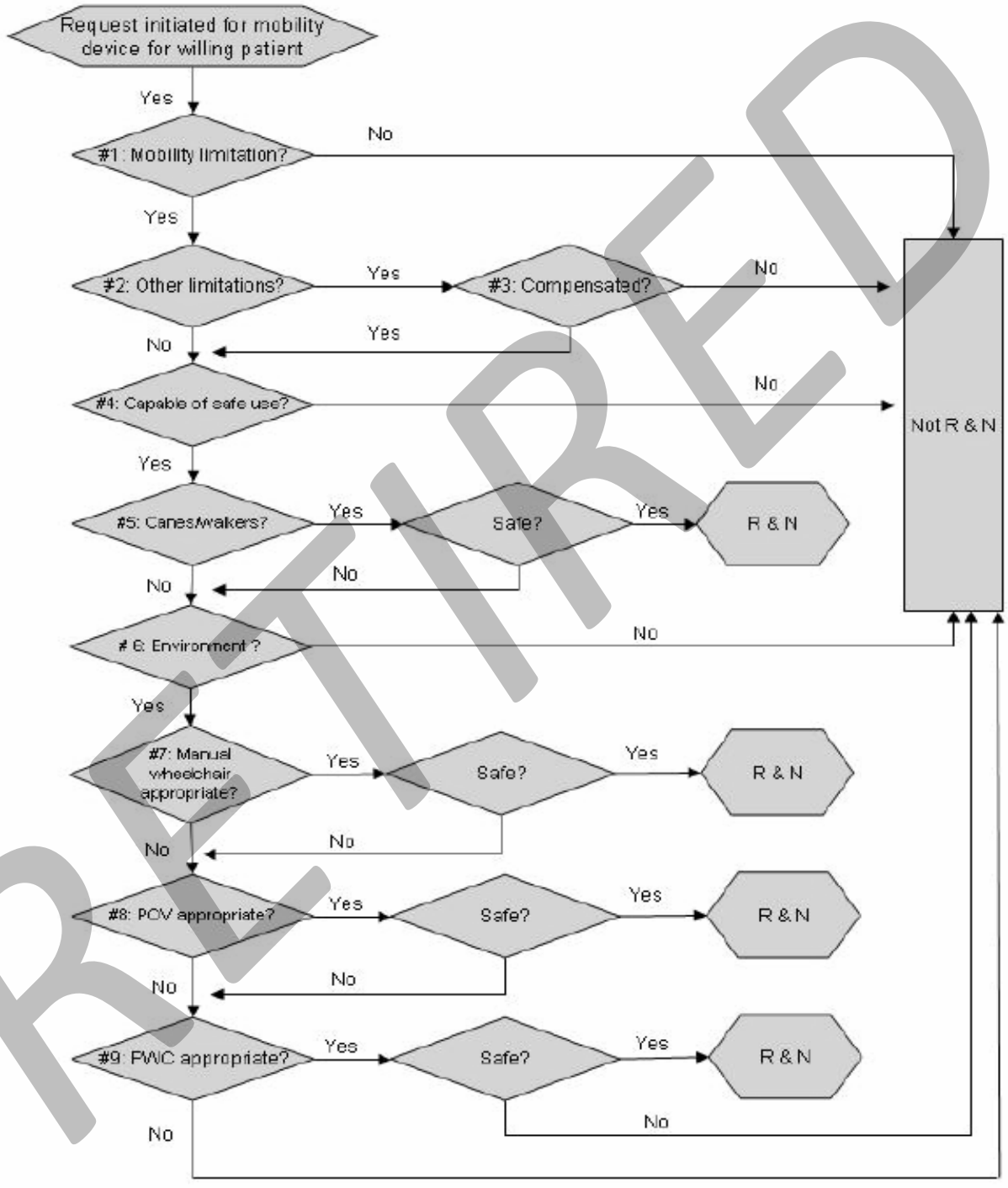
• The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.

• The beneficiary's home should provide adequate access, maneuvering space, and surfaces for the operation of a power wheelchair.

• Assess the beneficiary's ability to safely use a power wheelchair.

Note: If the beneficiary is unable to use a power wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair is appropriate. A caregiver's inability to operate a manual wheelchair can be considered in covering a power wheelchair so that the caregiver can assist the beneficiary.

Clinical Criteria for MAE Coverage



Nationally Non-Covered Indications

Medicare beneficiaries who do not meet the clinical criteria for prescribing MAE as outlined above, and as determined by the beneficiary's physician, would not be eligible for Medicare coverage of the MAE.

Note: All other durable medical equipment (DME) that does not meet the definition of MAE as described in this instruction, will continue to be covered or noncovered, as is currently described in the *NCD Manual* at Section 280, Medical and Surgical Supplies.

Also note that CR3791 revises the *Medicare National Coverage Determinations Manual* (Pub. 100-03, Section 280.3), and this revision is a National Coverage Determination (NCD) made under the Social Security Act (section 1862(a)(1)).

NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see the Code of Federal Regulations (CRF), Title 42, Sections 405.732, 405.860). An NCD that expands coverage is also binding on a Medicare advantage organization. In addition, an administrative law judge may not review an NCD. (See the Social Security Act (Section 1869(f)(1)(A)(i).)

Implementation

The implementation date for this instruction is July 5, 2005. Your DMERC or FI will adjust claims affected by this change, but processed before July 5, 2005, if you bring such claims to the attention of the DMERC/FI.

Additional Information

To view the single Medicare coverage wheelchair page, please visit https://www.cms.hhs.gov/coverage/wheelchairs.asp on the CMS web site. For complete details, please see the official instruction issued to your DMERC or FI regarding this change.

That instruction includes the complete section 280.3 and may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site.

From that web page, look for CR3791 in the CR NUM column on the right, and click on the files for that CR. You will note two files for CR3791. The file reflecting transmittal number 37 contains the revisions to the *Medicare National Coverage Determinations Manual* and the file with transmittal number 574 contains the Medicare claims processing business requirements/instructions.

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

MMA - Evidence Of Medical Necessity: Power Wheelchair And Power Operated Vehicle (POV)/ Power Mobility Device (PMD) Claims

Medlearn Matters Article Number: MM3952

Related Change Request (CR) #: 3952
Related CR Release Date: October 28, 2005
Related CR Transmittal #: 128
Effective Date: May 5, 2005

Implementation Date: The implementation date for the Medicare system changes contained in CR3952 is April 3, 2006; otherwise, implementation will occur on October 25, 2005.

Note: This article was revised on November 3, 2005, to reflect that CR3952 was revised and reissued on October 28, 23005. The CR release date and transmittal number (see above) were changed, but 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

Provider Action Needed

Impact to You - Effective for dates of service on or after May 5, 2005, the procedure for documenting and submitting a claim for a wheelchair or PMD has changed.

What You Need to Know - Make certain to meet criteria regarding who can prescribe PMDs, retain appropriate prescribing documentation, and understand the boundaries for prescribing and billing for PMDs.

What You Need to Do - Please be aware of the criteria addressed in the related instruction (CR3952) and ensure that billing staffs submit claims accordingly.

Background

This article includes information from Change Request (CR) 3952 that outlines the changes regarding Medicare adjudication of claims for PMDs as set forth in Section 302 (a) (2) (E) (iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Also outlined are criteria determining who can prescribe PMDs and a definition of the devices. The following rules are in place for claims with dates of service on or after May 5, 2005:

Rules for Adjudicating Claims for PMDs

Physicians should be aware of the critical role they play in prescribing power wheelchairs. Specifically, physicians evaluate a patient's medical conditions and need for mobility and, as such, are the primary gatekeepers of the information CMS uses to base decisions for payment.

To this end, physicians should be conscientious when documenting patient encounters and pay particular attention to describing the patient's clinical condition (e.g., medical history, disease progression, changes in health status), as well as their need for mobility, their living situation (e.g., family support and caregivers), and other treatments that have been tried and considered. All of this information is used by our contractors (Medicare's DMERCs) when evaluating a claim for payment.

Face-to-Face Examination and Prescription

A condition for payment for motorized or power wheelchairs is that the PMD must be prescribed by a physician or treating practitioner (a physician assistant, nurse practitioner, or a clinical nurse specialist) who has conducted a face-to-face examination of the beneficiary and has written a prescription for the PMD. The face-to-face examination requirement does not apply when only accessories for PMDs are being ordered.

The written prescription (order) must include the following:

- Beneficiary's name;
- Date of the face-to-face examination;
- Diagnoses and conditions that the PMD is expected to modify;
- Description of the item;
- How long it is needed;
- The physician or treating practitioner's signature; and
- The date the prescription is written.

The written prescription (order) must be:

- In writing;

- Signed and dated by the physician or treating practitioner (a physician assistant, nurse practitioner or clinical nurse specialist) who performed the face-to-face examination; and

- Be received by the supplier within 30 days after the face-to-face examination.

The physician or treating practitioner must submit a written prescription (order) for the PMD to the supplier.

This prescription must be received by the supplier within 30 days of the face-to-face evaluation, or, in the case of a recently hospitalized beneficiary, within 30 days after the date of discharge from the hospital.

Additional Documentation

The physician or treating practitioner must also provide the supplier with additional documentation describing how the patient meets the clinical criteria for coverage as described in the National Coverage Determination (NCD), as documented in CR3791. (Instructions for accessing CR3791 are in the *Related Instructions* section of this article.)

The actual documentation needed to describe how the coverage is met varies, but may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans, along with any other information explaining the patient's need for the equipment.

DME suppliers should retain on file the prescription (written order), signed and dated by the treating physician or treating practitioner, along with the supporting documentation that supports the PMD as reasonable and necessary.

Other Rules

- It is no longer necessary to require a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology to provide a written order for Power Operated Vehicles (POVs).

- The use of the Certificates of Medical Necessity (CMNs) for motorized wheelchairs, manual wheelchairs, and POVs will be phased out for claims with Dates of Service (DOS) on or after May 5, 2005.

• Until Medicare systems changes are fully implemented in April 2006, for claims with dates of service on or after May 5, 2005, suppliers must submit a partially completed and unsigned CMN.

• For claims with dates of service before May 5, 2005, claims must be submitted and processed using the appropriate fully completed and signed CMN.

Implementation

The implementation date for the system changes contained in CR3952 is April 3, 2006; otherwise, implementation will occur on October 25, 2005.

Related Instructions

MM3791 provides additional information that describes the steps the healthcare provider must take to justify the POV. MM3791 lists the *Clinical Criteria for MAE Coverage,* along with the *MAE Coverage Flow Chart.* Go to http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3791.pdf on the CMS web site to view that information.

For complete details, please see the official instruction regarding this change. The instruction includes the complete section 280.3; it may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site.

From that web page, look for CR3791 in the CR NUM column on the right, and click on the file for that CR. You will note two files for CR3791. The file reflecting transmittal number 37 contains the revisions to the *Medicare National Coverage Determinations Manual*, and the file with transmittal number 574 contains the Medicare claims processing business requirements/instructions.

Additional Information

For more information regarding wheelchair coverage, visit https://www.cms.hhs.gov/coverage/wheelchairs.asp on the CMS web site.

For complete details regarding CR3952, please see the official instruction issued to your DMERC regarding this change. The instruction may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site.

From that web page, look for CR3952 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your DMERC at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Power Mobility Devices – Grace Period For Implementation Of The Interim Final Rule

On August 26, 2005, CMS published an Interim Final Rule (IFR) in the Federal Register that established documentation requirements for the coverage of power wheelchairs and power operated vehicles. It specifies in part a requirement for a face-to-face examination of the beneficiary by the treating physician to determine the need for a power mobility device (PMD) and the required elements of an order for a PMD. It also defines time frames in which the supplier needs to obtain copies of that documentation. These requirements have been explained in articles published by the DMERCs and, most recently, in revisions of the Power Operated Vehicles and Power Wheelchairs medical policies. Refer to those policies for a full explanation of the requirements. The effective date of the Interim Final Rule was October 25, 2005.

Following discussions with CMS, the DMERCs are implementing a grace period for the application of the Interim Final Rule. It involves situations in which the ordering of a PMD was in process when the IFR went into effect. If the supplier had a detailed written order for a PMD that was signed and dated by the treating physician prior to October 25, the DMERCs will not apply the requirements of the IFR if the claim is subjected to manual medical review. Instead the prior documentation requirements will be applied – i.e., (a) there must be a dispensing order for the PMD from the physician which is obtained by the supplier prior to delivery of the device, (b) there must be a detailed written order for the PMD which is signed and dated by the treating physician and received by the supplier prior to billing the device, (c) there must be documentation in the patient's medical record that the coverage criteria for the PMD have been met, and (d) all of this documentation must be available to the DMERC on request.

Power Mobility Devices – Documentation Requirements

On August 26, 2005, an interim final rule (regulation) was published in the Federal Register defining documentation requirements for power mobility devices (PMDs) – i.e., power operated vehicles (POVs) and power wheelchairs. Change Request 3952 provided instructions to the DMERCs on the implementation of the

regulation. The following requirements are effective for claims with dates of service (i.e., delivery dates) on or after October 25, 2005.

For a POV or power wheelchair to be covered, the treating physician must conduct a face-to-face examination of the patient to determine and document the medical necessity for the item. Coverage criteria for PMDs are found in the National Coverage Determination (NCD) for Mobility Assistive Equipment (NCD Manual Section 280.3) which became effective on May 5, 2005. (See www.cms.hhs.gov/coverage/wheelchairs.asp to view the NCD and the regulation.) The examination must include pertinent elements of the patient's history, physical examination, and functional assessment describing the patient's mobility limitation and his/her physical and mental ability to operate a PMD.

The treating physician must complete this examination before writing an order for the PMD. A copy of the examination report must be received by the supplier within 30 days after the examination is completed. (Exception: If this examination is performed during a hospital or nursing home stay, the supplier must receive the report of the examination within 30 days after discharge.)

This face-to-face examination does not necessarily have to occur at a single visit and is not always performed by a single individual. For example, the physician may refer the patient to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of this face-to-face examination. (This person may not be an employee of the supplier or have any financial relationship with the supplier. Exception: If the supplier is owned by a hospital, a PT/OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face examination.) In these situations, the documentation requirements and the start of the "30-day window" for getting documentation to the supplier depend on whether the physician saw the patient in person to begin the examination prior to the referral.

If the patient was referred to the PT/OT before being seen by the physician, then once the physician has received and reviewed the written report of this examination, the physician must see the patient and perform any additional examination that is needed. The report of the physician's visit should state concurrence or any disagreement with the PT/OT examination. In this situation, the physician must provide the supplier with a copy of both examinations within 30 days after the face-to-face examination with the physician.

If the physician saw the patient to begin the examination before referring the patient to a PT/OT, then if the physician sees the patient again in person after receiving the report of the PT/OT examination, the 30 day period begins on the date of that second physician visit. However, it is also acceptable for the physician to review the written report of the PT/OT examination, to sign and date that report, and to state concurrence or any disagreement with that examination. In this situation, the physician must send a copy of the note from his/her initial visit to evaluate the patient plus the annotated, signed, and dated copy of the PT/OT examination to the supplier. The 30-day window begins when the physician signs and dates the PT/OT examination.

Finally, there may be cases in which the physician has treated a patient for an extended period of time and the information recorded at the face-to-face examination refers to previous notes in the medical record. In that case, copies of those previous notes should also be forward to the supplier.

For a POV or power wheelchair to be covered, the supplier must receive from the treating physician a written order within 30 days after completion of the physician's face-to-face examination and prior to delivery of the device. This order must contain all of the following elements:

1) Beneficiary's name
2) Description of the item that is ordered. This may be general – e.g., "power wheelchair" or "power mobility device" – or may be more specific.
3) Date of completion of the face-to-face examination (see above)
4) Pertinent diagnoses/conditions that relate to the need for the power mobility device
5) Length of need
6) Physician's signature
7) Date of physician signature

Exception: If the examination is performed during a hospital or nursing home stay, the supplier must receive the order within 30 days after discharge.

If the requirements listed above for the face-to-face examination and order are not met, the claim for the POV or power wheelchair and any related accessories will be denied as statutorily noncovered.

If the order described above does not identify the specific type of PMD that is provided, then the supplier must clarify this by obtaining another written order which lists the specific PMD that is being ordered and any options and accessories that will be separately billed. These

items may be entered by the supplier. This order must be signed and dated by the treating physician and must be received by the supplier prior to dispensing the power mobility device – but it does not have to be received within 30 days following completion of the face-to face examination.

If only wheelchair accessories are being ordered, a face-to-face examination is not required. Standard documentation requirements would apply – a detailed written order prior to billing the item and documentation in the medical record supporting the medical necessity for the item.

If the POV or power wheelchair is a replacement of a similar item that was previously covered by Medicare, a face-to-face examination is not required.

In the regulation that was posted on August 26, 2005 CMS also announced that it would create a new HCPCS code for physicians to bill their local carrier to be reimbursed for the additional work of creating this documentation and sending it to the supplier. This code will be billed in addition to the CPT code that the physician bills for the office/other facility visit. Information on this code will be provided by the local carriers to physicians.

Information from this article will be incorporated in future revisions of policies for POVs and power wheelchairs.

For claims for PMDs with dates of service on or after 5/5/05 (the effective date of the NCD) and prior to 10/25/05, the following documentation requirements remain in effect. The supplier must obtain a verbal or written dispensing order prior to providing the item. For POVs, the supplier must have a detailed written order prior to delivery. For power wheelchairs, the supplier must have a detailed written order prior to billing. For all PMDs, there must be information in the patient's medical record documenting that the coverage criteria described in the NCD are met. This information must be available to the DMERC on request. Refer to the *DMERC Region D Supplier Manual*, Chapter 3, "Documentation Requirements" for more information on orders and documentation in the medical record. For information about the use of CMNs during this time frame, refer to the article titled "Transitioning to the Mobility Assistive Equipment National Coverage Determination" in the October 2005 Region D *DMERC Dialogue* beginning on page 8 and to the article titled "Wheelchair CMNs – Transition Instructions" posted to the What's New section of the Region D DMERC Web site on September 23.

General

Policies Revised

The following policies have either been revised or converted from local medical review policies (LMRPs) to local coverage determinations (LCDs) and policy articles:

Effective for dates of service on or after May 5, 2005:

- Manual Wheelchair Base
- Motorized/Power Wheelchair Base
- Power Operated Vehicles

Effective for dates of service on or after January 1, 2006:

- Home Dialysis Supplies and Equipment
- Hospital Beds and Accessories
- Parenteral Nutrition
- Pneumatic Compression Devices
- Pressure Reducing Support Surfaces – Group 3
- Therapeutic Shoes for Persons with Diabetes
- Transcutaneous Electrical Nerve Stimulators (TENS)
- Urological supplies

Please refer to your supplier manual or DMERC Web site for further details. Suppliers are reminded that these policy revisions are published in the split format of a local coverage determination and policy article. Both documents taken together constitute the "medical policy." In the CMS coverage database (www.cms.hhs.gov/mcd/indexes.asp), the policy article can be accessed both as an attachment to the LCD and as a separate article in the Articles section of the database.

This is the final installment of the conversion of LMRPs to LCDs and policy articles that the DMERCs have been completing over the past year. The term LCD continues to refer to both stand-alone LCDs and the "reasonable and necessary" provisions of an LMRP where the date of service for an item billed is before the conversion of the LMRP to LCD.

Suppliers are strongly encouraged to read both the LCD and the policy article that accompanies the LCD for a full understanding of the coverage, coding and documentation requirements. A revision history field in each document provides summary details for each revision.

COVERAGE AND BILLING

Durable Medical Equipment

Advance Determination Of Medicare Coverage For Wheelchairs — Revised Instructions

Advance Determination of Medicare Coverage (ADMC) is a process by which the DMERC provides the supplier and beneficiary with a coverage decision prior to delivery of an item. Effective immediately, the requirement for the documentation that must accompany a request for ADMC has changed. The following is an explanation of the evidence of medical necessity that is required under the CMS IOM Pub. 100-04 National Coverage Determination 280.3 and CMS Change Request (CR) 3952. Please refer to the *DMERC Region D Supplier Manual*, Chapter 9, "Advance Determination of Medicare Coverage for Wheelchairs," for information about eligible HCPCS codes and the ADMC process.

All ADMC requests must be accompanied by a copy of the appropriate Certificate(s) of Medical Necessity (CMN) – CMS Form 844 for manual wheelchairs or CMS Form 843 for power wheelchairs. CMS plans to eliminate the use of CMNs for manual and power wheelchairs and related options and accessories. Until system changes are implemented, suppliers requesting ADMC must continue to submit the appropriate CMN form with their request for ADMC, and may follow these instructions:

- The physician does not need to review, complete, or sign any part of the CMN.
- Complete only section A. All other sections of the CMN should be left blank.

All requests must also include a complete listing of all items for which ADMC is requested, including the wheelchair base, related options and accessories, and wheelchair seating devices, and their corresponding HCPCS codes.

Manual Wheelchairs

The ADMC request must be accompanied by copies of:

1) the order which specifies the wheelchair base and all options and accessories to be provided that is signed and dated by the treating physician, and
2) information from the patient's medical record that documents that the coverage criteria defined in the DMERC medical policy on Manual Wheelchairs has been met.

Information about whether the patient's home can accommodate the wheelchair may be documented by the supplier.

If the patient currently has a wheelchair, the ADMC request must indicate the reason why it is being replaced.

If the ADMC request includes a seat or back cushion, an ICD-9 diagnosis code(s) must be provided.

Refer to the DMERC policies on Manual Wheelchairs, Wheelchair Options and Accessories, and Wheelchair Seating for more information on coverage criteria, coding guidelines, and documentation requirements.

Power Wheelchairs

The ADMC request must be accompanied by copies of:

1) the physician's order,
2) the follow-up physician's order if one is obtained by the supplier, and
3) the face-to-face examination report.

Physician's Order:

This order must be received by the supplier within 30 days after the completion of the face-to-face examination and must contain all of the following elements:

1) Beneficiary's name
2) Description of the item that is ordered. This may be general – e.g., "power wheelchair" or "power mobility device"– or may be more specific.
3) Date of completion of the face-to-face examination
4) Pertinent diagnoses/conditions that relate to the need for the power wheelchair
5) Length of need
6) Physician's signature
7) Date of physician signature

Follow-up Physician's Order:

If this order does not identify the specific type of power wheelchair that is provided, the supplier must clarify this by obtaining another written order which lists the specific power wheelchair that is being ordered and any options and accessories that will be separately billed. The items on this order may be entered by the supplier. This order must be signed and dated by the treating physician and must be received by the supplier prior to

dispensing the power wheelchair – but it does not have to be received within 30 days following the face-to face examination.

Face-to-face Examination:

The report of the face-to-face examination should provide information relating to the following questions:

What is this patient's mobility limitation and how does it interfere with the performance of activities of daily living?

Why can't a cane or walker meet this patient's mobility needs in the home?

Why can't a manual wheelchair meet this patient's mobility needs in the home?

Why can't a POV (scooter) meet this patient's mobility needs in the home?

Does this patient have the physical and mental abilities to operate a power wheelchair safely in the home?

The report should provide pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every examination.

- Symptoms
- Related diagnoses
- History
  - How long the condition has been present
  - Clinical progression
  - Interventions that have been tried and the results
  - Past use of walker, manual wheelchair, POV, or power wheelchair and the results
- Physical exam
  - Weight
  - Impairment of strength, range of motion, sensation, or coordination of arms and legs
  - Presence of abnormal tone or deformity of arms, legs, or trunk
  - Neck, trunk, and pelvic posture and flexibility
  - Sitting and standing balance
- Functional assessment – any problems with performing the following activities including the need to use a cane, walker, or the assistance of another person
  - Transferring between a bed, chair, and PMD
  - Walking around their home – to bathroom, kitchen, living room, etc. – provide information on distance walked, speed, and balance

If part of the face-to-face examination is performed by a licensed/certified medical professional, such as a physical therapist or occupational therapist, a copy of that report must be included. (**Note:** To be considered part of the face-to-face examination, this person may not be an employee of the supplier or have any financial relationship with the supplier.)

Information about whether the patient's home can accommodate the wheelchair may be documented by the supplier.

If the patient currently has a manual or power wheelchair or a power operated vehicle (POV), the ADMC request must indicate the reason why it is being replaced.

If the ADMC request includes a seat or back cushion, an ICD-9 diagnosis code(s) must be provided.

Refer to the DMERC policies on Motorized/Power Wheelchairs, Wheelchair Options and Accessories, and Wheelchair Seating for more information on coverage criteria, coding guidelines, and documentation requirements.

Documentation Tips Blood Glucose Monitors And Supplies

According to claim reviews conducted by the Comprehensive Error Rate Testing (CERT) Review Contractor, insufficient documentation continues to be the leading cause of CERT errors in Region D. Claims for blood glucose monitors (BGM) and supplies account for a large percentage of these errors. It is critical that suppliers adhere to Medicare's documentation rules and maintain required information in beneficiary files. The following reminders deal with the most common BGM documentation errors.

1. Suppliers must have a valid written order on file prior to billing Medicare. Modifier EY must be used for claims submitted before obtaining a valid written order.

2. The written order must contain all the elements listed in the Glucose Monitors local coverage determination (LCD). These elements are listed in the "Documentation Requirements" section of the Glucose Monitors LCD in the *DMERC Region D Supplier Manual*. (http://www.cignagovernmentservices.com/dmerc/lmrp_lcd/GM.html)

3. If requested by the DMERC or CERT contractor, the supplier must furnish medical records that support that the beneficiary meets the medical necessity coverage criteria outlined in the Glucose Monitors LCD. Failure to provide this information will result in claim denial.

