A Medicare Newsletter for Region D DMEPOS Suppliers - A service of CIGNA HealthCare Medicare Administration

REGION D
DMERC DIALOGUE
DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

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From the Medical Director...

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CERT Results And Support Surfaces Revisited

In April 2003, I reported in this column the results of a Progressive Corrective Action widespread probe review involving group 2 support surfaces (HCPCS Codes E0193, E0277, E0371, E0372 and E0373). Coverage, coding and documentation guidelines for these devices are found in the Pressure Reducing Support Surfaces – Group 2 local medical review policy (LMRP). The results of the widespread probe revealed that many of the claims in the sample did not meet Medicare guidelines.

Further review of Region D claims by the Comprehensive Error Rate Testing (CERT) contractor confirms these errors, finding that CIGNA Medicare's error rate for a sample of support surface claims submitted in 2003 was almost 30%. As with the widespread probe, all of the claims reviewed by the CERT contractor were group 2 products. As a result of these reviews and the high error rate in this policy group, CIGNA Medicare will be focusing greater efforts in 2005 on reducing errors for these items.

The following points summarize the types of errors found in the widespread probe from 2003 and from the CERT contractor, AdvanceMed.

1. Written Order Prior to Delivery: Suppliers must have a written, signed and dated order prior to delivering a group 2 support surface. If the supplier delivers the item prior to receipt of a written order, it will be denied as noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

Although not encompassed by the timelines for this probe review, effective for dates of service on or after April 1, 2003, claims without a written order prior to delivery must append modifier EY (No physician or other licensed health care provider order for this item or service) to the HCPCS code.

2. Orders Must be Complete and Sufficiently Detailed: The written order should contain sufficient detail to establish that the ordering physician's intent is to prescribe a group 2 support surface. For example, an order that simply states "air mattress" or "pressure pad" can be interpreted to mean a variety of group 1 or group 2 products. It should also be noted that the Statement of Ordering Physician (SOP) example in the *DMERC Region D Supplier Manual* cannot, as printed, serve as a substitute for a written order. If a supplier chooses to use this form as a written order, modifications are required to make sure all elements of a detailed written order are included.

3. Location and Number of Ulcers: One stage II decubitus ulcer on the trunk or pelvis does not meet coverage criteria. Group 2 support surface LMRP criterion one states that there must be **multiple** stage II pressure ulcers located on the trunk or pelvis. Use the appropriate ICD-9 diagnosis code with 5th digit specificity on the claim. As

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CERT Results And Support Surfaces Revisited (cont'd)

of October 1, 2004, ICD-9 codes describing covered decubitus ulcer locations are: 707.02 (upper back), 707.03 (lower back), 707.04 (hip) and 707.05 (buttock). With these new, site-specific ICD-9 codes, code 707.00 (unspecified site) is not specific enough to support coverage.

4. Support Surfaces for Prevention: Group 2 support surfaces are not covered for decubitus ulcer prevention, beneficiaries who only have stage I pressure ulcers or beneficiaries with ulcers located just on the extremities. In order to qualify for coverage, the beneficiary must actually have stage II-IV decubitus ulcers on the trunk or pelvis.

5. Statement of Ordering Physician: Suppliers are required to obtain information concerning which coverage criteria the beneficiary meets and obtain a signed and dated statement from the treating physician. Suppliers should not use the Support Surface Certificate of Medical Necessity (CMN). The DMERC encourages suppliers to use the Group 2 Support Surface Statement of Ordering Physician. The Support Surface CMN is only intended for group 3 support surfaces and does not contain all the information required to determine if beneficiaries meet group 2 coverage criteria.

6. Source of Medical Documentation: The medical information on the Statement of Ordering Physician cannot be completed by suppliers or anyone in a financial relationship with a supplier. Additionally, suppliers should ascertain that actual medical records exist that support the information on the Statement of Ordering Physician. Suppliers are not required to keep copies of these medical records in the beneficiary's file but must, if requested by the DMERC, be able to supply them in a timely manner.

7. Trial of Conservative Therapy: LMRP criterion two specifies that a comprehensive ulcer treatment program must be at least one month (not less than 30 days). The comprehensive ulcer treatment program must include documented use of a group 1 support surface for a minimum of one month (at least 30 days) immediately prior to beginning group 2 therapy. This criterion applies to patients attempting to qualify for the treatment of multiple stage II ulcers.

8. Size of Ulcer: While one stage III or IV pressure ulcer on the trunk or pelvis can qualify a beneficiary for group 2 support surface coverage, coverage criterion four states that this must be a "large ulcer". The DMERC, when reviewing medical records, generally considers any wound of 8 square centimeters (length X width) or more as meeting the definition of "large". Individual patient circumstances, however, are weighed. We also take into account whether undermining and/or tunneling are present, the anatomic location on the body and the size of the patient.

9. Continued Use for Capped Rental Items: Suppliers are strongly encouraged to perform monthly beneficiary status checks in order to lessen the chance of billing for a date of service that does not meet Medicare coverage criteria. Suppliers should make certain that the beneficiary is still using the mattress and has not been moved to a noncovered place of service (acute care hospital, SNF, etc.) or died. If the beneficiary is not in a covered place of service on the usual date of service billed, claim submissions should be discontinued until the day the beneficiary returns to a covered place of service and resumes use of the device. Additionally, if suppliers have knowledge that payment was received for a date of service not meeting coverage criteria, it is their responsibility to voluntarily refund the money.

10. Use After Wound is Healed: Continued use of a group 2 support surface is covered until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that: (1) other aspects of the care plan are being modified to promote healing, or (2) the use of the group 2 support surface is medically necessary for wound management. Once the wound is healed, group 2 support surfaces are no longer covered.

Finally, as with the widespread probe, the CERT contractor was unable to obtain records or an order for many of the claims. Suppliers are strongly encouraged to respond to record requests from the DMERC or the CERT contractor, AdvanceMed, in a timely manner when notified of a provider review.

MEDICAL POLICY

Durable Medical Equipment

CPAP And Documentation

A recent review of continuous positive airway pressure (CPAP) claims showed that documentation errors were the number one reason for claim denials. The majority of the errors in this policy group were related to modifier KX usage and the compliance statement. To avoid these types of errors, remember to:

A. Use modifier KX on claims for the first through the third months only if all of the coverage criteria have been met. CPAP is considered for coverage when the patient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (1 or 2):

   1) The AHI is greater than or equal to 15 events per hour; or,
   2) The AHI is from 5 to 14 events per hour with documented symptoms of:

      a) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
      b) Hypertension, ischemic heart disease, or history of stroke.

B. Use modifier KX on claims for the fourth month and any month thereafter only if all of the initial coverage criteria listed above have been met and you have obtained a statement from either the beneficiary or the treating physician that the beneficiary is continuing to use the CPAP device.

Studies show that compliance with CPAP therapy is very poor, with most patients who are non-compliant terminating therapy in the first 30 days. Consequently, the CPAP policy requires that the beneficiary compliance statement be obtained no sooner than the 61st day after initiating therapy. This statement should be documented in your records and made available to the DMERC or the CERT contractor upon request.

Finally, Medicare national policy prohibits the use of portable or in-home sleep studies to qualify patients for CPAP coverage. Prior to billing Medicare, you should confirm that the sleep study used to qualify the patient is a facility-based study.

Remember, a thorough intake process to review orders can prevent many of these errors. All items require an order if Medicare will be billed. All orders must be signed and dated by the treating physician. Physicians should be contacted to complete any missing information. For more details about these and other Medicare documentation requirements, visit the CIGNA Medicare Web site at www.cignamedicare.com/dmerc.

CIGNA Medicare's primary goal is to pay claims correctly. Your attention to these simple details can make the difference between claim payment and denial.

Group 2 Support Surfaces And ICD-9 Codes

According to the Pressure Reducing Support Surfaces - Group 2 local medical review policy (LMRP), coverage is considered for multiple 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 specificity. The 5th digit describes the specific location of the ulcer. Suppliers should ensure that the ICD-9 diagnosis code on the claim reflects the appropriate location of the decubitus ulcer. The following ICD-9 diagnosis codes are eligible for coverage. Claims for Group 2 support surfaces that do not include one of these diagnosis codes will be denied as not medically necessary.

707.02 – Upper back
707.03 – Lower back
707.04 – Hip
707.05 – Buttock

The ICD-9 diagnosis code 707.00 (unspecified site) does not have sufficient specificity to determine coverage. Suppliers should not use code 707.00 for Group 2 support surfaces claims. Please refer to the Pressure Reducing Support Surfaces - Group 2 LMRP for additional information on the coverage, coding and documentation of these items. The LMRP will be converted to a local coverage determination (LCD) and Policy Article in a future update and will reflect these changes.

Infusion Pumps: C-Peptide Levels As A Criterion For Use

Medlearn Matters Article Number: MM3705

Provider Types Affected - Physicians, suppliers, and providers providing continuous subcutaneous insulin infusion and related drugs/supplies in the treatment of diabetic patients in the home setting and billing Medicare carriers or Fiscal Intermediaries (FIs)

Provider Action Needed

Impact to You - This article and related CR 3705 adds beta cell autoantibody testing as an alternative diagnostic per the updated C-peptide testing requirement for the use of insulin infusion pumps, effective for services performed on or after December 17, 2004.

What You Need to Know - Providers/suppliers treating Medicare diabetic patients with infusion pumps should be aware of this new Medicare coverage policy.

What You Need to Do - Ensure that your staff is aware of this new coverage and that they bill according to the information in this article.

Background

On August 26, 1999, the Centers for Medicare & Medicaid Services (CMS) issued the first decision memorandum (DM) for continuous subcutaneous insulin infusion pumps (CSII) that utilized a C-peptide testing requirement for Medicare coverage of CSII pump therapy. On May 11, 2001, CMS issued a second DM for insulin pump: "C-Peptide Levels as a Criterion for Use," and on January 1, 2002, CMS revised the laboratory value for the C-peptide testing requirement for Medicare coverage of CSII pump therapy.

Effective for services performed on or after December 17, 2004, in addition to meeting criterion A or B, the beneficiary with diabetes must be insulinopenic per the fasting C-peptide testing requirement or, as an alternative must be beta cell autoantibody positive. Insulinopenia is defined as a fasting C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method. For patients with renal insufficiency and a creatinine clearance (actual or calculated from age, gender, weight, and serum creatinine) $\leq$ 50 ml/minute, insulinopenia is defined as a fasting C-peptide level that is less than or equal to 200% of the lower limit of normal of the laboratory's measurement method. CMS establishes that fasting C-peptide levels will only be considered valid when a concurrently obtained fasting glucose is $\leq$ 225 mg/dL. Levels need only be documented once in the patient's medical records.

Coverage of all other uses of CSII that adheres with the Category B IDE clinical trials regulation (42 CFR 405.201) or routine cost under the clinical trials policy (*Medicare NCD Manual* Chapter 1, Part 4, Section 310.1) will con-

tinue. Those billing for these services should note that Medicare carriers will accept, effective for services on or after December 17, 2004, CPT code 84681 (C-peptide) or CPT code 86337 (insulin antibodies) when diagnosis codes 250.00-259.93 are also reported on a claim.

Additional Information

The official instruction issued to your Medicare carrier/intermediary regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3705 in the CR NUM column on the right, and click on the file for that CR.

If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at: http://www.cms.hhs.gov/medlearn/tollnums.asp

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NOTE: These criteria have been added to the External Infusion Pump LCD and Policy Article posted on our Web site and available in the accompanying *DMERC Region D Supplier Manual* update. Please refer to the LCD and Policy article for more information on the coverage, coding and documentation requirements for these items.

Pharmacy

Immunosuppressive Drugs DIF Eliminated

In this update to the supplier manual, the Immunosuppressive Drugs local coverage determination (LCD) has been revised to eliminate the use of the DMERC Information Form (DIF), effective for dates of service on or after July 1, 2005. With the elimination of the DIF, suppliers should add modifier GY to claims if any of the coverage criteria for immunosuppressive drugs has not been met. In addition, suppliers should check claims closely to ensure that the ICD-9 diagnosis code on the claim accurately describes a covered transplant type. The following ICD-9 diagnosis codes are eligible for coverage under the Immunosuppressive Drugs benefit category:

V42.0 – Kidney
V42.1 – Heart
V42.6 – Lung
V42.7 – Liver
V42.81 – Bone Marrow
V42.82 – Peripheral Stem Cells
V42.83 – Pancreas
V42.84 – Intestines
V42.89 – Other (use for Pancreatic Islet Cell)
996.81 – Complications of transplanted organs – Kidney
996.82 – Complications of transplanted organs – Liver
996.83 – Complications of transplanted organs – Heart
996.84 – Complications of transplanted organs – Lung
996.85 – Complications of transplanted organs – Bone Marrow
996.86 – Complications of transplanted organs – Pancreas
996.87 – Complications of transplanted organs – Intestine
996.89 – Complications of transplanted organs – Other specified transplanted organ (e.g., pancreatic islet cells)

All other ICD-9 diagnosis codes will be denied as noncovered.

General

Policies Revised

Effective for dates of service on or after April 1, 2005, the following policies have either been revised or converted from local medical review policies (LMRPs) to local coverage determinations (LCDs) and policy articles:

- Ankle-Foot/Knee-Ankle-Foot Orthosis
- Cervical Traction Devices
- Commodes
- Enteral Nutrition
- Facial Prostheses
- External Infusion Pumps
- High Frequency Chest Wall Oscillation Devices
- Lower Limb Prostheses
- Nebulizers
- Oral Anticancer Drugs
- Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
- Ostomy Supplies
- Suction Pumps
- Urological Supplies
- Manual Wheelchair Base
- Motorized/Power Wheelchair Base
- Wheelchair Options and Accessories
- Wheelchair Seating

Effective for dates of service on or after July 1, 2005, the Immunosuppressive Drugs policy has been revised to eliminate the DMERC Information Form (DIF).

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 will constitute the "medical policy." In the CMS 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.

Over the next year the DMERCs will convert all existing LMRPs into LCDs and policy articles. Until the conversion is complete the term LCD will refer to both standalone LCDs and the "reasonable and necessary" provisions of an LMRP. **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

Joysticks, Controllers, And Replacements

As used in the Wheelchair Options and Accessories Policy Article, the term controller describes the microprocessor and other related electronics that receive and interpret input from the joystick (or other drive control interface). That input is then converted as power output to the motor and gears in the power wheelchair base.

The term drive control interface describes the mechanism for controlling the movement of a power wheelchair. Examples of interfaces include, but are not limited to, joystick, sip and puff, chin control, head control, etc.

The allowance for a power wheelchair (K0010-K0014) includes an integrated proportional joystick and controller – i.e., an electronics package in which a joystick and controller electronics are in a single box, which is mounted on the arm of the wheelchair.

The term "remote joystick" describes an electronics package in which the joystick is in one box that is mounted on the arm of the wheelchair and the controller electronics are located in a different box that is typically located under the seat of the wheelchair. A remote joystick may be used either for hand control or for chin control. Codes E2320 and E2321 describe proportional and nonproportional remote joysticks, respectively, including, but not limited to standard, mini-proportional, compact, and short throw remote joystick.

Effective for dates of service on or after January 1, 2005, a new modifier has been established for the replacement of special power wheelchair interfaces:

KC - Replacement of special power wheelchair interface

This modifier would never be used at the time of initial issue of a wheelchair. The KC modifier is used in the following situations:

• Due to a change in the patient's condition an integrated joystick and controller is being replaced by another drive control interface – e.g., remote joystick, head control, sip and puff, etc.

• The patient had a drive control interface described by codes E2320-E2322, E2325, or E2327-E2330 and both the interface (e.g., joystick, head control, sip and puff) and the controller electronics are being replaced due to irreparable damage.

Note: The KC modifier specifically states replacement, therefore, the RP modifier is not required.

Code E2399 (Not otherwise classified interface) is appropriately used in the following situations:

• An integrated proportional joystick and controller box are being replaced due to damage.

• The item being replaced is a remote joystick box only (without the controller).

• The item being replaced is another type of interface, e.g. sip and puff, head control (without the controller).

• The item being replaced is the controller box only (without the remote joystick or other type of interface).

• There is no specific E code which describes the type of drive control interface system which is provided. In this situation, E2399 would be used at the time of initial issue or if the item was being provided as a replacement.

Claims filed with E2399 must contain the following:

• A clear narrative description of the item that is being provided

• If billing for replacement, the claim must describe the item that is being replaced and the reason for replacement.

It is inappropriate to use the KC modifier when billing code E2399.

Questions concerning the correct coding of specific items should be directed to the SADMERC.

New K Code For Portable Oxygen System

The following HCPCS code has been added effective for dates of service on or after April 1, 2005:

K0671 PORTABLE OXYGEN CONCENTRATOR, RENTAL

Code K0671 describes a portable oxygen concentrator system and is to be used when billing Medicare for the portable equipment add-on fee for patients using lightweight oxygen concentrators that can function as both the patient's stationary equipment and portable equipment. Effective for claims with dates of service on or after April 1, 2005, code K0671 is to be used in conjunction with code E1390 (stationary oxygen concentrator) to describe combination stationary/portable oxygen concentrators for Medicare billing purposes. For claims with dates of service prior to April 1, 2005, codes E0431 (portable gaseous oxygen system) and E1390 are to be used to describe combination stationary/portable oxygen concentrators for Medicare billing purposes. Payment for code K0671 will be based on the current add-on fee schedule amounts for portable oxygen equipment. Suppliers should use Certificate of Medical Necessity (CMN) CMS Form 484.2 when filing claims for this new code. For beneficiaries with a CMN on file for HCPCS code E0431, a new CMN does not need to be submitted.

At the present time, the Inogen One[â] (Inogen, Inc.) is the only product that meets the description of this new add-on code. Suppliers with questions regarding the correct coding of their product should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

Nonstandard Seat Frame Dimensions – Power Wheelchairs

Codes E2340-E2343 describing nonstandard seat widths and depths for power wheelchairs were added in January 2004. Since that time it has come to the DMERCs' attention that there are three types of seating configurations and that the same pricing for nonstandard dimensions is not appropriate for all three. The three configurations are described as follows:

1) A seat frame which is integrated with the frame of the wheelchair base and cannot be removed. Examples include but are not limited to Invacare P9000XDT and Wheelchairs of Kansas BCW Powerchair.

2) A captain's seat which is not integrated with the power wheelchair base. It is not intended for use with separate seat or back cushions or positioning accessories. In particular, a headrest is not separately payable when the power wheelchair has a captain's seat.

3) A seat frame which is not integrated with the power wheelchair base and which is intended to accept seat and back cushions and positioning accessories to accommodate special seating and positioning needs. Examples include but are not limited to non-power tilt and/or recline seats on the Quickie S646 or the Invacare 3G Storm Series wheelchairs or the Synergy seating system on Pride Quantum wheelchairs.

Effective for claims with dates of service on or after January 1, 2005, codes E2340-E2343 may only be used for nonstandard dimensions when the seat frame is integrated with the wheelchair base – i.e., type 1 described above.

Nonstandard seat dimensions for other seating systems (not including power tilt and/or recline seating systems) should be billed with code K0108 (wheelchair component or accessory, not otherwise specified). The claim must include a description or the product name of the seat component, the width and depth of the seat, and the manufacturer and product name/ number of the wheelchair base.

Neither codes E2340-E2343 nor K0108 may be used for nonstandard dimensions of a power tilt and/or recline seating system (E1002-E1008). The definition of those codes includes any frame width and depth.

Questions concerning the correct coding of specific items should be directed to the SADMERC.

Orthotics/Prosthetics

Billing Of Enteral Nutrition Products

Effective January 1, 2005, many enteral products were reclassified into different or new HCPCS codes. For example, a number of products that were previously coded as B4150 are now coded as B4154. For dates of service on or after January 1, 2005, the following instructions should be followed when submitting claims for enteral products for which a Certificate of Medical Necessity (CMN) is already on file with the DMERC:

1. Consult the SADMERC product classification list for Enteral Nutrition (http://www2.palmettogba.com/classifications/enteral%20nutrition.pdf) to determine if the HCPCS code assigned to the enteral product has changed.

2. If the HCPCS code has changed and you are billing electronically, submit an initial CMN listing the new HCPCS code. The initial date should be 1/1/05. You do not need a hardcopy initial CMN signed by the treating physician if the only change necessary is the HCPCS code.

3. If the HCPCS code has changed and you are billing in hardcopy, attach a copy of this article to the claim and indicate that you are billing an enteral nutrient that has undergone a HCPCS code change. Submission of an initial CMN is not necessary.

Regardless of whether the claim is filed electronically or in hardcopy, maintain a record of these instructions in your files for future reference or in the event of a record request by the DMERC.

Grandfathering

Beneficiaries with existing coverage prior to January 1, 2005: For beneficiaries who have an existing CMN allowing covered enteral nutrients and whose HCPCS code changed January 1, 2005, coverage will continue without the necessity to meet the coverage criteria for the new code.

Beneficiaries seeking initial coverage on or after January 1, 2005: For beneficiaries who do not have existing coverage of an enteral nutrition product, they must meet the coverage criteria for the code that is billed.

(Refer to the article entitled "Enteral Nutrition – Code Changes" published in the Winter 2005 *DMERC Dialogue* for additional information regarding HCPCS codes for enteral nutrition.)

Prosthetics And Orthotics Ordered In A Hospital Or Home Prior To A Skilled Nursing Facility Admission

Medlearn Matters Article Number: SE0507

Provider Types Affected - Skilled Nursing Facilities (SNFs), physicians, suppliers, and providers

Provider Action Needed - This article is informational only and describes who is responsible for billing when a customized device is ordered for beneficiary while in the hospital or home but delivered to the beneficiary at a skilled nursing facility.

Background - When a customized device is ordered while a beneficiary is an inpatient at a hospital, and the device is not delivered until after the beneficiary has moved to a Skilled Nursing Facility (SNF), the issue arises as to who is responsible for the billing of the item.

When a beneficiary is going from a hospital stay to a SNF Part A stay and needs an orthotic or prosthetic device, the facility where the medical need occurred is responsible for billing (rather than the supplier or provider of the device, which would bill for instances when need is established while the beneficiary is at home or in the community). Thus, if a prosthetic or orthotic device is medically necessary at the time the beneficiary is in the hospital, in the rare case when the prosthetic or orthotic is not delivered until the beneficiary has arrived at the SNF, the hospital remains responsible for billing for the item.

However, when the medical necessity for the prosthetic or orthotic device occurs after the time the Part A resident enters the SNF; the SNF is responsible for the billing of the prosthesis or orthosis. Given that most prosthetics (and all orthotic devices) are subject to SNF consolidated billing, the cost would be covered in the SNF's global per diem payment unless the item is specifically excluded from SNF consolidated billing. Certain specified customized prosthetics are excluded and if the need for these devices was established in the SNF, the supplier is to bill the Durable Medical Equipment Regional Carrier (DMERC).

When a beneficiary requires prosthesis or orthosis while

in the home and then enters a SNF for a covered Part A stay, the DMERC would be billed by the party which supplied the device (not the SNF). Medical necessity must have been established while the beneficiary was in the home.

If the beneficiary enters a SNF for a non-covered stay and thereafter develops a medical need for a customized device which the SNF orders, the SNF would bill the DMERC for the item, since SNF consolidated billing rules do not apply.

Additional Information - See the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 20, §110.3, "Pre-Discharge Delivery of DMEPOS for Fitting and Training," which covers instances in which a beneficiary may take delivery of DME, a prosthetic, or an orthotic for use at home during his or her last two days in an inpatient facility before returning home. This publication can be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Also, see Medlearn Matters Special Edition SE0437 for an article that provides specifics on how SNF consolidated billing applies to prosthetics and orthotics. This article can be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf

In addition, the CMS Medlearn Consolidated Billing web site can be found at: http://www.cms.hhs.gov/medlearn/snfcode.asp

It includes the following relevant information:

• General SNF consolidated billing information;
• HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
• Therapy codes that must be consolidated in a non-covered stay; and
• All code lists that are subject to quarterly and annual updates should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing web site can be found at: http://www.cms.hhs.gov/providers/snfpps/cb

It includes the following relevant information:

• Background;
• Historical questions and answers;
• Links to related articles; and
• Links to publications (including transmittals and Federal Register notices).

Replacement Of Change Request (CR) 3373 - Payment To Providers/ Suppliers Qualified To Bill Medicare For Prosthetics And Certain Custom-Fabricated Orthotics

Medlearn Matters Article Number: MM3607

Provider Types Affected - Physicians, pedorthists, physical therapists, occupational therapists, orthotics personnel, and prosthetics personnel who provide or supply Prosthetics and Orthotics (P&O) billing Medicare Durable Medical Equipment Regional Carriers (DMERCs).

Impact to You - If the National Supplier Clearinghouse (NSC) does not have your correct specialty code on file, your claim for prosthetics and certain custom-fabricated orthotics will be rejected. Please be sure your correct specialty codes are on file with the NSC.

What You Need to Know - Medicare will only reimburse for prosthetics and certain custom-fabricated orthotics (P&O) when furnished by physicians, pedorthists, physical therapists, occupational therapists, orthotics personnel, and prosthetics personnel as recognized by the appropriate specialty code.

CR 3607 puts new edits in the DMERC claims processing system to look for specialty codes 51, 52, 53, 55, 56, 57, 65, 67 & all Physician Specialty Codes listed in Manual 100.04, Chapter 26, Section 10.8.2, in order to assure that only those who specify P&O on their Enrollment Application Forms (Form CMS-855S), are reimbursed for P&O supplies.

What You Need to Do - Make sure that your billing staffs have provided your specialty codes to the NSC.

Background - Section 1834(h) of the Social Security Act provides for payment of "orthotics and prosthetics," which are described in section 1861(s)(8) and (9) of the Act and in Medicare regulations (42 CFR § 414.202).

DMERCs have historically processed prosthetic and orthotic claims from all enrolled and approved providers/suppliers without regard to the specialty identified and services to be provided on the Enrollment Application Form (Form CMS 855S).

However, Section 1834(h)(1)(F) of the Act specifies that

no payment is to be made for custom-fabricated orthotics and prosthetics unless furnished by a qualified practitioner or a qualified supplier. This instruction puts new edits in the DMERC claims processing system to look for particular specialty codes to assure that those providers specifying P&O on their Enrollment Application Forms are the only entities billing Medicare for P&O supplies.

To explain, CMS has deemed that certain specialties (who are licensed or certified by the State, when applicable) are qualified to furnish prosthetics and certain custom-fabricated orthotics, and may bill for Medicare services when State law permits them to furnish a prosthetic or orthotic item.

These qualified specialties (and their specialty codes) are:

- Medical Supply Company with Orthotics Personnel – Specialty Code 51;
- Medical Supply Company with Prosthetics Personnel – Specialty Code 52;
- Medical Supply Company with Orthotics and Prosthetics Personnel – Specialty Code 53;
- Orthotics Personnel – Specialty Code 55;
- Prosthetics Personnel – Specialty Code 56;
- Orthotics Personnel, Prosthetics Personnel, and Pedorthists – Specialty Code 57;
- Physical Therapist – Specialty Code 65;
- Occupational Therapist – Specialty Code 67; and
- All Physician Specialty Codes listed in Manual 100.04 Chapter 26, Section 10.8.2

Please remember that the National Supplier Clearinghouse (NSC) is responsible for maintaining a central data repository for information regarding suppliers. Therefore, if you want to bill to Medicare for P&O, you should check with the NSC to ensure that your correct specialty code is on file, and if 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. In turn, the NSC will transmit this information to your DMERC.

You should also be aware that the effective date for the new or revised specialty code for P&O claims will be the date the NSC issues the specialty code. The new or revised specialty code will not be applied retroactively.

Additional Information - You can find more information about payment to providers/suppliers qualified to bill Medicare for prosthetics and certain custom-fabricated orthotics, including the 2004 list of HCPCS Codes for customized orthotics and prosthetics by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3607 in the CR NUM column on the right, and click on the file for that CR.

You might also want to look at the online manual 100.04, chapter 20, Section 130.1 (Provider Billing for Prosthetics and Orthotic Services). You can find this manual at: http://www.cms.hhs.gov/manuals/104_claims/clm104c20.pdf

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.

Pharmacy

CWF Editing For Method Selection On Durable Medical Equipment Regional Carrier (DMERC) Claims For Epoetin Alfa (EPO) And Aranesp

Medlearn Matters Article Number: MM3547

Provider Types Affected - Durable Medical Equipment (DME) Suppliers billing DMERCs for EPO and Aranesp

Provider Action Needed

Impact to You - Please note that Medicare DMERCs will only pay claims for *Epoetin Alfa* (EPO) and *Darbepoetin Alfa* (Aranesp) for Method II home dialysis (ESRD) patients.

What You Need to Know - Edits will be added to the Medicare systems to assure that the DMERCs pay claims for EPO and Aranesp only for Method II ESRD beneficiaries.

What You Need to Do - Claims will be denied for Aranesp and EPO where the beneficiary is not a Method II home dialysis patient. Such denials will be noted by a message on the remittance advice (ANSI message 7011) which will state: "Claim not covered by this payer contractor. You must send the claims to the correct payer contractor."

Background - When requirements for a patient care plan and patient selection (per the *Medicare Benefit Policy Manual*, Chapter 11), are met - Medicare will cover

EPO or Aranesp used in the home for dialysis patients.

When EPO or Aranesp is prescribed for a home patient, it may be:

• Administered in a facility, e.g., the one shown on the Form CMS-382 (ESRD Beneficiary Method Selection Form), or
• Furnished by a facility or Method II supplier for self-administration to a home patient determined to be competent to administer this drug.

For EPO or Aranesp furnished for self-administration to competent Method I and Method II home patients the following applies:

• The renal facility bills its Fiscal Intermediary and
• The Method II supplier bills its DMERC.

A Method II beneficiary is one who has chosen home dialysis and has chosen via Form CMS-382 to deal with a supplier of home dialysis equipment and supplies.

No additional payment is made for training a prospective self-administering patient or retraining an existing home patient to self-administer EPO or Aranesp.

Method II patients who self-administer EPO or Aranesp will only be able to obtain it from their Method II supplier, or from a Medicare certified ESRD facility.

In this case, the DMERC will pay at the same rate that applies to facilities. Program payment cannot be made for EPO or Aransep furnished by a physician to a patient for self-administration.

Additional Information - The *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 8 (Outpatient ESRD Hospital, Independent Facility, and Physician/ Supplier Claims), Section 60 (Separately Billable ESRD Items and Services), Subsections 60.4.4 and 60.7.4 have been revised to reflect this change. The revised part of the manual is attached to the official instruction issued to your DMERC regarding this change. This instruction may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3547 in the CR NUM column on the right, and click on the file for that CR.

For additional information relating to this issue, please refer to your DMERC. Please find the toll free phone number for your DMERC at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Dispensing Fees - Nebulizer Drugs

Effective for dates of service on or after January 1, 2005, two new codes have been established for dispensing fees for nebulizer drugs:

G0371 PHARMACY DISPENSING FEE FOR INHALATION DRUG(S); PER 30 DAYS

G0374 PHARMACY DISPENSING FEE FOR INHALATION DRUG(S); PER 90 DAYS

Code E0590 which has been used for nebulizer drug dispensing fees is invalid for claim submission to the DMERC for dates of service after December 31, 2004.

The new codes are to be used for drugs dispensed on or after January 1, 2005. The dispensing fee applies to all drugs administered by a DME nebulizer, but does not apply to saline.

The dispensing fee must be billed on the same claim as the drug(s). If it is not, the dispensing fee will be denied as incorrect billing.

The dispensing fee is eligible for coverage only for nebulizer drugs that are covered by the DMERC. If all the nebulizer drugs on the claim are denied as not medically necessary, the dispensing fee will be denied as not medically necessary.

The dispensing fee covers all nebulizer drugs provided by the same supplier during the 30 days (G0371) or 90 days (G0374) after the date of service of the dispensing fee – regardless of the number of drugs dispensed or the number of dispensing dates during that time. If the dispensing fee is billed sooner than the interval specified by the last covered dispensing fee, it will be denied as not separately payable. For example, a 90 day fee (G0374) on 1/3/05 is covered and there is a subsequent claim for a 30 day fee (G0371) on 2/3/05; the dispensing fee on 2/3 will be denied as not separately payable.

Both a G0371 and a G0374 dispensing fee are not covered on the same date of service. If a supplier dispenses a 90 day supply of one drug and a 30 day supply of another drug on the same day, code G0374 (90 day fee) must be billed.

The Medicare allowance for G0371 is $57 and for G0374 is $80. Deductibles and co-payment apply. There is no separate coding or payment for a compounding fee.

Reminder - When billing using the National Council for Prescription Drug Programs (NCPCP) format, the supply fee (not the code) must appear on the same line as the drug. The fee should be placed in the Dispensing Fee Submitted field (field 412DC) on the pricing segment of the NCPCP claim.

Influenza Treatment Demonstration

Medlearn Matters Article Number: MM3696

Provider Types Affected - Physicians, providers, and suppliers

Provider Action Needed - Physicians, providers, and suppliers should note that Medicare will cover four new flu medications, including—where applicable—their generic equivalents. These medications are Amantadine Hydrocloride; Zanamivir, Inhalation Power Administered through Inhaler; Oseltamivir Phosphate, Oral; and Rimantadine Hydrochloide, Oral.

These drugs will be paid under a Centers for Medicare & Medicaid Services (CMS) Demonstration for dates of service through May 31, 2005. In addition, physicians, providers and suppliers that enroll in Medicare before May 31, 2005 may also file claims for drugs furnished under this demonstration for dates of service beginning when the provider or supplier completes such enrollment.

Background - The Centers for Disease Control and Prevention (CDC) recommends that individuals in the following groups should be vaccinated against influenza annually:

- Adults aged 65 years and older;
- Residents of nursing homes and long term care facilities; and
- Those with underlying chronic medical conditions.