4. If the claim under review is for quantities above the normal allowances specified in the LCD, the supplier must provide documentation to support the medical necessity of the quantity billed. This documentation must include information from the treating physician as to the specific reason for the prescribed frequency of blood glucose testing and documentation (patient log, etc.) that shows the patient is actually testing at the prescribed frequency. Failure to provide this information will result in denial of amounts over the normal allowance specified in the LCD.

5. The supplier must not submit claims using modifier KX unless the patient is being treated with insulin injections. Claims for patients not being treated with insulin injections must be billed with modifier KS.

6. Suppliers are required to maintain proof of delivery in the beneficiary's file. If either the DMERC or the CERT contractor requests documentation in conjunction with a claim review, a copy of this information must be included in the material you submit.

CIGNA Government Services has prepared several online education tools that suppliers are encouraged to use to better comply with Medicare's documentation requirements. These tools include Documentation Checklists covering several policy groups including Glucose Monitors. Documentation Checklists are designed to help suppliers with the intake process and ensure that their files contain the necessary information for claim submission. These checklists are available at the following URL: http://www.cignagovernmentservices.com/dmerc/mr/CERT/doccheclists.html

A number of NetCourses, including one on Blood Glucose Monitors and Supplies, are also available to enhance the policy information in the *DMERC Region D Supplier Manual*. NetCourses are online tutorials that are available on demand to fit the needs of your busy schedule. Each course contains a pre-test and a post-test so you can evaluate your knowledge of the subject. Go to this URL to view a list of available NetCourses and link to the NetCourse of your choice: http://www.cignamedicare.com/wrkshp/netcourses.html

Wheelchair CMNs – Transition Instructions

On August 21, 2005 the Centers for Medicare and Medicaid Services (CMS) announced its plan to eliminate use of Certificates of Medical Necessity (CMNs) for manual wheelchairs, power operated vehicles (POVs), power wheelchairs, and related accessories. This applies to claims with dates of service on or after May 5, 2005, the effective date of the new National Coverage Determination (NCD). Because of the need for major system changes by CMS, this cannot be fully implemented until April 2006. Until then, suppliers must submit partially completed CMNs with initial claims for these items.

Effective for claims with dates of service on or after 5/5/05 that are received on or after October 1, suppliers may follow these instructions concerning the submission of CMNs for manual wheelchairs, POVs, and power wheelchairs:

- The physician does not need to review, complete, or sign any part of the CMN.
- For CMNs that are transmitted electronically:
  - Section A: Enter the "date of service" (i.e., the delivery date) in the "Initial" date field.
  - Section A: Enter information in all required fields as is currently being done, including HCPCS codes for the wheelchair base and all accessories which require a CMN.
  - Section B: Enter 99 in the "Est. Length of Need" field.
  - Section B: Enter the primary diagnosis in the "Diagnosis Codes" field.
  - Section B: Enter "D" as the answer to all questions. Exception: Enter "24" for question #5 on the manual wheelchair and power wheelchair CMNs.
  - Section C: Leave blank.
  - Section D: Enter a "Yes" in the "Physician's Signature" field. Enter 5/5/05 in the "Signature Date" field.
- For CMNs that are sent hard copy, only complete section A. All other sections of the CMN should be left blank.

Orthotics/Prosthetics

Full Replacement Of CR3607, Payment Edits In Applicable States For DMEPOS Suppliers Of Prosthetics And Certain Custom-Fabricated Orthotics; CR 3607 Is Rescinded

Medlearn Matters Article Number: MM3959

Related Change Request (CR) #: 3959
Related CR Release Date: August 19, 2005
Related CR Transmittal #: 656
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

Provider Types Affected - Physicians, pedorthists, physical therapists, occupational therapists, orthotics personnel, and prosthetics personnel in Alabama, Florida, Illinois, New Jersey, Ohio, Oklahoma, Rhode Island, Texas, or Washington who provide or supply Prosthetics and Orthotics (P&O) and bill Medicare Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

Impact to You

If you are an affected supplier in **Alabama, Florida, Illinois, New Jersey, Ohio, Oklahoma, Rhode Island, Texas, or Washington,** your state requires the use of a licensed/certified orthotist or prosthetist for furnishing orthotics or prosthetics. Medicare DMEPOS suppliers in any one of these nine states planning to submit claims for Medicare payment for prosthetics and orthotics may enroll with the National Suppler Clearinghouse (NSC) and provide all required licenses and/or certifications to comply with Medicare requirements.

What You Need to Know

CR3959 puts new edits in the DMERC claims processing system that will look for Specialty Codes 51, 52, 53, 55, 56, 57, 65, 67 and all Physician Specialty Codes listed in the *Medicare Claims Processing Manual, Chapter 26, Section 10.8.2*, in order to ensure that only those who specify P&O on their Enrollment Application Forms (Form CMS-855S) are reimbursed for P&O supplies. (**Note:** A copy of the State License for these specialty codes should also be on file at the NSC.)

What You Need to Do

Make certain that your billing staffs provide your specialty codes, required licenses, and/or certifications to the NSC.

Background

At this time, DMERCs process claims from enrolled and approved DMEPOS suppliers without noting the specialty identified and services to be provided on the Enrollment Application Form (Form CMS-855S). Because there is no national Medicare policy regarding who may bill and be paid for prosthetics and certain custom-fabricated orthotics, the **NSC follows State requirements** that are in place in the (currently) nine states that require the use of an orthotist or prosthetist for furnishing of orthotics or prosthetics.

New Specialty Code Edits

The claims system used by the DMERCs will have new edits—effective for services supplied on or after the implementation date for this Change Request—that look for specialty codes to ensure that suppliers billing for prosthetics and/or orthotics are permitted to bill in accordance with the law **in the applicable states**. CMS regulations (see 42 CFR 424.57(c)) require that all DMEPOS suppliers wishing to bill Medicare meet all supplier standards. The standard in section 424.57(c)(1) requires suppliers to operate their business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements.

The following specialties may be licensed or certified by the state when applicable and they can bill for Medicare services when State law permits them to furnish Prosthetic or Orthotic items:

Specialty	Specialty Code
Medical Supply Company with Orthotics Personnel	51
Medical Supply Company with Prosthetics Personnel	52
Medical Supply Company with Orthotics and Prosthetics Personnel	53
Orthotics Personnel	55
Prosthetics Personnel	56
Orthotics Personnel, Prosthetics Personnel, and Pedorthists	57
Physical Therapist	65
Occupational Therapist	67
All Physician Specialty Codes listed in the *Medicare Claims Processing Manual, Pub 100-04 Chapter 26, § 10.8.2.*	

If you are located in one of the nine states listed in this article, check with the NSC to make certain that the correct specialty code is on file. The NSC is responsible for maintaining a central data repository for information regarding suppliers.

To ensure that your correct specialty code is on file and/or you need to update your file with the correct code, you must submit to the NSC a "Change of Information" on the CMS 855S form. The NSC will transmit this information to your DMERC.

Implementation

The implementation date for this instruction is October 3, 2005.

Additional Information

You can find more information about payment to suppliers qualified to bill Medicare for prosthetics and certain custom-fabricated orthotics, including the complete list of HCPCS Codes for Customized Orthotics and Prosthetics affected by the edit by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page look for CR3959 in the CR Column on the right, and click on the file for that CR. A list of the Prosthetic and Orthotic codes affected by this edit is attached to CR3959.

The following is contact information for the National Supplier Clearinghouse (NSC):

Toll Free Number: 1-866-238-9652

Web site: http://www.PalmettoGBA.com. Click on "Other Partners" ***or*** click on "Providers," then National Supplier Clearinghouse.

Email: medicare.nsc@palmettogba.com

Mailing address:

National Supplier Clearinghouse
P.O. Box 100142
Columbia, S.C. 29202-3142

Overnight Mailing Address:

National Supplier Clearinghouse
2300 Springdale Dr.
Bldg 1, AG-495
Camden, S.C. 29020

Supplies

New Diagnosis Code Requirements For Method II Home Dialysis Claims

Medlearn Matters Article Number: MM4095
Related Change Request (CR) #: 4095
Related CR Release Date: October 7, 2005
Effective Date: October 1, 2005
Related CR Transmittal #: 701
Implementation Date: November 7, 2005

Provider Types Affected - All providers/suppliers who submit Method II Home Dialysis claims to Medicare Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

Impact to You - This article revises the diagnosis code requirements for Method II Home Dialysis claims.

What You Need to Know - Be aware that, on October 1, 2005, **diagnosis code 585.0 will no longer be accepted** by Medicare. Instead, **use diagnosis code 585.6** (End Stage Renal Disease) on Method II home dialysis claims.

What You Need to Do - Make certain that your billing staff knows that, on your DMERC claims, they must use diagnosis code 585.6 instead of 585.0.

Background

On June 24, 2005, the Centers for Medicare & Medicaid Services (CMS) published the annual update to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes. Based on that update, effective October 1, 2005, diagnosis code 585.0 will no longer be acceptable and suppliers must use diagnosis code 585.6 (End Stage Renal Disease) on Method II home dialysis claims. Previously, instructions published in the *Medicare Claims Processing Manual*, Chapter 8, Section 90.2.1, required suppliers to use diagnosis code 585.0.

Implementation - The implementation date for the instruction is November 7, 2005.

Additional Information

The official instructions issued to DMERCs regarding this change can be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS

web site. On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR4095. Click on the link to open and view the CR.

Medlearn Matters article MM3888 describes the ICD-9-CM annual update. You may view the article at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3888.pdf on the CMS web site.

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

General

Announcement Of New National Provider Identifier (NPI) Web Page

Announcing the new CMS web page dedicated to providing all the latest NPI news for Fee-For-Service (FFS) Medicare providers! Visit http://www.cms.hhs.gov/providers/npi/default.asp on the web! While this page is dedicated to the Medicare FFS community, it contains helpful information and links that may benefit all health care providers. Reminder — Health care providers are required by law to apply for a National Provider Identifier (NPI). To apply online, visit: https://nppes.cms.hhs.gov.

2006 Annual Update Of Healthcare Common Procedure Coding System (HCPCS) Codes For Skilled Nursing Facility (SNF) Consolidated Billing (CB)

Medlearn Matters Article Number: MM4086

Related Change Request (CR) #: 4086
Related CR Release Date: October 7, 2005
Related CR Transmittal #: 696
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers and Fiscal Intermediaries (FIs) for services supplied to Medicare patients in SNFs

Provider Action Needed

Impact to You - This article is based on Change Request (CR) 4086 regarding the annual update of HCPCS codes for SNF Consolidated Billing and how the updates affect edits in Medicare claims processing systems, especially the Common Working File (CWF).

What You Need to Know - CR4086 provides updates to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with the policy for SNF consolidated billing that is detailed in Chapter 6 (Section 110.4.1) for carriers, and Chapter 6 (Section 20.6) for FIs.

What You Need to Do - Physicians, suppliers, and providers should review the new coding files that will be posted on the CMS web site.

Background

The Common Working File (CWF)

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered Skilled Nursing Facility (SNF) stay as well as for beneficiaries in a non-covered stay. These edits allow only those services excluded from consolidated billing to be separately paid by the carrier and\or FI.

For physicians and providers billing carriers: By the first week of December 2005, new code files will be posted to http://www.cms.hhs.gov/medlearn/snfcode.asp on the CMS web site.

For those providers billing FIs: By the first week of December 2005, new Excel and PDF files will be posted to http://www.cms.hhs.gov/providers/snfpps/snffi/ on the CMS web site, under the "2006 Annual and Quarterly Updates" section.

Note: It is important and necessary for the provider community billing the FIs to view the "General Explanation of the Major Categories" bullet located under each Annual update bullet, at the http://www.cms.hhs.gov/providers/snfpps/snffi/ link, to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

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

Additional Information

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

site. From that web page, look for CR4086 in the CR NUM column on the right, and click on the file for that CR.

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

Financial Liability For Services Subject To Home Health Consolidated Billing

Medlearn Matters Article Number: MM3948

Related Change Request (CR) #: 3948
Related CR Release Date: August 5, 2005
Related CR Transmittal #: 635
Effective Date: October 1, 2000
Implementation Date: November 3, 2005

Provider Types Affected - Home Health Agencies (HHAs) and providers and suppliers of services to Medicare patients in a home health episode of care

Provider Action Needed

This instruction is intended mostly as an informational refresher. However, the article and CR3948 clarify guidance regarding Home Health Services (HHS) consolidated billing, particularly the guidance that addresses potential provider and beneficiary liability for payment. **Providers/suppliers treating Medicare patients in an episode of home health care are encouraged to review the entire CR3948.** Instructions for accessing CR3948 are provided at the end of this article.

The Centers for Medicare & Medicaid Services (CMS) is providing this information because questions about payment liability have persisted since the Home Health Prospective Payment System (HH PPS) was implemented in October 2000. CMS believes that providing clear answers in the *Medicare Claims Processing Manual* will help you better understand HH PPS.

Background

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing for all home health services that are included under a physician-authorized home health care plan. Earlier guidance and information about HH PPS consolidated billing was primarily published in articles attached to Program Memoranda.

CR3948 (from which this article is taken) improves the organization of and clarifies instructions about HH PPS. In particular, it identifies circumstances in which providers or beneficiaries may be liable for payment for services subject to HH PPS consolidated billing.

A Short Summary of the Guidance

Under HHS consolidated billing, only the primary HHA can bill for services included in a beneficiary's home health benefit during the beneficiary's HHA episode of care. With the exception of Durable Medical Equipment (DME) and physician-provided therapy services (discussed below), Medicare will not separately pay other providers or suppliers for any home health services that they render. Therefore, providers and suppliers of home health services should be aware that, under certain circumstances, they, or the beneficiary, could potentially bear the cost of these services.

The Guidance in More Detail

HH PPS consolidated billing provides that the Medicare payment for all of a beneficiary's home health items and services is to be made to a single (known as "primary") HHA that oversees that beneficiary's physician-authorized home health plan. This primary HHA is the **only** agency that may bill Medicare for home care for a given homebound beneficiary at a specific time. Further, the payment Medicare makes is to the primary HHA, regardless of who actually furnishes the service (including services furnished by others under arrangement to the primary HHA, by any other contracting or consulting arrangements existing with the primary HHA, or by any other mechanism).

However, while the primary HHA is responsible for providing all of a patient's home health services, they would not be responsible for payment to another provider if they were unaware of the physician's orders for that service. Therefore, if an independent provider/supplier were to provide the beneficiary a home health service that was already consolidated into the HHA's payment, their claim would be denied by Medicare and they would not receive payment.

Types of Services Subject to Home Health Billing

The following types of services are subject to this home health consolidated billing provision, and are included in the primary HHA's payment:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;

• Speech-language pathology;
• Occupational therapy;
• Medical social services;
• Routine and non-routine medical supplies;
• Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital; and
• Care for homebound patients involving equipment too cumbersome to take to the home.

Two types of services, however, are an exception to this guidance, and are therefore not subject to the home health consolidated billing methodology. These services are:

• Physician-performed therapy services (which means that although the procedure code would be subject to HH consolidated billing, the specialty code which indicates that it was provided by a physician removes it); and
• Durable Medical Equipment (DME).

Billing of Durable Medical Equipment

DME warrants some further discussion. DME may be billed by a supplier to a Durable Medical Equipment Regional Carrier (DMERC) or billed by an HHA (including HHAs other than the primary HHA) to a Regional Home Health Intermediary (RHHI). To prevent duplicate RHHI and DMERC billing (the same dates of service for the same beneficiary), Medicare system edits ensure that all DME items billed by HHAs have a line-item date of service and HCPCS code, even though, by law, HH consolidated billing does not apply to DME. If the RHHI and the DMERC receive duplicate bills (for either purchase or rental), the first claim received will be processed and paid, and the subsequent duplicate claims will be denied.

How Do You Protect Yourself and the Beneficiaries?

In general, all providers and suppliers serving a home health patient should attempt to protect the beneficiary from unexpected liability by notifying them of the possibility that they can be responsible for payment.

Primary HHAs

Let's first discuss your responsibilities if you are the primary HHA. When a homebound beneficiary seeks care from you, you need to determine if they are already being served by a primary HHA. You can ask the beneficiary or his/her representative, if they are already being served by an HHA. Or, you can send an inquiry to your RHHI.

If the response indicates that the beneficiary is not already under the care of another HHA, you may admit them and you will become primary. The HHA that submits a successfully processed request for anticipated payment (RAP) or No-RAP Low Utilization Payment Adjustment (LUPA) will be recorded as the primary HHA for a given episode in the Common Working File (CWF).

You may also admit them, even if an episode is already open at another HHA, if the patient has chosen to transfer. If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for that patient's consolidating billing.

At the time of their initial home health care admission, you, as the primary HHA, must advise the patient that you will be providing all of their home health services, including therapies and supplies. You must also explain the disciplines (e.g., skilled nursing, physical therapy, home health aide, etc.) that will be furnishing their care, and the proposed visit frequency.

In addition, you must advise the patient, in advance (both orally and in writing), about possible payment sources, including what Medicare is expected to cover, as well as other payment sources, including payment from the patient. This discussion should help alert the beneficiary to the possibility of payment liability if they were to obtain services from anyone other than their primary HHA.

Independent Providers/Suppliers

Since Medicare payment for services that fall under home health consolidated billing is made to the primary HHA, independent providers or suppliers of these services need to understand that Medicare will not pay you separately. Therefore, before you provide a homebound beneficiary any services, you need to first determine if they are being served by a primary HHA.

To get this information you can, first, ask the beneficiary (or their authorized representative) if they are currently receiving home health services under a home health plan of care. In fact, beneficiaries and their representatives should have the most complete information as to whether or not they are receiving home health care. But, beneficiary-derived HH information, in and of itself, does not shift liability to either the beneficiary or to Medicare. Additionally, you can ask your intermediary or carrier.

Institutional providers who bill Fiscal Intermediaries (FIs) can access this information electronically through the home health Common Working File (CWF) inquiry process (See Chapter 10, Section 30.1, Health Insurance Eligibility Query to Determine Episode Status attached to CR3948.) Independent therapists who bill carriers or suppliers who bill DMERCs can call the provider toll free line to request home health eligibility information available on the CWF. (Those toll free numbers are available at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.) But remember that the carrier's or DMERC's information is based only on claims Medicare has received from HHAs by the day of the contact.

If you are concerned about the reliability of any of this information, you should advise the HH beneficiary that if they decide to accept your services rather than those provided by the primary HHA, they can be liable for the payment.

Finally, if you learn of a home health episode and contact the primary HHA, you might inquire about the possibility of making a payment arrangement with them for the service. Such contacts may foster relationships between therapy providers, suppliers and HHAs that are beneficial both to the providers involved and to Medicare beneficiaries.

Hospitals

Hospitals are responsible for making Medicare beneficiaries and caregivers aware of Medicare home health coverage policies in order to:

• Help ensure that those services are provided appropriately; and

• Alert the beneficiary to their potential liability under home health consolidated billing.

Under the Medicare Conditions of Participation (COP) for Hospitals: Discharge planning, (42 CFR, §482.43 (b) (3) and (6)), your discharge planning process must include an evaluation of the likelihood that a patient will require post-hospital services and an evaluation of their availability. Hospitals need to counsel those beneficiaries who are to receive HH services after discharge that their primary HHA will provide all of their home health services. You should also provide them with a list of HHAs from which to choose, and notify the agency that you are referring the patient to and provide the agency with any counseling notes. This should serve as a reminder to the HHA to notify the beneficiary that they will be providing all of their HH services.

Other Important Information

Institutionalizing an HH patient

Under HH PPS, claims for inpatient hospital and Skilled Nursing Facility (SNF) services have priority over claims for home health services. Because institutionalized beneficiaries cannot receive home care, if Medicare detects dates of service on an HH PPS claim that fall within the dates of an inpatient or SNF claim (not including the dates of admission and discharge), the RHHI will reject the HH claim. This will be the outcome even if the HH PPS claim were received first and the SNF or inpatient hospital claims came in later.

Edits and Denials

Claims subject to consolidated billing may be identified either pre-payment or post payment. HH consolidated billing editing is applied when Medicare has received and processed the episode claim. Any line item services within the episode start, and end, or last billable service dates, will be edited.

Medicare sends information to the FIs and carriers that enable them to reject or deny line items on claims subject to consolidated billing. This rejection or denial may take place either prior to, or after, payment. If it occurs after payment, Medicare notifies the FI or carrier to make a post-payment rejection or denial. FI post-payment recoveries will be made automatically in the claims process, and carriers follow their routine overpayment identification and recovery procedures.

Important editing issues include the following:

• If Medicare receives only a Request for Anticipated Payment (RAP) from an HHA for an episode and an incoming claim from another provider contains dates of service within the 60-day home health episode period, Medicare alerts the FI or carrier that the incoming claim may be subject to consolidated billing.

The FI or carrier will process the claim for payment, but also alerts the provider on the remittance advice with remark code N88: "*This payment is being made conditionally. An HHA episode of care* notice has been filed for this patient...This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."

• If an independent provider/supplier submits a claim for services (subject to home health consolidated billing) for a beneficiary under a home health care plan (place

of service on the claim is "12 home"), but Medicare does not yet have a record of either a RAP or a home health claim for the episode of care, your carrier will alert you on the remittance advice with remark code N116: *"This payment is being* made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care…This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."

• In HH PPS consolidated billing, non-routine medical supplies are identified as a list of discrete items by HCPCS code. Medicare periodically publishes Routine Update Notifications that contain updated lists of non-routine supply codes and therapy codes that must be included in home health consolidated billing. The lists are updated annually, effective January 1, as a result of the annual changes in HCPCS codes, and also as frequently as quarterly if required by the creation of new, mid-year HCPCS codes. (Medlearn Matters articles are prepared to inform providers of these periodic updates.)

- Any claim submitted to a DMERC, with dates of service that overlap the dates of an open HH PPS episode and containing a non-routine supply HCPCS code, will be denied.

- Non-routine supply HCPCS codes, which may be claimed as part of providing certain emergency, surgical, diagnostic, and End Stage Renal Disease (ESRD) services, are either bundled into the rate paid for the primary service, or are otherwise incident to the primary service(s) being rendered. They do not fall within the bundling provisions of HH PPS, and are not subject to CWF consolidated billing edits.

• Medicare enforces consolidated billing for outpatient therapies on claims submitted to FIs, recognizing as therapies all services billed under revenue codes 042X, 043X, 044X. These revenue codes have been cross-referenced to a list of HCPCS codes that represent the same services for use in editing against carrier claims. This list will also be updated periodically by Routine Update Notification.

• Remember, however, as mentioned earlier, physician-performed therapy services are not subject to home health consolidated billing.

• **Osteoporosis drugs** are subject to home health consolidated billing, even though they continue to be paid on a cost basis. Only a primary HHA can bill for their use by Medicare patients in an episode of care. For more detailed information, refer to Section 90.1 of Chapter 10 of the *Medicare Claims Processing Manual*, which is available at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the CMS web site.

Additional Information

This article summarizes the information made available in CR3948. Providers treating Medicare patients in a home health episode of care are encouraged to be familiar with all the details of CR3948. You can find CR3948 at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS website. From that web page, look for CR3948 in the CR NUM column on the right, and click on the file for that CR. CR3948 includes revised portions of the *Medicare Claims Processing Manual* related to the HH PPS. Finally, if you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

Medical Review Additional Documentation Requests (ADRs)

Medlearn Matters Article Number: MM4022

Related Change Request (CR) #: 4022
Related CR Release Date: September 30, 2005
Related CR Transmittal #: 125
Effective Date: December 30, 2005
Implementation Date: December 30, 2005

Provider Types Affected - All Medicare providers and suppliers

Provider Action Needed

Impact to You - Through the use of the Additional Documentation Request (ADR), your carrier, including Durable Medical Equipment Regional Carriers (DMERCs), or intermediary may ask you for additional documentation regarding a particular Medicare claim.

What You Need to Know - To get a more complete picture of a patient's clinical condition, CR4022 allows carriers, DMERCs, and intermediaries to request additional documentation about the patient's condition before and after a specific service to gain a more complete picture of the patient's clinical condition.

What You Need to Do - Your staffs should be aware of ADRs and should be prepared to respond to them within 30 days.

Background

When a carrier, DMERC, or intermediary (also referred to as Medicare contractor(s)), cannot make a coverage or coding determination from the information that has been provided on a claim and its attachments, they may ask for additional documentation by issuing an Additional Documentation Request (ADR). The Medicare contractor must request records related to the claim(s) being reviewed. The Medicare contractor may collect documentation related to the patient's condition before and after a service in order to get a more complete picture of the patient's clinical condition. Your Medicare contractor will not deny other claims related to the documentation of the patient's condition before and after the claim in question unless they review and give appropriate consideration to the actual additional claims and associated documentation.

Additional Information

For more information about ADRs during prepayment or postpayment medical review, go to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4022 in the CR NUM column on the right and click on the file for that CR. Also useful is the *Medicare Program Integrity Manual,* Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.2 (Additional Documentation Requests (ADR) During Prepayment or Postpayment MR), which is an attachment to CR4022.

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

Medicare's Implementation Of The National Provider Identifier (NPI): The Second In The Series Of Special Edition Medlearn Matters Articles On NPI-Related Activities

Medlearn Matters Article Number: SE0555

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

Revised: This article was revised on October 3, 2005, to modify the language (in italicized print) in the first sentence under Part 2 on Page 5. All other information remains the same.

Provider Types Affected

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

Part 1: Information That Applies to All Providers

Background

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

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

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

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

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

• An easy web-based application process is available at https://nppes.cms.hhs.gov.

• A paper application may be submitted to an entity that assigns the NPI (the Enumerator). A copy of the application, including the Enumerator's mailing address, is available at https://nppes.cms.hhs.gov.

A copy of the paper application may also be obtained by calling the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.

• With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

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

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

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

Sharing Your NPI

Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction.

For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are:

• Any provider with which they do business (e.g., pharmacies);

• Health plans with which they conduct business; and

• Organizations where they have staff privileges.

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

Electronic File Interchange (EFI): Formerly Known as Bulk Enumeration

The Centers for Medicare & Medicaid Services (CMS) is in the process of putting into place a mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many healthcare providers, with provider approval, to the NPPES within a single electronic file.

For example, a large group practice may want to have its staff handle the NPI applications for all its members. If an organization/provider employs all or a majority of its physicians and is willing to be considered an EFI submitter, EFI enumeration may be a good solution for that group of providers.

The EFI Steps

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

• An organization that is interested in being an EFI organization will log on to an EFI home page (currently under construction) on the NPPES web site (https://nppes.cms.hhs.gov) and download a certification form.

• The organization will send the completed certification form to the Enumerator to be considered for approval as an EFI organization (EFIO).

• Once notified of approval as an EFIO, the entity will send files in a specified format, containing NPI application data, to the NPPES.

• Providers who wish to apply for their NPI(s) through EFI must give the EFIO permission to submit their data for purposes of applying for an NPI.

• Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.

• The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s). An EFIO may also be used for updates and deactivations, if the providers agree to do so.

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

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

Crosswalks

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

Subparts of a Covered Organization

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

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

Covered organizations/providers must obtain NPI(s) for their subparts, or instruct the subparts to obtain their own NPIs. The subparts would use their NPIs to identify themselves in the standard transactions they conduct.

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

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

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

What Providers Can Do to Prepare for NPI Implementation

• Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.

• Check with your billing services, vendors, and clearinghouses about NPI compliance and what you need to do to facilitate the process.

• Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.

• Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

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

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

NPI Transition Plans for Medicare FFS Providers

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

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:	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. Small health plans have an additional year to be NPI compliant.

Crosswalk

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

Subparts Policy

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

Resources for Additional Information

Coming Soon—CMS is developing a Medlearn web page on NPI for Medicare FFS providers, which will house all Medicare fee for service educational resources on NPI, including links to all Medlearn Matters articles, frequently-asked-questions, and other information. CMS will widely publicize the launch of this web page in the coming weeks. *(See previous article entitled "Announcement of New National Provider Identifier (NPI) Web Page.)*

You may wish to visit http://www.cms.hhs.gov/hipaa/hipaa2/ regularly for the latest information about the NPI, including Frequently Asked Questions, announcements of Roundtables, conferences, and guidance documents regarding the NPI.

Go to http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/CoveredEntityFlowcharts.pdf to access a tool to help establish whether one is a covered entity under the administrative simplifications of HIPAA.

A helpful tool that provides an overview of the NPI and the application process for obtaining an NPI is available at http://www.cms.hhs.gov/medlearn/npi/npiviewlet.asp

The Federal Register notice containing the NPI Final Rule is available at http://a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf

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

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

National Modifier And Condition Code To Be Used To Identify Disaster-Related Claims

Medlearn Matters Article Number: MM4106

Related Change Request (CR) #: 4106
Related CR Release Date: October 14, 2005
Related CR Transmittal #: 184
Effective Date: August 21, 2005
Implementation Date: October 3, 2005, but no later than October 31, 2005

Note: This article was revised on October 14, 2005, to clarify that CR4106 related to Medicare beneficiaries and it also relates to Hurricane Rita. In addition, the CR release date and transmittal number (see above) were modified.

Provider Types Affected - Physicians, suppliers, and providers billing Medicare contractors (carriers, including Durable Medical Equipment Regional Carriers (DMERCs) and/or Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs)) for services rendered to beneficiaries affected by Hurricane Katrina.

Provider Action Needed

Impact to You - This article is based on Change Request (CR) 4106, which establishes a new condition code and modifier for providers to use to indicate claims for victims of Hurricanes Katrina and Rita and other disasters.

What You Need to Know - To accommodate the emergency health care needs of Medicare beneficiaries and providers affected by Hurricanes Katrina and Rita and any future disasters, the Centers for Medicare & Medicaid Services (CMS) has created the following new condition code and modifier, effective for dates of service on and after August 21, 2005. The new condition code is **"DR (Disaster Related)"** and the new modifier is "**CR (Catastrophe/Disaster Related)**."

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

Background

CMS has acted to ensure that the Medicare program will be flexible enough to accommodate the emergency health care needs of beneficiaries and medical providers in the states devastated by Hurricanes Katrina and Rita. Many of the programs' normal operating procedures have been relaxed to speed the provision of health care services to the elderly and persons with disabilities who depend on Medicare services.

Because of hurricane damage to local health care facilities, many Medicare beneficiaries have been evacuated to neighboring states where receiving hospitals and nursing homes have no access to patients':

- Health care records;
- Current health status; or
- Verification of status as Medicare beneficiaries.

Note: CMS is assuring facilities and medical providers receiving Medicare beneficiaries affected by Hurricanes Katrina and Rita that ***the normal requirements for documentation will be waived and the presumption of eligibility should be made***.

Health care providers that furnish medical services in good faith, but who cannot comply with normal program

requirements because of Hurricanes Katrina and Rita, will be:

• Paid for services provided; and
• Exempt from sanctions for noncompliance (unless it is discovered that fraud or abuse occurred).

New Condition Code and Modifier

To facilitate Medicare claims processing and track services and items provided to victims of Hurricanes Katrina and Rita and any future disasters, CMS has established a new condition code and modifier for providers to use on disaster-related claims. The new condition code and modifier are for use by providers submitting claims for Medicare beneficiaries who are Katrina disaster patients in any part of the country and are effective for dates of service on and after August 21, 2005. The new codes are the following:

• The new condition code is **DR - Disaster Related**
• The new modifier is **CR - Catastrophe/Disaster Related**

For physicians or suppliers billing their local carrier or DMERC, only the modifier (CR) should be reported and not the condition code. A condition code is used in FI billing.

For institutional billing, either the condition code or modifier may be reported. The condition code would identify claims that are impacted or may be impacted by specific payor policies related to a national or regional disaster. The modifier would indicate a specific Part B service that may be impacted by policy related to the disaster.

CR4106 instructs Medicare contractors to recognize the new condition code and modifier on October 3, 2005, if possible, but no later than October 31, 2005.

In addition to this Medlearn Matters Article, CMS regional offices will help facilitate contractor outreach regarding provider education on the use of the new modifier and condition code.

Implementation

The targeted implementation date is October 3, 2005, but no later than October 31, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/FI regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4106 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC/FI at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

APPEALS

MMA - Changes To Chapter 29 - Appeals Of Claims Decisions: Redeterminations And Reconsiderations (Implementation Date May 1, 2005)

Medlearn Matters Article Number: MM3942

Related Change Request (CR) #: 3942
Related CR Release Date: October 7, 2005
Related CR Transmittal #: 697
Effective Date: May 1, 2005
Implementation Date: January 9, 2006

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

Provider Action Needed

Impact to You - The new second level in the administrative appeals process is called a **"reconsideration."** It is different from the previous first level of appeal for Part A claims performed by Medicare Fiscal Intermediaries (FIs). Reconsiderations will be processed by Qualified Independent Contractors (QICs).

What You Need to Know - Medicare contractors (FIs, including Regional Home Health Intermediaries (RHHIs), or carriers, including Durable Medical Equipment Regional Carriers (DMERCs)) may consider as **good cause for late filing,** written redetermination requests that are:

• Mailed or personally delivered to CMS, SSA, RRB office or another
Government agency; and
• Mailed in good faith and within the time limit, **but**
• Do not reach the appropriate Medicare contractor until after the time period to file a request expired.

In this case, the Medicare contractor may extend the period for filing.

What You Need to Do - Please refer to the *Background* section of this article for additional new policy information about the time limit for filing a request for redetermination.

Background

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

Requests for redeterminations of appeal decisions (determinations) should go either to the Qualified Independent Contractor (QIC), the Administrative Law Judge (ALJ), or the Hearing Officer (HO), depending on whether the claim is a Part A or Part B claim; whether the Medicare contractor who issued the initial claim decision is an FI or a carrier; and the date the claim was issued.

Time Limit for Filing a Request for Redetermination

A request for redetermination must be filed within 120 days of the date of receipt of the notice of initial determination (either the Medicare Summary Notice (MSN) supplied to the beneficiary or the Remittance Advice (RA) supplied to the provider).

• For requests filed in writing - the date received is defined as the date received by the Medicare contractor in the corporate mailroom.
• For requests filed in person - the date received is defined as the date of the office's date stamp on the request.

Please refer to the following table for clarification.

Appeal Rights for Requests for Redeterminations
The First Level of Appeal

Medicare Claims	Medicare Contractor Issuing Redetermination	Date Redetermination Issued and Mailed	Where to Appeal the Redetermination*
Part A/Part B	FI	On or after May 1, 2005	QIC
Part B	Carrier	On or after January 1, 2006	QIC
Part A	FI	Before May 1, 2005	ALJ
Part B	FI	Before May 1, 2005	HO
Part B	Carrier	Before January 1, 2006	HO

*Qualified Independent Contractor (QIC); Administrative Law Judge (ALJ); Hearing Officer (HO)

Additional Information

Medicare Claims Processing Manual, Chapter 29 - Appeals of Claims Decisions, 310.2, 310.3 can be found at http://www.cms.hhs.gov/manuals/104_claims/clm104c29.pdf on the CMS web site. Medlearn Matters article MM3530 - "MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title - Appeals Transition - BIPA 521 Appeals) Revised: 4/12/2005 can be found at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3530.pdf on the CMS web site. Change Request CR3530 "Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title-Appeals Transition – BIPA 521 Appeals) Revised: 4/12/2005 can be found at http://www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf on the CMS web site.

The official instruction issued to your FI, DMERC, or carrier regarding this change may be found by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look

for CR3942 in the CR NUM column on the right, and click on the file for that CR. The new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR3942.

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

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

Medlearn Matters Article Number: MM4019

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

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

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. It is different from the previous first level of appeal for Part A claims performed by Fiscal Intermediaries (FIs). Reconsiderations will be processed by Qualified Independent Contractors (QICs). CR4019 focuses on the general appeals process in Initial Determinations. CR4019 contains a considerable amount of information that is pertinent to the entire process of Medicare claims appeals, and focuses specifically on the additions of Sections 200 to 260 to Chapter 29 of the *Medicare Claims Processing Manual*.

Key Points

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

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

Minor Errors and Omissions

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

Who May Appeal

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

Provider or Supplier Appeals When the Beneficiary Is Deceased

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

Parties to an Appeal

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

Steps in the Appeals Process: Overview

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

The Medicare Fee-for-Service Appeals Process

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold to be Met or Amount in Controversy (AIC)
1. Redetermination			
▪ Performed by the Medicare Contractor	120 days from date of receipt of the notice initial determination (MSN or RA). (The notice of initial determination is presumed to be received five days from the date of the notice unless there is evidence to the contrary.)	**Part A** – FI (MAC) **Part B** – Carrier (MAC)	None
2. Reconsideration			
▪ Performed by QIC ▪ Case file prepared by the Medicare contractor and forwarded to the QIC.** ▪ Medicare contractor may have effectuation responsibilities for decisions made by the QIC.	180 days from date of receipt of the redetermination	**Part A** and **B** – QIC	None
3. Administrative Law Judge (ALJ) Hearing			
▪ Case file prepared by the QIC and forwarded to the HHS Office of Medicare Hearings and Appeals (OMHA). ▪ Medicare contractor may have effectuation responsibilities for decisions made at the ALJ level.	60 days from the date of receipt of the reconsideration notice	**Part A** and **B** – HHS OMHA Field Office	At least $100 remains in controversy*** *For requests made on or after January 1, 2006, at least $110 remains in controversy*
4. Departmental Appeals Board (DAB) Review			
▪ Contractor may have effectuation responsibilities for decisions made at the DAB level.	60 days from the date of receipt of the ALJ hearing decision/dismissal	**Part A** and **B** – DAB or ALJ Hearing Office	None
5. Federal Court (Judicial) Review			
▪ Medicare contractor may have effectuation responsibilities for decisions made at the Federal Court level.	60 days from date of receipt of DAB decision or declination of review by DAB		At least $1,050 remains in controversy*** *For requests made on or after January 1, 2006, at least $1,090 remains in controversy*

*Where to Appeal - Part A includes Part B claims filed with the FI.

** In accordance with the appropriate manual section and the Joint Operating Agreement (JOA).

***Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar Amount in Controversy (AIC) requirement will increase by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Where to Appeal

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

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

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

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

Procedures to establish good cause are effective for all requests for redeterminations received by FIs on or after May 1, 2005, and all requests for redeterminations received by the carrier on or after January 1, 2006. The new Section 240 of Chapter 29 of the *Medicare Claims Processing Manual* lists the general procedure for establishing good cause for late filing; when a favorable decision for good cause is made; and when an unfavorable decision for good cause is made. A listing of conditions and examples that may establish good cause for late filing by beneficiaries, or by providers, physicians, and suppliers, can be found in Section 240, which is attached to CR4019.

Amount in Controversy (AIC) Requirements

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

Additional Information

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

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

Tips For Filing Claims, Adjustments And Appeals

At CIGNA Government Services, we strive to handle your inquiries in the quickest and most efficient manner. You can help us achieve this high quality standard by following these tips:

- If a claim is returned as unprocessable, you should refile the claim electronically or submit a paper claim using the valid CMS-1500 red and white claim form.

- When resubmitting a claim for processing, you should file the claim electronically or submit a paper claim using the valid CMS-1500 red and white claim form.

- Corrected claims should be sent to the attention of Written Adjustments. You may use the Request for Written Adjustment form for your correction(s). This form is available on our Web site at http://www.cignagovernmentservices.com/dmerc/resource.html.

Examples of a request for adjustment include (but is not limited to):

  - o Changes to the date(s) of service
  - o Changes to the number of units
  - o Claims denied due to not receiving the CMN with the initial claim submission
  - o Modifier changes

- Requests for Redeterminations should be sent to P. O. Box 22995. You should not use this Post Office box to submit new claims for processing, requests for written adjustments, hearing requests, or any other type of correspondence.

- Be sure that you are filing your Redetermination requests to the correct DMERC. Requests submitted to the incorrect DMERC will delay the response to your appeal requests.

- Requests for Hearings for redetermination decisions issued prior to January 1, 2006, should be sent to P. O. Box 22263. You should not use this Post Office box to submit new claims for processing, requests for written adjustments, redetermination requests, or any other type of correspondence.

For more information regarding the proper address to use for general correspondence, please refer to Chapter 15 of the *DMERC Region D Supplier Manual*.

Upcoming Changes To The Medicare Appeals Process

As January 1, 2006 fast approaches, so are changes to the Medicare Appeals process. Below is a summary of the upcoming changes.

Redeterminations

- Beginning with overpayment letters dated January 1, 2006 the first level of appeal is Redeterminations.
- Redetermination letters will be sent on fully favorable decisions made January 1, 2006 forward.
- Redetermination dismissals will have appeal rights at the Reconsideration level. Reconsiderations must be requested within 60 days of receipt of the dismissal letter.
- Only true medical necessity denials have appeal rights. Clerical errors, minor errors, and minor omissions must be handled as claim reopenings.

Reconsiderations

- Reconsiderations is the next level of appeal. Beginning January 1, 2006, Reconsiderations will be processed by Qualified Independent Contractors (QICs). All requests for a Reconsideration should be mailed to: Q2 Administrators, LLC, Part B/DME QIC West Operations, P. O. Box 100213, Columbia, SC, 29202-0213.
- Effective January 1, 2006, there is no amount in controversy to meet for Reconsiderations.
- Reconsideration decisions must be made within 60 days of receipt.
- All medical documentation must be submitted with the Reconsideration request. If documentation is not submitted, it cannot be submitted at the Administrative Law Judge (ALJ) level.

Administrative Law Judge

- Effective for Reconsideration decisions made January 1, 2006, the next level of appeal is an ALJ hearing.
- The amount in controversy for an ALJ hearing is $110.
- ALJ hearing decisions must be made within 60 days of receipt.
- All requests for an ALJ hearing should be mailed to one of the following locations based on the appellant's address:

o HHS Office of Medicare Hearings and Appeals (OMHA)
BP Tower & Garage
200 Public Square, Suite 1300
Cleveland, OH 44144-2316

HHS Region I – Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
HHS Region II – New York, New Jersey, Puerto Rico, Virgin Islands
HHS Region III – Delaware, Maryland, Pennsylvania, Virginia, West Virginia, District of Columbia
HHS Region V – Illinois, Indiana, Ohio, Michigan, Minnesota, Wisconsin

o HHS Office of Medicare Hearings and Appeals (OMHA)
100 SE 2nd Street, Suite 1700
Miami, FL 33131-2100

HHS Region IV – Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
HHS Region VI – Arkansas, Louisiana, New Mexico, Oklahoma, Texas

o HHS Office of Medicare Hearings and Appeals (OMHA)
27 Technology Drive, Suite 100
Irvine, CA 92618-2364

HHS Region VII – Iowa, Kansas, Missouri, Nebraska
HHS Region VIII – Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
HHS Region IX – Arizona, California, Hawaii, Nevada, Guam, Trust Territory of the Pacific Islands, American Samoa
HHS Region X – Alaska, Idaho, Oregon, Washington

- Administrative Law Judges will not accept evidence that was not submitted and considered at the Reconsideration level.

Reopenings

- Effective with initial determinations made January 1, 2006, clerical errors, minor errors, and minor omissions must be handled as claim reopenings. These types of errors can no longer be handled as an appeal.
- To request a claim reopening complete the Written Adjustment Request Form, or submit a request that includes the information on the form, and mail to CIGNA

Government Services, DMERC Region D, P. O. Box 690, Nashville, TN 37202

• All requests for claim reopenings must be made within 1 year of the initial claim determination.

For additional information, refer to the following Medlearn Matters articles: MM3942, MM4019

ELECTRONIC DATA INTERCHANGE (EDI)

Claim Status Code/Claim Status Category Code Update

Medlearn Matters Article Number: MM3960

Related Change Request (CR) #: 3960
Related CR Release Date: July 29, 2005
Related CR Transmittal #: 631
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

Provider Types Affected - All providers submitting Health Care Claim Status Transactions to Medicare carriers, including Durable Medical Equipment Carriers (DMERCs), and Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs)

Provider Action Needed

This is a reminder item regarding the periodic update of certain code sets used as a result of the Health Insurance Portability and Accountability Act (HIPAA). Effective January 1, 2006, the Medicare Claims processing system will update its lists of Health Care Claims Status Codes and Health Care Claims Status Category Codes with all applicable code changes posted online with the "new as of 10/05" and prior date designations.

Background

Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets.

Claim Status Category Codes and Claim Status Codes are used in the Health Care Claim Status Inquiry and Response (276/277) transactions:

• Claim Status Category Codes indicate the general payment status of the claim.

• Claim Status Codes provide more detail about the status communicated in the general Claim Status Category Codes.

These codes are available online at: http://www.wpc-edi.com/codes/Codes.asp

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/FI/RHHI regarding this change. That instruction may be viewed by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3960 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your Medicare carrier/DMERC/FI/RHHI at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Medicare Announces End Of HIPAA Contingency Plan For Claims Submissions

Medlearn Matters Article Number: MM3956

Related Change Request (CR) #: 3956
Related CR Release Date: August 4, 2005
Related CR Transmittal #: 171
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

Provider Types Affected - All Medicare physicians, providers, and suppliers who continue to submit electronic claims in non-compliant HIPAA formats

Impact on Providers

Impact to You

The Centers for Medicare & Medicaid Services (CMS) is ending its contingency plan that allowed providers to submit claims formats electronically that were not in the format required by the Health Insurance Portability and Accountability Act (HIPAA). As of October 1, 2005, all providers must use the HIPAA compliant format for claims submitted to Medicare. **In June, 2005, over 99% of claims submitted to Medicare were in HIPAA compliant formats.**

What You Need to Know

Non-compliant claims submitted to Medicare on or after October 1, 2005, will be rejected and returned to the provider.

What You Need to Do

To assure that your claims are processed timely and that your cash flow is not interrupted, be sure to submit HIPAA compliant claims as of October 1, 2005.

Background

The Health Insurance Portability and Accountability Act (HIPAA) regulation required claims be submitted electronically effective October 16, 2003, in a format adopted for national use. To allow additional time for entities to become compliant, CMS established a contingency plan to continue Medicare fee-for-service (FFS) payments beyond October 16, 2003 based on non-compliant formats.

In a measured step toward full compliance, CMS announced that effective July 1, 2004, non-compliant electronic claims would be paid after 27 days (the same as paper claims). Further information on the contingency plan may be found in Medlearn Matters articles MM2981 and SE0414 at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2981.pdf and http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0414.pdf respectively. These articles also provided important information to assist those few remaining providers who need to begin sending HIPAA compliant claims.

Through provider outreach activities, CMS has seen a steady decrease in the number of non-HIPAA compliant providers. In June 2005, fewer than 4% of Medicare FFS billing providers submitted electronic non-HIPAA compliant claims. Considering the number of all active Medicare providers, it is clear that the Medicare provider community at large has done an outstanding job of adopting the HIPAA claims formats. CMS believes that the industry has surpassed critical mass in both the total number of compliant claims and number of providers capable of sending compliant claims. Therefore, Medicare will end its HIPAA contingency Plan for claims submission on October 1, 2005.

Claims that are not compliant as of October 1, 2005 will be returned to the provider for submission as a compliant claim. **But, prior to October 1, if you are not submitting HIPAA compliant claims your** Medicare carrier, Durable Medical Equipment Regional Carrier (DMERC), or intermediary will contact you directly regarding the need to become compliant to offer further assistance.

CMS expects to end the contingency plan for other transactions in the near future. The remittance advice (835) is our next target to end the full contingency. We will continue to monitor progress toward use of the HIPAA standards to guide in that decision.

Additional Information

As previously mentioned, further information on the contingency plan and on help in becoming compliant may be found in Medlearn Matters articles MM2981 and SE0414 at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2981.pdf and http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0414.pdf respectively. As Medlearn Matters article MM2981 indicates Medicare carriers and intermediaries can provide free/low cost software that will enable submission of HIPAA compliant claims electronically. If you need such software, contact your carrier or intermediary at their special EDI telephone number. Your carrier/intermediary will also have a list of vendors who may assist you in submitting compliant claims. For those billing Medicare Part A (including hospital outpatient services), a list of these carrier/intermediary numbers by State is available at: http://www.cms.hhs.gov/providers/edi/anum.asp For those billing Medicare Part B, you may find those numbers listed by State at: http://www.cms.hhs.gov/providers/edi/bnum.asp

For additional information on HIPAA, visit the CMS Web site at: http://www.cms.hhs.gov/hipaa/hipaa2/default.asp

To view the revised manual chapter for the claims receipt rules, see Chapter 1, Section 80.2.1.2, which can be found in Pub 100-04, the *Medicare Claims Processing Manual*. This can be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Introduction – Medicare Remit Easy Print (MREP)

Are you still using the Standard Paper Remittance (SPR)? Save TIME and MONEY by taking advantage of FREE Medicare Remit Easy Print (MREP) software now available for viewing and printing the HIPAA compliant Electronic Remittance Advice (ERA)! The MREP software gives providers and suppliers the following abilities:

• Easy navigation and viewing of the ERA using your personal computer;
• Print the ERA in the Standard Paper Remittance (SPR) format;
• Search capability that allows providers and suppliers the ability to find claims information easily;
• Print and export reports about ERAs including denied, adjusted and deductible applied claims;
• Easy-to-use method to archive, restore and delete imported ERAs

Providers and suppliers can view and print as many or as few claims as needed. This will be especially helpful when you need to print only one claim from the remittance advice when forwarding the claim to a secondary payer. This FREE software can save you time resolving Medicare claim issues. Take advantage of the MREP features unavailable with the SPR.

In order to utilize the MREP software, you will need to receive a HIPAA compliant ERA. Contact the CIGNA Government Services EDI Department at 866.224.3094 to find out more about MREP and/or for information on how to receive a HIPAA compliant ERA. Take advantage of this new software. Begin using MREP today!

The link to the Medicare Remit Easy Print (MREP) on the CMS Web site is http://www.cms.hhs.gov/IT.

Update To The Healthcare Provider Taxonomy Codes (HPTC) Version 5.1

Medlearn Matters Article Number: MM4072

Related Change Request (CR) #: 4072
Related CR Release Date: September 30, 2005
Related CR Transmittal #: 694
Effective Date: October 30, 2005
Implementation Date: October 30, 2005

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

Impact to You - This article is based on Change Request (CR) 4072, which includes details regarding the Version 5.1 HPTC update.

What You Need to Know - CR4072 advises your carrier and/or DMERC to obtain the Healthcare Provider Taxonomy Code list Version 5.1 and use it to update their internal HPTC tables to process your claim(s) correctly.