Early in the flu vaccination season it was reported that there would be a shortage of vaccine due to manufacturing problems. Although it appears that there will be ample flu vaccine, many Medicare beneficiaries may not have been vaccinated and remain at risk. Vaccination against flu is still the best protection; however, for those Medicare beneficiaries who have been unable to receive a flu vaccination, the next best approach to protect them is to provide coverage for antiviral medicines that can prevent the complications of influenza infection by reducing the duration and severity of the infection. The shorter the duration of the infection, the less time the individual is contagious to others. In some cases, the antiviral medicine can also act as a primary preventive agent.

Influenza Treatment Demonstration

CMS is undertaking a demonstration project to measure the impact of providing coverage for certain antiviral drugs to treat and/or prevent influenza.

The Influenza Treatment Demonstration will provide coverage to Medicare beneficiaries for Food and Drug Administration (FDA)-approved drugs for the treatment and targeted prevention of influenza.

Specifically, under this demonstration, Medicare will cover certain anti-viral drugs when furnished:

- To a beneficiary with symptoms of influenza;
- As a prophylaxis for a beneficiary exposed to a person with a diagnosis of influenza; or
- To a beneficiary in an institution where there has been an outbreak of influenza.

However, the demonstration does **not** cover these antiviral drugs for general prophylactic use.

The following drugs (including, when applicable, bioequivalents or generic equivalents) are included in the demonstration:

- Amantadine Hydrocloride, Oral;
- Zanamivir, Inhalation Power Administered through Inhaler;
- Oseltamivir Phosphate, Oral; and
- Rimantadine Hydrochloide, Oral.

The drugs under this demonstration must be furnished incident to a physician service or must be prescribed by a physician (or other practitioner authorized by State law to prescribe such drugs). Except as noted below, all ancillary Medicare rules apply to the furnishing of these drugs to Medicare beneficiaries under this demonstration. Also, information regarding treatment and drug dosage of these influenza antiviral medications is included in the Additional Information Section of this special edition.

The demonstration will include dates of service through May 31, 2005. Also, note that **a**ll claims for drugs furnished under this demonstration **must be filed no later than December 31, 2005.**

Physicians, providers, and suppliers that enroll in Medicare before May 31, 2005 may also file claims for drugs

furnished under this demonstration for dates of service beginning when the provider or supplier completes such enrollment.

Payment Amounts

Both the Medicare co-payment and deductible apply to all claims under this demonstration, including claims for Medicare Advantage (MA) beneficiaries. The exception is in the calculations of co-payments for beneficiaries participating in the Drug Discount Card program. These beneficiaries will pay the lesser of 20% of the Medicare allowable amount or 20% of the negotiated Drug Discount Sponsor's price for antiviral medicines, plus $.20 (20% of a $1.00 administrative charge). A chart explaining how to do the calculations for determining co-payment amount for Drug Discount Card participants is attached. CMS will also make this chart available on its web site at http://www.cms.hhs.gov/researchers/demos/flu and will update cost information monthly. Finally, no deductible will apply to claims from Federally Qualified Health Centers (FQHCs).

Except as noted below, the Medicare allowed amount for these demonstration drugs will be based on 95% of the average wholesale price (AWP) for the brand name of each drug (Zanamivir and Oseltamivir Phosphate) covered under this demonstration, determined in accordance with customary Medicare payment policy. For drugs marketed as bioequivalent or generics (Amantadine and Rimantadine), the allowed amount will be based on 90% of AWP.

For the duration of the demonstration, the allowed HCPCS codes/charges are as follows:

• G9017: Amantadine Hydrocloride, Oral, per 100 mg, (for use in a Medicare-approved demonstration project), $0.76.
• G9018: Zanamivir, Inhalation Powder Administered Through Inhaler, per 10 mg, (for use in a Medicare approved demonstration project), $5.43.
• G9019: Oseltamivir Phosphate, Oral, per 75 mg, (for use in a Medicare-approved demonstration project), $6.99.
• G9020: Rimantadine Hydrochloride, Oral, per 100 mg, (for use in a Medicare-approved demonstration project),$1.65.
• G9033: Amandatine Hydrocloride, oral, brand, per 100 mg (for use in a Medicare-approved demonstration project), $1.32
• G9034: Zanamivir, Inhalation Powder Administered Through Inhaler, brand, per 10 mg, (for use in a Medicare-approved demonstration project), $5.43
• G9035: Oseltamivir Phosphate, Oral brand, per 75 mg, (for use in a Medicare-approved demonstration project), $6.99.
• G9036: Rimantadine Hydrochloride, Oral brand, per 100 mg, (for use in a Medicare-approved demonstration project),$2.17.

Those entities that are to be paid on a basis other than of 90% or 95% of AWP are as follows:

• Indian Health Service (IHS) hospitals will be reimbursed on the basis of the outpatient all-inclusive rate.
• IHS Critical Access Hospitals (CAHs) will be reimbursed on the basis of a facility-specific visit rate.
• Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) will be reimbursed on the basis of the all-inclusive rate when one of the drugs is furnished as part of a billable encounter under revenue code 052X. An encounter cannot be billed if furnishing the drug is the only service the RHC/FQHC provides. (Although the provision of these drugs in and by themselves does not constitute a billable encounter in the RHC/FQHC setting, the cost of the drugs can be claimed on the RHC/FQHC cost report and bundled into the all-inclusive payment rate calculation.)
• Maryland hospitals that are under the jurisdiction of the Health Services Cost Review Commission (HSCRC) are paid under the Maryland waiver.

Billing Instructions

Claims for drugs furnished under this demonstration may be submitted by enrolled Medicare providers as follows: hospitals including CAHs, skilled nursing facilities (SNFs), renal dialysis facilities (RDFs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Home Health Agencies (HHAs) and by enrolled physicians, other practitioners, or other suppliers that are authorized under State law to dispense these drugs.

Except as noted below, providers, physicians, and other suppliers must follow customary Medicare billing and claims processing rules.

• An entity possessing a supplier number issued by the National Supplier Clearinghouse (NSC) must bill the DMERC having jurisdiction for the location of the beneficiary's permanent residence.
• All hospitals (other than Indian Health Service (IHS) hospitals, IHS-CAHs, Maryland hospitals as noted above, and hospitals which do not have a supplier number issued by the NSC) must bill the appropriate DMERC using the CMS-1500 or electronic equivalent. Otherwise, billing by the hospital is to the fiscal intermediary on the CMS-1450/UB-92 or electronic equivalent.
• All other institutional providers, not possessing an NSC-

issued supplier number, must bill the fiscal intermediary on the CMS-1450/ UB-92 or electronic equivalent.
• All physicians, practitioners, and other suppliers, not possessing an NSC-issued supplier number, must submit claims to their local area carrier using the CMS-1500 or electronic equivalent.
• HHAs should follow billing requirements already in place for vaccines when billing for these drugs as specified in Pub. 100-4, Chapter 18, Section 10.2.3, which may accessed at http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp.
• All institutional providers billing their fiscal intermediary must submit a separate claim for these drugs.
• Roster billers submit claims in accordance with the instructions specified in Pub.100-4, Chapter 18, Section 10.3, except:

- HCPCS Codes G0008, G0009, 90657, 90658, 90659, and 90732 should not be reported on the same roster bill under this demonstration;
- An administration fee will not be paid for drugs administered under this demonstration;
- Roster billers must bill different dates of service, dosages, codes, and quantities on different roster or claims forms; and
- Payment may be made for MA beneficiaries under this demonstration and such claims should be reported to the provider's regular carrier or intermediary.
- Medicare Advantage (MA) plans, if enrolled in fee for service billing, must bill for these items using their normal procedures for billing for Medicare Fee-For-Service items and services. Providers and suppliers may submit claims for MA beneficiaries to their normal FI or carrier.

Acceptance of assignment is mandatory for all claims submitted under this demonstration and Medicare Secondary Payer (MSP) rules apply to claims under this demonstration.

Implementation - The implementation date for this instruction is January 17, 2005.

Additional Information

Treatment and Drug Dosage of Influenza Antiviral Medications[1]

You are referred to the Centers for Disease Control and Prevention website (Antiviral Agents for Influenza:

Background Information for Clinicians) at: http://www.cdc.gov/flu/professionals/antiviralback.htm

Treatment

For the treatment of influenza, controlled studies have found that neuraminidase inhibitor drugs (Zanamivir, Oseltamivir) and adamantane derivative drugs (Amantadine, Rimantadine) administered within 48 hours of illness onset, decrease viral shedding and reduce the duration of influenza A illness by approximately 1 day compared with placebo. The usual recommended duration of treatment is 5 days.

Chemoprophylaxis

Known exposure: For chemoprophylaxis of known exposure, treatment should begin within 2 days of contact with an infected individual and continue for 2 weeks.

In lieu of vaccination: To be maximally effective as prophylaxis in lieu of vaccination, influenza antiviral medications must be taken each day for the duration of influenza activity in the community. However, one study of amantadine or rimantadine prophylaxis reported that the drugs could be taken only during the period of peak influenza activity in a community.[2]

Outbreak in an institution: For residents of an institution, chemoprophylaxis is recommended during an outbreak, and should be continued for at least two weeks. If surveillance indicates that new cases continue to occur, chemoprophylaxis should be continued until approximately one week after the end of the outbreak.

Dosage:

Recommended Daily Dosage of Influenza Antiviral Medications for Treatment and Prophylaxis[3]		
Antiviral Agent	**Age Groups (yrs)**	
	13-64	**> 65**
Amantadine* (Symmetrel®)		
Treatment, influenza A	100mg twice daily §	≤ 100 mg/day
Prophylaxis, influenza A	100mg twice daily §	≤ 100 mg/day
Rimantadine (Flumadine®)		
Treatment, ** influenza A	100mg twice daily §§	100 mg/day
Prophylaxis, influenza A	100mg twice daily §	100 mg/day
Zanamivir*†† (Relenza®)**		
Treatment, influenza A and B	10mg twice daily	10mg twice daily
Oseltamivir (Tamiflu®)		
Treatment, §§§ influenza A and B	75mg twice daily	75mg twice daily
Prophylaxis, influenza A and B	75mg/day	75mg/day

***** The drug package insert should be consulted for dosage recommendations for administering amantadine to persons with creatinine clearance ≤ 50 ml/min/1.73m 2.

† 5 mg/kg of amantadine or rimantadine syrup = 1 tsp/ 22 lbs.

§ Children ≥ 10 years who weigh < 40 kg should be administered amantadine or rimantadine at a dosage of 5 mg/kg/day.

A reduction in dosage to 100 mg/day of rimantadine is recommended for persons who have severe hepatic dysfunction or those with creatinine clearance ≤ 10 mL/ min. Other persons with less severe hepatic or renal dysfunction taking 100 mg/day of rimantadine should be observed closely, and the dosage should be reduced or the drug discontinued, if necessary.

** Only approved by FDA for treatment among adults.

§§ Rimantadine is approved by FDA for treatment among adults. However, certain experts in the management of influenza consider it appropriate also for treatment among children. (See American Academy of Pediatrics, 2000 Red Book.)

Older nursing-home residents should be administered only 100 mg/day of rimantadine. A reduction in dosage to 100 mg/day should be considered for all persons aged ≥ 65 years if they experience possible side effects when taking 200 mg/day.

******* Zanamivir administered via inhalation using a plastic device included in the medication package. Patients will benefit from instruction and demonstration of the correct use of the device.

††† Zanamivir is not approved for prophylaxis.

§§§ A reduction in the dose of oseltamivir is recommended for persons with creatinine clearance < 30 ml/ min.

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[1] Source: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5306a1.htm.

[2] Patriarca PA, Arden NH, Koplan JP, Goodman RA. Prevention and control of type A influenza infections in nursing homes: benefits and costs of four approaches using vaccination and amantadine. Ann Intern Med 1987;107:732—40.

[3] http://www.cdc.gov/flu/professionals/antiviralback.htm

Further Claims Preparation Instructions

Because Medicare carriers will hold claims received until Medicare systems changes are made on January 17, 2005, interest will be paid to providers, where applicable, when the held claims are processed on or after January 17, 2005. In addition, physicians, providers, and suppliers should note the following:

- The type of service code for these claims is "1".
- An appropriate diagnosis code must be included on the claim in order to be HIPAA compliant.
- Carriers will apply the 5% reduction in payment on claims from non-participating physicians.
- Assignment is mandatory for all claims filed under this demonstration.
- Providers billing for services under this demonstration for hospice patients should include condition code 07 on the claim.
- Hospitals, SNFs, CORFs, Renal Dialysis Facilities, CAHs, IHS hospitals, and IHS CAHs should use revenue code 0636 along with the appropriate HCPCS code.
- Billing for codes G9017, G9018, G9019, G9020, G9033, G9034, G9035, or G9036 must be done on separate claims and **no other codes may be present on such claims.**
- For claims submitted to intermediaries, providers should use types of bill (TOB) 12X, 13X, 22X, 23X, 34X, 72X, 75X, or 85X. **Claims submitted with any other TOB for services under this** demonstration will be returned to the provider.
- Drugs covered under this demonstration will be payable even if the beneficiary has already received a flu vaccine.
- Beneficiaries may receive no more than two of the drugs permitted under this demonstration (e.g., the same drug twice or a combination of two different drugs).
- Medicare will not pay for code G0008 (administration fee) under this demonstration.

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

From that Web page, look for CR3696 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

ATTACHMENT: LOOK-UP TABLE FOR CALCULATING BENEFICIARY CO-PAYMENT

FOR ANTIVIRAL INFLUENZA TREATMENT (See Appendix 1)

INSTRUCTIONS FOR USING THIS TABLE

NOTE: This table is only used to calculate the beneficiary co-payment amount for those participating in the Medicare Drug Discount Card Program.

1. Locate the name of the Medicare Drug Discount Card Sponsor in column A, or the Sponsor's plan number in column B.
2. Locate the prescribed medicine in column C through I.
3. Find the cost per unit for the prescribed medicine for the specific Card Sponsor.
4. Multiply the unit cost of the medicine by the number of units in the prescription, PLUS $1.00, to calculate the total Drug Card Sponsor's cost.
5. Multiply the Medicare Allowed Payment Amount by the number of units in the prescription to calculate the Medicare allowed cost.
6. Compare the total cost of the Drug Card Sponsor with the total cost of the Medicare allowed cost.
7. If the total Medicare allowed cost is less than the total Drug Card Sponsor's cost the co-payment will be 20% of the Medicare Allowed cost.
8. If the total Drug Card Sponsor's cost is less than the Medicare allowed cost the co-payment will be 20% of the Drug Card Sponsor's costs.

** In either case Medicare will reimburse the pharmacy 80% of the Medicare allowed cost.

Modifications To Duplicate Editing For Dispensing/Supply Fee Codes For Oral Anti-Cancer, Oral Anti-Emetic, Immunosuppressive, And Inhalation Drugs

Medlearn Matters Article Number: MM3666

Provider Types Affected - Pharmacies and suppliers billing Medicare Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

Impact to You - If you bill Medicare for services with an HCPCS code of E0590, this change may impact you.

What You Need to Know - This article provides information on HCPCS code E0590, for which DMERCs paid dispensing fees for nebulizers. **Although E0590 was discontinued January 1, 2005, the DMERCs could still receive valid claims for the code due to timely filing rules.**

What You Need to Do - Be aware of these changes as they could affect your reimbursements.

Background - In addition to the change mentioned relative to HCPCS code E0590, remember that the DMERCs will only pay dispensing fees when also making payment for the associated oral cancer, oral anti-emetic, and immunosuppressive drugs.

Reminder: A pharmacy that submits a claim for G0374 (90-day dispensing fee) may not receive another dispensing fee (G0371 or G0374) until 90 days after the date of service on the claim for G0374.

Additional Information - Beneficiaries are required to pay the normal co-pay and deductibles on dispensing fees. For further details on these fees, see the Medlearn Matters article MM3620, which was based on CR 3620.

That article may be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3620.pdf

To view the official instruction issued to your DMERC on this issue, visit: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at the above page, scroll down the CR NUM column on the right to find the link for CR 3666. Click on the link to open and view that file.

If you have any questions, contact your DMERC at their toll free number, which is available at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Skilled Nursing Facility Consolidated Billing And Erythropoietin (EPO, Epoetin Alfa) And Darbepoetin Alfa (Aranesp)

Medlearn Matters Article Number: SE0434

Note: This article was revised on January 25, 2005 to include clarifying language, but no substantive changes were made.

Provider Types Affected - Skilled Nursing Facilities (SNF), physicians, suppliers, end-stage renal disease (ESRD) facilities and hospitals

Provider Action Needed - This Special Edition is informational only and describes SNF Consolidated Billing (CB) as it applies to Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) and related services.

Clarification: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare covered stay, except for a small number of services that are specifically excluded from this provision. These excluded services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of services (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare Durable Medical Equipment Regional Carrier (DMERC)).

Background - The original Balanced Budget Act of 1997 list of exclusions from the PPS and CB for SNF Part A residents specified the services described in section 1861(s)(2)(O) of the Social Security Act—the Part B erythropoietin (EPO) benefit. This benefit covers EPO and items related to its administration for those dialysis patients who can self-administer the drug, subject to methods and standards established by the Secretary for its safe and effective use (see 42 CFR 405.2163(g) and (h)). See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB.