What You Need to Do - Please see the *Background* section of this article for further details regarding this update.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that submitted data, which is part of a named code set, be valid data from that code set. Claims with invalid data are noncompliant. Because healthcare provider taxonomy is a named code set in the American National Standards Institute (ANSI) X12N 837 Professional Implementation Guide, Medicare carriers, including DMERCs, must validate the inbound taxonomy codes against their internal HPTC tables.

The HPTC is an external non-medical data code set designed for use in classifying healthcare providers in an electronic environment according to provider type, or practitioner specialty. HPTCs are scheduled to be updated twice per year (April and October).

The updated code list is available from the Washington Publishing Company at http://www.wpcedi.com/codes/taxonomy in two forms:

• Free Adobe PDF download; and
• Available for purchase, an electronic representation of the list, which will facilitate the automatic loading of the code set.

CR4072 advises your carrier and/or DMERC to use the most cost effective means to obtain the Version 5.1 HPTC list and update their HPTC tables as necessary.

Implementation - The implementation date for the instruction is October 3, 2005.

Additional Information

To summarize the changes in Version 5.1, the following taxonomy codes are added:

• 170300000X
• 171000000X
• 1710I1002X
• 1710I1003X

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change at http://www.cms.hhs.gov/manuals/transmittals/

comm_date_dsc.asp on the CMS web site. From that web page, look for CR 4072 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

HIPAA

Clarification On Termination Of The Incoming Claim Health Insurance Portability And Accountability Act (HIPAA) Contingency Plan And Impact Upon The Administrative Simplification Compliance Act (ASCA) Reviews

The Centers for Medicare & Medicaid Services (CMS) has received a number of inquiries about the impact of termination of the contingency plan for incoming claims on October 1, 2005, on submission of Medicare Secondary Payer (MSP) claims. The following information is being furnished to clarify the Medicare requirements for submission of compliant MSP claims as required by the Health Insurance Portability and Accountability Act (HIPAA).

On August 4, 2005, CMS announced that the HIPAA contingency period for claims sent to Medicare would end on October 1, 2005. This termination does not apply to claims that Medicare sends outbound to other payers that have signed a coordination of benefits (COB) trading partner agreement for the transfer of claims by Medicare. It does apply to claims sent to Medicare for secondary payment following processing by a primary payer, however. Therefore, effective October 1, 2005, electronic MSP claims must comply with all X12 837 version 4010A1 implementation guide requirements, and include standard claim adjustment reason (CAS) codes to describe adjustments that a primary payer made during adjudication, or they will be rejected.

CMS is aware of provider concerns that primary payers frequently send paper explanations of benefits or 835 transactions that contain local messages or codes rather than standard CAS codes. HIPAA does not require that standard CAS codes be reported in paper explanations of benefits, and payers that still have an X12 835 HIPAA contingency plan in effect may not yet be able to report standard CAS codes. HIPAA does require health care benefit payers to send providers X12 835 version 4010A1 transactions if requested by providers, and those 835 transactions must contain standard CAS codes by the end of each payer's 835 contingency period.

CMS is working with the HIPAA standards committee that maintains the CAS codes to develop a simplified means to translate non-standard messages and codes into standard CAS codes. We expect this process to be approved and implemented quickly. However, until an alternate solution is approved for use, electronic MSP claims sent to Medicare are required to contain standard CAS codes, along with other loops, segments, and data elements that apply. It is the provider's responsibility to convert local adjustment reason codes or messages into the appropriate standard CAS codes prior to transmission of an 837 version 4010A1 claim to Medicare for secondary payment.

FEE SCHEDULE

2006 Reasonable Charge Codes

Payment for dialysis supplies and dialysis equipment are made on a reasonable charge basis per regulations contained in 42 CFR 405.501.

As part of the development of reasonable charge data, the DMERCs shall compute 2006 customary and prevailing charges for the codes identified below using actual charge data from July 1, 2004, through June 30, 2005. In addition, the DMERCs will compute the Inflation Indexed Charge (IIC) for these codes for 2006. The IIC update factor for 2006 is 2.5 percent.

Dialysis Supplies Billed With AX Modifier

A4215 A4216 A4217 A4248 A4244 A4245 A4246 A4247 A4450 A4452 A6250 A6260 A4651 A4652 A4657 A4660 A4663 A4670 A4927 A4928 A4930 A4931 A6216 A6402

Dialysis Supplies Billed Without AX Modifier

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

Dialysis Equipment Billed With AX Modifier

E0210NU E1632 E1637 E1639

Dialysis Equipment Billed Without AX Modifier

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

HCPCS Coding changes for 2006

HCPCS codes A4215, A6216 and A6402 have been added to the dialysis supplies that require an AX modifier for payment. Therefore, suppliers must attach the AX modifier to these codes when they are used to bill for dialysis supplies.

HCPCS code A4656AX will be deleted effective January 1, 2006, and crosswalked to HCPCS code A4215AX.

DMEPOS Fee Schedule Update For 2006

Fees for the new 2006 HCPCS codes are not included in the 1st quarter fee schedule that is included on the Winter 2006 publications CD-ROM. The 1st quarter fee schedule will be revised to include the new codes and will be posted on our Web site at http://www.cignamedicare.com/dmerc/fsch/ index.html in mid-December 2005. The 1st Quarter 2006 DMEPOS fee schedule will apply to all claims with dates of service January 1, 2006 through December 31, 2006.

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

Medlearn Matters Article Number: MM3992

Related Change Request (CR) #: 3992
Related CR Release Date: August 19, 2005
Related CR Transmittal #: 653
Effective Date: April 1, 2005, July 1, 2005, and October 1, 2005, respectively

Implementation Date: October 3, 2005

Note: This article was revised on September 19, 2005, to reflect that three quarters of updated files were made available for the quarters specified for the effective dates shown above.

Provider Types Affected - All Medicare providers who bill Medicare contractors: carriers, including Durable Medical Equipment Regional Carriers (DMERCs), Fiscal Intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs)

Provider Action Needed

Impact to You - CR3992 provides the payment allowance limits in the April 2005, July 2005, and October 2005 drug pricing files. The revised payment limits for the codes listed in this article supersede the payment limits for these codes in any publication published prior to this document.

What You Need to Know - Be aware that certain Medicare Part B drug payment limits were revised for dates of service on or after April 1, 2005; on or before June 30, 2005; on or after July 1, 2005, and on or before September 30, 2005.

What You Need to Do - Make certain your billing staff is aware of these changes. The downloads for the April 2005, July 2005, and October 2005 ASP drug pricing files are available after September 19, 2005. See the *Additional Information* section in this article for the web site address.

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

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis. Each quarter, CMS will update your carrier/FI payment allowance limits with the ASP files.

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

The **one new exception** listed in this CR states that the payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors (carriers,

DMERCs, FIs, and RHHIs) will determine payment limits for radiopharmaceuticals based on invoice pricing or the methodology in place in November 2003.

Implementation - The implementation date for the instruction is October 3, 2005.

Additional Information - The official instruction issued to your Medicare contractor regarding this change may be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that
web page, look for CR3992 in the CR NUM column on the right and click on the file for that CR.

CMS will also update the Microsoft Excel files on the CMS web site to reflect these revised payment limits.

Those files are at http://www.cms.hhs.gov/providers/drugs/asp.asp on the CMS web site. If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

October 2005 Quarterly Fee Schedule Update For Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS)

Medlearn Matters Article Number: MM4026

Related Change Request (CR) #: 4026
Related CR Release Date: September 2, 2005
Related CR Transmittal #: 665
Effective Date: January 1, 2005 for implementation of revised fee schedule amounts for codes in effect on January 1, 2005; October 1, 2005 for all other changes
Implementation Date: October 3, 2005

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs) and/or Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs), for services paid under the DMEPOS Fee Schedule

Provider Action Needed - This article is based on Change Request (CR) 4026 and provides specific information regarding the October quarterly update of the 2005 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

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

• Implement fee schedule amounts for new codes; and
• Revise any fee schedule amounts for existing codes that were calculated in error.
Payment on a fee schedule basis is required for:
• Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)); and
• Parenteral and Enteral Nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

Note: There are no changes to the PEN fee schedule file for October 2005.

The following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) on October 1, 2005, and are effective for claims with dates of service on or after October 1, 2005:

Code	Description of Code
Q0480	Driver for use with pneumatic ventricular assist device, replacement only
Q0481	Microprocessor control unit for use with electric ventricular assist device, replacement only
Q0482	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only
Q0483	Monitor/display module for use with electric ventricular assist device, replacement only
Q0484	Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0485	Monitor control cable for use with electric ventricular assist device, replacement only
Q0486	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only
Q0488	Power pack base for use with electric ventricular assist device, replacement only
Q0489	Power pack base for use with electric/pneumatic ventricular assist device, replacement only
Q0490	Emergency power source for use with electric ventricular assist device, replacement only
Q0491	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only
Q0492	Emergency power supply cable for use with electric ventricular assist device, replacement only

Code Description of Code

Q0493 Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only
Q0494 Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0495 Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0496 Battery for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0497 Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0498 Holster for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0499 Belt/vest for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0500* Filters for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0501 Shower covers for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0502 Mobility cart for pneumatic ventricular assist device, replacement only
Q0503 Battery for pneumatic ventricular assist device, replacement only, each
Q0504 Power adapter for pneumatic ventricular assist device, replacement only, vehicle type
Q0505 Miscellaneous supply or accessory for use with ventricular assist device

*** Replacement filters** described by code Q0500 are furnished in boxes of varying quantities by different manufacturers. Therefore, the base unit for code Q0500 for billing purposes is per each filter.

Note: Instructions regarding the implementation of the above codes were furnished in CR3931.

The following table describes upcoming changes in certain HCPCS codes for wheelchairs beginning October 1, 2005.

HCPCS CODE	New Information
E0971 (anti-tipping device for wheelchairs)	The fee schedule amount for code E0971 is being revised to reflect a base **billing unit of "EACH."** Up to this point E0971 represented "each" or a "pair" of devices. In October the fee schedule will be standardized to represent fees per each unit.
E1038 & E1039 (transport chairs)	The fee schedule amounts for E1038 are being revised to correct errors in the fee calculations and reflect changes in billing for items under these codes. The fees **erroneously included elevating leg rests and those should be billed separately using code K0195.** The updated schedule will no longer include prices for the leg rests.
K0195 (elevating leg rests)	Suppliers should be billing these leg rests under this code.
E1039 (transport chairs with patient weight capacity **over 300 pounds)**	Claims dated on/after October 1, 2005 should contain E1039 for chairs with weight capacity OVER 300 pounds.
E1038 (transport chairs with patient weight capacity **under 300 pounds**)	Claims dated on/after October 1, 2005 should contain E1038 for chairs with weight capacity of 300 pounds or less.
E1238 (Pediatric size, folding, adjustable wheelchair without seating system)	The fee schedule is being revised for E1238 to correct fee schedule calculation errors.

HCPCS codes L3000 through L3649 were added to the fee schedule file effective July 1, 2005, for use in paying claims for shoes that are an integral part of an orthoses.

L5685 was added to the HCPCS effective January 1, 2005. The fee schedules are being established as part of this report.

Implementation

The implementation date for this instruction is October 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4026 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site. Also, the quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual* (Pub 100-04, Chapter 23, Section 60). This manual can be accessed at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the CMS web site.

Revised October 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective October 1, 2005

Medlearn Matters Article Number: MM4160
Related Change Request (CR) #: 4160
Related CR Release Date: October 28, 2005
Effective Date: October 1, 2005
Related CR Transmittal #: 729
Implementation Date: November 28, 2005

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

Provider Action Needed

Impact to You - CR4160 revises the payment allowance limits in the October 2005 Medicare Part B drug pricing files.

What You Need to Know - The revised October 2005 payment allowance limits apply to dates of service October 1, 2005, through December 31, 2005.

What You Need to Do - Make sure that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA), Section 303(c), revises the methodology for paying for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs are paid based on the new Average Sales Price (ASP) drug payment methodology.

The ASP file, used in the ASP methodology, is based on data CMS receives quarterly from manufacturers.

Each quarter, the Centers for Medicare & Medicaid Services (CMS) will update your carrier and fiscal intermediary (FI) payment allowance limits with the ASP drug pricing files based on these manufacturers' data.

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

Exceptions to General Rule

However, there are exceptions to this general rule as summarized below:

- For **blood and blood products** (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003.

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

- For **infusion drugs** furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the DME is implanted. **The** payment allowance limits will not be updated in 2005.

The payment allowance limits for infusion drugs 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 percent of the first published AWP.

• For **influenza, pneumococcal, and hepatitis B vaccines,** payment allowance limits are 95 percent of the AWP as reflected in the published compendia.

• For **drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File,** payment allowance limits are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing.

In determining the payment limit based on WAC, carriers/FIs will follow the methodology specified in Chapter 17 of the *Medicare Claims Processing Manual* for calculating the AWP, but substitute WAC for AWP. Chapter 17 (Drugs and Biologicals) is available at http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf on the CMS web site:

The payment limit is 100 percent of the WAC for the lesser of the lowest brand or median generic. Your carrier or FI 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 carrier/FI or by posting an MS Excel file on the CMS web site. If the payment limit is available from CMS, carriers/FIs will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

• For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File,** payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.

• The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Payment limits for radiopharmaceuticals are based on the methodology in place as of November 2003.

Your carrier/FI will not search and adjust claims that are processed prior to implementation of this change unless you bring such claims to their attention.

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.

Note that the absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Implementation

The implementation date for the instruction is November 28 2005

Additional Information

The official instructions issued to the intermediary regarding this change can be found at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR4160. Click on the link to open and view the CR.

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

HCPCS UPDATES

2006 HCPCS Updates – New, Discontinued And Verbiage Changes

The following new codes are effective for dates of service on or after January 1, 2006. If billed before January 1, 2006, the claims will be denied as an invalid code. The appearance of a HCPCS code in the list below does not necessarily indicate coverage.

New Code	Description
A4218	Sterile saline or water, meter dose dispenser, 10 ml
A4233	Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each
A4234	Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each
A4235	Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each

A4236 Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each
A4363 Ostomy clamp, any type, replacement only, each
A4411 Ostomy skin barrier, solid 4 X 4 or equivalent, extended wear, with built-in convexity, each
A4412 Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each
A4604 Tubing with integrated heating element for use with positive airway pressure device
A5120 Skin Barrier, wipes or swabs, each
A5512 For Diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contract with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each
A5513 For diabetic only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each
A6457 Tubular dressing with or without elastic, any width, per linear yard
A6513 Compression burn mask, face and/or neck, plastic or equal, custom fabricated
A6530 Gradient compression stocking, below knee, 18-30 MMHG, each
A6531 Gradient compression stocking, below knee, 30-40 MMHG, each
A6532 Gradient compression stocking, below knee, 40-50 MMHG, each
A6533 Gradient compression stocking, thigh length, 18-30 MMHG, each
A6534 Gradient compression stocking, thigh length, 30-40 MMHG, each
A6535 Gradient compression stocking, thigh length, 40-50 MMHG, each
A6536 Gradient compression stocking, full length/ chap style, 18-30 MMHG, each
A6537 Gradient compression stocking, full length/ chap style, 30-40 MMHG, each
A6538 Gradient compression stocking, full length/ chap style, 40-50 MMHG, each
A6539 Gradient compression stocking, waist length, 18-30 MMHG, each
A6540 Gradient compression stocking, waist length, 30-40 MMHG, each
A6541 Gradient compression stocking, waist length, 40-50 MMHG, each
A6542 Gradient compression stocking, custom made
A6543 Gradient compression stocking, lymphedema
A6544 Gradient compression stocking, garter belt
A6549 Gradient compression stocking, not other wise specified
A9275 Home Blood Glucose disposable monitor, includes test strips
A9281 Reaching/grabbing device, any type, any length, each
A9282 Wig, any type, each
B4185 Parenteral nutrition solution, per 10 grams lipids
E0170 Commode chair with integrated seat lift mechanism, electric, any type
E0171 Commode chair with integrated seat lift mechanism, non-electric, any type
E0172 Seat lift mechanism placed over or on top of toilet, any type
E0485 Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment
E0486 Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment
E0641 Standing frame system, multi-position (e.g., three-way stander), any size including pediatric, with or without wheels
E0642 Standing frame system, mobile (dynamic stander), any size including pediatric
E0705 Transfer board or device, any type, each
E0762 Transcutaneous electrical joint stimulation device system, includes all accessories
E0764 Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program
E0911 Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar
E0912 Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar
E1392 Portable oxygen concentrator, rental
E1812 Dynamic knee, extension/flexion device with active resistance control
E2207 Wheelchair accessory, crutch and cane holder, each
E2208 Wheelchair accessory, cylinder tank carrier, each

E2209 Wheelchair accessory, arm trough, each
E2210 Wheelchair accessory, bearings, any type, replacement only, each
E2211 Manual wheelchair accessory, pneumatic propulsion tire, any size, each
E2212 Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each
E2213 Manual wheelchair accessory, insert for pneumatic propulsion tire (removable) any type, any size, each
E2214 Manual wheelchair accessory, pneumatic caster tire, any size each
E2215 Manual wheelchair accessory, tube for pneumatic caster tire, any size each
E2216 Manual wheelchair accessory, foam filled propulsion tire, any size, each
E2217 Manual wheelchair accessory, foam filled caster tire, any size, each
E2218 Manual wheelchair accessory, foam propulsion tire, any size, each
E2219 Manual wheelchair accessory, foam caster tire, any size, each
E2220 Manual Wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, each
E2221 Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, each
E2222 Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, each
E2223 Manual wheelchair accessory, valve, any type, replacement only, each
E2224 Manual wheelchair accessory, propulsion wheel excludes tire, any size, each
E2225 Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each
E2226 Manual wheelchair accessory, caster fork, any size, replacement only, each
E2371 Power wheelchair accessory, group 27 sealed lead acid battery, each (e.g. gel cell, absorbed glassmat), each
E2372 Power wheelchair accessory, group 27 non-sealed lead acid battery, each
L0491 TLSO, sagittal-coronal control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated includes fitting and adjustment
L0492 TLSO, sagittal-coronal control., modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated includes fitting and adjustment
L0621 Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion above the sacroiliac joint, includes straps, closures, may includes pendulous abdomen design, prefabricated, includes fitting and adjustment
L0622 Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion above the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated
L0623 Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion above the sacroiliac joint, includes straps, closures, may includes pendulous abdomen design, prefabricated, includes fitting and adjustment
L0624 Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels places over the sacrum and abdomen, reduces motion above the sacroiliac joint, include straps, closures, may includes pendulous abdomen design, custom fabricated
L0625 Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, includes fitting and adjustment
L0626 Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated includes fitting and adjustment
L0627 Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design,

prefabricated includes fitting and adjustment

L0628 Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

L0629 Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom prefabricated

L0630 Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal juntion to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

L0631 Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior xtends from sacrococcygeal juntion to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

L0632 Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal juntion to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated

L0633 Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal juntion to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

L0634 Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal juntion to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated

L0635 Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal juntion to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment

L0636 Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal juntion to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated

L0637 Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal juntion to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, includes fitting and adjustment

L0638 Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal juntion to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated

L0639 Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal juntion to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures,

includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, includes fitting and adjustment

L0640 Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal juntion to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated

L0859 Addition to halo procedure, magnetic resonance image compatible systems, rings and pins, any material

L2034 Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, medial lateral rotation control, with our without free motion ankle, custom fabricated

L2387 Addition to lower extremity, polycentric knee joint, for custom fabricated knee ankle foot orthosis, each joint

L3671 Shoulder orthosis, shoulder cap design, without joint, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3672 Shoulder orthosis, abduction positioning (airplane design), thoracic components and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3673 Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, includes nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3702 Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3763 Elbow wrist hand orthosis, rigid, without joints, may include soft interface material, straps, custom fabricated, includes fitting and adjustment

L3764 Elbow wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3765 Elbow wrist hand finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3766 Elbow wrist hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3905 Wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3913 Hand finger orthosis, without joint, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3919 Hand orthosis, without joint, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3921 Hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3933 Finger orthosis, without joints, may includes soft interface, custom fabricated, includes fitting and adjustment

L3935 Finger orthosis, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment

L3961 Shoulder elbow wrist hand orthosis, should cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment.

L3967 Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3971 Shoulder elbow wrist hand orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3973 Shoulder elbow wrist hand orthosis, abduction positioning (airplane design) thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3975 Shoulder elbow wrist hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3976 Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and

adjustment

L3977 Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L3978 Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design) thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment

L5703 Ankle, symes, molded to patient model, socket without solid ankle cushion heel (sach) foot, replacement only

L5858 Addition to lower extremity prosthesis, endoskeletal knee shin system, microproces sor control feature, stance phase only, includes electronic sensor(s), any type

L5971 All lower extremity prosthesis, solid ankle cushion heel (sach) foot, replacement only

L6621 Upper extremity prosthesis addition, flexion/ extension wrist with our without friction, for use with external powered terminal device.

L6677 Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow

L6883 Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power

L6884 Replacement socket, above elbow disarticulation, molded to patient model, for use with or without external power

L6885 Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power

L7400 Addition to upper extremity prosthesis, below elbow/wrist disarticulation ultralight material (titanium, carbon fiber, or equal)

L7401 Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber, or equal)

L7402 Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, ultralight material (titanium, carbon fiber or equal)

L7403 Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material

L7404 Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material

L7405 Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, acrylic material

L7600 Prosthesis donning sleeve, any material, each

L8609 Artificial Cornea

Q0510 Pharmacy Supply fee for initial immunosuppressive drug(s), first month following implant

Q0511 Pharmacy Supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for the first prescription in a 30 -day period

Q0512 Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s): for a subsequent prescription in a 30-day period

Q0513 Pharmacy dispensing fee for inhalation drug(s); per 30 days

Q0514 Pharmacy dispensing fee for inhalation drug(s): per 90 days

V2788 Presbyopian correction function of intraocular lens

Discontinued Codes With Replacements HCPCS Codes

The following codes will be deleted effective for dates of service on or after January 1, 2006. Reminder: the three month grace period no longer applies; therefore, if these codes are billed on or after January 1, 2006 they will be returned as unprocessable or denied as an invalid code.

Discontinued Codes	Replacement Crosswalk Codes
A4254	A4233 – A4236
A4656 AX	A4215 AX
A5119	A5120
E0169	E0170 – E0171
E0953	E2211
E0954	E2219
E0972	E0705
G3069	Q0510
G0370	Q0511 – Q0512
G0371	Q0513
G0374	Q0514
J7616	J7620
K0064	E2213
K0066	E2220
K0067	E2211
K0068	E2212
K0074	E2214
K0075	E2219
K0076	E2221
K0078	E2215
K0102	E2207
K0104	E2208
K0106	E2209
K0452	E2210
K0600	E0764

Discontinued Codes	Replacement Crosswalk Codes
K0618	L0491
K0619	L0492
K0620	A6457
K0628	A5512
K0629	A5513
K0630	L0621
K0631	L0622
K0632	L0623
K6033	L0624
K6034	L0625
K0635	L0626
K0636	L0627
K0637	L0628
K0638	L0629
K0639	L0630
K0640	L0631
K0641	L0632
K0642	L0633
K0643	L0634
K0644	L0635
K0645	L0636
K0646	L0637
K0647	L0638
K0648	L0639
K0649	L0640
K0670	L5858
K0671	E1392
L0860	L0859
L1750	A4565
L8100	A6530
L8110	A6531
L8120	A6532
L8130	A6533
L8140	A6534
L8150	A6535
L8160	A6536
L8170	A6537
L8180	A6538
L8190	A6539
L8195	A6540
L8200	A6541
L8210	A6542
L8220	A6543
L8230	A6544
L8239	A6549
Q0136	J0885
Q0137	J0881
Q4054	J0882
Q4055	J0886
Q4072	J0133
Q4076	J1265
Q4077	J3285

Discontinued Codes With No Replacement Codes

A6551	B4184	B4186	E1019	E1021
E1025	E1026	E1027	E1239	J0880
J1563	J1564	J1750	J2324	J7051
J7317	J7320	J7617	K0415	K0416
L2039	L3943	Q9941	Q9942	Q9943
Q9944				

Verbiage Changes For 2006

The following list contains HCPCS codes for which verbiage will be changed effective January 1, 2006. Refer to the *DMERC Region D Supplier Manual*, Chapter 16, HCPCS coding section for the new verbiage.

A4215	A4216	A4372	A4630	A6550
A7032	A7033	B4149	E0116	E0637
E0638	E0935	E0971	E1038	E1039
J7626	K0669	L1843	L1844	L1845
L1846	L2036	L2037	L2038	L2405
L3170	L3215	L3216	L3217	L3219
L3221	L3222	L3230	L3906	L3923

MEDICARE SECONDARY PAYER

Modification To Online Medicare Secondary Payer Questionnaire

The Medicare Secondary Payer (MSP) questionnaire found in the Centers of Medicare and Medicaid Services (CMS) online manual, Pub. 100-05, *Medicare Secondary Payer (MSP) Manual,* Chapter 3, § 20.2.1, has been updated as follows:

- Questions 1 and 2 (Parts IV and V) – add the responses “No” and “Never Employed.”
- Question 4 (Part IV), question 5 (Part V), and question 1 (Part VI) – use “Policy Identification Number” to mean a number that is sometimes referred to as the health insurance benefit package number.
- Question 4 (Part IV), question 5 (Part V), and question 1 (Part VI) – add “Membership Number” and use it to mean the unique identifier assigned to the policyholder/patient.
- Question 2 (Part V) – use “spouse” instead of “family member.”

- Question 4 (Part V) – modify question to read: "Are you covered under the group health plan of a family member other than your spouse?" – "Yes", "Name and address of your family member's employer", and "No."
- The previous question 4 in Part V should be modified to say "the GHP" and should become question 5 of Part V.
- Question 6 (Part VI) – modify question to read: "Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?"

The MSP questionnaire is a model of the type of questions that may be asked to help determine if Medicare is the primary or secondary payer. The entire instruction regarding the questionnaire may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for Change Request 4098 in the CR NUM column on the right, and click on the file for that CR.

The revised MSP Questionnaire is provided as Appendix 1 in this newsletter and is available on our Web site on the DMERC Region D Resource Center page at http://www.cignagovernmentservices.com/dmerc/resource.html.

MISCELLANEOUS

Alert Regarding End Of Eligibility-File Based Crossover Processes

The CMS decided that it will not continue to maintain both an eligibility file-based crossover process at all Medicare contractors and the consolidated COBA process at the COBC. Therefore, Medicare contractors shall no longer cross claims over to trading partners pursuant to signed crossover agreements and the submission of eligibility files beyond December 31, 2005. As of that date, the COBC will exclusively cross over all claims to trading partners in the HIPAA ANSI X12-N 837 COB formats via the eligibility file-based COBA process, unless Medicare contractors request specific waivers on behalf of current trading partners. Waivers will be granted on a case-by-case basis and must include a justification for not testing the COBA process with the COBC.

Clarification On Part D And Fee-For-Service (FFS) Providers, New Web-based Educational Products, And The Latest Information On Medicare Prescription Drug Coverage – The Seventh In The Medlearn Matters Series

Medlearn Matters Article Number: SE0557

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

Provider Types Affected - Physicians, providers, suppliers, and their staff who provide service to people with Medicare

Important Points to Remember

√ On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.

√ It will cover brand name and generic drugs.

√ This new drug coverage requires all people with Medicare to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Therefore, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients.

√ You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.

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

Clarifying Information for Fee-For-Service (FFS) Medicare Providers Billing for Drugs Covered Under Part D

There has been some confusion among FFS providers regarding their ability to bill drugs covered under Part D, commonly referred to as "Medicare Prescription Drug Coverage." In short, being an enrolled

provider in the FFS program does not impart Part D-related billing privileges. Medicare Part B covers a limited number of prescription drugs and biologicals. Currently, covered Medicare drugs generally fall into three categories:

• Drugs furnished incident to a physician's service;
• Drugs furnished through a Medicare Part B covered item of durable medical equipment (DME); and
• Drugs specifically covered by statute (for example, oral immunosuppressive drugs).

These drugs continue to be covered and paid for under the FFS Medicare program (i.e., Part B) and FFS providers (e.g., physicians, hospitals, and pharmacies) will continue to bill their Carriers, Fiscal Intermediaries, and Durable Medical Equipment Regional Carriers (DMERCs) for these drugs. This coverage under Part B continues after the January 1, 2006 effective date for Part D. (For a more detailed discussion of Medicare Part B covered drugs, see http://www.cms.hhs.gov/providers/drugs/ on the CMS web site.)

How Medicare Prescription Drug Coverage Will be Administered

Medicare prescription drug coverage under Part D will be administered through Medicare Advantage Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs). For a person with Medicare who joins an MA or a PDP, their provider must have a contractual relationship with that MA-PD or PDP to bill and receive payment from the MA-PDP or PDP for that individual's covered prescription drugs. This is true regardless of whether or not the provider is enrolled in the FFS Medicare program and billing FFS Medicare for Medicare Part B covered drugs.

Example: Suppose a pharmacy is currently receiving payment under Medicare Part B for an individual's Medicare Part B covered drug, albuterol, delivered through a *nebulizer,* which is considered to be DME. The pharmacy would, as they do today, bill the local DMERC for this drug. The same individual has joined a PDP and has coverage of albuterol *delivered through a metered dose inhaler (*which is not considered DME under Part B). The pharmacy can only bill the MA-PD or PDP for covered albuterol delivered through a metered dose inhaler if the pharmacy has a contractual relationship with that MA-PD or PDP.

New Information on the Medicare Prescription Drug Coverage Information for Providers Web Page

The following new information can be found on the Medicare Prescription Drug Coverage Information for Providers web page at http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the CMS web site.

Toolkit for Health Professionals: Medicare Prescription Drug Coverage

The Centers for Medicare & Medicaid Services (CMS) has released the Toolkit for Health Care Professionals: Medicare Prescription Drug Coverage, available as an Adobe PDF file (860Kb) at http://www.cms.hhs.gov/medlearn/provtoolkit.pdf on the CMS web site. This toolkit includes downloadable educational materials specifically for physicians and other health care professionals and their staff to learn the basics about Medicare Prescription Drug Coverage. It also includes materials that can be distributed to Medicare patients. The kit contains reproducible artwork, a letter from the CMS Administrator, a fact sheet (English and Spanish), a brochure, an article, and a list of other resources. You may add your logo and business information to these materials and copy freely.

Limited Income? SSA Can Help - Posters to Display in Health Care Settings

Flat wall posters directing people with Medicare who have limited income to a number they can call to find out if they are eligible for help with prescription drug costs are available now. Posters are suitable for display in a physician's, provider's or supplier's office, a pharmacy, or other health care setting where people with Medicare will see this information. Easel posters are no longer available. To order, visit the Medlearn Product Ordering Page at http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS web site.

New Fact Sheets Available On the Medicare Web Site

The following Fact Sheets are now available at http://www.medicare.gov. These can help your patients better understand Medicare's new prescription drug coverage:

Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Have Coverage from an Employer or Union (Publication Number 11107)

Basic information about Medicare's new prescription drug coverage for people who have prescription coverage from an employer or union. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11107.pdf

Quick Facts about Medicare's New Coverage for Prescription Drugs for People with a Medicare-approved Drug Discount Card (Publication Number 11104)

Basic information about Medicare's new prescription drug coverage for a person with a Medicare-approved drug discount card. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11104.pdf

New Medicare Prescription Drug Coverage—Who Can Help Me Apply and Enroll? (Publication Number 11125)

Explains who can help people with Medicare apply for extra help in paying for prescription drug costs and join a Medicare prescription drug plan. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11125.pdf

Quick Facts about Medicare's New Coverage for Prescription Drugs for People in a Medicare Health Plan with Drug Coverage (Publication Number 11135)

Basic information about Medicare's new prescription drug coverage for people with a Medicare health plan with prescription drug coverage. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11135.pdf

New Medicare Prescription Drug Coverage: A Message for People Who Care for Someone with Medicare (Publication Number 11126)

Explains Medicare's new prescription drug coverage to those who make health care decisions for people with Medicare. (4 pages) http://www.medicare.gov/Publications/Pubs/pdf/11126.pdf

Quick Facts about Medicare's New Coverage for Prescription Drugs for Alaskans with Limited Income and Resources (Publication Number 11105_AK)

Basic information about Medicare's new prescription drug coverage for a person with limited income and resources in Alaska. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11105_AK.pdf

Quick Facts about Medicare's New Coverage for Prescription Drugs for Hawaiians with Limited Income and Resources (Publication Number 11105_HI)

Basic information about Medicare's new prescription drug coverage for a person with limited income and resources in Hawaii. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11105_HI.pdf

Quick Facts About Medicare Prescription Drug Coverage and Protecting Your Personal Information (Publication Number 11147)

Information about how people with Medicare can protect their personal information when dealing with plans and others about Medicare prescription drug coverage. (2 pages) http://www.medicare.gov/Publications/Pubs/pdf/11147.pdf

New Publications Available on the CMS Web Site

The following new publications are available by going to http://www.cms.hhs.gov/medicarereform/factsheets.asp on the CMS web site and clicking on the appropriate links described below:

Basic Questions and Answers About Prescription Drug Coverage

We encourage you to use these basic questions and answers to respond to inquiries from people with Medicare: http://www.cms.hhs.gov/partnerships/news/mma/qsandas.pdf

What Medicare Prescription Drug Coverage Means to You:

A Guide to Getting Started A new brochure available to explain the basics of prescription drug coverage: http://www.cms.hhs.gov/medicarereform/91007_MedicareBrochure.pdf

Additional Information

More information on provider education and outreach regarding drug coverage can be found at http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the CMS website.

Detailed drug coverage information for CMS partners and advocates for people with Medicare can be found at http://www.cms.hhs.gov/partnerships/news/mma/default.asp on the CMS website. You can also find additional information regarding prescription drug plans at http://www.cms.hhs.gov/pdps on the CMS website.

Further information on CMS implementation of the Medicare Modernization Act MMA can be found at http://www.cms.hhs.gov/medicarereform/ on the CMS website.

Hurricanes Katrina And Rita – Frequently Asked Questions – Medicare Issues

Related Change Request (CR) #: N/A
Medlearn Matters Article Number: SE0563
Related CR Release Date: N/A

Provider Types Affected - All providers who are affected by Hurricanes Katrina and Rita or serving Medicare patients affected by those hurricanes

Key Points

This article contains important information about Medicare issues resulting from Hurricanes Katrina and Rita. The Centers for Medicare & Medicaid Services (CMS) has posted pertinent information on its web site at http://www.cms.hhs.gov/hki. This web site is updated on a daily basis.

The information on this site includes the following:

A Question and Answer Document

This document was created to answer frequently asked questions about Medicare issues resulting from Hurricanes Katrina and Rita. Please review each question and answer and take appropriate action to implement them into your claims process. Account and document all activities associated with implementing these instructions. (To view this information, scroll down to the *Question and Answer* section on the page (http://www.cms.hhs.gov/hki) and select the category desired (e.g., Section 1135, General, Ambulance, etc.).

Hurricane Katrina Electronic Mailing List

This is an electronic mailing list service for those interested in receiving news automatically via e-mail from the CMS.

Hurricane Katrina: What Government Is Doing

This Department of Homeland Security web site focuses on the government's response to Hurricane Katrina - including links to:

- How to Get Help;
- Donations and Volunteering;
- Finding Friends and Information;
- Health and Safety; and
- A link to Hurricane Katrina-related information in Spanish.

Fact Sheet: CMS Actions to Help Beneficiaries, Providers in Katrina Stricken Areas

This link leads to specific Medicare-related hurricane relief information for healthcare providers who furnish medical services related to Hurricane Katrina.

Phone Numbers for State Medical Assistance Offices

This web page contains contact information for all states; related websites; and resources (a download of the Helpful Contacts tool).

State Health Officials Letter and 1115 Model Waiver Template

This links to state Medicaid directors' information, including:

- A Letter to State Medicaid Directors and State Children's Health Insurance Program Directors;
- An Application Template – Medicaid and SCHIP Coverage for Evacuees of Hurricane Katrina;
- Information on Evacuee Eligibility Simplification Based on Home State Eligibility Rules; and
- Medicaid Eligibility Groups – Income and Resource Limits.

Approved Katrina 1115 Waiver Information

This web page contains approved Katrina 1115 Waiver documents for the states of Alabama, Arkansas, District of Columbia, Florida, Georgia, Idaho, Mississippi, and Texas, including an Approval Letter, the Terms and Conditions, and the Attachments for each of the states.

Hurricane Information from the Department of Health and Human Services

Topics on this page include:

- What HHS is Doing;
- Health and Safety;
- How to Get Help;
- Donate and Volunteer;
- Finding Friends and Information;
- What Other Federal Agencies are Doing; and
- Key State Government Agencies in the Region.

Hurricane Katrina Medicare Contractor and CMS Regional Office Contacts

This web page informs Medicare providers about relevant contact points for those in the affected areas; and notifies providers about a list of Questions and Answers

available online at http://www.cms.gov in the "Spotlight" section.

Signed Waiver Under Section 1135 of the Social Security Act 9/4/2005

Section 1135 of the Social Security Act allows the Secretary of Health and Human Services to waive or modify certain Medicare, Medicaid, or State Children's Health Insurance Program requirements in order to protect the public health and welfare in times of national crisis. On Wednesday August 31, 2005, Secretary Michael Leavitt notified the Congress that he was invoking this authority, as a consequence of Hurricane Katrina, in order to protect the health and welfare of the public in areas impacted by this crisis. CMS is taking action consistent with this authority to ensure that the people in these areas receive all necessary health care services.

Hurricane Katrina Recovery Information from FirstGov.gov

Links on this page include:

- Find Family and Friends;
- How to Get Help;
- Shelter and Housing for Survivors;
- Donate and Volunteer;
- Health and Safety;
- What Government is Doing; and
- Frequently Asked Questions.

Katrina Information Resources

Links on this page include:

- National Voluntary Organizations Active in Disaster (NVOAD) Resources; and
- CCD information related to Tetanus Prevention, non-01 and non-0139 Vibro cholerae; and
- Cancer Patient Resources for Hurricane Katrina.

Informational And Educational Materials For The New Preventive Services

Medlearn Matters Special Edition: SE0556
Related CR Release Date: N/A

Revised: This article was revised on October 12, 2005, to provide clarifying language regarding non-physician practitioners and to provide definitions related to diabetes.

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers and Fiscal Intermediaries (FIs)

Introduction

This Special Edition article provides an overview of the many informational and educational products developed by the Centers for Medicare & Medicaid Services (CMS) to inform and educate physicians, providers, suppliers, and other health care professionals, including non-physician practitioners, about the array of Medicare-covered preventive services and screenings available. These include the following three new services that became effective January 1, 2005:

- Diabetes Screening Tests
- Cardiovascular Screening Blood Tests
- The Initial Preventive Physical Examination (IPPE)

(For the purpose of this article, non-physician practitioners are physician assistants, nurse practitioners, or clinical nurse specialists.)

Note: It is important to emphasize that the diabetes screening tests and cardiovascular screening blood tests are each stand alone billable services separate from the Initial Preventive Physical Examination (IPPE) or "Welcome to Medicare" Physical Exam. The IPPE is a unique benefit for beneficiaries new to the Medicare program. This benefit must be received in the first six months after the effective date of the beneficiary's first Part B coverage period, which must begin on or after January 1, 2005.

To ensure that your Medicare patients receive the best possible health care, it is important to be aware of the preventive benefits available for these patients.

Diabetes Screening Tests

Section 613 of the MMA provides for coverage, under Medicare Part B, of diabetes screening tests, effective for services furnished on or after January 1, 2005, for beneficiaries at risk for diabetes (see eligibility below) or those diagnosed with pre-diabetes.

Medicare provides coverage for the following diabetes screening blood tests:

- A fasting blood glucose test; and
- A post-glucose challenge test:
  - An oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults; or
  - A two-hour post-glucose challenge test alone.

Who Is Eligible?

To be eligible for the diabetes screening tests, beneficiaries must have any of the risk factors or at least two of the characteristics discussed below.

Risk Factors

Individuals who have any of the following risk factors are eligible for diabetes screening:

- Hypertension;
- Dyslipidemia;
- Obesity (with a body mass index greater than or equal to 30 kg/m2); or
- Previous identification of elevated impaired fasting glucose or glucose tolerance.

Characteristics

Alternatively, individuals who have a risk factor consisting of at least two of the following characteristics are eligible for diabetes screening:

- Overweight (a body mass index >25, but <30kg/m2);
- A family history of diabetes;
- Age 65 years or older; or
- A history of gestational diabetes mellitus or giving birth to a baby weighing > 9 lb.

Frequency of Screening Tests

Effective for services performed on or after January 1, 2005, Medicare provides coverage for diabetes screening tests with the following frequency:

- Two screening tests per calendar year are covered for individuals diagnosed with pre-diabetes.
- One screening test per year is covered for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested.

Nationally Non-Covered Indications

- No coverage is permitted under the MMA benefit for individuals previously diagnosed with diabetes.
- Other diabetes screening blood tests for which Medicare has not specifically indicated national coverage continue to be non-covered.

CMS provides the following definitions for the purpose of this article:

Diabetes: diabetes mellitus, a condition of abnormal glucose metabolism diagnosed from a fasting blood sugar > 126 mg/dL on two different occasions; a 2-hour post-glucose challenge > 200 mg/dL on two different occasions; or a random glucose test > 200 mg/dL for an individual with symptoms of uncontrolled diabetes.

Pre-diabetes: abnormal glucose metabolism diagnosed from a previous fasting glucose level of 100 to125 mg/dL, or a 2-hour post-glucose challenge of 140 to 199 mg/dL. The term "pre-diabetes" includes impaired fasting glucose and impaired glucose tolerance.

Post-glucose challenge test: an oral glucose tolerance test with a glucose challenge of 75 gms of glucose for non-pregnant adults, or a 2-hour post-glucose challenge test alone.

Reimbursement

Reimbursement for the diabetes screening tests is made under the Medicare Clinical Laboratory Fee Schedule. There is no deductible or co-payment for this benefit.

For detailed instructions regarding Type of Bills (TOBs) to use, including special instructions for Maryland Hospitals and Critical Access Hospitals (CAHs), see CR3637 (Transmittal 446, Re-issued on January 21, 2005, "MMA – Diabetes Screening Tests") at http://www.cms.hhs.gov/manuals/pm_trans/R446CP.pdf on the CMS web site. There is a related Medlearn Matters article (MM3637) at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3637.pdf on the CMS web site.

Cardiovascular Screening Blood Tests

Section 612 of the MMA provides for coverage, under Medicare Part B, of cardiovascular screening blood tests (tests for the early detection of cardiovascular disease or abnormalities associated with an elevated risk for that disease) effective for services performed on or after January 1, 2005.

The MMA permits coverage of tests for cholesterol and other lipid or triglycerides levels for this purpose. Therefore, effective January 1, 2005, coverage is provided for the following three screening blood tests:

- Total cholesterol test;
- Cholesterol test for high density lipoproteins; and
- Triglycerides test.

Other cardiovascular screening tests for which CMS has not specifically indicated national coverage continue to be non-covered.

The implementation of this new benefit permits Medicare beneficiaries who have not been previously diagnosed with cardiovascular disease to receive cardiovascular screening blood tests for risk factors associated with cardiovascular disease. This includes individuals who have no prior knowledge of heart problems but recognize that their behavior or lifestyle may put them at risk because of diet or lack of exercise.

Under Part B, Medicare provides coverage for each of these three cardiovascular screening blood tests once every five years (i.e., 59 months after the last covered screening tests). These tests must be ordered by the physician who is treating the beneficiary for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms.

Reimbursement

Reimbursement for the cardiovascular screening blood tests is made under the Medicare Clinical Laboratory Fee Schedule. There is no deductible or co-payment for this benefit.

Details regarding HCPCS/CPT codes and diagnosis codes, and how carriers and intermediaries will treat claims, are described in CR3411 (Transmittal 408, dated December 17, 2004, "MMA – Cardiovascular Screening Blood Tests," which can be found at http://www.cms.hhs.gov/manuals/pm_trans/R408CP.pdf on the CMS web site. In addition, there is a related Medlearn Matters article (MM3411) at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3411.pdf on the CMS web site.

The Initial Preventive Physical Examination (IPPE)

Section 611 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), provides for coverage, under Medicare Part B, of an Initial Preventive Physical Examination (IPPE), including a screening electrocardiogram (EKG) for new beneficiaries, effective for services furnished on or after January 1, 2005 (subject to certain eligibility and other limitations).

Once in a Lifetime Benefit

The IPPE is a once-in-a-lifetime benefit that must be performed within six months after the effective date of the beneficiary's first Part B coverage, but only if such Part B coverage begins on or after January 1, 2005. An IPPE furnished on January 10, 2005, for example, to a beneficiary whose Medicare Part B coverage was effective initially on December 1, 2004, would not be covered under this benefit. If a beneficiary is first covered by Part B on January 1, 2005, however, then a physical provided on January 10, 2005 ***would*** be covered by this new benefit.

This service provides for payment for an IPPE to be performed in various provider settings by physicians, or qualified non-physician practitioners (NPPs). However, coverage is provided for only one IPPE per beneficiary lifetime.

Services Included in the IPPE Visit

The complete IPPE visit consists of all of the following services furnished to a beneficiary with the goal of health promotion and disease detection:

1) Review of an individual's medical and social history, with attention to modifiable risk factors for disease detection

This review includes, at a minimum, past medical and surgical history, such as experience with illnesses, hospital stays, operations, allergies, injuries and treatments, current medication and supplements (including calcium and vitamins), family history (including diseases that may be hereditary or place the individual at risk), and social history of alcohol, tobacco, and illicit drug use, diet, and physical activities.

2) Review of an individual's potential (risk factors) for depression

This review includes current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression. The physician or other qualified NPP may select a screening instrument from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.

3) Review of the individual's functional ability and level of safety

This review is based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations. The review

must include, at a minimum, a review of hearing impairment, activities of daily living, risk of falls, and home safety.

4) An examination

This examination includes measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified NPP, based on the individual's medical and social history (refer to service element 1) and current clinical standards.

5) Performance and interpretation of an EKG

As required by statute, the IPPE benefit always includes a screening EKG. If the primary physician or qualified NPP is not able to perform the EKG during the IPPE visit, arrangements should be made for the beneficiary to be referred to another physician or entity to perform and interpret the EKG. The primary physician or qualified NPP must document the results of the screening EKG in the beneficiary's medical record to complete and bill for the IPPE benefit. Both the IPPE and the screening EKG must be performed and interpreted before the physician, qualified NPP, and/or entity can submit the claims.

6) Education, counseling, and referral

These will be conducted, as deemed appropriate, by the physician or qualified NPP, based on the results of the review and evaluation services described in the previous five elements.

7) Education, counseling, and referral for other preventive services

Education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are covered separately under Medicare Part B. These services include the following:

- Pneumococcal, influenza, and hepatitis B vaccines and their administration
- Screening mammography
- Screening pap smear and screening pelvic examinations
- Prostate cancer screening tests
- Colorectal cancer screening tests
- Diabetes outpatient self-management training services
- Bone mass measurements
- Screening for glaucoma
- Medical nutrition therapy for individuals with diabetes or renal disease
- Cardiovascular screening blood tests
- Diabetes screening tests.

Note: The MMA did not make any provision for the waiver of Medicare coinsurance and Part B deductible for the IPPE. Payment for this service would be subject to the required deductible, which is $110 for Calendar Year 2005, if the deductible has not been met, with the exception of Federally Qualified Health Centers (FQHCs). In addition, the usual coinsurance provisions would apply.

For more detailed instructions regarding HCPCS codes to use, including special instructions for Rural Health Clinics/Federally Qualified Health Centers (RHCs)/ FQHCs, Maryland Hospitals, Critical Access Hospitals (CAHs), and Indian Health Service (IHS) Hospitals, review Change Request (CR) 3638 (Transmittal 417, dated December 22, 2004, "MMA – Initial Preventive Physical Examination") at http://www.cms.hhs.gov/manuals/pm_trans/R417CP.pdf on the CMS web site.

You can also view the related Medlearn Matters article (MM3638) at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3638.pdf on the CMS web site.

Preventive Services Informational and Educational Products

CMS has developed a variety of informational and educational products for health care professionals to:

- Increase your awareness about Medicare's coverage for disease prevention and early detection;
- Provide you with important information about Medicare coverage, coding, billing, and reimbursement;
- Help you file preventive services claims effectively; and
- Give you information that will equip you to encourage utilization of these benefits.

The *Additional Information* section of this Special Edition article will tell you where you can find informational/ educational products specifically for Medicare beneficiaries.

The following informational and educational products have been developed especially for you, the Medicare fee-for-service physician, provider, supplier, and health care professional.

The Preventive Services Educational Resource Web Guide

CMS has developed a Medlearn web page where Medicare fee-for-service providers can find links to all provider/supplier specific informational and educational related preventive services products and resources.

The web page is located at http://www.cms.hhs.gov/medlearn/preventiveservices.asp on the CMS web site. Access to products discussed in this Special Edition article can be found on that web page.

The Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals

This comprehensive guidebook to Medicare-covered preventive services and screenings is intended to provide physicians, providers, suppliers, and other health care professionals that bill Medicare fee-for-service contractors with information on coverage, coding, billing, and reimbursement to help them file claims effectively.

It also gives providers information that will enable them to encourage utilization of these benefits as appropriate. You may order a print copy of *The Guide* or download, view, and print a copy by going to http://www.cms.hhs.gov/medlearn/preventive/psguide.asp on the CMS web site.

Brochures

Five two-sided, tri-fold brochures provide an overview of the coverage information for each preventive service covered by Medicare. These brochures may be ordered through the Medlearn product ordering system, or they may be downloaded, viewed, and printed at http://www.cms.hhs.gov/medlearn/preventiveservices.asp on the CMS web site.

Expanded Benefits

The *Expanded Benefits* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for the three new preventive services and screenings (the IPPE, cardiovascular screening blood tests, and diabetes screening tests), as well as other covered diabetes benefits. This brochure can be found at http://www.cms.hhs.gov/medlearn/expanded_benefits_06-08-05.pdf on the CMS web site.

Cancer Screenings

The *Cancer Screenings* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for screening mammography, screening Pap test, pelvic examination, colorectal cancer screening, and prostate cancer screening benefits. This brochure can be found at http://www.cms.hhs.gov/medlearn/cancer_screening_06-08-05.pdf on the CMS web site.