This article can be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

Regulations at 42 CFR 414.335 describe payment for EPO and require that EPO be furnished by either a Medicare approved End Stage Renal Disease (ESRD) facility or a supplier of home dialysis equipment and supplies. The amount that Medicare pays is established by law. Thus, the law and implementing regulations permit a SNF to unbundle the cost of the Epogen drug when it is furnished by an ESRD facility or an outside supplier, which can then bill their carrier/intermediary for it.

An SNF that elects to furnish EPO to its Part A resident itself cannot be separately reimbursed over and above the Part A SNF PPS per diem payment amount for the Epogen drug. As explained above, the exclusion of EPO from CB and the SNF PPS applies only to those services that meet the requirements for coverage under the separate Part B EPO benefit, i.e., those services that are furnished and billed by an approved ESRD facility or an outside dialysis supplier.

By contrast, if the SNF itself elects to furnish EPO services (including furnishing the Epogen drug) to a resident during a covered Part A stay (either directly with its own resources, or under an "arrangement" with an outside supplier in which the SNF itself does the billing), the services are no longer considered Part B EPO services, but rather, become Part A SNF services. Accordingly, they would no longer qualify for the exclusion of Part B EPO services from CB, and would instead be bundled into the PPS per diem payment that the SNF receives for its Part A services.

Note: The Part B coverage rules that apply to EPO are applied in the same manner to Aranesp. (See *Medicare Claims Processing Manual*, Pub.100-04, Chapter 8 – Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, §60.7.2; see also Medicare Benefit Policy Manual, Pub. 100-02, Chapter 11 – End Stage Renal Disease (ESRD), §90). Accordingly, Aranesp is now excluded on the same basis as EPO.

Note: EPO (Epoetin Alfa, trade name Epogen)/DPA (Darbepoetin Alfa, trade name Aranesp) are not separately billable when provided as treatment for any illness other than ESRD. In this case, the SNF is responsible for reimbursing the supplier. The SNF should include the charges on the Part A bill filed with its intermediary for that beneficiary.

Additional Information - Medlearn Matters SE0431, containing the list of services excluded from SNF CB, can be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

The Medicare Renal Dialysis Facility Manual, Chapter II, Coverage of Services can be found at the following CMS web site: http://www.cms.hhs.gov/manuals/29_rdf/rd200.asp?#_1_17

Also, you can find the *Medicare Benefit Policy Manual* Chapter 11 and Chapter 17 regarding billing and payment details for EPO and DPA at the following CMS web site: http://www.cms.gov/manuals/102_policy/bp102c11.pdf and: http://www.cms.gov/manuals/102_policy/bp102c17.pdf

The CMS Consolidated Billing web site can be found at: http://www.cms.hhs.gov/medlearn/snfcode.asp

It includes the following relevant information:

• General SNF consolidated billing information;
• HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
• Therapy codes that must be consolidated in a noncovered stay; and
• All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The CMS Skilled Nursing Facility Prospective Payment System (SNF PPS) web site can be found at: http://www.cms.hhs.gov/providers/snfpps/cb

It includes the following relevant information:

• Background;
• Historical questions and answers;
• Links to related articles; and
• Links to publications (including transmittals and Federal Register notices).

Supply Fee - Immunosuppressive Drugs

Effective for dates of service on or after January 1, 2005, two new codes have been established for supply fees for immunosuppressive drugs:

G0369 PHARMACY SUPPLY FEE FOR INITIAL IMMUNOSUPPRESSIVE DRUG(S) FIRST MONTH FOLLOWING TRANSPLANT
G0370 PHARMACY SUPPLY FEE FOR ORAL ANTICANCER, ORAL ANTIEMETIC, OR IMMUNOSUPPRESSIVE DRUG(S)

The new codes are to be used for drugs dispensed on or after January 1, 2005. There has never been a separately billable or payable dispensing or supply fee for these drugs prior to this date.

The supply fee(s) must be billed on the same claim as the drug(s). If it is not, the supply fee will be denied as incorrect billing.

The supply fees are eligible for coverage only for immunosuppressive drugs that are covered by the DMERC – refer to the DMERC policy on Immunosuppressive Drugs for coverage and medical necessity criteria. If the drug on the claim is denied as noncovered, the supply fee will be denied as noncovered. If the drug on the claim is denied as not medically necessary, the supply fee will be denied as not medically necessary.

One unit of service of code G0370 is covered for each covered drug that is dispensed on each date of service that it is dispensed. (See exception below when G0369 is covered in place of G0370.) If the billed units of service of G0370 exceed the number of drugs on the claim, the excess units will be denied as not separately payable. If two dosage strengths of the same drug are dispensed on the same day, a G0370 supply fee is payable for each one.

One unit of service of code G0369 is payable in place of G0370 for one drug on the first claim for immunosuppressive drugs following a transplant . For example, if three drugs are dispensed, the correct coding for the supply fees on the first claim is one unit of service of G0369 and two units of service of G0370. If more than one organ is transplanted at the same time (e.g., heart-lung transplant), only one unit of service of G0369 is payable. G0369 is payable to only one supplier after each transplant. If the patient has another transplant at a later date, another unit of service of code G0369 is payable. If more than one unit of service of code G0369 is billed per beneficiary per transplant, the excess units of service will be paid comparable to code G0370.

The Medicare allowance for G0369 is $50 and G0370 is $24. Deductibles and co-insurance apply. There is no separate coding or payment for a compounding fee.

Reminder - When billing using the National Council for Prescription Drug Programs (NCPCP) format, the supply fee (not the code) must appear on the same line as the drug. For the $50.00 fee, providers should place $24.00 of the fee in the Dispensing Fee Submitted field (field 412DC) and the remaining $26.00 in the Incentive Amount Submitted field (Field 438-E3).

Supply Fee – Oral Anticancer And Oral Antiemetic Drugs

Effective for dates of service on or after January 1, 2005, a new code has been established for supply fees for oral anticancer drugs and oral antiemetic drugs:

G0370 PHARMACY SUPPLY FEE FOR ORAL ANTICANCER, ORAL ANTIEMETIC, OR IMMUNOSUPPRESSIVE DRUG(S)

The new code is to be used for drugs dispensed on or after January 1, 2005. There has never been a separately billable or payable dispensing or supply fee for these drugs prior to this date.

The supply fee must be billed on the same claim as the drug(s). If it is not, the supply fee will be denied as incorrect billing.

The supply fee is eligible for coverage only for oral anticancer and oral antiemetic drugs that are covered by the DMERC. This includes oral anticancer drugs and related oral antiemetic drugs addressed in the DMERC Oral Anticancer Drugs policy. (The supply fee is not eligible for coverage for rectal antiemetic drugs related to oral anticancer drugs.) The supply fee is also used for oral antiemetic drugs addressed in the DMERC policy on Oral Antiemetic Drugs (Replacement of Intravenous Antiemetics). If the drugs on the claim are denied as noncovered, the supply fee will be denied as noncovered.

One unit of service of the supply fee is covered for each covered drug that is dispensed on each date of service that it is dispensed. If the billed units of service exceed the number of drugs on the claim, the excess units will be denied as not separately payable. If two dosage strengths of the same drug are dispensed on the same day, a supply fee is payable for each one.

The Medicare allowance for G0370 is $24. Deductibles and co-insurance apply. There is no separate coding or payment for a compounding fee.

Reminder - When billing using the National Council for Prescription Drug Programs (NCPCP) format, the supply fee (not the code) must appear on the same line as the drug. The fee should be placed in the Dispensing Fee Submitted field (field 412DC) on the pricing segment of the NCPCP claim.

The First In A Series Of Medlearn Matters Articles For Providers On Medicare's New Prescription Drug Program

Medlearn Matters Number: SE0501

MMA - Coming Soon - The New Medicare Prescription Drug Program

Provider Types Affected - All physicians, providers, suppliers, and their staff providing service to people with Medicare

Provider Action Needed

Impact to You - On January 1, 2006, a very important new benefit will be available to your Medicare patients. These new Medicare Prescription Drug Plans will be of significant value to your patients by providing assistance with prescription drug expenses. This program is authorized under the Medicare Modernization Act of 2003 (MMA). Your patients may ask you about this new benefit.

What You Need to Know - The Centers for Medicare & Medicaid Services (CMS) is preparing an extensive campaign for both providers and beneficiaries, and will be disseminating information to these audiences. Over the next year, as materials are developed, you will be notified through a series of Medlearn Matters articles and other resources. Some providers will choose to be active in giving information to their Medicare patients, and we will help you do that. CMS encourages and appreciates the work providers are willing to do to help people with Medicare learn about this important new benefit.

What You Need to Do - Stay informed. Go to the newly established web site: http://www.cms.hhs.gov/medicarereform/pdbma/ and check it often as new information is always being added. This easy-to-use website has a "General Information" link to the press releases, issue papers, fact sheets, and full copies and summaries of both regulations. Users can follow the menu and select the area that best matches their area of interest. Refer your Medicare patients to information resources – **1-800- MEDICARE** and www.medicare.gov.

Background

On December 8, 2003, the Medicare Modernization Act (MMA) was enacted, adding a very important new benefit to the Medicare program. This new benefit takes effect on January 1, 2006, and provides a much-needed new drug benefit to help serve the 41 million Americans who rely on Medicare for their health care needs.

On January 21, 2005, Health and Human Services Secretary Tommy G. Thompson announced the final regulations establishing the new Medicare prescription drug benefit program. This is a very important step in making this great addition to the Medicare program a reality for your Medicare patients.

This is a very special time for your patients with Medicare, full of many exciting program improvements and enhancements. Great opportunities exist right now, through the MMA, to make the Medicare program more personalized and more up to date, and to keep it up to date. The Medicare Drug Benefit is a major step in that direction. A very important step toward fulfilling that opportunity is in the final regulation for the Medicare Drug

Benefit Program. Along with the new Medicare Preventive benefits, this major program improvement bring Medicare's coverage up to date with 21st Century prevention-minded medicine.

WE NEED YOUR HELP

Because people with Medicare trust their physicians, other clinicians, pharmacists, and other health care providers, you are in a unique position to direct them to the resources available to help them learn about the new benefit. If any of your patients rely on caregivers, CMS appreciates your efforts to get this information into their hands as well.

CMS will be pursuing a number of activities to make sure the physician, provider, and supplier communities know about this new benefit, understand how it works, and will be highlighting the information that may be of most value to your Medicare patients. As educational materials are developed, you will be notified of their availability. These materials will help you and your staff understand the new benefit. CMS will keep you up-to-date with education and outreach efforts on the new drug benefit. Here's how you can stay connected:

- Pay attention to correspondence from your Medicare carrier or fiscal intermediary or your national professional associations—they are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their listservs and read their newsletters;
- Register to receive listserv email messages to alert you when new Medlearn Matters articles have been released on the new drug benefit (and other Medicare information). Medlearn Matters articles provide succinct and timely messages on Medicare claims processing and other changes. These articles can be found on the web at: http://www.cms.hhs.gov/medlearn/matters
- Participate in CMS Open Door Forums to hear from and ask questions of CMS leadership on topics of interest to your particular provider-type. Information regarding these Open Door Forums may be found on the web at: http://www.cms.hhs.gov/opendoor

General

2005 Annual Update For Skilled Nursing Facility (SNF) Consolidated Billing For The Common Working File (CWF) And Medicare Carriers

Medlearn Matters Article Number: MM3535

Provider Types Affected - Skilled Nursing Facilities (SNFs)

Provider Action Needed

Impact to You

The 2005 update for SNF Consolidated Billing (CB) is available. These codes are used in applying the SNF CB edits that only allow services that are excluded from CB to be separately paid by Medicare carriers.

What You Need to Know

These new code files are posted to the Centers for Medicare & Medicaid Services (CMS) web site at: www.cms.hhs.gov/medlearn/snfcode.asp.

What You Need to Do

The edits for claims received for beneficiaries in both Part A SNF stays and covered and non-covered Part A SNF stays allow services that are excluded from consolidated billing to be separately paid by the carrier.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/pm_trans/R328CP.pdf

For additional information relating to this issue, please contact your carrier at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Administrative Simplification Compliance Act (ASCA) Enforcement Of Mandatory Electronic Submission Of Medicare Claims

Medlearn Matters Article Number: MM3440

Note: This article was revised on January 31, 2005, to reflect a new CR release date and CR Transmittal number since the CR was re-issued. All other information in the article remains the same.

Provider Types Affected - All Medicare Providers

Provider Action Needed

Impact to You - If you don't submit your Medicare claims electronically, your payments could be affected (unless you meet specific exception criteria mentioned below).

What You Need to Know - ASCA prohibits Medicare from making payments on or after October 16, 2003, for claims that are not submitted electronically. You must submit your claims electronically, unless you meet one of the exceptions listed below.

What You Need to Do - Make sure that your billing staff submits your Medicare claims electronically. Or, if you believe that you meet one of the exception criteria, make sure that you appropriately complete the "Request for Documentation" letter from your carrier or fiscal intermediary to process your claims.

Background

Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires you, with limited exceptions, to submit all your initial claims for reimbursement under Medicare electronically, on or after October 16, 2003.

Further, ASCA amendment to Section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Consequently, unless you fit one of the exceptions listed below, any paper claims that you submit to Medicare will not be paid. In addition, if it is determined that you are in violation of the statute or rule, you may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.

There are some exceptions to this electronic claim submission requirement. They include the following:

• You are a small provider - a provider billing a Medicare fiscal intermediary that has fewer than 25 Full-Time Equivalent employees (FTEs), and a physician, practitioner, or supplier with fewer than 10 FTEs that bills a Medicare carrier;
• A dentist;
• A participant in a Medicare demonstration project in which paper claim filing is required due to the inability of the Applicable Implementation Guide, adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to report data essential for the demonstration;
• A provider that conducts mass immunizations, such as flu injections, and may be permitted to submit paper roster bills;
• A provider that submits claims when more than one other payer is responsible for payment prior to Medicare payment;
• A provider that only furnishes services outside of the United States;
• A provider experiencing a disruption in electricity and communication connections that are beyond its control; and
• A provider that can establish an "unusual circumstance" exists that precludes submission of claims electronically.

The process for post-payment based enforcement is as follows:

• Your Medicare contractor will analyze reports displaying the number of paper claims that all providers submitted each quarter.
• By the end of the month following the quarter, selected providers who have submitted the highest numbers of paper claims will be reviewed.
• Medicare contractors will ask these providers to provide information that establishes the exception criteria listed above.

If you, as one such provider, do not respond to this initial "Request for Documentation" letter within 45 days of receipt, your contractor will notify you by mail that Medicare will deny and not pay any paper claims that you submit beginning ninety days after the date of the initial request letter. If you **do** respond to this initial letter, and your response does not establish eligibility to submit paper claims, the contractor will notify you by mail of your ineligibility to submit paper claims. This Medicare decision is not subject to appeal.

In these letters, your Medicare contractor will also tell

you how to obtain free and commercially available HIPAA-compliant billing software packages.

If you respond with information that does establish eligibility to submit paper claims, the contractor will notify you by mail that you meet one or more exception criteria to the requirements in Section 3 of the ASCA, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, and you will be permitted to submit paper claims.

However, you will be cautioned that if your situation changes to the point that you no longer meet the exception criteria, you will be required to begin electronic submission of your claims.

If you are permitted to submit paper claims, your carrier/intermediary will not review your eligibility to submit paper claims again for at least two years.

Additional Information

You can learn more about the instructions issued to your carrier/intermediary regarding ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Look for CR 3440 in the CR NUM column on the right, and click on the file for that CR. These instructions provide more detail on what constitutes an "unusual circumstance" that precludes submission of claims electronically. You might also want to look at the online Manual 100.04, Chapter 24, Section 90, Subsection 5 (Enforcement). You can find this manual at: http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf

If you have any questions, please contact your contractor at his toll-free number: http://www.cms.hhs.gov/medlearn/tollnums.asp

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

Medlearn Matters Article Number: MM3542

Provider Types Affected - Skilled Nursing Facilities, physicians, providers, and suppliers

Provider Action Needed - Affected providers should note that this article and the related CR3542 contain the annual update of HCPCS codes used for SNF CB. It provides an updated list of exclusions and some inclusions to SNF CB, and only applies to codes affected by Medicare Fiscal Intermediary (FI) claims processing.

Background - The Social Security Act (Section 1888) codifies SNF Prospective Payment System (PPS) and Consolidated Billing (CB). New coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates. The new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

This notification provides a list of the exclusions, and some inclusions, to SNF CB, and applies only to codes affected by Medicare FI claims processing.

A separate notification is published for codes affected by Medicare carrier claims processing.

2005 Annual Update

CR3542 is the 2005 annual update in the routine and comprehensive process that the Centers for Medicare & Medicaid Services (CMS) has established for updating SNF CB edits affected by HCPCS coding changes in each quarter.

It is the first quarterly SNF CB update for Fiscal Year (FY) 2005, and it incorporates a list of new temporary codes (such as K codes, if applicable), as well as the annual update of all HCPCS codes.

Since this is the only quarter in which new permanent HCPCS codes are produced, the instruction is referred to as an annual update. Other updates for the remaining quarters of the FY will occur **as needed** due to the creation of new temporary codes prior to the next annual update. In lieu of any other update, editing based on these codes remains in effect.

In several past instructions, the (CMS) established the process of periodically updating the lists of HCPCS codes that are subject to the CB provision of the SNF PPS. Services that appear on this list of HCPCS codes submitted on claims to both Medicare fiscal intermediaries (FIs) and carriers (including Durable Medical Equipment Regional Carriers (DMERCs)) will not be paid by Medicare to providers, other than a SNF, when **included** in SNF CB.

For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay; however, SNF CB applies to physical and occupational therapies and speech-language pathology services whenever they are furnished to an SNF resident, regardless of whether Part A covers the stay.

Services **excluded** from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay. In order to assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

Note: A revised SNF Help File, separate from the code list, is **not** included in CR3542. The Help File provides billing guidance **only** to FIs, SNFs, and suppliers on HCPCS codes. It includes codes affected by SNF CB and many other codes, and it will be updated from the current version **separately** after release of this notification with the new code list.

Implementation

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

Additional Information

The official instruction issued to your intermediary contains a comprehensive list of HCPCS codes involved in editing claims submitted to FIs for services subject to SNF consolidated billing (CB).

In that list, new codes listed subsequent to prior publications appear in bold in HCPCS code charts, and boldface is also used outside of the code charts in cases as noted when type of bill (i.e., bill type) or revenue codes, rather than HCPCS codes, are used to perform editing. Bolding is also used to highlight titles, captions, and other billing information for SNFs. Codes from previous lists not appearing have been deleted. For complete details and to see the comprehensive list, please see the official instruction issued to your intermediary 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 CR3542 in the CR NUM column on the right, and click on the file for that CR.

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

April Quarterly Update To 2005 Annual Update Of HCPCS Codes Used For Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

Medlearn Matters Number: MM3683

Note: This article was revised on February 8, 2005 to correct punctuation in the first bullet point on page 3. No other changes were made.

Provider Types Affected

Institutional providers billing claims to Medicare fiscal intermediaries and physicians, practitioners, and suppliers billing Medicare carriers for services

Provider Action Needed

Impact to You - HCPCS codes are being added to or removed from the SNF consolidated billing enforcement list.

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

What You Need to Do - Be aware of the requirements explained below and how they can impact your Medicare payment.

Background - The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (SNF PPS).

Quarterly updates now apply to both Fiscal Intermediaries (FIs) and Carriers/Durable Medical Equipment Regional Carriers (DMERCs). This is the first joint FI/Carrier/DMERCs quarterly update published subsequent to the 2005 Annual Updates. These updates affect claims with dates of service on or after the effective date of the instructions printed below unless otherwise indicated. **Services appearing on this HCPCS list** (that are submitted on claims to both Medicare FIs and Carriers,

including DMERCs), **will not be paid by Medicare to providers, other than a SNF, when included in SNF CB.**

For the annual notice on SNF CB each January, separate instructions are published for FI and Carriers/ DMERCs. The 2005 Annual Update for FIs can be found on the CMS web site at: http://www.cms.hhs.gov/manuals/pm_trans/R360CP.pdf

Information on the 2005 annual update for Carriers can be found at: http://www.cms.hhs.gov/medlearn/snfcode.asp

Please take note of the following important points:

• For non-therapy services, SNF CB applies only when the services are furnished to a SNF resident during a covered Part A stay.
• For physical, occupational or speech-language therapy services, SNF CB applies whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay.
• Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay.
• Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB to assure proper payment in all settings.

This notification provides a list of the exclusions, and some inclusions, to SNF CB, and the codes below are being added or removed from the annual update.

Note the following:

Major Category I additions noted below means these codes:

• May only be billed by hospitals and critical access hospitals (CAHs) for beneficiaries in SNF Part A stays, and
• Will only be paid when billed by these providers.

Major Category III additions noted below means these services:

• May be provided by any Medicare provider licensed to provide them, except a SNF, and
• Are excluded from SNF PPS and CB.

Major Category IV additions noted below means these services:

• Are covered as Part B benefits and not included in SNF PPS, however
• Must be billed by the SNF for beneficiaries in a Part A stay with Part B eligibility on type of bill (TOB) 22x.

Major Category V additions to therapy inclusions noted below means:

• SNFs alone can bill and be paid for these services when delivered to beneficiaries in a SNF, whereas codes being removed from this therapy inclusion list now can be billed and potentially paid to other types of providers for beneficiaries **NOT** in a Part A stay or in a SNF bed receiving ancillary services billed on TOB 22x.

Computerized Axial Tomography (CT) Scans

(**Major Category I**, FI Annual Update, **EXCLUSION**)

• **Remove G0131** - computerized tomography, bone mineral density study, one or more sites; axial skeleton
• **Remove G0132** - computerized tomography, bone mineral density study, one or more sites; appendicular skeleton
• **Add 76070*** - computed tomography, bone mineral density study, one or more sites; axial skeleton
• **Add 76071*** - computed tomography, bone mineral density study, one or more sites; appendicular skeleton

Note on Codes above:

***** Codes replaced HCPCS codes G0131 and G0132. The professional components of these codes were already added with the 2005 annual update as separately payable by the carrier for claims with dates of service on or after January 1, 2005**.**

Radiation Therapy

(**Major Category I,** FI Annual Update, **EXCLUSION**)

• **Remove C9714^** - Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; concurrent/immediate
• **Remove C9715^** - Placement of balloon catheter into the breast for interstitial radiation therapy following a partial mastectomy; delayed
• **Remove G0256.** - prostate brachytherapy
• **Add 19296^^** - placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance
• **Add 19297 ^^**- placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioele-

ment application following partial mastectomy, includes imaging guidance; concurrent
• **Add C1715** - brachytherapy needle
• **Add C1717** - brachytx seed, HDR Ir-192
• **Add C1728** - Cath, brachytx seed adm
• **Add C2633**- brachytx source, Cesium-131
• **Add C2634** - Brachytx source, HA, I-125
• **Add C2635** - Brachytx source, HA, P-103
• **Add C2636** - Brachytx linear source, P-103
• **Add C9722** - KV imaging w/IR tracking

Notes on Codes above:

^ These codes were discontinued December 31, 2004.

HCPCS code G0256 was discontinued December 31, 2003

^^ These codes are effective January 1, 2005 and replaced codes C9714 and C9715 and these codes were already added with the 2005 annual update as separately payable by the carrier for claims with dates of service on or after January 1, 2005.

Dialysis Supplies

(**Major Category II**, FI Annual Update, **EXCLUSION**)

• **Remove A4712** - water, sterile, for injection

Note: HCPCS code A4712 was discontinued December 31, 2003.

Chemotherapy Administration

(**Major Category III**, FI Annual Update, **EXCLUSION**)

• **Add G0357+** - Intravenous, push technique, single or initial substance/drug
• **Add G0358+** - Intravenous, push technique, each additional substance/drug
• **Add G0359+** - chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
• **Add G0360+** - Each additional hour, 1 to 8 hours
• **Add G0361+** - initiation of prolonged chemotherapy infusion (more than 8 hours)
• **Add G0362+** - Each additional sequential infusion (different substance/drug), up to 1 hour
• **Add G0363+** - Irrigation of implanted venous access device for drug delivery systems

Note on Codes above:

+ These codes were effective January 1, 2005. These codes were already added with the 2005 annual update as separately payable by the Medicare carrier for claims with dates of service on or after January 1, 2005.

Mammography

(**Major Category IV**, FI Annual Update**, EXCLUSIONS**)

• **Remove G0203** - screening mammography
Note: HCPCS code G0203 was discontinued December 31, 2001.

Diabetic Screening

(**Major Category IV**, FI Annual Update, **EXCLUSIONS**)

• **Add 82950** - Glucose; post glucose dose

Note: This is not a physician service and will not be added as separately payable by the Medicare carrier.
New Preventive Benefit (Per section 611 of the Medicare Modernization Act (MMA)– Initial

Preventive Physical Exam

(**Major Category IV**, FI Annual Update, **EXCLUSIONS**)

• **Add G0344** – Initial prev exam
• **Add G0367•** - EKG tracing for initial prev

Note on Code above:

• HCPCS code G0367 was effective January 1, 2005. Only the corresponding professional component of this code, G0368, will be separately payable by the carrier. It was already added with the 2005 annual update. G0367 is the technical component only and will be subject to consolidated billing.

Therapies

(**Major Category V**, FI Annual Update, **INCLUSIONS**)

• **Update for HCPCS 92605 and 92606 already included in the 2005 annual update.** Payment for these codes is bundled with other rehabilitation services. They may be bundled with any therapy code.
No payment can be made for these codes.
• **Remove 92601** - Cochlear implant w/ programming
• **Remove 92602** - Cochlear implant, subsequent programming
• **Remove 92603** - Diagnostic analysis, cochlear implant w/ programming
• **Remove 92604** - Diagnostic analysis, cochlear implant, subsequent programming

• **Remove 92525** - Evaluation of swallowing
• **Remove 97014** - E stim unattended (not payable by Medicare)(this was replaced by G0283)
• **Remove 97545** - Work hardening, initial 2 hrs
• **Remove 97546** - Work hardening, each add'l hr
• **Add 96110** - Development testing, limited
• **Add 96111** - Developmental testing, extended
• **Add 96115** - Neurobehavioral status exam

Note: HCPCS code 92525 was discontinued December 31, 2002.

Note: Section 1888 of the Social Security Act codifies SNF PPS and CB. The new coding identified in each update describes the same services that are subject to SNF PPS payment by law. No additional services will be added by these routine updates; that is, new updates are required by changes to the coding system, not because the services subject to SNF CB are being redefined. Other regulatory changes beyond code list updates will be noted when and if they occur.

Implementation - The implementation date for this instruction is April 4, 2005.

Additional Information

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

From that web page, look for CR 3683 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

ICD-9 Reminder – CMS 1500 Form

The Administrative Simplification Compliance Act (ASCA) mandates the submission of electronic claims to Medicare *unless* you meet certain "exceptions" described within the law. If you believe you meet the exception criteria and will be submitting your claims on paper, please adhere to the following guideline for entering the patient's diagnosis:

Block 21 - Be sure to enter the primary diagnosis in field number 1. If this field is left blank, your claim will be returned as unprocessable. All other diagnosis codes should be listed in fields 2, 3, and 4. Make sure the ICD-9 you are billing is valid and is coded to the highest level of specificity.

Mandatory Assignment For MMA Section 630 Claims

Medlearn Matters Article Number: MM3587

Provider Types Affected - Indian Health Services (IHS), tribe, and tribal organization (non-hospital or non-hospital based) facilities billing for those Part B drugs that are under the jurisdiction of Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed - This article is chiefly for informational purposes. It explains that if the IHS or an Indian tribe or tribal organization facility (hospital-based or non-hospital-based) submits an unassigned claim for a Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Section 630 item or service with a date of service on or after July 1, 2005, the DMERC must process the claim as though the IHS or the Indian tribe or tribal organization facility had accepted assignment of the claim.

Background - MMA Section 630 was implemented on January 3, 2005, according to CR 3288 (Transmittal R241CP).

This instruction provides that claims submitted by the IHS or by an Indian tribe or tribal organization facility (hospital-based or non-hospital-based) to the DMERCs for the items and services listed below must be processed on an assigned basis. These items and services include the following:

• Durable medical equipment
• Prosthetics and orthotics
• Surgical dressings, splints, and casts
• Drugs (DMERC only)
• Clinical laboratory services
• Ambulance services

The process for submitting claims for Part B drugs furnished by the IHS or by Indian tribe or tribal organization facilities (hospital-based or non-hospital-based) was previously implemented under BIPA 432.

MMA Section 630 has not changed the requirements for Trailblazers to process claims for Part B drugs inaccordance with the *Medicare Claims Processing Manual*, Pub. 100-4, Chapter 19, Section 70.1. (This

manual can be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

MMA Section 630 merely allows the IHS and Indian tribe and tribal organization facilities to submit claims to the DMERCs for those drugs for which the DMERCs have jurisdiction. This clarification also instructs the DMERCs to process such claims as assigned claims, even if the claim was submitted as unassigned.

Implementation - The implementation date for this instruction is July 5, 2005.

Additional Information - The official instruction issued to your DMERC regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3587 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

MMA - Processing Durable Medical Equipment (DME), Orthotics, Prosthetics, Drugs, And Surgical Dressings Claims For Indian Health Services (IHS) And Tribally Owned And Operated Hospitals Or Hospital-Based Facilities Including Critical Access Hospitals (CAHs)

Medlearn Matters Article Number: MM3674

Provider Types Affected - All IHS and Tribally owned and operated hospitals or hospital-based facilities including Critical Access Hospitals (CAHs) billing Medicare Durable Medical Equipment Regional Carriers (DMERCs) and Fiscal Intermediaries (FIs)

Provider Action Needed

Impact to You - Effective July 1, 2005, IHS hospitals and Tribally owned and operated hospitals and hospital-based facilities, including CAHs, may begin billing for DME, prosthetics and orthotics, surgical dressings, drugs and therapeutic shoes, as further discussed in this article.

What You Need to Know - Affected providers may need to enroll with the National Supplier Clearinghouse (NSC) as some of these services must be billed to a Medicare DMERC. Other services will be billable to the Medicare Fiscal Intermediary (FI).

What You Need to Do - Please be aware of the changes addressed in this instruction and ensure that billing staffs submit claims accordingly.

Background

This article advises affected providers and suppliers that beginning July 1, 2005, IHS and Tribally owned and operated hospitals and hospital-based facilities including CAHs may begin billing for:

- DME used in the patient's home;
- Orthotics and Prosthetics;
- Drugs paid by DMERCs;
- Surgical Dressings; and
- Therapeutic shoes furnished in accordance with the requirements of Section 1861 (s)(12)

Note: For the remainder of this article, the term IHS/Tribal facilities will be used and will refer to facilities owned by the Indian Health Services (IHS) and to tribally owned and operated hospitals and hospital-based facilities, including CAHs.

The **appropriate DMERC** should be **billed for DME, therapeutic shoes, and drugs** and the **designated FI billed for prosthetics, orthotics, and surgical dressings.** All **suppliers** should have a **Supplier Number** from the National Supplier Clearinghouse (NSC) to bill the DMERC.

For information on the process for enrolling as a supplier with the NSC, visit: http://www.cms.hhs.gov/providers/enrollment/forms/

Note: To bill drugs to the Medicare DMERC, IHS/Tribal facilities must be registered with the NSC as a pharmacy and have a pharmacy license number on file with the NSC.

Prior to the enactment of §630 of the Medicare Modernization Act (MMA) in 2003, IHS facilities were not permitted to bill for Part B services unless covered under §1848 of the Social Security Act. The new MMA legislation expands the scope of the items and services paid to IHS hospital-based facilities to include all Part B covered items and services that are not paid under the Medicare Physician Fee Schedule and are not included in the Medicare IHS all-inclusive rate for a five-year pe-

riod beginning January 1, 2005.

Additional Information

Some key billing information for IHS/Tribal facilities is as follows:

• Beginning with services provided on or after July 1, 2005, IHS/Tribal facilities may send claims to their Medicare DMERC for DME, therapeutic shoes, and drugs showing a specialty code of A9 (IHS/Tribal facility) and a place of service code of 12 to indicate patient's home on the claim. If a claim is received with **a date of service prior to July 1, 2005, the DMERC will deny the claim with reason code 26.** Also, coinsurance and deductibles are waived for these claims.
• Payment for DME will be based on the DME fee schedule and payment for drugs will be based on the Average Sales Price (ASP) drug file.
• Beginning for services provided on or after July 1, 2005, IHS/Tribal facilities may begin billing their Medicare FI for orthotics, prosthetics, and surgical dressings.
• When billing orthotics, prosthetics, and surgical dressings to the FI, IHS/Tribal facilities should use the following revenue codes:
• 0274 for orthotics with the appropriate HCPCS code,
• 0274 for prosthetics with the appropriate HCPCS code, and
• 0623 for surgical dressings and the appropriate HCPCS code.
• When billing for prosthetics, orthotics, and surgical dressings to the FI, IHS/Tribal facilities should show only those items on the TOB13X bill that are payable under the DME fee schedule.

Clarification of Rules for Drug Administration

In addition to the changes described above, IHS/Tribal facilities need to note that related CR 3674 also clarifies the All Inclusive Rate (AIR) billing rules for drug administration (injections) occurring without a medically indicated outpatient encounter. In an effort to ensure that the AIR is paid appropriately, any injection (e.g., B-12) that requires only a licensed professional's administration must not be billed as a visit payable at the AIR. A visit cannot be billed if the injection is the only service the facility provides.

If the patient receives an injection and no qualifying visit takes place, the charges/expenses for the injection should be combined with the expenses/charges for the next qualifying visit. The qualifying visit should be for the condition being treated with the injection or drug.