Adult Immunizations

The *Adult Immunizations* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for influenza, hepatitis B, and pneumococcal polysaccharide vaccines and their administration. This brochure can be found at http://www.cms.hhs.gov/medlearn/adult_immunization_06-08-05.pdf on the CMS web site.

Glaucoma Screening

The *Glaucoma Screening* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for the glaucoma screening benefit. This brochure can be found at http://www.cms.hhs.gov/medlearn/glaucoma_06-08-05.pdf on the CMS website.

Bone Mass Measurements

The *Bone Mass Measurements* brochure provides Medicare fee-for-service physicians, providers, suppliers, and other health care professionals with an overview of Medicare's coverage for the bone mass measurements (bone density studies) benefit. The *Bone Mass Measurements* brochure is available at http://www.cms.hhs.gov/medlearn/bone_mass_06-08-05.pdf on the CMS website.

The above brochures can be ordered or downloaded, viewed, and printed by going to http://www.cms.hhs.gov/medlearn/preventiveservices.asp on the CMS web site.

Quick Reference Information: Medicare Preventive Services

This two-sided laminated chart gives Medicare fee-for-service physicians, providers, suppliers, and other health care professionals a quick reference to Medicare's preventive services and screenings. It identifies coding requirements, eligibility, frequency parameters, and co-payment/coinsurance and deductible information for each

benefit. You may order copies of the *Quick Reference Chart* or download, view, and print a copy by going to http://www.cms.hhs.gov/medlearn/preventiveservices.asp on the CMS web site.

Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals (CD ROM)

CMS has created a special CD ROM titled *Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals* that contains useful preventive services resources for Medicare fee-for-service physicians, providers, suppliers, and other health care professionals who bill Medicare fee-for-service contractors (FIs and carriers). These resources include:

• The *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals*;

• The *Quick Reference Information: Medicare Preventive Services* chart; and

• The following five brochures (described above):

- Expanded Benefits
- Cancer Screenings
- Adult Immunizations
- Glaucoma Screenings
- Bone Mass Measurements

To order the *Medicare Preventive Services Resources for Physicians, Providers, Suppliers, and Other Health Care Professionals* CD ROM, go to http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5 on the CMS web site.

Preventive Services Web-Based Training (WBT) Courses

The current WBT course, *Medicare Preventive Services: Osteoporosis, Diabetes, and Prostate Cancer,* is being expanded to include the new MMA benefits, and will be renamed *Medicare Preventive Services Series: Part 3 Expanded Benefits*. The *Medicare Preventive Services Series: Part 1 Adult Immunizations* WBT is being updated to include hepatitis B, and the *Medicare Preventive Services Series: Part 2 Women's Health* WBT is also being updated.

These updated products will be available later in 2005. To access the preventive services web-based training courses, see the Provider Education section of the Preventive Services Educations Resource Web Guide at http://www.cms.hhs.gov/medlearn/preventiveservices.asp on the CMS web site.

Preventive Services Medlearn Matters Articles

CMS issued the following *Medlearn Matters* articles in January 2005 for each new preventive service as corresponding implementing instructions were released:

• The Initial Preventive Physical Examination (MM3638) athttp://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3638.pdf

• Cardiovascular Screening Blood Tests (MM3411) at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3411.pdf; and

• Diabetes Screening Tests (MM3637) at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3637.pdf.

Coming Soon! An Overview of Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Health Care Professionals (Video and Audio programs)

This educational video and audio program will provide an overview of Medicare's coverage for preventive services and screenings, including the new MMA services. The program will also discuss risk factors associated with various diseases and highlight the importance of disease prevention and early detection. The video will be available in three formats, VHS, DVD, and CD to accommodate changing technological demands of the provider community, and the audio will be available in CD format. You will be able to order these in late 2005.

Summary

In addition to helping you file your claims more effectively, these new products will help you increase your awareness about Medicare's coverage for disease prevention and early detection so you are better prepared to:

• Talk to your Medicare patients about the new services; and

• Encourage their utilization of Medicare-covered preventive services and screenings for which they may be eligible.

We encourage you to order and use these products; however, provider-specific products are not meant for

distribution to Medicare beneficiaries. They have been developed for you, the Medicare physician, provider, and supplier.

Additional Information

For Medicare Beneficiaries

In addition to the variety of products for Medicare providers, CMS has also developed resources that can be used by physicians, partners, and beneficiary advocates to educate beneficiaries about Medicare-covered preventive screenings and services. A few of the many products available are listed below:

2005 Prevention ToolKit

CMS joined forces with the American Cancer Society (ACS), the American Diabetes Association (ADA), and the American Heart Association (AHA) to develop materials that you can use as a reference and to educate beneficiaries in your community about the new preventive benefits. These resources including brochures, fact sheets, FAQs, a poster, and booklets can be downloaded, viewed, and printed at http://www.cms.hhs.gov/partnerships/tools/2005preventive/toolkit/default.asp on the CMS web site.

Guide to Medicare's Preventive Services Booklet

This guide is available at http://www.medicare.gov/Publications/Pubs/pdf/10110.pdf on the CMS web site.

The "Staying Healthy" Web Site

This website is located at http://www.medicare.gov/health/overview.asp. This web site provides information about preventive services that are available to people with Medicare. The site includes the following information:

Resource	Web Page
Diabetes Screening, Supplies, and Self Management Training	http://www.medicare.gov/health/diabetes.asp
Cardiovascular Screening	http://www.medicare.gov/health/cardio.asp
One-time "Welcome to Medicare" Physical Exam	http://www.medicare.gov/health/physicalexam.asp
Cancer Tests	http://www.medicare.gov/health/cancer.asp
Breast Cancer Screening (Mammograms)	http://www.medicare.gov/health/mammography.asp
Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)	http://www.medicare.gov/health/cervical.asp
Colon Cancer Screening (Colorectal)	http://www.medicare.gov/health/coloncancer.asp
Prostate Cancer Screening (PSA)	http://www.medicare.gov/health/prostate.asp
Shots	http://www.medicare.gov/health/shots.asp
Flu	http://www.medicare.gov/health/flu.asp
Pneumococcal	http://www.medicare.gov/health/pneumococcal.asp
Hepatitis B	http://www.medicare.gov/health/hepatitis.asp
Bone Mass Measurements	http://www.medicare.gov/health/osteoporosis.asp
Glaucoma Tests	http://www.medicare.gov/health/glaucoma.asp

Patient Publications may be ordered online at http://www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227).

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

Instructions For Provider Notification Regarding Provider Drug Coverage Medlearn Web Page And Posting Of Public Service Announcements

Coming in 2006! Beginning January 1, 2006, Medicare prescription drug coverage will be available to people with Medicare. Health care professionals can find information about this new coverage at www.cms.hhs.gov/medlearn/drugcoverage.asp, on the CMS website. (See Appendix 2)

Medicare + Choice (M+C) Organizations And Hospice Election

Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for managed care enrollees who elect hospice; specifically, regulations at 42 CFR Part 417, Subpart P: 42 CFR 417.585 Special Rules: Hospice Care (b); and 42 CFR 417.531 Hospice Care Services (b).

A. Covered Services

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a provider treating an illness not related to the terminal condition, or an M+C organizations to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;

2. Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;

3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or

4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.

B. Billing of Covered Services

M+C organizations may bill the Medicare carrier for non-hospice services provided to M+C enrollees who elect hospice benefits. These claims should be submitted with a GW (for services not related to the terminal condition) modifier as applicable. Carriers process these claims in accordance with regular claims processing rules.

Any covered Medicare services not related to the treatment of the terminal hospice condition, and which are furnished during a hospice election period, may be billed by the rendering provider to the Fiscal Intermediary (FI) or carrier for non-hospice Medicare payment. These services are coded with the GW modifier "service not related to the hospice patient's terminal condition" when submitted to a carrier. Contractors process services coded with the GW modifier in the normal manner for coverage and payment determinations. If warranted, contractors may conduct prepayment development or post payment review to validate that services billed with the GW modifier are not related to the patient's terminal condition.

Medicare Care Management For High Cost Beneficiaries (CMHCB) Demonstration

Medlearn Matters Article Number: MM4100

Related Change Request (CR) #: 4100
Related CR Release Date: September 23, 2005
Related CR Transmittal #: 28
Effective Date: October 1, 2005

Implementation Date: October 3, 2005

Provider Types Affected - Provider types affected by CR4100 include physicians and providers who bill any Medicare contractor (Carrier, Durable Medical Equipment Regional Carrier (DMERC), Fiscal Intermediary (FI), or Regional Home Health Intermediary (RHHI)) for services provided to Medicare Fee-for-Service (FFS) beneficiaries (i.e., those in the traditional FFS Medicare program) who reside in any one of the geographic areas described below and who have enrolled in a CMHCB program.

The CMHCB programs in these geographic areas are operated by one of six organizations, known as Care Management Organizations (CMOs), that will deliver provider-based intensive care management services to certain FFS Medicare beneficiaries with one or more chronic conditions. Beneficiaries eligible for participa-

tion in the demonstration will be designated by the Centers for Medicare & Medicaid Services (CMS). If you submit claims to the Medicare contractors listed in the following charts, for Medicare patients who reside in the geographic areas shown in the charts, this article is of special interest to you:

Carrier, FI, DMERC, RHHI	Geographic Areas to be Served
1. Anthem Health Plans of Maine, Inc.	Massachusetts
2. Blue Cross and Blue Shield of South Carolina, also known as Palmetto GBA	Florida, Texas
3. Connecticut General Life Insurance Company	California, Nevada, Oregon, Washington
4. Empire HealthChoice Assurance, Inc.	New York
5. First Coast Service Options, Inc.	Florida
6. Group Health Incorporated	New York
7. HealthNow New York, Inc.	Massachusetts, New York
8. National Heritage Insurance Company	California, Massachusetts
9. Noridian Mutual Insurance Company	Nevada, Oregon, Washington
10. Regence BlueCross BlueShield of Oregon	Oregon
11. Trailblazer Health Enterprises, LLC	Texas
12. United Government Services, LLC	Nevada, Oregon, Washington, California, New York

Provider Action Needed

Impact to You - This article contains information from CR4100 that describes the CMS CMHCB Demonstration project and the associated Care Management Organizations (CMOs') programs. These programs are being implemented under the demonstration project to test whether supplemental care management services can improve quality of care and health results, and reduce unnecessary hospital stays and emergency room visits for Fee-for-Service (FFS) beneficiaries who have one or more chronic diseases. Care management services provided by the CMOs may include facilitating collaboration among beneficiaries' primary and specialist providers, and enhanced communication of relevant clinical information to providers for the beneficiaries enrolled in a CMHCB program.

What You Need to Know - A beneficiary's participation in this demonstration program will not change his or her FFS Medicare benefits. The beneficiary is **not** enrolled in an HMO, Medicare Advantage Plan, or other non-FFS plan. The beneficiary remains entitled to all FFS benefits. You may be contacted by one of the CMOs in your geographic area.

What You Need to Do - Make sure that your office and billing staffs are aware that these beneficiaries remain eligible for FFS services. **There are no changes to Medicare FFS billing instructions or claims processing as a result of this CMHCB program.** Provider participation in care plans developed by, and other collaboration with, the CMO is voluntary and at provider discretion.

Background - This article provides information on CMS's implementation of the CMHCB project to conduct a three-year study of various care management models for certain beneficiaries in the traditional Medicare FFS program. These programs will be administered by the CMOs.

The CMO programs will support collaboration among demonstration participants' primary and specialist providers and enhance communication of relevant clinical information. The programs are intended to:

- Help increase adherence to evidence-based care;
- Reduce unnecessary hospital stays and emergency room visits; and
- Help participants avoid costly and debilitating complications.

FFS Medicare benefits will continue to be covered, administered, and paid under the traditional FFS Medicare program. Demonstration programs will be offered at no additional charge to the participating beneficiaries beyond their normal original Medicare plan premiums, co-payments, and/or deductibles. The CMOs will not be able to restrict beneficiary access to care, or restrict beneficiary provider choice.

Since the CMO services may include collaboration with the physician on the beneficiary's plan of care, you may be contacted by the CMO regarding any of your patients who enroll in the CMHCB demonstration. It is up to each physician to determine whether he or she wishes to collaborate with the CMO.

Note: Beneficiaries enrolled in these demonstrations remain eligible for FFS services, and physicians and providers of those services should continue to bill as they normally would. There are no changes to Medicare FFS billing instructions or claims processing as a result of this demonstration.

CMO Program Features and Geographic Areas

The following table describes the name, target population, special features, scheduled launch date, and designated geographical areas of each program.

Name of Program	Population Focus and Program Features	Geographic Area
Health Buddy Program	• Serves beneficiaries with congestive heart failure, diabetes, and or chronic obstructive pulmonary disease. • Uses a technology platform. Patients receive a Health Buddy appliance that coaches them about their health, collects vital signs and symptoms, and transmits results back to multi-specialty medical groups. • Physicians and nurses will use information provided through the Health Buddy program to spot problems early and ensure patients stay healthy. • **Launch date:** Early CY 2006	**Oregon:** Deschutes, Jefferson, Crook, Lake, Malheur, and Harney **Washington:** Chelan, Grant, Okanogan, and Douglas **Nevada:** Clark, Nye
Care Level Management	• Serves beneficiaries who are seniors suffering from advanced, progressive chronic disease(s) and comorbidities with two or more condition-related hospital admissions in the past year. • Care management via a distributed network of Personal Visiting Physicians (PVPs) who see patients in their homes and nursing facilities and who are available 24 hours a day, 7 days a week. • PVPs are supported by Personal Care Advocate Nurses who are based in nearby regional offices and who provide care coordination and maintain regular phone contact with beneficiaries. • Utilizes a web-based electronic medical record. • **Launch date:** October 1, 2005	**California:** Alameda, San Francisco, Marin, San Mateo, Contra Costa, Sacramento, Santa Clara, Sonoma, Solano, San Joaquin, Fresno, Stanislaus, Monterey, Tulare, Madera, Merced, Santa Cruz, San Benito, Los Angeles, Ventura, Santa Barbara, San Luis Obispo, Riverside, San Bernardino, Kern, Kings, Orange, San Diego **Texas:** Bexar, Atascosa, Bandera, Comal, Guadalupe, Kendall, Medina, Wilson **Florida:** Brevard, Indian River, Osceola, Seminole, Orange
Mass General Care Management	• Serves beneficiaries who seek care from Massachusetts General healthcare system. • Comprehensive care management by a dedicated team of doctors and nurses. • Specialized programs for patients with chronic conditions. • Home visits and home telemonitoring as needed. • Electronic medical record system assures coordination, continuity, and adherence to physician-approved care management plan. • **Launch date:** Early CY 2006	**Massachusetts:** Norfolk, Suffolk, Middlesex, Essex, and Plymouth

Montefiore Care Guidance	• Serves beneficiaries with multiple chronic conditions, residing in naturally-occurring retirement communities regardless of where they currently receive care, and FFS beneficiaries cared for within the Montefiore healthcare network. • Offers enhanced home-based services to participants using telemonitoring equipment and home visit programs. • Also offers medication management, falls prevention, palliative care, and disease management programs. • **Launch date:** Early CY 2006	**New York:** Bronx
RMS KEY to Better Health	• Serves beneficiaries with chronic kidney disease. • Provides intensive disease management directed by nephrologists in supplementary clinics to identify potential problems and avoid complications, coordinate early intervention plans and prevent acute hospitalization. • **Launch date:** November 1, 2005	**New York:** Nassau, Suffolk, Queens
Texas Senior Trails	• Serves beneficiaries who receive care from the Texas Tech Physician Associates primary care and specialist physicians and who are at greatest risk for readmission and adverse events in largely underserved, rural areas • Team coordinates a home and office based program • **Launch date:** Early CY 2006	**Texas:** Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Stonewall, Swisher, Terry, Wheeler, and Yoakum

Additional Information

Additional information on the demonstration project may be found at http://www.cms.hhs.gov/researchers/demos/cmhcb.asp on the CMS web site.

For complete details, please see the official instruction issued to your Carrier/FI/DMERC/RHHI regarding this change, which can be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4100 in the CR NUM column on the right, and click on the file for that CR.

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

MMA - New G Code For Power Mobility Devices (PMDs)

Medlearn Matters Article Number: MM4121

Related Change Request (CR) #: 4121
Related CR Release Date: November 4, 2005
Effective Date: October 25, 2005
Related CR Transmittal #: 748
Implementation Date: October 25, 2005

NOTE: This article is being published as informational only. The DMERC does not process claims for HCPCS code G0372.

Note: This article was revised on November 6, 2005, to reflect a revision made to CR4121. That CR was revised to show that the changes impact physician services only and do not impact claims billed to Medicare fiscal intermediaries (FIs).

Provider Types Affected - Physicians, suppliers, and providers billing Medicare carriers for services related to power mobility devices (PMDs).

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4121, which announces that a new G Code (G0372) has been established to recognize the additional physician service and resources required to establish and document the need for PMDs.

What You Need to Know

The new G code is only payable if all of the information necessary to document the PMD prescription is included in the medical record after a face-to-face examination of the beneficiary, and the prescription is received by the PMD supplier within 30 days after the face-to-face examination.

What You Need to Do

Please see the Background section of this article for further details.

Background

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA, Section 302(a)(2)(E)(iv)) details the revised conditions for Medicare payment of PMDs. It states that payment for motorized or power wheelchairs may not be made unless a face-to-face examination of the beneficiary has been conducted, and a written prescription (order) for the PMD has been provided by a:

- Physician (as defined in Section 1861(r)(1) of the Social Security Act);
- Physician assistant; Nurse practitioner; or
- Clinical nurse specialist (as those terms are defined in Section 1861(aa)(5) of the Social Security Act).

Note: Payment for the history and physical examination will be made through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient.

New G Code

Due to the MMA requirement that the physician or treating practitioner create a written prescription and a regulatory requirement that the physician or treating practitioner prepare pertinent parts of the medical record for submission to the durable medical equipment supplier, the Centers for Medicare & Medicaid Services (CMS) has established the new G Code (G0372) to recognize additional physician services and resources required to establish and document the need for a PMD.

CMS believes that the typical amount of additional physician services and resources involved is equivalent to the physician fee schedule relative values established for a level 1 office visit for an established patient (Current Procedural Terminology (CPT) code 99211).

The payment amount for such a visit is $21.60; therefore, the payment amount for G0372 for 2005 will be $21.60, adjusted by the geographic area where the services is provided, and based on the physician fee schedule values for a level 1 established patient office visit (CPT 99211).

Code G0372 indicates that:

- All of the information necessary to document the PMD prescription is included in the medical record; and
- The prescription, along with the supporting documentation, has been received by the PMD supplier within 30 days after the face-to-face examination.

Effective October 25, 2005, G0372, will be used to recognize additional physician services and resources required to establish and document the need for the PMD, and it will be added to the Medicare physician fee schedule.

G Code & Payment Information	Short Descriptor	Long Descriptor
G0372 Procedure Status = A WRVU = 0.17 Non-Facility PE RVU = 0.39 Facility PE RVU = 0.06 Malpractice RVU = 0.01 PC/TC = 0 Site of Service = 1 Global Surgery = XXX Multiple Procedure Indicator = 0 Bilateral Procedure Indicator = 0 Assistant at Surgery Indicator = 0 Co-Surgery Indicator = 0 Team Surgery Indicator = 0 Diagnostic Supervision = 0 Type of Service = 1	MD service required for PMD	Physician service required to establish and document the need for a power mobility device

Implementation - The implementation date for the instruction is October 25, 2005.

Additional Information

For full details regarding wheelchair coverage, visit the CMS page for wheelchairs at https://www.cms.hhs.gov/coverage/wheelchairs.asp on the CMS web site. For complete details on the new G code, please see the official instruction issued to your carrier regarding this change. That instruction may be viewed at http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR4121 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier at their toll-free number, which may be found at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

MMA – The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contract (RAC) Initiative

Medlearn Matters Article Number: SE0565

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

Provider Types Affected - Physicians, providers, and suppliers, especially in California, Florida, and New York

Provider Action Needed

Physicians, providers, and suppliers should note that this initiative is designed to determine whether the use of Recovery Audit Contracts (RACs) will be a cost-effective means of ensuring that you receive correct payments and to ensure that taxpayer funds are used for their intended purpose.

As the states with the largest Medicare expenditure amounts, California, Florida, and New York were selected for pilot RACs that began earlier this year and that will last for three years. Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the Medicare Affiliated Contractors (MACs), which include carriers, fiscal intermediaries (FIs), and durable medical equipment regional carriers (DMERCs).

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 306) directs the secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

Update

On January 11, 2005, CMS announced the recovery audit contractor demonstration project. (See MedLearn Matters article SE0469 which is available at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0469.pdf on the CMS web site.) The demonstration, mandated by the MMA, will evaluate the use of recovery audit contractors in identifying Medicare underpayments and overpayments and recouping overpayments.

On March 28, 2005, CMS awarded five RACs and officially announced the beginning of the recovery audit contractor demonstration. Three of the five recovery audit contractors will perform post-payment medical review in the states of California, Florida, and New York. Those firms and the state they are responsible for are as follows:

• Connolly Consulting will perform claim reviews for providers who are serviced by a FI or carrier in New York. Connolly Consulting will also perform reviews for durable medical equipment claims for Medicare beneficiaries who reside in New York.
• PRG Schultz and its subcontractor, Concentra Preferred Systems, will perform claim reviews for providers who are serviced by a FI or carrier in California. PRG Schultz will also perform reviews for durable medical equipment claims for beneficiaries who reside in California.
• HealthData Insights will perform claim reviews for providers who are serviced by a fiscal intermediary or carrier in Florida. Connolly Consulting will also perform reviews for durable medical equipment claims for beneficiaries who reside in Florida.

CMS is committed to alerting the provider community regarding the focus of the recovery audit contractor demonstration. The recovery auditors have at least three years of claims they may review.

Three-Tiered Review Process

The recovery audit contractors have a three-tiered process that is explained below:

• The first level involves Part A Diagnosis Related Group (DRG) reviews. These reviews normally involve making a request for medical records. Providers located in Florida began seeing medical record requests in August. Providers located in New York began seeing medical record requests in September. California providers will see medical record requests some time after October.
• The second level involves overpayments determined by the recovery audit contractor's proprietary data mining systems. These are overpayments that clearly do not meet the requirements of Medicare policies. These overpayments do not require a medical record request because it is very clear that an overpayment has occurred.

However, CMS is approving a sample of these overpayments before the demand letters are released. In October 2005, physicians in Florida may receive overpayment demand letters resulting from these automated reviews. Beginning in October, physicians in California and New York may also see overpayment demand letters resulting from these reviews.

• The last level involves the actual request of medical records for Part B services. All of the recovery companies have indicated that physicians may see medical record requests for Part B services in October or November of 2005. In a future Medlearn Matters article, CMS will update the provider community when medical record requests could be made.

Note: Questions concerning the recovery audit contractor demonstration may be directed to an email address CMS has established for the demonstration. That email address is **cmsrecoveryauditdemo@cms.hhs.gov.**

Additional Information

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

Find out more about the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) at http://www.cms.hhs.gov/medicarereform/ on the CMS web site.

Nature And Effect Of Assignment On Carrier Claims

Medlearn Matters Article Number: MM3897

Related Change Request (CR) #: 3897
Related CR Release Date: August 12, 2005
Related CR Transmittal #: 643
Effective Date: January 1, 2005
Implementation Date: November 14, 2005

Provider Types Affected - Physicians and suppliers who are Medicare participating physicians/suppliers and nonparticipating physicians/suppliers who are required by law to accept assignment (direct payment) from Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs) for covered Part B services, equipment, and supplies.

Provider Action Needed

Providers need to be aware that on January 1, 2005, Medicare regulations at 42 C.F.R. 424.55 were amended to eliminate the requirement that beneficiaries formally assign claims to suppliers when suppliers are **required by law** to accept assignment. In other words, the beneficiary is not required to assign the claim to the physician or supplier in order for an assignment to be effective in "mandatory assignment" situations.

Background

This action affirms the pattern that has emerged over time as the Social Security Act was amended in various sections to require suppliers to accept assignment for Medicare covered services whether or not the beneficiary actually assigned the claim to the supplier. The following is a synopsis of the CR3897 and the revised Medicare Claims Processing instructions (Chapter 1, Section 30.3.2) that are attached to CR3897:

• Physicians and suppliers who accept assignment from Medicare, by choice or by law, may not attempt to collect more than the appropriate Medicare deductible and coinsurance amounts from the beneficiary, his/her other insurance, or anyone else.

• If the physician/supplier is not satisfied with the amount allowed by Medicare, procedures are in place for appeal of the contractor initial determination.

• If an enrollee has private insurance in addition to Medicare the physician/supplier is in violation of his/her assignment if he/she collects from the enrollee or the private insurance an amount that when added to the Medicare benefit exceeds the Medicare allowed amount.

• The beneficiary must continue to authorize the release of medical or other information necessary to process the claim.

• A nonparticipating physician/supplier who accepts assignment for some Medicare covered services is not prohibited from billing the patient for services for which he/she does not accept assignment. Also, the nonparticipating physician/supplier is not precluded from billing a patient for services that are not covered by Medicare.