For complete details, including the revised sections of the *Medicare Claims Processing Manual*, please see the official instruction issued to your FI/DMERC regarding this change. This instruction may be viewed at: http://www.cms.hhs.gov/manuals/transmittals/cr_num_dsc.asp

Once at that site, scroll down the CR NUM column on the right looking for CR 3674 and click on the file for that CR. For details regarding enrollment as a supplier for the purpose of billing a DMERC, please visit: http://www.cms.hhs.gov/providers/enrollment/forms/ See sections 100 through 140 of Chapter 15 of the *Medicare Benefit Policy Manual* for a detailed description of DME, prosthetics, and orthotics. This manual can be accessed at: http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp

IHS/Tribal facilities should note that they may not bill for items or services that fall outside the scope of the benefits described in these sections. If you have any questions please contact your FI or DMERC at their toll-free number which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Modified Edits For Matching Claims Data To Beneficiary Records

Medlearn Matters Article Number: SE0516

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

Provider Action Needed

Impact to You - Claims submitted to Medicare must match a Medicare beneficiary record on Health Insurance Claim Number, beneficiary's last name (surname) and the beneficiary's first name.

What You Need to Know - The name reported on the claim should always be the name shown on the beneficiary's Medicare card. If the name submitted does not match the name on Medicare's files for that beneficiary claim number, Medicare will deny the claim.

What You Need to Do - Be aware of this issue and advise your billing staff they should always use the name from the Medicare card when submitting the claim, even if the patient indicates the name on the Medicare card is incorrect.

Background - Over the past several months, the Cen-

ters for Medicare & Medicaid Services (CMS) reviewed its personal characteristics editing logic for processing Medicare claims. The review identified a weakness where processed claims were approved for payment under the wrong beneficiary account number. One of Medicare's key claims processing systems, known as the Common Working File (CWF), was approving claims where the beneficiary name and Health Insurance Claim Number did not match the name and number on the Medicare card.

The Office of the Inspector General in the Department of Health and Human Services recommended that CMS implement a modified process for matching the claim information to the beneficiary information on CWF files to eliminate erroneous payments caused by the existing matching criteria.

In October 2004, CMS made a software change to require an exact match on beneficiary First Initial, Surname, and Health Insurance Claim Number submitted on the claim. Since this change was implemented the number of denials because of name/number mismatch tripled.

To resolve these claim denials, providers should bill using the name and number as it appears on the beneficiary Medicare card. If the beneficiary insists the Medicare card is incorrect, advise the beneficiary to contact their local servicing Social Security Field Office to obtain a new Medicare card.

If you have any questions regarding this issue, contact your Medicare carrier, intermediary, or durable medical equipment regional carrier at their toll free number. You can find that number on the web at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Skilled Nursing Facility Consolidated Billing

Medlearn Matters Article Number: SE0431

NOTE: This article was revised on February 9, 2005 to include clarifying language, but no substantive changes were made.

Provider Types Affected - All Medicare providers, suppliers, physicians, skilled nursing facilities (SNFs), and rural swing bed hospitals

Provider Action Needed - This article is informational only and is intended to remind affected providers that SNFs must submit all Medicare claims for the services its residents receive, except for a short list of specifically excluded services as mentioned in the "Excluded Services" below. This requirement was established initially as specified in the Balanced Budget Act of 1997 (BBA, P.L. 105-33) and is known as SNF Consolidated Billing (CB).

Clarification: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These included services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare durable medical equipment regional carrier (DMERC.)

Background - Prior to the Balanced Budget Act of 1997 (BBA), a SNF could elect to furnish services to a resident in a covered Part A stay, either:

- Directly, using its own resources;
- Through the SNF's transfer agreement hospital; or
- Under arrangements with an independent therapist (for physical, occupational, and speech therapy services).

In each of these circumstances, the SNF billed the Medicare Part A intermediary for the services.

However, the SNF also had the further option of "unbundling" a service altogether; that is, the SNF could permit an outside supplier to furnish the service directly to the resident, and the outside supplier would submit a bill to its Medicare Part B carrier (or DMERC), without any involvement of the SNF itself. This practice created several problems, including the following:

- A potential for duplicate (Parts A/B) billing if both the SNF and outside supplier billed;
- An increased out-of-pocket liability incurred by the beneficiary for the Part B deductible and coinsurance even if only the supplier billed; and
- A dispersal of responsibility for resident care among various outside suppliers adversely affected quality (coordination of care) and program integrity, as documented in several reports by the Office of the Inspector General (OIG) and the General Accounting Office (GAO).

Based on the above-mentioned problems, Congress enacted the Balanced Budget Act of 1997 (BBA), Public Law 105-33, Section 4432(b), and it contains a CB requirement for SNFs. Under the CB requirement, **an SNF itself must submit all Medicare claims for the services that its residents receive** (except for specifically excluded services listed below).

Conceptually, SNF CB resembles the bundling requirement for inpatient hospital services that's been in effect since the early 1980s—assigning to the facility itself the Medicare billing responsibility for virtually the entire package of services that a facility resident receives, except for certain services that are specifically excluded.

CB eliminates the potential for duplicative billings for the same service to the Part A fiscal intermediary by the SNF and the Part B carrier by an outside supplier. It also enhances the SNF's capacity to meet its existing responsibility to oversee and coordinate the total package of care that each of its residents receives.

Effective Dates

CB took effect as each SNF transitioned to the Prospective Payment System (PPS) at the start of the SNF's first cost reporting period that began on or after July 1, 1998.

The original CB legislation in the BBA applied this provision for services furnished to every resident of an SNF, regardless of whether Part A covered the resident's stay. However, due to systems modification delays that arose in connection with achieving Year 2000 (Y2K) compliance, the Centers for Medicare & Medicaid Services (CMS) initially postponed implementing the Part B aspect of CB, i.e., its application to services furnished during noncovered SNF stays.

The aspect of CB related to services furnished during noncovered SNF stays has now essentially been repealed altogether by Section 313 of the Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554, Appendix F). Thus, with the exception of physical therapy, occupational therapy, and speech language pathology services (which remain subject to CB regardless of whether the resident who receives them is in a covered Part A stay) this provision now applies only to those services that an SNF resident receives during the course of a covered Part A stay.

Excluded Services

There are a number of services that are excluded from SNF CB. These services are outside the PPS bundle, and they remain separately billable to Part B when furnished to an SNF resident by an outside supplier. However, Section 4432(b)(4) of the BBA (as amended by Section 313 (b)(2) of the BIPA) requires that bills for these particular excluded services, when furnished to SNF residents, must contain the SNF's Medicare provider number. Services that are categorically excluded from SNF CB are the following:

• Physicians' services furnished to SNF residents. These services are not subject to CB and, thus, are still billed separately to the Part B carrier.
• Certain diagnostic services include both a professional component (representing the physician's interpretation of the test) and a technical component (representing the test itself), and the technical component is subject to SNF CB. **The technical component of these services must be billed to and reimbursed by the SNF**. (See Medlearn Matters Special Edition Article SE0440 for a more detailed discussion of billing for these diagnostic tests.)
• Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that **physical therapy, occupational therapy, and speech-language pathology services are subject to CB**, even when they are furnished by (or under the supervision of) a physician.
• Physician assistants working under a physician's supervision;
• Nurse practitioners and clinical nurse specialists working in collaboration with a physician;
• Certified nurse-midwives;
• Qualified psychologists;
• Certified registered nurse anesthetists;
• Services described in Section 1861(s)(2)(F) of the Social Security Act (i.e., Part B coverage of home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies);
• Services described in Section 1861(s)(2)(O) of the Social Security Act, i.e., Part B coverage of Epoetin Alfa (EPO, trade name Epogen) for certain dialysis patients. Note: Darbepoetin Alfa (DPA, trade name Aranesp) is now excluded on the same basis as EPO;
• Hospice care related to a resident's terminal condition;
• An ambulance trip that conveys a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge.

Physician "Incident To" Services

While CB excludes the types of services described above and applies to the professional services that the practitioner performs personally, ***the exclusion does not apply to physician "incident to"*** **services** fur-

nished by someone else as an "incident to" the practitioner's professional service. These "incident to" services furnished by others to SNF residents are subject to CB and, accordingly, must be billed to Medicare by the SNF itself.

In Program Memorandum (PM) Transmittal # A-98-37 (November 1998, reissued as PM transmittal # A-00-01, January 2000), CMS identified specific types of outpatient hospital services that are so exceptionally intensive or costly that they fall well outside the typical scope of SNF care plans. CMS has excluded these services from SNF CB as well (along with those medically necessary ambulance services that are furnished in conjunction with them). These excluded service categories include:

- Cardiac catheterization;
- Computerized axial tomography (CT) scans;
- Magnetic resonance imaging (MRIs);
- Ambulatory surgery that involves the use of an operating room;
- Emergency services;
- Radiation therapy services;
- Angiography; and
- Certain lymphatic and venous procedures.

Effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) has identified certain additional exclusions from CB. The additional exclusions enacted in the BBRA apply only to certain specified, individual services ***within*** a number of broader service categories that otherwise remain subject to CB. Within the affected service categories the exclusion applies only to those individual services that are specifically identified by HCPCS code in the legislation itself, while all other services within those categories remain subject to CB. These service categories are:

- Chemotherapy items and their administration;
- Radioisotope services; and
- Customized prosthetic devices.

In addition, effective April 1, 2000, this section of the BBRA has unbundled those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services.

Finally, effective January 1, 2004, as provided in the August 4, 2003 final rule (68 Federal Register 46060), two radiopharmaceuticals, Zevalin and Bexxar, were added to the list of chemotherapy drugs that are excluded from CB (and, thus, are separately billable to Part B when furnished to a SNF resident during a covered Part A stay).

Effects of CB

SNFs can no longer "unbundle" services that are subject to CB to an outside supplier that can then submit a separate bill directly to the Part B carrier. Instead, the SNF itself must furnish the services, either directly, or under an "arrangement" with an outside supplier in which the SNF itself (rather than the supplier) bills Medicare. The outside supplier must look to the SNF (rather than to Medicare Part B) for payment. In addition, SNF CB:

- Provides an essential foundation for the SNF PPS, by bundling into a single facility package all of the services that the PPS payment is intended to capture;
- Spares beneficiaries who are in covered Part A stays from incurring out-of-pocket financial liability for Part B deductibles and coinsurance;
- Eliminates potential for duplicative billings for the same service to the Part A fiscal intermediary (FI) by the SNF and to the Part B carrier by an outside supplier; and
- Enhances the SNF's capacity to meet its existing responsibility to oversee and coordinate each resident's overall package of care.

Additional Information

While this article presents an overview of the SNF CB process, CMS also has a number of articles that provide more specifics on how SNF CB applies to certain services and/or providers. These articles are as follows:

- Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0432.pdf
- Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Service http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0433.pdf
- Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0434.pdf
- Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0435.pdf
- Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0436.pdf
- Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetics and Orthotics http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf
- Medicare Prescription Drug, Improvement, and Modernization Act – Skilled Nursing Facility Consolidated Billing and Services of Rural Health Clinics and Federally Qualified Health Centers http://www.cms.hhs.gov/

medlearn/matters/mmarticles/2004/SE0438.pdf
• Skilled Nursing Facility Consolidated Billing as It Relates to Clinical Social Workers http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0439.pdf
• Skilled Nursing Facility Consolidated Billing as It Relates to Certain Diagnostic Tests http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0440.pdf
• Skilled Nursing Facility Consolidated Billing and "Incident To" Services (Services That Are Furnished as an Incident to the Professional Services of a Physician or Other Practitioner) (coming soon) In addition, the CMS SNF Consolidated Billing web site can be found at: http://www.cms.hhs.gov/medlearn/snfcode.asp

It includes the following relevant information:

• General SNF consolidated billing information;
• HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
• Therapy codes that must be consolidated in a non-covered stay; and
• All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS Consolidated Billing web site can be found at: http://www.cms.hhs.gov/providers/snfpps/cb

It included the following relevant information:

• Background;
• Historical questions and answers;
• Links to related articles; and
• Links to publications (including transmittals and Federal Register notices).

Skilled Nursing Facility (SNF) Consolidated Billing As It Relates To Dialysis Coverage

Medlearn Matters Article Number: SE0435

Note: This article was revised on February 2, 2005, to include clarifying language, but no substantive changes were made.

Provider Types Affected - Skilled Nursing Facilities (SNFs), physicians, End-Stage Renal Disease (ESRD) facilities, and hospitals

Provider Action Needed - This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to dialysis coverage for SNF residents. See Medlearn Matters article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

Clarification: The SNF CB requirement makes the SNF itself responsible for including on the Part A bill that it submits to its Medicare intermediary almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These excluded services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their Medicare intermediary, as well as practitioners and suppliers who would generally submit their bills to a Medicare Part B carrier. (Bills for certain types of items or equipment would be submitted by the supplier to their Medicare Durable Medical Equipment Regional Carrier (DMERC))

Background

Dialysis furnished to a SNF resident during a covered Part A stay falls within the scope of the SNF benefit under the Social Security Act, Section 1861(h)(7), as long as the SNF elects to provide the dialysis itself, either directly or under an "arrangement" with a qualified outside supplier in which the SNF itself assumes the Medicare billing responsibility. When covered in this manner, the dialysis would be included in the global Medicare Part A per diem payment that the SNF receives under the Prospective Payment System (PPS).

However, the SNF PPS legislation also gives SNFs the option of "unbundling" the dialysis and, thereby, allowing and outside supplier to furnish the dialysis services and submit a bill directly to its Medicare Part B carrier.

If the SNF elects this option, dialysis services that meet the requirements for separate coverage under the Part B dialysis benefit (as described in the Social Security Act, Section 1861(s)(2)(F) are excluded from SNF CB. As such, these services can be furnished and billed directly to the Medicare Part B carrier by the outside dialysis supplier itself. In addition, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section103) excluded from SNF CB those ambulance services that are necessary to transport a SNF resident offsite to receive the Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

As noted previously, if the SNF elects to provide the dialysis services under Part A, either directly or under an arrangement with an outside supplier, these services would be included in the SNF's PPS per diem payment (since dialysis services that SNFs furnished in this manner during the PPS base period would have been included on their cost reports and reflected in the PPS base). Further, since the Social Security Act (Section 1833 (d)) expressly prohibits payment under Part B for any service that is covered under Part A, such services would not be excluded from SNF CB, since they would no longer meet the statutory criteria (Section 1888(e)(2)(A) (ii)) of being items and services that meet the requirements for coverage under the separate Part B dialysis benefit of the Social Security Act (Section 1861 (s)(2)(F)).

Additional Information

See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing web site may be found at: http://www.cms.hhs.gov/medlearn/snfcode.asp

It includes the following relevant information:

• General SNF CB information;
• HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in CB);
• Therapy codes that must be consolidated in a non-covered stay; and
• All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest versions.

The SNF PPS Consolidated Billing web site can be found at: http://www.cms.hhs.gov/providers/snfpps/cb

It includes the following relevant information:

• Background;
• Historical questions and answers;
• Links to related articles; and
• Links to publications (including transmittals and Federal Register notices).

Skilled Nursing Facility (SNF) Consolidated Billing Service Furnished Under An "Arrangement" With An Outside Entity

Medlearn Matters Article Number: MM3592

Note: This article was revised on February 8, 2005 to provide some clarifying language, but no substantive changes were made.

Provider Types Affected - Any physician, provider or supplier who renders a Medicare-covered service subject to consolidated billing to a SNF resident

Provider Action Needed - No provider action is necessary. This article is informational only and clarifies the instruction contained in CR 3248, issued on May 21, 2004. It explains that an "arrangement" between a Medicare Skilled Nursing Facility (SNF) and its supplier is validated not by the presence of specific supporting written documentation but rather by their actual compliance with the requirements governing such "arrangements." However, supporting written documentation that provides details regarding the services to be provided "under arrangement" and the manner in which the SNF will pay the supplier for those services can help both parties arrive at a mutual understanding on these important points.

Background - Under the SNF consolidated billing provisions of the Social Security Act (the Act) the Medicare billing responsibility is placed with the SNF itself for most of its residents' services. (See Sections 1862(a)(18), 1866(a)(1)(H)(ii) and 1888(e)(2)(A)). The SNF must include on its Part A claim submitted to its Medicare intermediary almost all of the services a resident receives during a covered stay. The SNF should not include on the claim those services which are excluded from the SNF's prospective payment system (PPS) per diem payment for the particular stay.

These excluded services continue to be separately billable under Part B by those outside suppliers that actually furnish the service. In this context, the term "supplier" can also refer to:

• A provider of services (such as a hospital), which would submit the bill for Part B services to its Medicare intermediary; and
• Practitioners who, in addition to performing their separately billable professional services, essentially act as

a supplier by also furnishing other services that are subject to the consolidated billing requirement.

Outside entities (other than a provider of services) would generally submit their Part B bills to a Medicare carrier, but Part B bills for certain types of items or equipment are submitted to the Medicare Durable Medical Equipment Regional Carrier (DMERC).

In addition, Part B consolidated billing makes the SNF itself responsible for the submission of Part B bills for any *physical, occupational or speech-language therapy services* received by a resident during a *non-covered* stay.

Further, the SNF must provide any Part A or Part B service that is subject to SNF consolidated billing either directly with its own resources, or through an outside entity (e.g., a supplier) under an "arrangement," as set forth in Section 1861(w) of the Act. If an outside entity provides a service that is subject to SNF consolidated billing to a SNF resident during a covered stay, the outside entity must look to the SNF for payment (rather than billing under Part B). In these situations, Medicare's payment to the SNF represents payment in full for the arranged-for service, and the SNF in turn is responsible for making payment to an outside entity that furnishes a service which is included in the SNF's prospective payment system (PPS) per diem payment.

Problem Situations

Since the start of the SNF PPS, problematic situations have arisen when the SNF resident receives services that are subject to consolidated billing from an outside entity, such as a supplier. These problems are usually connected with either of two scenarios, namely:

• An SNF does not accurately identify services as being subject to consolidated billing when ordering such services from a supplier; or
• A supplier fails to ascertain a beneficiary's status as an SNF resident when the beneficiary (or other individual acting on behalf of the beneficiary) seeks to obtain such services directly from the supplier without the SNF's knowledge.

Documenting Arrangements

SNFs should document, in writing, arrangements with suppliers that render services on an ongoing basis (e.g., pharmacies, laboratories and x-ray suppliers) to the SNF's patients. Documentation of a valid arrangement, including mutually agreeable terms, should help to avoid confusion and friction between SNFs and their suppliers. Suppliers need to know which services fall under the consolidated billing provisions so they do not improperly bill Medicare carriers under Part B or other payers (like Medicaid and beneficiaries) directly for services.

It is also important that when ordering or providing services "under arrangement," the parties reach a mutual understanding of all the payment terms, e.g., how to submit an invoice, how payment rates are determined, and how long it will take for payment after the supplier presents an invoice to the SNF.

SNF's Responsibility

However, the absence of an agreement with its supplier (written or not) does not relieve the SNF of its responsibility to pay suppliers for services "bundled" in the SNF PPS payment from Medicare. The SNF must be considered the responsible party (even in cases where it did not specifically order the service) when beneficiaries in Medicare Part A stays receive medically necessary supplier services, because the SNF has already been paid under the SNF PPS. Examples of this obligation occur when:

• The physician performs additional diagnostic tests during a scheduled visit that had not been ordered by the SNF; or
• A family member arranges a physician visit without the knowledge of SNF staff and the physician bills the SNF for "incident to" services.

Establishing a valid arrangement prior to ordering services from a supplier minimizes the likelihood of a payment dispute between the parties. However, occasional disagreements between the parties that result in non-payment by the SNF of a supplier claim may occur. When patterns of such non-payment are identified, there are potentially adverse consequences to SNFs with regard to their Medicare agreement. All SNFs, under the terms of their Medicare provider agreement, must comply with program regulations. These **regulations require a valid arrangement to be in place between the SNF and any outside entity providing resident services subject to consolidated billing. Moreover, in receiving a bundled per diem payment under the SNF PPS that includes such services, the SNF is accepting Medicare payment and financial responsibility for the service.**

Under Section 1862(a)(18) of the Act, there is no valid "arrangement" if a SNF obtains services subject to consolidated billing from an outside supplier but refuses to

pay the supplier for those services. This situation could result in the following consequences:

• The SNF is found in violation of the terms of its provider agreement; and/or
• Medicare does not cover the particular services at issue.

The SNF's provider agreement includes a section requiring a specific commitment to comply with the requirements of the consolidated billing provision (see Section 1866(a)(1)(H)(ii) of the Act and the regulations at 42 CFR 489.20(s)). Also Section 1866(g) of the Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.

Additional Guidance - In the absence of a valid "arrangement" between a SNF and its supplier, the problems which arise tend to fall into one of the following problem scenarios.

Problem Scenario 1

A SNF elects to utilize an outside supplier to furnish a type of service that would be subject to Part A consolidated billing, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay. This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing.

Based on the inaccurate impression that the resident's SNF stay is non-covered, the supplier inappropriately submits a separate Part B claim for the service and may also improperly bill other insurers and the resident. Then the supplier only learns of the actual status of the resident's Medicare-covered SNF stay when that Part B claim is denied by Medicare.

In this scenario, even though the supplier may have made reasonable efforts to ascertain from the SNF both the beneficiary's status as an SNF resident and the specific nature of the beneficiary's SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

The Centers for Medicare & Medicaid Services (CMS) realizes that unintentional mistakes occasionally may occur when furnishing such information. However, the SNF is responsible for making a good faith effort to provide accurate information to its supplier and to pay the supplier once the error is pointed out.

In Scenario 1, if the SNF refuses to pay the supplier even after the supplier brings the situation to the attention of the SNF, the SNF would risk being in violation of its provider agreement by not complying with consolidated billing requirements. As stated previously, supporting written documentation for services provided "under arrangement" would provide a basis for resolving the dispute and ensuring compliance with the consolidated billing requirements.

By making sure that it sends accurate and timely information to its supplier regarding a resident's covered stay, the SNF can often prevent disputes such as those described in Scenario 1 from arising. The communication of accurate and timely resident information by the SNF to the supplier is especially important when a portion of an otherwise "bundled" service remains separately billable to Part B (e.g., the professional component representing a physician's interpretation of an otherwise "bundled" diagnostic test).

Problem Scenario 2

A resident temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident's behalf) obtains services that are subject to the consolidated billing requirement, but fails to notify the SNF. The SNF refuses to pay for the offsite services and the supplier bills the beneficiary/family member directly.

As in the previous scenario, the SNF remains responsible for any services included in the SNF "bundle" of services subject to consolidated billing that are furnished to the resident by an outside entity, *even in the absence of a valid arrangement with the SNF.*

The SNF can take steps to prevent problems like this from occurring by making sure that the resident or his/her representative fully understands the applicable requirements. For example, under Section 1802 of the Act, Medicare law guarantees to a beneficiary the right to choose any qualified entity willing to provide services to him/her. By selecting a particular SNF, the beneficiary has in effect exercised this right of choice regarding the entire array of services for which the SNF is responsible under the consolidated billing requirement and agrees to use only those suppliers that the SNF selects or approves to provide services.

The staff of the SNF should explain these rights and requirements to the beneficiary and his/her family members or representative(s) during the admission process. In addition, the SNF should periodically remind the ben-

eficiary or his/her representative of these rights/requirements throughout the resident's stay, and especially upon the resident's temporarily leaving the facility.

The supplier in this scenario also retains responsibility for preventing problems from arising by understanding and complying with the consolidated billing requirements. Therefore, before providing beneficiary services, the supplier should determine whether that beneficiary currently receives any comprehensive Medicare benefits (e.g., SNF or home health) which could include the supplier's services. If the beneficiary is a resident of an SNF with which the supplier does not have a valid "arrangement," the supplier should consult with the SNF before actually furnishing any services which may be subject to the consolidated billing provision. Further, the supplier should know that the beneficiary cannot be charged for the bundled service in accordance with the regulations at 42 CFR 489.21(h).

Additional Information

The Medicare Claims Processing Manual has been revised to include language reflecting this clarification. That revision is attached to the official instruction issued to your carrier/intermediary regarding this change. The official instruction may be found at: http://www.cms.hhs.gov/manuals/pm_trans/R412CP.pdf

Also 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

FEE SCHEDULE

2005 Region D Drug Fees

Effective January 1, 2005, DMEPOS drugs will be paid on the basis of 106 percent of the Average Sales Price (ASP), except for infusion drugs furnished through a covered item of durable medical equipment. Infusion drug payment limits will be based on 95 percent of the October 1, 2003 Average Wholesale Price (AWP). The payment limits for drugs not included in the ASP Drug Pricing file will be based on the published Wholesale Acquisition Cost (WAC) or invoice pricing. Several drugs were not on the ASP Drug Pricing File, nor was a WAC available. Invoices will be needed for these drugs until a fee can be established. The fee listings on our Web site have these drugs identified with "TBD" in the fee field. Refer to the Region D DMERC Web site (www.cignamedicare.com/dmerc/fsch/index).

The ASP file from CMS is scheduled for quarterly updates; however, CMS can issue additional updates as needed. As updates from CMS are implemented, we will update our Web site and send a ListServ notification.

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

Medlearn Matters Article Number: MM3669

Provider Types Affected - Physicians, providers, and suppliers billing Durable Medical Equipment Regional Carriers (DMERCs) and/or intermediaries

Provider Action Needed - This article is based on Change Request (CR) 3669, and it provides specific information regarding the April quarterly update for the 2005 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

Background

This article provides specific information regarding the April quarterly update for the 2005 DMEPOS fee schedule. The DMEPOS fee schedules are updated on a quarterly basis in order to 1) implement fee schedule amounts for new codes and 2) to 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 April 2005.

HCPCS code K0670 (addition to lower extremity prosthesis…) is added, effective April 1, 2005 to the list of Healthcare Common Procedural Coding System (HCPCS) accepted by DMERCs and intermediaries.

Also, **HCPCS Code K0671 is being added to the HCPCS effective April 1, 2005** as an accepted code by DMERCs and regional home health intermediaries.

This code:

• Describes a rental portable oxygen concentrator system and
• Is to be used when billing Medicare for the portable equipment add-on fee for patients using lightweight oxygen concentrators that can function as both the patient's stationary equipment and portable equipment.

The following HCPCS Codes are to be used to describe combination stationary/portable oxygen concentrators for Medicare billing purposes.

• **For** claims for combination stationary/portable oxygen concentrators with **dates of service prior to April 1, 2005**, use:
• HCPCS Code E1390 (stationary oxygen concentrator) **with**
• HCPCS Code E0431 (portable gaseous oxygen system).
• For claims with dates of service **on or after April 1, 2005**, use
• HCPCS Code E1390 (stationary oxygen concentrator) in conjunction **with**
• HCPCS Code K0671 (portable oxygen concentrator system).

Note: Payment for HCPCS Code K0671 will be based on the current add-on fee schedule amounts for portable oxygen equipment. 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

Implementation - The implementation date for this instruction is April 4, 2005.

Additional Information

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

From that web page, look for CR 3669 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/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

April 2005 Quarterly Fee Schedule Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

States	E0463RR	E0464RR	K0670	K0671RR
AK	1406.38	1406.38	$9447.23	$42.14
AZ	1406.38	1406.38	$9447.23	$35.97
CA	1406.38	1406.38	$9447.23	$35.97
HI	1406.38	1406.38	$9447.23	$45.09
IA	1406.38	1406.38	$9631.72	$35.97
ID	1406.38	1406.38	$9447.23	$35.22
KS	1406.38	1406.38	$9631.72	$31.06
MO	1406.38	1406.38	$9631.72	$32.96
MT	1406.38	1406.38	$9785.38	$30.57
ND	1406.38	1406.38	$9785.38	$30.57
NE	1406.38	1406.38	$9631.72	$35.97
NV	1406.38	1406.38	$9447.23	$35.97
OR	1406.38	1406.38	$9447.23	$35.15
SD	1406.38	1406.38	$9785.38	$30.57
UT	1406.38	1406.38	$9785.38	$34.02
WA	1406.38	1406.38	$9447.23	$35.97
WY	1406.38	1406.38	$9785.38	$30.57

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

Medlearn Matters Article Number: MM3574

Provider Types Affected - Physicians, providers, and suppliers

Provider Action Needed - This instruction provides specific information regarding the 2005 annual update for the DMEPOS fee schedule.

Background

The DMEPOS fee schedules are updated on an annual basis in accordance with the statute and regulations, as described in the *Medicare Claims Processing Manual* (Pub 100-04, Section 60, Chapter 23). This notification provides details regarding the 2005 annual update for the DMEPOS fee schedule.

The Social Security Act (SSA) (Sections 1834(a), (h), and (i)) requires payment on a fee schedule basis for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. In addition, the Code of Federal Regulations (42 CFR 414.102) requires payment on a fee schedule basis for Parenteral and Enteral Nutrition (PEN).

The 2005 DMEPOS fee schedule update factors for items furnished from January 1, 2005 through December 31, 2005 are as follows:

• DME other than items classified as class III devices by the Food and Drug Administration (FDA) – 0 percent
• DME classified as class III devices by the FDA – 3.3 percent
• Prosthetic devices, prosthetics, and orthotics – 0 percent
• PEN – 3.3 percent
• Surgical dressings – 0 percent

Please refer to the table below for comments and notes on several Healthcare Common Procedure Coding System (HCPCS) codes. The descriptions for the items falling under the HCPCS codes listed in the table can be obtained from the HCPCS file at https://www.cms.hhs.gov/medicare/hcpcs/default.asp

Healthcare Common Procedure Coding System Codes

A4253, A4259, E0260,E0277, E0424, E0431, E0434, E0439, E0570, E1390, E1391, K0001, and K0011

These codes are affected by the provision in Section 302 (c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requiring reductions for certain DME equal to the percentage difference between 2002 Medicare fee schedule amounts and the median 2002 price paid under Federal Employee Health Benefit (FEHB) plans surveyed by the Office of the Inspector General. The reductions take effect January 1, 2005, and will be implemented as part of this annual update to the DMEPOS fee schedules.

A5500 (extra-depth shoe)A5501 (custom molded shoe)K0628 (direct formed insert)K0629 (custom molded insert)

Section 627 of the MMA requires the calculation and implementation of fee schedule amounts for therapeutic shoes and inserts effective January 1, 2005. Fee schedules for these HCPCS codes have been calculated by CMS using the methodology contained in section 1834(h) of the Social Security Act for prosthetic devices, prosthetics, and orthotics. These fee schedule amounts will be implemented as part of this annual update to the DMEPOS fee schedules.

A5503 thru A5507 (shoemodification codes)K0628 or K0629 (inserts)

In accordance with section 1833(o)(2)(C) of the Social Security Act, the payment amounts established for shoe modification codes (A5503 thru A5507) must be established in a way that prevents a net increase in expenditures when substituting these items for inserts (codes K0628 or K0629). Therefore, the 2005 fee schedule amounts for codes A5503 thru A5507 have been calculated based on the weighted average of the fee schedule amounts for insert codes K0628 and K0629. The fees for K0628 and K0629 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004. For 2006 and each subsequent year, the weighted average insert fee used to establish the fee schedule amounts for the shoe modification codes will be based on an updated weighted average (i.e., using more current allowed service data for each insert code).

E0675

Code E0675 was added to the HCPCS effective January 1, 2004. The fee schedule for code E0675 was calculated using retail prices for two products; however, the fee schedule is being revised effective January 1, 2005, to remove pricing for one product that was not yet anestablished product in the market at the time the code was added.

E1010

The description for code E1010 for "wheelchair accessory, addition to power seating system, including leg rest, …**each**" is changed effective January 1, 2005, to show "wheelchair accessory, addition to power seating system,……., including leg rest, **pair**" and the fee schedule for E1010 is revised to reflect this change. Suppliers should bill single leg rest powerelevation systems under code K0108.

E2320 thru E2330, and Modifier KC

Codes E2320 thru E2330 for special power wheelchair interfaces were added to the HCPCS effective January 1, 2004. The fee schedule amounts for these codes were calculated based on pricing for the differential cost of furnishing these special interfaces over a standard-interface that is paid for as part of the payment for the wheelchair (e.g., K0011). However, when these items are furnished to replace existing interfaces on wheelchairs that have been in use by the patient for a period of time due to a change in the patient's medical condition or in cases where the existing interface is irreparably damaged or has exceeded its reasonable useful lifetime, the fee schedule payment should reflect payment for the full cost of the replacement special interface. Modifier KC is being added to the HCPCS effective Janu-

ary 1, 2005, to identify replacement of special power wheelchair interfaces in these cases. Fee schedule amounts for replacement of special power wheelchair interfaces will be established effective January 1, 2005, for use in paying claims for use Codes E2320 thru E2330 billed with the KC modifier.

E2340 thru E2343, and K0108

Codes E2340 thru E2343 for nonstandard power wheelchair seat frame width and depth were added to the HCPCS effective January 1, 2004. The fee schedule amounts for these codes were calculated using retail prices for some products for nonstandard seat dimensions (i.e., captain's chairs that sit on top of power wheelchair bases) as opposed to nonstandard seatframe dimensions. The base fee schedule amounts for codes E2340 thru E2343 will be adjusted to remove these products from the base fee calculations. Suppliers of nonstandard seat dimensions should bill HCPCS K0108 instead of codes E2340 thru E2343.

K0646, K0648, and L0565

The fee schedule amounts for codes K0646 and K0648 are being revised effective January 1, 2005, by crosswalking the fee schedule amounts for previous code L0565 to both code K0646 and K0648. As a result of a court settlement, previously paid claims for K0646 and K0648 that were submitted between July 6, 2004 and January 1, 2005, shall be adjusted if such claims are resubmitted by suppliers on or after January 1, 2005, and on or before 18 months after the date the claim was originally submitted.