• Physicians/suppliers should remember they may not attempt to "fragment" their bills. Fragmenting is defined as accepting assignment for some services and then billing the enrollee for other services performed at the same place and on the same occasion. When Medicare carriers become aware that services are being "fragmented" they will inform the physician/supplier that the practice is unacceptable and that he/she must either accept assignment or bill the enrollee for all services performed at the same place on the same occasion. There is an **EXCEPTION**. In situations where assignment is mandatory, i.e., where a physician/supplier must accept assignment for certain services as a condition for any payment or for full payment to be made (e.g., clinical diagnostic laboratory tests, physician assistants), he/she may accept assignment for those conditional services without accepting assignment for other services furnished by him/her for the same enrollee at the same place and on the same occasion.

Implementation - The implementation date for CR 3897 is November 14, 2005.

Related Instructions

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR3897 in the CR NUM column on the right, and click on the file for the desired CR. For additional information relating to this issue, please refer to your carrier/DMERC. To find their toll free phone numbers go to http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

CMS Manual System, Pub 100-04 Medicare Claims Processing

30.3.2 - Nature and Effect of Assignment on Carrier Claims

(Rev. 643, Issued: 08-12-05, Effective: 01-01-05, Implementation: 11-14-05)

Assignment is a written agreement between beneficiaries, their physicians or other suppliers, and Medicare. The beneficiary agrees to let the physician or other supplier request direct payment from Medicare for covered Part B services, equipment, and supplies by assigning the claim to the physician or supplier. The physician/supplier in return agrees to accept the Medicare allowed payment amount by the carrier as his/her full charge for the items or services. A physician/supplier who agrees to accept assignment on all claims for Medicare services, rather than on a claim-by-claim basis is known as a participating physician/supplier. See Publication 100-4, chapter 1, sections 30.3 and 30.3.12.2 of the IOM. In effect, the physician/supplier who accepts assignment on a claim-by-claim basis or who is a participating physician/supplier is precluded from charging the enrollee more than the deductible and coinsurance based upon the approved payment amount determination. If dissatisfied with the amount of the Medicare allowed amount, a physician/supplier may follow the procedures for appeals of contractor initial determinations.

In "mandatory assignment" situations, i.e., where payment under the Act can be made only on an assignment-related basis or where payment is for services furnished by a participating physician or supplier, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) is not required to assign the claim to the physician or supplier in order for an assignment to be effective. However, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) must continue to authorize the release of medical or other information necessary to process the claim and request payment of Medicare benefits for the Medicare Part B covered services, equipment, or supplies pursuant to 42 C.F.R 424.32 and 424.36 (see also Pub. 100-04, ch. 1, sect. 50.1). Physicians or suppliers who agree to (or must by law) accept assignment from Medicare cannot attempt to collect more than the appropriate Medicare deductible and coinsurance amounts from the beneficiary, his/her other insurance, or anyone else.

In situations where mandatory assignment is not applicable and a nonparticipating physician or supplier indicates on the claim that he/she accepts assignment, but the beneficiary does not assign the claim to that nonparticipating physician/supplier— payment must be made on an unassigned basis (i.e., directly to the beneficiary).

A violation of the assignment occurs if the physician/supplier collects (or attempts to collect) from the enrollee or anyone else any amount which, when added to the benefit, exceeds the Medicare allowed amount. A bill for assigned services is considered paid in full when the Medicare allowed amount is paid. The carrier payment determination takes into account all of the services furnished by the physician/supplier in connection with the claim. Therefore, a physician/supplier may not charge the enrollee for paperwork involved in filing an assigned claim.

If the enrollee has private insurance in addition to Medicare, the physician/supplier who has accepted assignment of SMI benefits is in violation of his/her assignment agreement if he/she bills or collects from the enrollee and/or the private insurer an amount which, when added to the Medicare benefit received, exceeds the Medicare allowed amount. If it comes to a carrier's attention that a physician/supplier has received an excessive amount, inform him/her to refund such amount to the appropriate party. Where it is not clear as to who is entitled to receive the refund under the terms of the private insurance, any excess amount paid by the enrollee may be returned to the enrollee.

A nonparticipating physician/supplier who accepts assignment for some Medicare covered services is not ordinarily precluded from billing the patient for other Medicare covered services for which the nonparticipating physician/supplier does not accept assignment, and is also not precluded from billing the patient for services that are not covered by Medicare. However, a physician/supplier may not attempt to circumvent the Medicare allowed amount limitation by "fragmenting" his/her bills. Bills are "fragmented" when a physician/supplier accepts assignment for some services, and claims payment from the enrollee for other services performed at the same place and on the same occasion. When a carrier becomes aware that a physician/supplier is fragmenting his/her bills, it must inform him/her that this practice is unacceptable and that he/she must either accept assignment for, or bill the enrollee for, all services performed at the same place and on the same occasion.

EXCEPTION

In mandatory assignment situations, i.e., where a phy-

sician/supplier must accept assignment for certain services as a condition for any payment or for full payment to be made (e.g., clinical diagnostic laboratory tests, physician assistants), he/she may accept assignment for those services without accepting assignment for other services furnished by him/her for the same enrollee at the same place and on the same occasion.

New Educational Products Available On Medicare Prescription Drug Coverage – The Eighth In The Medlearn Matters Series

Medlearn Matters Number: SE0559
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A
Related CR Transmittal #: N/A
Implementation Date: N/A

Provider Types Affected - Physicians, health care professionals, providers, suppliers, and staff who provide service to people with Medicare

Important Points to Remember

• On January 1, 2006, new prescription drug coverage will be available to all people with Medicare.
• It will cover brand name and generic drugs.
• Drugs that are currently covered by Medicare Part B will continue to be covered by Part B.
• This new drug coverage is not automatic - all people with Medicare will need to make a decision this fall. Since you're a trusted source, your patients may turn to you for information about this new coverage. Therefore, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients learn more about this new coverage.
• You should encourage all your Medicare patients to learn more about the new prescription drug coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.
• If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to http://www.medicare.gov for additional information and assistance.

Medicare prescription drug coverage under Part D will be administered through Medicare Advantage Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs). For Medicare beneficiaries who join a MA-PD or a PDP, their provider must have a contractual relationship with that MA-PD or PDP to bill and receive payment from the plans for that individual's covered prescription drugs. FFS providers cannot bill Medicare fiscal intermediaries (FIs) or carriers for Part D covered drugs. Our next article in this series will provide further information on Part B versus Part D billing.

New Products Available on http://www.cms.hhs.gov/medlearn/drugcoverage.asp

New products are available to download at the *Medicare Prescription Drug Coverage Information for Providers* web page. This page is dedicated to providing the latest drug coverage information for Fee-For-Service (FFS) Medicare providers. The new products include the following:

Medicare Rx Training Course: Important Information for Health Care Professionals – Earn CME Credit

This training course covers important information about Medicare prescription drug coverage, including the fundamental components of the program, types of drug plans available, resources for people with Medicare and health care professionals, and important dates in 2005 and 2006.

The University of Kansas Medical Center (KUMC) is offering Continuing Education Credit for this course in coordination with the Centers for Medicare & Medicaid Services (CMS):

• **Doctors:** 1.5 CME Category 1 Credit
• **Nurses:** 1.8 CNE Contact Hours
• **Other Health Care Professionals:** 1.5 Credit Hours

Once you complete the course and receive a passing score on the post-assessment, you will be provided with a link to KUMC. KUMC will charge a nominal fee for credit courses.

Physician Brochure

This publication explains the new Medicare prescription drug coverage for physicians and their staff.

Physician Tear-off Sheet

This resource is appropriate for distribution in physicians' offices and other clinical settings. It contains basic information on the new coverage, as well as contact numbers for each state's State Health Insurance Assistance Program (SHIP). The SHIPs will direct people with Medicare to resources for individual counseling.

"Have Limited Income? SSA Can Help" - Posters for Your Office or Clinic

These posters direct people with Medicare who have limited income and resources to sources for help with prescription drug costs. The posters are suitable for display in healthcare settings where people with Medicare and their caregivers will see the information. To view and order the posters, go to http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the CMS web site.

New Beneficiary Publications Available

New publications for people with Medicare that explain various aspects of the new coverage are available at http://www.cms.hhs.gov/medlearn/drugcoveragepubs.asp on the CMS web site.

Additional Information

To find Medicare Prescription Drug Plans available in each state, visit the **Landscape of Local Plans** on the Medicare website for a complete listing.

You can use the new **Medicare Prescription Drug Plan Finder** to help people with Medicare learn about the new Medicare prescription drug coverage, find and compare prescription drug plans that meet personal needs, and enroll in the prescription drug plan that is right for him/her.

The new **Formulary Finder** on the Medicare website will help people with Medicare find plans in each state that match their required drug lists.

Bookmark the Medicare Prescription Drug Coverage Information for Providers page, http://www.cms.hhs.gov/medlearn/drugcoverage.asp, for the latest information and educational resources.

Non-Physician Practitioner Questions And Answers

Medlearn Matters Article Number: SE0418

Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Effective Date: N/A - This is informational only.

Note: This article was revised on August 16, 2005. The only change was the answer (A14) to question 14 (Q14) on page 4. All other information remains the same.

Provider Types Affected - Non-Physician Practitioners (NPPs), physicians, suppliers, and providers

Provider Action Needed

Be sure to understand the policies related to services for Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) as they relate to Non-Physician Practitioners.

Background

The Balanced Budget Act of 1997 modified the way the Medicare program pays for Non-Physician Practitioner (NPP) services. Prior to January 1, 1998, these services were reimbursed by Medicare Part B only in certain geographical areas and health care settings. The Balanced Budget Act removed the restrictions on settings and effective January 1998, payment is allowed for non-physician practitioner services in all geographic areas and health care settings permitted under State licensing laws.

On November 13, 2003, CMS issued the Survey & Certification letter (S&C-04-08), which addresses the differences in requirements concerning the delegation of physician tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) from a survey and certification perspective. Please note that reimbursement requirements for NPPs may differ from the survey and certification requirements. The following questions (Q1 through Q17) have been asked by NPPs, and each question has been answered (A1 through A17) by the Centers for Medicare & Medicaid Services (CMS).

Q1. Why do new regulations from CMS governing physician delegation of services differ between Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)?

A1. The requirements addressing physician delegation of services are not new. The distinction made between the delegation of physician visits and tasks between SNFs and NFs is mandated by Congress in the law.

The original authority for 42 Code of Federal Regulations (CFR) § 483.40 was the sentence in section 1819(b)(6)(A) of the Social Security Act requiring that every SNF resident's medical care be under the supervision of a physician (the same sentence appeared in section 1919(b)(6)(A) of the Social Security Act for NFs). The requirements contained in 42 CFR, § 483.40, include a prescribed visit schedule and the requirement for the physician to perform the initial visit personally.

Section 483.40 of the CFR originally applied these same standards uniformly in both SNFs and NFs.

However, in section 4801(d) of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress subsequently amended the Medicaid provisions of the law (section 1919(b)(6)(A) of the Social Security Act) to allow, at the option of the State, all physician tasks (including the initial visit) to be delegated to physician extenders who are not employed by the facility but who are working in collaboration with the physician. In response, CMS amended the regulations to reflect this broader authority for delegating physician tasks in NFs (see § 483.40(f)). Since Congress declined to make a similar change in the statutory requirements for SNFs at section 1819(b)(6)(A) of the Social Security Act, the corresponding SNF requirements in § 483.40(c) and (e) remain unchanged.

Q2. When may non-physician practitioners (NPPs) begin to bill for medically necessary visits that occur prior to the initial comprehensive visit in a SNF and in a NF?

A2. CMS defined "initial comprehensive visit" in the November 13, 2003 S&C-04-08 and stated that NPPs may perform any medically necessary visits even if they occur prior to the initial comprehensive visits in both SNFs and NFs. Medically necessary visits that NPPs perform on or after November 13, 2003, may be billed to the carrier when collaboration and billing requirements are met in the SNF and NF setting. The Survey & Certification letter S&C-04-08, may be found at: http://www.cms.hhs.gov/medicaid/survey-cert/letters.asp

Q3. If State regulations require a physician co-signature for orders and/or notes written by an NPP, may the physician bill for this action?

A3. No. CMS only pays for medically necessary face-to-face visits by the physician or NPP with the resident. Since the NPP is performing the medically necessary visit, the NPP would bill for the visit.

Q4. If State regulations require more frequent visits than those that are federally mandated, are NPPs able to bill for those visits?

A4. CMS only reimburses physicians and NPPs for medically necessary visits and federally prescribed visits. Visits required to fulfill or meet State requirements are considered administrative requirements and are not medically necessary for the resident. Medicare pays for services that are reasonable and medically necessary for the treatment of illness or injury only, as stated in the Social Security Act, section 1862(a)(1)(A).

Q5. May NPPs who are employed by the facility bill or medically necessary visits?

A5. Payment may be made for the services of Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) who are employed by a SNF or NF when their services are rendered to facility residents. If NPs and CNSs employed by a facility opt to reassign payment for their professional services to the facility, the facility can bill the appropriate Medicare Part B carrier under the NPs' or CNSs' PINs for their professional services. Otherwise, the NPs or CNSs who are employed by a SNF or NF bill the carrier directly for their services to facility residents.

On the other hand, Physician Assistants (PAs) who are employed by a SNF or NF cannot reassign payment for their professional services to the facility because Medicare law requires the employer of a PA to bill for the PA's services. Hence, the facility must always bill the Part B carrier under the PA's PIN for the PA's professional services to facility residents.

Q6. May NPPs employed by the NF perform the initial comprehensive visit, sign initial orders, or perform other federally required visits in NFs?

A6. No. The statute specifies that the NPPs are prohibited from providing these services when **employed** by the facility. The Social Security Act states at section 1919(b)(6)(A) that the health care of every resident must be provided under the supervision of a physician or under the supervision of an NPP **not** employed by the facility who is working in collaboration with a physician.

Q7. May NPPs perform the initial comprehensive visit in SNFs?

A7. No. The Social Security Act states at Section 1819(b)(6)(A) "that the medical care of every resident must be provided under the supervision of a physician." Congress did not extend this benefit to NPPs in an SNF as was done under 1919(b)(6)(A).

Q8. When may NPPs sign the initial orders for a SNF resident?

A8. NPPs may not sign initial orders for an SNF resident. However, they may write initial orders for a resident (only) when they review those orders with the attending physician in person or via telephone conversation and have the orders signed by the physician.

Q9 Must a physician verify and sign orders written by an NPP who is employed by the NF?

A9. Yes. The regulation at 42 CFR, § 483.40(b)(3) states, the physician must "Sign and date all orders with the

exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications."

In accordance with 42 CFR, Section 483.40(f), required physician tasks, such as verifying and signing orders in an NF, can be delegated under certain circumstances to a physician assistant, nurse practitioner, or clinical nurse specialist who is **not** an employee of the facility but who is working in collaboration with a physician. Therefore, in order to comply with survey and certification requirements, the physician must sign all orders written by an NPP who **is** employed by the NF.

Q10. Why must a physician verify and sign orders written by an NPP in the SNF?

A10. In SNFs, depending on State law and the facility's policy, physicians do NOT have to verify and sign orders written by an NPP after the initial comprehensive visit. Nonetheless, the ultimate responsibility for delegated tasks remains with the physician, as indicated in § 483.40(e)(1)(iii). For a NF, depending upon State law, NPPs not employed by the facility but who are working in collaboration with a physician are not required to have their orders (initial or ongoing) cosigned by a physician.

Q11. Referring to S&C –04-08 issued on November 13, 2003, the chart under the "Other Medically Necessary Visits and Orders" column, it specifies the ability of the NPP to perform AND sign but in the column for "Other Required Visits" it does not address signing. Does CMS require a physician's signature in such cases?

A11. 'Other Required Visits' refers to the federally required visits. During these required visits, it is not always necessary to write orders. However, during a "Medically Necessary Visit," which is when the resident's condition may have changed, thus, warranting a visit outside the federally required schedule, the resident is exhibiting signs and/or symptoms that require medical attention. In these cases, CMS believes orders will often be required and, thus, expect orders to address the resident's change in condition.

Therefore, an NPP may sign the medically required orders. Please remain mindful that the survey and certification requirement that the physician must sign and date all orders remains in effect. (See Q&As 9 & 10.)

Q12. Why can't a PA, regardless of employment, sign certifications/re-certifications for SNF residents?

A12. Congress amended section 1814(a)(2) of the Social Security Act in 1989. The Social Security Act **specifies** that NPs and CNSs who are not employed by the facility may certify (and recertify) that the services the beneficiary requires may only be performed in the SNF. They did not extend this benefit to PAs. Therefore, by statute, PAs may not sign SNF certifications/re-certifications.

Q13. If a physician extender is not employed by the NF but is employed by an organization related to the NF, may he/she still provide services in the nursing home?

A13. The requirement in 42 CFR, § 483.40(f), is specific in that the physician tasks may be performed by a NP, PA, or CNS "who is not an employee of the facility." In this case, the NPP is not an employee of the NF and, thus, can perform physician tasks as long as they work in collaboration with the physician.

Q14. If an NP or CNS is not employed by the SNF but is employed by an organization related to the SNF, may he/she sign the certification and re-certifications?

A14. The requirement in 42 CFR § 424.20(e) is specific in that an NP or CNS "neither of whom has a direct or indirect employment relationship with the facility" may sign the certifications and re-certifications. Under 42 CFR 424.20(e)(2)(ii), when an NP or CNS has a direct employment relationship (as defined under common law) with an entity other than the SNF itself, he or she is also considered to have an indirect employment relationship with the SNF in any instance where the employing entity has an agreement with the SNF for the provision of general nursing services. For further explanation of this provision, please refer to the FY 2006 SNF prospective payment system final rule, 70 FR 45035 - 36, August 4, 2005. (Social Security Act section 1814(a)(2))

Q15. If physician delegation responsibilities are based on payment source, what are the physician delegation responsibilities for private pay resident, VA contracts or managed care?

A15. If the resident's stay is being paid for by a source other than Medicare or Medicaid AND the resident is residing in a Medicare/Medicaid dually-certified facility, follow the most stringent requirement. If the resident is residing in a Medicare only or a Medicaid only certified facility, then follow the requirements for that specific certified facility.

Q16. Are NPPs allowed to certify/recertify therapy plans of care under Medicare Part B?

A16. 42 CFR § 424.24(c)(3) states that if a physician or NPP establishes the plan of care, he/she must also certify the plan of care. If the plan of care is established by a physical or occupational therapist or speech language pathologist, a physician or NPP who has knowledge of the case must sign the plan of care. (This Q&A was **not** addressed in the November 13, 2003, Survey & Certification letter, S&C-04-08.) Should you have any questions concerning this article, please submit your inquiry via the CMS Web site as follows:

1) Click on Feedback in top tool bar of http://www.cms.hhs.gov (from Home page or any page on cms.hhs.gov).
2) Select and click "Site Feedback" in last paragraph.
3) User should:
   a. Enter his/her email address;
   b. At Category, select "Providers" from the drop down menu;
   c. At the sub-category, select Nursing Home Quality Initiative;
   d. Enter feedback in space provided; and
   e. Submit feedback.

Related Instructions

The CMS Web site contains considerable information regarding SNF billing procedures and NPP billing processes. Some of the specific sites are as follows: The *Medicare Claims Processing Manual, Pub. 100-04, Chapter 7 (SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule))* can be found at the following CMS Website: http://www.cms.hhs.gov/manuals/104_claims/clm104c07.pdf

The *Skilled Nursing Facility Manual, Chapter V (Billing Procedures)* is located at the following CMS Website: http://www.cms.hhs.gov/manuals/12_snf/sn500.asp

The Home Health Agency Manual, Chapter IV (Billing Procedures) Website is located at: http://www.cms.hhs.gov/manuals/11_hha/hh400.asp.

Additional Information

The CMS Quarterly Provider Update Websites for Non-Physician Practitioners (NPPs) for 2004 can be found at:

http://www.cms.hhs.gov/providerupdate/january2004/nonphys.asp
http://www.cms.hhs.gov/providerupdate/april2004/nonphys.asp
http://www.cms.hhs.gov/providerupdate/July2004/nonphys.asp
http://www.cms.hhs.gov/providerupdate/october2004/nonphys.asp

In addition, the CMS Quarterly Provider Update Websites for NPPs for 2003 can be found at:

http://www.cms.hhs.gov/providerupdate/january2003/nonphys.asp
http://www.cms.hhs.gov/providerupdate/april2003/nonphys.asp
http://www.cms.hhs.gov/providerupdate/july2003/nonphys.asp
http://www.cms.hhs.gov/providerupdate/october2003/nonphys.asp

Acronyms

CFR = Code of Federal Regulations
CMS = Centers for Medicare & Medicaid Services
CNS = Clinical Nurse Specialist
NF = Nursing Facility
NP = Nurse Practitioner
NPP = Non-Physician Practitioner (NPs, CNSs, & PAs are considered NPPs)
OBRA '90 = Omnibus Budget Reconciliation Act of 1990
PA = Physician Assistant
S&C = Survey & Certification
SNF = Skilled Nursing Facility
VA = Veterans Administration

Posters Now Available!

Posters titled "Have Limited Income? Social Security Can Help with Prescription Costs" can be ordered free of charge on the Centers for Medicare and Medicaid Services' (CMS) website. The posters are suitable for display in a physician's, provider's, or supplier's office, a pharmacy, or other health care setting where Medicare beneficiaries will see this information. The posters direct Medicare beneficiaries with limited income to a toll free number where they can find out if they are eligible for help with prescription drug costs. Flat posters are suitable for wall display. Easel posters are suitable for counter display. Order the size and style appropriate for your use. Artwork cannot be specified as posters will be sent based on availability at the time the order is received. To view and order the posters, go to the Medlearn Prescription Drug Coverage web page located at: http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the CMS website. We need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

Provider Customer Service Announcement

Beginning October 2005, DMERC Region D Provider Customer Service Representatives (CSRs) will be unavailable from 9:30 am to 11:30 am CST on the 1st and 3rd Thursday of each month. CSR training will be conducted during this time to assist our agents' ability to answer complex provider issues. Our Interactive Voice Response (IVR) system (1.877.320.0390) will continue to be operational during this time for various claim, beneficiary, and payment information. We appreciate your patience during this training initiative.

Quarterly Provider Update

Medlearn Matters Article Number: SE0303

The Quarterly Provider Update is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs and complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update list-serv (electronic mailing list) at: http://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1.

The Quarterly Provider Update can be accessed at http://www.cms.gov/providerupdate. We encourage you to bookmark this Web site and visit it often for this valuable information.

Requirements For Voided, Canceled, And Deleted Claims

Medlearn Matters Article Number: MM3627

Related Change Request (CR) #: 3627
Related CR Release Date: June 17, 2005
Related CR Transmittal #: 159
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

Note: This article was revised on October 4, 2005, to correct errors on page 2. Specifically, references to form HCFA 1500 were corrected to state form CMS 1500.

Provider Types Affected - All Medicare physicians, providers, and suppliers billing Medicare carriers, Durable Medical Equipment Regional Carriers (DMERCs) and Fiscal Intermediaries (FIs)

Provider Action Needed - This Medlearn Matters article is based on information contained in Change Request (CR) 3627, which describes new CMS procedures and specific instructions to Medicare Contractors (Medicare carriers, intermediaries, and DMERCs) for voiding, canceling, and deleting claims.

As a result of these changes, providers should note that some claims they were able to delete in the past will no longer be deleted from Medicare's systems, but will instead become denied claims.

Background

The Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) has verified instances in which Medicare claims have been voided, cancelled, or deleted by Medicare carriers, DMERCs, and FIs. Further, the Medicare contractors have not traditionally maintained an audit trail for the voided, cancelled, or deleted claims. The OIG has indicated that Medicare must maintain an audit trail for voided, cancelled, and deleted claims.

The Centers for Medicare & Medicaid Services (CMS) is therefore implementing requirements for Medicare contractors (carriers/FIs, including DMERCs and Regional Home Health Intermediaries (RHHIs)) to:

- Deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons;
- Cancel, void, or delete claims that are unprocessable for acceptable reasons;
- Return as unprocessable claims that meet conditions

mentioned below for the return of unprocessable claims; and
• Maintain an audit trail for all cancelled, voided, or deleted claims that Medicare systems have processed far enough to have assigned a Claim Control Number (CCN) or Document Control Number (DCN).

Note: CR3627 requires that Medicare carriers, intermediaries, and DMERCs keep an audit trail on these claims once a CCN or DCN has been assigned to the claim.

Acceptable Claims Deletions

Below is a list of acceptable reasons a Medicare contractor may cancel, delete, or void a claim:

1. The current CMS 1500 form or the current CMS 1450 form is not used.
2. The front and back of the CMS 1500 (12/90) claim form are required on the same sheet and are not submitted that way (claims submitted to carriers only).
3. A breakdown of charges is not provided, i.e., an itemized receipt is missing.
4. Only six line items have been submitted on each CMS 1500 claim form (Part B only).
5. The patient's address is missing.
6. An internal clerical error was made.
7. The Certificate of Medical Necessity (CMN) was not with the claim (Part B only).
8. The CMN form is incomplete or invalid (Part B only).
9. The name of the store is not on the receipt that includes the price of the item (Part B only).

Note: The Medicare contractor must keep an audit trail for all claims in the above "Acceptable Claims Deletions" category if a CCN or a DCN was assigned to the claim.

Unacceptable Claims Deletions

The following are unacceptable reasons for Medicare contractors to void, cancel, or delete claims:

1. A provider notifies the Medicare contractor that claim(s) were billed in error and requests the claim be deleted (carrier claims only).
2. The provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (Type of Bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review. (FI claims only)
3. The patient's name does not match any Health Insurance Claim Number (HICN).
4. A claim meets the criteria to be returned as unprocessable under the incomplete or invalid claims instructions in the *Medicare Claims Processing Manual*, Chapter 1, Section 80.3.2.ff, which is available at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp on the CMS web site.

Medicare contractors must deny or reject claims in the above "Unacceptable Claims Deletions" category.

Return as Unprocessable Claims

Medicare contractors may return a claim as unprocessable for the following reasons:

1. Valid procedure codes were not used and/or services are not described (e.g., block 24D of the CMS 1500) (Part B only).
2. The patient's HICN is missing, incomplete, or invalid (e.g., block 1A of the CMS 1500).
3. The provider number is missing or incomplete.
4. No services are identified on the claim.
5. Block 11 (insured policy group or FECA Number) of the CMS 1500 is not completed to indicate whether an insurer primary to Medicare exists (Part B only).
6. The beneficiary's signature information is missing (Part B only).
7. The ordering physician's name and/or UPIN are missing/invalid (blocks 17 and 17A of the CMS 1500).
8. The place of service code is missing or invalid (block 24B of the CMS 1500 – Part B only).
9. A charge for each listed service is missing (e.g., block 24F of the CMS 1500).
10. The days or units are missing (e.g., block 24G of the CMS 1500).
11. The signature is missing from block 31 of the CMS 1500 (Part B only).
12. Dates of service are missing or incomplete (block 24A of the CMS 1500).
13. A valid HICN is on the claim, but the patient's name does not match the name of the person assigned that HICN.

Summary

In summary, CMS believes the following:

• The problems listed under the "Acceptable Claims Deletions" heading are valid reasons to void/delete/ cancel a claim if the Medicare contractor maintains an audit trail; and
• Claims with problems listed under the "Unacceptable Claims Deletions" heading should be denied or rejected by Medicare, and the decision to deny/reject the claim should be recorded in the Medicare contractor's claims processing system history file.

If a Medicare contractor determines that a claim is unprocessable before the claim enters that contractor's claims processing system (i.e., the claim processing system **did not assign a CCN or DCN** to the claim):

• The claim may be denied; and
• The contractor does not have to keep a record of the claim or the deletion.

If a Medicare contractor determines that a claim is unprocessable after the claim enters their claims processing system (i.e., the claim processing system **did assign a CCN or DCN** to the claim):

• The denied or rejected claim will not be totally deleted from Medicare's claims processing system. The Medicare contractor must maintain an audit trail for all deleted claims that have entered the claims processing system (i.e., the system assigned a CCN or DCN to the claim).

Implementation - The implementation date for the instruction is October 3, 2005.

Additional Information - For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp on the CMS web site. From that web page, look for CR3627 in the CR NUM column on the right, and click on the file for that CR.

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

The Comprehensive Error Rate Testing (CERT) Process For Handling A Provider's Allegation Of Medical Record Destruction

Medlearn Matters Article Number: SE0547

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

Provider Types Affected - All Medicare providers

Provider Action Needed

Impact to You - SE0547 outlines the process Medicare providers should follow when medical records requested by Medicare's Comprehensive Error Rate Testing (CERT) Documentation Contractor (CDC) and/or Medicare's CERT Review Contractor (CRC) are destroyed by disaster.

What You Need to Know - For CERT purposes, a "disaster" is defined as any natural or man-made catastrophe which causes damages of sufficient severity and magnitude to partially or completely destroy or delay access to medical records and associated documentation.

• Natural disasters would include hurricanes, tornadoes, earthquakes, volcanic eruptions, fires, mudslides, snowstorms, and tsunamis.

• Man-made disasters would include terrorist attacks, bombings, floods caused by manmade actions, civil disorders, and explosions. A disaster may be widespread or impact multiple structures or be isolated and impact a single site only.

What You Need to Do - If you cannot submit the requested medical records because they were destroyed by a disaster, the CDC/CRC will ask you to attest, under penalty of perjury, to the destruction of the medical records. The **Attestation Form** is available to providers at http://www.certprovider.org. Providers who need to use this form can print and fax the form to the CDC who will either retain the form or send it to the CRC depending on which contractor sent the initial request letter for medical record documentation to the provider.

Background

The Centers for Medicare & Medicaid Services (CMS) recognizes that there are circumstances in which destruction of medical record documentation because of unforeseen events should not count as a "no documentation error." Therefore, CMS has established the following process and procedures to corroborate allegations that CERT-requested medical records were destroyed by a disaster.

The **corroboration process is comprised of two steps: 1) qualification and 2) accuracy**. In the first step, the CDC/CRC will review the attestation statement to determine if the event qualifies as a disaster. Provider induced disasters and disasters caused by negligence on the part of providers will be counted as "no documentation errors."

The following are examples of provider induced disasters and **disasters caused by negligence** on the part of providers that **would NOT qualify** as a natural or

man-made disaster:

• My dog ate the medical record
• My computer lost or destroyed the medical record

If the event does not qualify as a natural or man-made disaster defined in the Provider Action Needed section of this article, the claim associated with that medical record is documented as a "no documentation error."

The following are examples of events that **WOULD qualify** as a natural or man-made disaster:

• The medical record was destroyed by a flood.
• Office fire consumed the medical record.

If the event does qualify as a natural or man-made disaster, the CDC/CRC will move to the **second step in the corroboration** process: confirming the accuracy of the attestation. The CDC will confirm the attestation statement through any or all of the following means:

The CDC **checks the following database records for evidence** of natural, man-made, and/or provider induced disasters: Pacer (Civil and Criminal Searches), Crimetime.com, News Searches, Internet Search, HHS OIG Sanctioned Providers ,Merlin, State Record Searches (Courthouse Records, Insurance Carriers or http://www.insurancefraud.org/ Choicepoint/Autotrak, Argyli, Tracer, and the National Crime Insurance Bureau).

The **CDC interviews the provider** who reported the destruction of medical records. The CDC determines the events leading up to the destruction of medical records, such as: what caused the destruction (weather, fire, etc.), were back-up records maintained (electronic or otherwise), what else might have been destroyed, were fire, police, insurance adjusters called to review the damage? The CDC will identify the magnitude of the destruction to medical records, determine if the Medicare Carrier/DMERC/FI has copies, interview other third parties as necessary, and determine if medical records were retained elsewhere and how were they maintained.

The **CDC validates additional supporting evidence** for the event, which may include but not be limited to the following sources:

• Weather related events, such as, rain, floods, hurricanes, tornadoes, etc., that can be confirmed by NOAA on a state and county geographical basis.
• Fire that can be confirmed by checking with the local Fire Marshall.
• Explosions, such as, natural gas that can be confirmed by the local Fire Marshal or local gas company.
• Explosions, such as, chemical explosions that can be confirmed by the local Fire Marshall and the Bureau of Alcohol, Tobacco, and Firearms.
• Local, state, and federal investigative officials can confirm explosions.
• State insurance officials can confirm whether doctors, hospitals, and DME suppliers applied for insurance coverage under their insurance policies.
• FEMA can confirm if doctors, hospitals, and DME suppliers applied for disaster recovery loans.
• Local and state investigative agencies may be able to confirm events leading to the destruction of medical records.
• Employees or non employees of doctors, hospitals, and DME suppliers may have contributed to the destruction of medical records and there should be records disclosing charges against that individual(s).

Where the CDC is unable to verify the accuracy of the explanation provided in the attestation statement, the claim will be counted as a "no documentation error."Please note that this could eventually lead to a determination that an overpayment has occurred and overpayment recovery action could result.

Additional Information

Medlearn Matters article MM2976 describes the CERT program and MM3812 provides additional information on CERT. Those articles can be viewed at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2976.pdf and http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3812.pdf, respectively on the CMS web site.

To review copies of the letters CERT contractors use to request medical record documentation from Medicare Physicians/Providers go to http://www.cms.hhs.gov/CERT/letters.asp on the CMS web site. Also on this site are CERT Newsletters that provide information about the entire CERT process. If you have questions, please contact your carrier or intermediary at their toll free number, which is available at http://www.cms.hhs.gov/medlearn/tollnums.asp on the CMS web site.

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Frequently Asked Questions

1. Do I need to use the KX modifier when submitting a claim for a commode chair?

   ANSWER: If the patient meets the coverage criteria as explained in the "Indications and Limitations of Coverage and/or Medical Necessity" section in the Commode Local Coverage Determination (LCD), the KX modifier must be added to all commode HCPCS codes. *(DMERC Region D Supplier Manual, Chapter 9, COM)*

2. How long do I have to request a hearing? Can I make this request over the phone?

   ANSWER: A hearing must be requested within 6 months of the date of the redetermination decision. A hearing must be requested in writing. *(DMERC Region D Supplier Manual, Chapter 13, page 5)*

3. What information should be entered in item 11 of the CMS-1500 claim form?

   ANSWER: Item 11 of the CMS-1500 claim form is a required field and must be completed. If the beneficiary has insurance primary to Medicare item 11 must contain the primary insurance policy or group number and items 11a-d must also be completed. If the beneficiary has no other primary insurance the word "NONE" should be entered. *(DMERC Region D Supplier Manual, Chapter 6, pages 37-38)*

4. Is a supplier permitted to create its own Advance Beneficiary Notice (ABN) or is there a standard form that must be used?

   ANSWER: A supplier must use the OMB-approved ABN form. *(DMERC Region D Supplier Manual, Chapter 6, page 3)*

5. Are there new requirements concerning Group 2 Pressure Reducing Support Surfaces?

   ANSWER: One of the coverage criterion as explained in the "Indications and Limitations of Coverage and/or Medical Necessity" section in the Group 2 Support Surfaces LCD states the presents of "multiple stage II pressure ulcers located on the trunk or pelvis". As of October 1, 2004 the ICD-9 diagnosis code for decubitus ulcer (707.0) requires 5th digit that describes the specific location of the ulcers. Claims for Group 2 Support Surfaces are being edited for proper ICD-9 codes. Suppliers should ensure the ICD-9 code used reflects the appropriate location of the decubitus ulcer. *(DMERC Region D Supplier Manual, Chapter 9, SPSRB)*

6. I understand for the DMERC to consider starting a new capped rental period for an item there must be a documented break in service of at least 60 days. What other documentation is required?

   ANSWER: To start a new capped rental period there must be documentation that supports an interruption in medical necessity and that the interruption lasted for 60-plus days. This documentation must include, but is not limited to: 1) a description of the patient's prior condition that necessitated the previous item, 2) a statement explaining when and why the medical necessity for the previous item ended, and 3) a statement explaining the patient's new or changed medical condition and when the new need began. This information must be entered in the HAO record of an electronic claim, or attached to a paper claim. If the interruption is because the beneficiary is in the hospital or in a skilled nursing facility a new capped rental period would not begin. *(DMERC Region D Supplier Manual, Chapter 3, pages 10-12)*

Frequently Asked Questions (cont'd)

7. How can I check status of a claim?

   ANSWER: A toll-free number has been designated for the exclusive use of suppliers. The toll-free number is 877.320.0390. This number will be answered by an Interactive Voice Response (IVR) system that is capable of responding to a variety of supplier inquiries and requests including claim status inquiries. *DMERC Region D Supplier Manual, Chapter 13, page 1)*

   There are two other electronic claim status options available for suppliers or submitters:

   1) Claim Status Inquiry Direct Data Entry (DDE) - this option allows a supplier to dial in and manually key in a beneficiaries Health Insurance Claim number (HIC#) and other key personal information and receive a response within seconds.
   2) Real Time Option – with this option the supplier sends a batch of one beneficiary inquiry into our system through the stratus bulletin board system and then receives a response.

   Both options require completion of the DMERC Customer Profile. Contact the Region D Electronic Data Interchange (EDI) department for more information at 1.866.224.3094, option 1.

8. What states are included in Region D?

   ANSWER: Region D includes the following states and territories: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming. *(DMERC Region D Supplier Manual, Chapter 15, page 1) (CMS Change Request 4002 Released 09/02/2005)*

9. I have an oxygen patient whose physician has retired. What CMN do I need to complete to show the new physician?

   ANSWER: A revised CMN would need to be completed indicating the new physician. This CMN would not need to be submitted to the DMERC but kept in the suppliers file and available to the DMERC upon request. *(DMERC Region D Supplier Manual, Chapter 4, page 11)*

10. For What Place of Service codes will the DMERC consider coverage?

    ANSWER: Coverage for any DMEPOS items will be considered if the place of service is:

    04 – Homeless Shelter
    12 – Home
    13 – Assisted Living Facility
    14 – Group Home
    33 – Custodial Care Facility
    54 – Intermediate Care Facility/Mentally Retarded
    55 – Residential Substance Abuse Treatment Facility
    56 – Psychiatric Residential Treatment Center
    65 – End Stage Renal Disease Treatment Facility

    Coverage consideration for DMEPOS items in Skilled Nursing Facility (31) or Nursing Facility (32) is limited to the following:

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

    (DMERC Region D Supplier Manual, Chapter 5, page 9)

Medicare Secondary Payer (MSP) Questionnaire

Patient Name _____ Date: _____

HICN: _____

Part I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes Date benefits began: _____(MM/DD/CCYY)

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

___ No

2. Are the services to be paid by a government program such as a research grant?

___ Yes Government Program will pay primary benefits for these services

___ No

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

___Yes

DVA IS PRIMARY FOR THESE SERVICES.

___ No

4. Was the illness/injury due to a work related accident/condition?

___ Yes Date of injury/illness: _____(MM/DD/CCYY)

Name and address of WC plan:

_____

_____

_____

Policy or identification number: _____

Name and address of your employer:

_____

_____

_____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.

___ No **GO TO PART II**.

Part II

1. Was illness/injury due to a non-work related accident?

___ Yes Date of accident: _____(MM/DD/CCYY)

___ No **GO TO PART III**

Medicare Secondary Payer (MSP) Questionnaire (page 2)

2. What type of accident caused the illness/injury?

___ Automobile

___ Non-automobile

Name and address of no-fault or liability insurer:

_____

_____

_____

Insurance claim number: _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ Other

3. Was another party responsible for this accident?

___ Yes

Name and address of any liability insurer:

_____

_____

_____

Insurance claim number: _____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ No **GO TO PART III**

Part III

1. Are you entitled to Medicare based on:

___ Age **Go to Part IV.**

___ Disability **Go to Part V.**

___ ESRD **Go to Part VI.**

Part IV – Age

1. Are you currently employed?

___ Yes

Name and address of your employer:

_____

_____

_____

Medicare Secondary Payer (MSP) Questionnaire (page 3)

___ No Date of retirement:_____(MM/DD/CCYY)

___ No Never employed

2. Is your spouse currently employed?

___ Yes

Name and address of spouse's employer:

_____

_____

_____

___ No Date of retirement:_____(MM/DD/CCYY)

___ No Never Employed

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

___ Yes

___ No **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. Does the employer that sponsors your GHP employ 20 or more employees?

___ Yes **STOP. GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

_____

_____

_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/ patient):_____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

Medicare Secondary Payer (MSP) Questionnaire (page 4)

Part V - Disability

1. Are you currently employed?

___ Yes

Name and address of your employer:

_____

_____

_____

___ No Date of retirement:_____(MM/DD/CCYY)

___ No Never Employed

2. If married, is your spouse currently employed?

___Yes

Name and address of your spouse's employer:

_____

_____

_____

___ No Date of retirement:_____(MM/DD/CCYY)

___ No Never Employed

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?

___ Yes

___ No **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART I OR II.**

4. Are you covered under the group health plan of a family member other than your spouse?

___ Yes

Name and address of our family member's employer:

_____

_____

_____

___ No

5. Does the employer that sponsors the GHP employ 100 or more employees?

___ Yes **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Medicare Secondary Payer (MSP) Questionnaire (page 5)

Name and address of GHP:

_____

_____

_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

Part VI – ESRD

1. Do you have group health plan (GHP) coverage?

If yes, name and address of GHP:

_____

_____

_____

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____

_____

___ No **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

___Yes Date of transplant:_____(MM/DD/CCYY)

___ No

Medicare Secondary Payer (MSP) Questionnaire (page 6)

3. Have you received maintenance dialysis treatments?

___Yes Date dialysis began:_____(MM/DD/CCYY)

If you participated in a self-dialysis training program, provide date training started:

_____(MM/DD/CCYY)

___ No

4. Are you within the 30-month coordination period that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)

___ Yes

___ No **STOP. MEDICARE IS PRIMARY**.

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ Yes

___ No

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

___ Yes **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

___ No **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY**.

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement)?

___ Yes **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD**.

___ No **MEDICARE CONTINUES TO PAY PRIMARY**.


What do you say when asked about new Medicare Prescription Drug Coverage?
Beginning in January all your Medicare patients can get help from Medicare with their prescription drug costs. We want to help you answer questions you might get from your Medicare and Medicaid patients. There are local resources available for your patients to go to for more help.
• Visit www.medicare.gov to get personalized information through to Medicare Rx Plan Finder. Your patients should have their Medicare information, list of medicines and address of their local pharmacy with them before they start.
• Call 1-800-677-1116 or visit www.eldercare.gov to find local counselors.
• Call 1-800-Medicare to speak to a counselor.
If you need more information for your practice, go to www.cms.hhs.gov/medlearn/drugcoverage.asp.
Help is Here 24/7
1-800-MEDICARE
TTY 1-877-486-2048
www.medicare.gov
MedicareRx
Prescription Drug Coverage

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Completion of Medicare Certificates of Medical Necessity

Dear Physician:

Certificates of Medical Necessity, commonly known as CMNs, are documents used by the DMERCs to assist in gathering information about the medical necessity of an item. It is your responsibility to determine both the medical need for, and the utilization of, all healthcare services.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are *your partners* in caring for *your patient.* They will not receive payment for their services until you return the completed, signed and dated CMN. If you have ordered equipment or supplies as part of your patient's treatment plan, completing the CMN accurately and in a timely manner helps insure that your treatment plan will be carried out. Moreover, your cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p)(4) of the Act provides that:

> *[i]n case of an item or service…ordered by a physician or a practitioner…but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.*

Remember, everyone has tight cash flow these days – help your DMEPOS supplier continue good service to your patients by prompt completion and return of the CMN.

Sincerely,

Medical Director, Region D
Durable Medical Equipment Regional Carrier

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DMERC Region D Publications Designation Form

DMERC Region D quarterly publications are distributed via Internet (www.cignamedicare.com) and CD-ROM. The CD-ROM includes the *DMERC Dialogue*, *DMERC Region D Supplier Manual* and update and various other supplier resources. Suppliers may choose to receive a paper copy of the *DMERC Dialogue* only in lieu of a CD-ROM.

Suppliers with multiple sites and supplier numbers may choose to eliminate publication distribution to some or all of the sites by designating that one CD-ROM be mailed to the supplier's corporate address. The CD-ROM will be mailed to the designated "Mail To" address for the corporate office on the supplier's enrollment application.

Complete the applicable section(s) below to **change** the method of publications distribution preferred. You may also submit your request in writing on your company letterhead to: CIGNA Government Services, Communications Department, Two Vantage Way, Nashville, TN 37228 or by fax: 615.782.4445.

Request for Paper Copy – DMERC Dialogue (Opt-Out of CD-ROM distribution)

_____
SUPPLIER NUMBER

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

Reason for requesting paper version:
- ☐ No personal computer
- ☐ No CD-ROM drive
- ☐ Prefer paper copy
- ☐ Other _____

(List additional supplier numbers to be included in this request on the back of this form.)

Request for CD-ROM (Opt-In or return to CD-ROM distribution)

_____
SUPPLIER NUMBER

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

(List additional supplier numbers to be included in this request on the back of this form.)

Request for elimination of CD-ROM distribution to multiple sites-Corporate address designation

_____
SUPPLIER NUMBER TO REMAIN ON PUBLICATIONS MAIL LIST

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

- ☐ Eliminate CD-ROM for all supplier numbers with the same "mail to" address shown on this form. [When this option is selected all newly assigned supplier numbers will be included in this request.]
- ☐ Eliminate CD-ROM only for the supplier numbers listed on the back of this form.

(List supplier numbers to be excluded from the publications mail list on the back of this form.)

DMERC Region D Publications Designation Form (cont'd)

List additional supplier numbers to be included in the request on the front of this form.

SUPPLIER NUMBER(S):

SUPPLIER NUMBER(S):

The privacy of our customers is important to CIGNA Government Services. Personally identifying information that is collected will be used only in connection with the specified request. CIGNA Government Services will protect all personally identifying information, sensitive and non-sensitive, that you share with us.

DMERC Region D Publication Order Form

Name:

Company Name:

Address:

City:	**State:**	**Zip:**

Email:

Note: Government agencies, state associations, CMS, CIGNA employees and other insurance companies do not need to submit payment.

Subscription (4 quarterly publications) $40.00

Region D *DMERC Dialogue*_____ (quantity) ***Subtotal*** **$_____**

CD-ROM _____ (quantity) (Includes *DMERC Dialogue*, *DMERC Region D Supplier Manual* and updates and various other materials.) ***Subtotal*** **$_____**

Individual Publication Requests

Region D *DMERC Dialogue** **($10.00 each issue)** (*Previous issues may include the supplier manual update.)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

CD-ROM ($10.00 each)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

DMERC Region D Supplier Manual
$40.00 per manual _____(quantity) ***Subtotal*** **$_____**

DMERC Region D Supplier Manual Update* **($10.00 each)** (*Previous updates may include the *DMERC Dialogue*.)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

NOTE: Beginning Spring 2003, hardcopies of supplier manual updates are no longer mailed and must be downloaded from our Web site at http://www.cignagovernmentservices.com/dmerc/dmsm/index.html. (Also, hardcopies are not available for the Summer and Fall 2002 updates, please download from the Web.)

DMERC DMEPOS Fee Schedule* ($10.00 each) (*DMERC DMEPOS suppliers do not need to submit payment for the fee schedule unless ordering more than one copy.)

Quantity_____ Year _____ ***Subtotal*** **$_____**

Total Amount Due **$_____**

Payment/Order Information

Checks or money orders should be made payable to CIGNA Government Services. Send completed order form and payment to:

Connecticut General Life Insurance Company
Attn: DMERC Publication Fulfillment Center
P. O. Box 360295
Pittsburgh, PA 15251-0295

If your order does not require a payment, send the completed order form to:

CIGNA Government Services
Attn: DMERC Region D Publications
P. O. Box 690
Nashville, TN 37202

If you have not billed CIGNA Government Services within the last 12 months, you will not be included on the current publication mailing list and will not receive your complementary CD-ROM or hardcopy *DMERC Dialogue*. Region D publications are available at http://www.cignagovernmentservices.com/dmerc/index.html.

(Rev. 07/2005)

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Customer Service Available

Telephone Inquiries—Customer Service Agents are available from 8:00 am to 6:00 pm CST, Monday through Friday. The Interactive Voice Response (IVR) System is available any time as long as the mainframe system is functional.

IVR System*:* 877.320.0390 ***Supplier Help Line****:* 866.243.7272 ***Beneficiary Help Line****:* 1-800-MEDICARE (1-800-633-4227, Ask for Medical Supplies)

Paper Claim Submission & Written Inquiries:
CIGNA Government Services
DMERC Region D
PO Box 690
Nashville TN 37202

Review Requests:
CIGNA Government Services
DMERC Reviews
PO Box 22995
Nashville TN 37202

Hearing Requests:
CIGNA Government Services
DMERC Hearings
PO Box 22263
Nashville TN 37202

Local Medical Review Policies (LMRPs), Local Coverage Determinations (LCDs), and Policy Articles

LMRPs, LCDs and Policy Articles are available to view and download on the CIGNA Government Services Web site (http://www.cignagovernmentservices.com/dmerc/lmrp_lcd/index.html) and the Centers for Medicare & Medicaid Services (CMS) Web site (http://www.cms.hhs.gov/coverage). Region D maintains paper copies of current, previously revised, or retired policies. Paper copies of policies are available upon request by writing to: CIGNA Government Services, DMERC Region D, ATTN: Elesha Campbell, P.O. Box 690, Nashville, TN 37202; or call 866.243.7272.

Requests may also be made by contacting the CIGNA Government Services Online Help Center at http://www.cignagovernmentservices.com/dmerc/resource.html. Requests for retired policies must include the name of the policy and the date the desired policy was in effect. In addition, you must provide a contact name, phone number and an address to which the policy may be mailed. CIGNA Government Services regrets we will not be able to fax or e-mail copies of the retired policies to the requester.

Supplier Application Packages and Changes of Address—If you need a supplier number application package or if you have questions concerning supplier number requirements, contact the National Supplier Clearinghouse (NSC) at the following: National Supplier Clearinghouse, PO Box 100142, Columbia SC 29202-3142, Phone: 866.238.9652, Web site: www.palmettogba.com.

Also, remember that no checks will be issued if the address on file with the NSC is different than any forwarding order on file with the U.S. Postal Service. Please notify the NSC if you have an address change or are planning to move in the near future.

EDI—For information on implementing electronic claim transmission, including testing procedures, call our EDI representatives at 866.224.3094, or send us e-mail at www.cignagovernmentservices.com/customer_service.

Coding Questions—The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) answers coding questions. Call 877.735.1326.

Overpayments/Refunds—When refunding a check, make it payable to CGLIC - Medicare and send it to:

CIGNA Federal Insurance Benefits—DMERC
PO Box 10927
Newark NJ 07193–0927

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PO Box 690
Nashville TN 37202

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The *DMERC Dialogue*, together with occasional special releases, serves as legal notice to suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

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