E0617, E0691 thru E0694,K0606 thru K0609, and-Modifier KF

A one-time notification (Transmittal 35, Change Request 3020) was issued on December 24, 2003, and listed HCPCS codes for categories of DME items identified by the FDA as class III devices. As indicated above, the fee schedule amounts for class III DME will be increased by 3.3 percent effective January 1, 2005, whereas the fee schedule amounts for items that are not classified as class III devices by the FDA will not be increased on January 1, 2005. Transmittal 35 indicated that HCPCS codes E0617, E0691 thru E0694, and K0606 thru K0609 represented codes for categories of DME items identified by the FDA as class III devices. However, some products billed under these codes are not class III devices. Therefore, effective January 1, 2005, separate fee schedules will be provided in the DMEPOS fee schedule file: one for class III products within these codes that must be billed with HCPCS modifier KF and one for products within these codes that are not class III devices that may not be billed with HCPCS modifier KF.

A7040, A7041, L8615 thruL8618, L8620 thru L8622

Codes A7040, A7041, L8615 thru L8618, and L8620 thru L8622 describe items that are subject to the fee schedule for prosthetics and orthotics (PO) and are being added to the HCPCS effective January 1, 2005. These codes fall under the jurisdiction of the local carriers rather than the DMERCs. CMS will be calculating the fee schedule amounts for these items using the standard gap-filling process. The description for these codes can be obtained from the 2005 HCPCS file as soon as it is available at: http://www.cms.hhs.gov/medicare/hcpcs/default.asp

A4324 thru A4325; 4347; A4609 thru A4610; B4151; B4156; E0176 thru E0179; E0192; E0454; E0962 thru E0965; E1012 thru E1013 K0023 thru K0024; K0059-thru K0061; K0081;K0114 thru K0116; K0627;L0476; L0478; L0500; L0510;L0515; L0520; L0530; L0540;-L0550L0560 thru L0561; L0565*L0600; L0610; L0620-L2435; L5674 thru L5675L5846 thru L5847; L5989-L8490

These codes are being deleted from the HCPCS effective January 1, 2005, and are therefore being removed from the DMEPOS and PEN fee schedule files.

*As indicated above, the fee schedule amounts for code L0565 are being crosswalked to codes K0646 and K0648.

Additional Information

The official instruction issued to your carrier, intermediary, or DMERC regarding this change, can be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3574. Click on the link to open and view the file for the CR.

If you have questions regarding this issue, you may also contact your carrier, fiscal intermediary, or DMERC at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

MMA Drug Pricing Update—Payment Limit For J0207 (Amifostine)

Medlearn Matters Article Number: MM3552

NOTE: This article is being published as informational only for services billable by physicians and local carrier providers. DMEPOS suppliers should refer to Medlearn Matters Article # MM3025, "MMA - New Basis for Medicare Payment Amounts for DMERC Drugs," regarding pricing for drugs billable to the DMERC.

Provider Types Affected

Physicians and providers billing Medicare carriers for Amifostine

Provider Action Needed

This article informs affected providers that Medicare will implement the Medicare Modernization Act of 2003 (MMA) payment limit for Amifostine (HCPCS drug code J0207) with the new rate listed in this article for dates of service starting April 1, 2004 through December 31, 2004.

Please note that this payment limit for Amifostine (J0207) supercedes the payment limit published in Change Request (CR) 3161, Transmittal 119, dated March 15, 2004, and any other publication published prior to this document.

Background

The MMA (Section 303(b)(2)) specifies that the Centers for Medicare & Medicaid Services (CMS) may adjust the percentage used in the calculation for pricing Medicare Part B drugs effective January 1, 2004 (based on data and information submitted by the manufacturer after October 15, 2003 and before January 1, 2004).

Therefore, based on information received by CMS, the payment limit for Amifostine (J0207) has been revised. From April 1, 2004 through December 31, 2004, the Medicare payment limit for the Healthcare Common Procedure Coding System (HCPCS) drug code J0207 applies when it is not paid on a cost or prospective payment basis. The old and revised payment limits are as follows:

Status	HCPCS	Short Description	Average Wholesale Price (AWP) %	2004 Payment Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)
OLD	J0207	Amifostine	85	$405.29
NEW	J0207	Amifostine	89	$422.21

Note that the absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug.

Implementation - The implementation date for the instruction is December 6, 2004.

Additional Information

To view the official instruction issued to your carrier regarding this change, go to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR3552 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

MMA Drugs Paid By Average Selling Price Beginning January 1, 2005

Medlearn Matters Article Number: MM3232

Note: This article was revised on December 16, 2004, to reflect revised effective and implementation dates. Related CR3232 was also re-issued on December 16 for the same purpose.

Provider Types Affected - Physicians, suppliers, and providers

Provider Action Needed - Physicians, suppliers, and providers should note that beginning January 1, 2005, the payment limit for Part B drugs and biologicals, not paid on a cost or prospective payment basis, will be paid based on the Average Sales Price (ASP) plus six (6) percent. Drugs will be paid based on date of service and the lower of:

1) The submitted charge; **or**
2) The ASP plus six (6) percent.

Background

According to the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA), beginning January 1, 2004 through December 31, 2004, drugs and biologicals not paid on a cost or prospective payment basis are paid based on various standards specified in the statute, although the default payment limit standard is 85 percent of Average Wholesale Price (AWP).

MM3232 notifies contractors (Part B Local Carriers and Durable Medical Equipment Carriers (DMERCs)) that the MMA mandates that drugs and biologicals not paid on a cost or prospective payment basis are to be paid based on the ASP beginning January 1, 2005.

Therefore, beginning January 1, 2005, the Centers for Medicare & Medicaid Services (CMS) will:

• Supply contractors with a drug payment limit file for drugs and biologicals; and
• Send quarterly updates of this file to contractors.

Payment will be based on:

• The lower of the submitted charge or the payment limit on this file; and
• The date-of-service.

Finally, contractors will:

• Develop payment limits when CMS does not supply a payment limit for the drug on the file;
• Continue to determine the payment limit for compounded drugs; and
• Continue to determine the payment limit for new drugs.

Implementation - The implementation date for this instruction is January 3, 2005.

Related Instructions

The *Medicare Internet Only Manual* (IOM) has been edited with revised and new sections to reflect changes implemented with this instruction. These revised and new sections include the following:

The *Medicare Claims Processing Manual (Pub. 100-4), Chapter 17 (Drugs and Biologicals)*:

• Section 10 (Payment Rules for Drugs and Biologicals) – **revised**
• Section 20 (Payment Allowance Limit for Drugs and Biologicals Not Paid on a Cost or Prospective Payment Basis) – **revised**
• Subsection 20.1 (MMA Drugs) - **new**

These revised and new sections of the *Medicare Claims Processing Manual* are included in the actual instruction (CR 3232) issued to your carrier or DMERC.

Additional Information

The official instruction issued to your carrier/DMERC regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3232 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

MMA - New Dispensing/Supply Fee Codes For Oral Anti-Cancer, Oral Anti-Emetic, Immunosuppressive, And Inhalation Drugs

Medlearn Matters Article Number: MM3620

Note: This article was revised on December 23, 2004 to show that the payment for code G0369 is a one time payment per beneficiary, per transplant. The article was also revised on December 29, 2004 to show that beneficiaries are required to pay the normal co-pay and deductible on both the drug and the dispensing/supply fee.

Provider Types Affected - Suppliers and pharmacies

Provider Action Needed

Impact to You - Effective January 1, 2005, Medicare will pay a supplying fee for immunosuppressive drugs, oral anti-cancer chemotherapeutic drugs, and oral anti-emetic drugs used as part of an anti-cancer chemotherapeutic regimen in accordance with Section 303(e)(2) of the Medicare Modernization Act (MMA). Medicare will provide a dispensing fee for inhalation drugs supplied through durable medical equipment in accordance with Section 305 of the MMA.

What You Need to Know - Please note the distinction between supply fee and dispensing fee: The supply fee

is for immunosuppressives, oral anti-cancer drugs, and oral anti-emetic drugs. The dispensing fee is for inhalation drugs furnished through durable medical equipment only. Also note that Medicare will not pay separately for compounding drugs because Medicare considers that cost as covered in the dispensing fees. Both the drug and the dispensing fee or the supply fee must be billed on the same claim. If the dispensing fee or supply fee is billed alone on the claim, it will be denied.

What You Need to Do - This affects pharmacies and suppliers who submit claims to a Medicare Durable Medical Equipment Regional Carrier (DMERC). To ensure accurate claims processing, review the information included here and stay current with instructions for Medicare dispensing/supply fees.

Background - Section 303(e) (2) and Section 305 of the MMA provide for:

• Supplying fees for immunosuppressive drugs, oral anti-cancer chemotherapeutic drugs, and oral antiemetic drugs used as part of an anti-cancer chemotherapeutic regimen; and
• Dispensing fees for inhalation drugs supplied through durable medical equipment.

The following table shows the codes to use in billing a DMERC and the payments that will be made by Medicare:

Code	Fee	Comments
G0370	$24	• G0370 applies to pharmacy supply fee for oral anti-cancer, oral anti-emetic, or immunosuppressive drug(s). • Effective January 1, 2005, Medicare will pay a supplying fee of $24 to a pharmacy *for each supplied prescription* of immunosuppressive drugs, oral anti-cancer drugs, and oral anti-emetic drugs.
G0369	$50	• G0369 applies to pharmacy supply fee for initial immunosuppressive drug(s) first month following transplant. • Effective January 1, 2005, Medicare will pay a supplying fee of $50 to a pharmacy *for the initial supplied prescription of immunosuppressive drugs to the patient during the first month following the transplant.* • This is a one-time payment per beneficiary, per transplant.
G0371	$57	• G0371 applies to pharmacy dispensing fee for inhalation drug(s), per 30 days. • Effective January 1, 2005, Medicare will pay a dispensing fee of $57 to a pharmacy *for a 30-day period of inhalation drugs furnished through DME regardless of the number of shipments or drugs dispensed during that time.* • Only one dispensing fee payment will be made for the 30-day supply. • Please note that Medicare includes the cost of compounding drugs in the dispensing fees.
G0374	$80	• G0374 applies to pharmacy dispensing fee for inhalation drug(s), per 90 days. • Effective January 1, 2005, Medicare will pay a dispensing fee of $80 to a pharmacy *for each dispensed 90-day period of inhalation drugs furnished through DME regardless of the number of shipments or drugs dispensed during that time.* • Only one dispensing fee payment will be made for the 90-day supply. • Please note Medicare includes the cost of compounding drugs in the dispensing fees.

Additional Information - Beneficiaries are required to pay the normal co-pay and deductible on both the drug and the supply/dispensing fee.

Also, remember that, based on the code descriptions, a supply fee and a dispensing fee is not appropriate for one drug, because the supply fee is for immunosuppressives, oral anti-cancer and oral anti-emetic drugs, whereas the dispensing fee is for inhalation drugs only. Also, remember that both the drug and the dispensing fee or supply fee

must be billed on the same claim. If the dispensing fee or supply fee is billed alone, it will be denied.

When billing using the National Council for Prescription Drug Programs (NCPDP) format, the dispensing fee for supply fee (not the code) must appear on the same line as the drug. More specifically, providers should place the $24 (G0370) supplying fee amount, the $57 (G0371) dispensing fee amount, or the $80 (G0374) dispensing fee amount in the Dispensing Fee Submitted field (field 412DC) on the pricing segment of the NCPDP claim.

For the $50 fee (G0369), providers should place $24 of the fee in the field 412DC and the remaining $26 in the Incentive Amount Submitted field (Field 438-E3). When billing a dispensing fee with a drug on the NCPDP claim, providers should bill only one drug per claim.

The official instruction issued to your DMERC regarding this change can be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above page, scroll down the CR NUM column on the right to find the link for CR 3620. Click on the link to open and view the file for the CR.

The online document also includes the revisions to *Medicare's Claims Processing Manual* resulting from this change.

If you have questions regarding this issue, you may contact your DMERC at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Number Of Drug Pricing Files That Must Be Maintained Online For Medicare By Durable Medical Equipment Regional Carriers (DMERCs)

Medlearn Matters Article Number: MM3584

Provider Types Affected - Durable Medical Equipment (DME) Suppliers that bill Medicare DMERCs

Provider Action Needed - None, this article is informational only.

Beginning January 1, 2005, the payment limit for Part B drugs and biologicals will be based on the Average Sales Price (ASP). Drugs will be paid based on either the lower of the submitted charge or the ASP and will continue to be priced based on date of service. To facilitate the implementation of this ASP pricing methodology, CR 3584, beginning on July 1, 2005, increases (to eight) the number of online fee screens/pricing files that DMERC systems must maintain in order to determine the amount to pay for fee-for-service drug claims. This increase will allow DMERCs to maintain 2 years of drug pricing files to facilitate the implementation of the ASP pricing methodology.

Additional Information - The official instruction issued to your DMERC can be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp From that web page, look for CR 3584 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

Revisions To January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File

Medlearn Matters Article Number: MM3695

Provider Types Affected - Providers who bill fiscal intermediaries and carriers (including DMERCs) for the affected drugs

Provider Action Needed

Impact to You - The Centers for Medicare & Medicaid Services (CMS) is replacing payment limits for the first quarter of 2005 for certain Medicare Part B drugs, effective January 1, 2005.

What You Need to Know - The revised payment limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. Please note that the related CR 3695 makes revisions to the earlier CR 3539 and that the revised payment limits in this notification supercede the payment limits for these codes in any publication published prior to this document.

What You Need to Do - To ensure accurate claims processing, please review the information included here and stay current with guidelines on Medicare Part B drugs and biologicals.

Background - Section 303(c) of the Medicare Modern-

ization Act (MMA) of 2003 revises the payment methodology for Part B covered drugs that are not paid on a cost or prospective payment basis. Effective January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the new Average Sale Price (ASP) drug payment methodology.

The ASP payment methodology is based on data submitted to CMS by manufacturers at the 11-digit National Drug Code (NDC) level. CMS uses published drug pricing compendia and other sources to identify the number of billable units per NDC.

Through receipt of additional data, CMS has determined that certain payment limits included in the first quarter of calendar year 2005 (1Q05) Medicare Part B Drug Pricing File require revision. The revised payment limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. The revised payment limits in this notification supercede the payment limits for these codes in any publication published prior to this document.

The affected drugs and the associated revised payment limits are contained in the following table.

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit
90747*	ENGERIX-B	40 MCG	$113.91	$113.91
J0835	Inj cosyntropin per 0.25 MG	0.25 MG	$64.60	$64.60
J1563	IV immune globulin	1 GRAM	$56.72	$56.72
J1564	Immune globulin 10 mg	10 MG	$0.57	$0.57
J1655	Tinzaparin sodium injection	1000 IU	$2.60	$2.60
J2324	Nesiritide	0.25 MG (revised)	$73.33	$73.33
J3315	Triptorelin pamoate	3.75 MG	$180.93	$180.93
J3470	Inj hyaluronidase	up to 150 units	$20.00	$20.00
J7030	Sodium Chloride	1000 CC	$0.10	$0.10
J7350	Injectable human tissue	10 MG	$4.53	$4.53
J7611	Albuterol concentrated form	1 MG	$0.07	$0.07
J8501	Oral aprepitant	5 MG	$4.62	$4.62
J9185	Fludarabine phosphate inj	50 MG	$272.09	$272.09
J9214	Intron-A	1 UNIT	$13.12	$13.12
Q0179	Zofran	8 MG	$30.86	$30.86
Q2014	Geref	0.5 MG	$8.77	$8.77

*The revised payment limit for 90747 is based on the pricing methodology for vaccines (95% AWP).

Note: The absence or presence of a HCPCS code and its associated payment limit in the ASP files does not indicate Medicare coverage of the drug or biological.

Additional Information - The official instruction issued regarding this change can be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above page, scroll down the CR NUM column on the right to find the link for CR 3695. Click on the link to open and view the file for the CR.

You may also refer to the earlier CR 3539 for additional background information – CR 3695 makes revisions to information provided in CR 3539.

If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll free number, which may be found at: http://www. cms.hhs.gov/medlearn/tollnums.asp

Revisions To January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File

Medlearn Matters Article Number: MM3728

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

Provider Action Needed

Impact to You - The Centers for Medicare & Medicaid Services (CMS) is revising certain payment limits included in the first quarter 2005 (1Q05) Medicare Part B Drug Pricing File used by Medicare carriers and intermediaries, including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs).

What You Need to Know - Medicare carriers and intermediaries, including DMERCs and RHHIs, will not apply these limits to claims already processed unless brought to their attention by the provider/supplier.

What You Need to Do - Medicare carriers and intermediaries, including DMERCs and RHHIs, will not apply these limits to claims already processed unless brought to their attention by the provider/supplier.

Background - According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005 drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the new Average Sales Price (ASP) method. The ASP method is based on data submitted to CMS by manufacturers at the 11-digit National Drug Code (NDC) level. CMS then determines the number of billable units per NDC based on published drug pricing information as well as other sources available to CMS.

Through receipt of additional information, CMS has determined certain payment limits in the 1Q05 Medicare Part B Drug Pricing File need revision. Tables 1 and 2 below identify the revised payment limits. The limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. The revised payment limits in this notification supersede the payment limits for these codes in any publication published prior to CR 3728.

Also, note that the ASP-based 1Q05 payment limit for J7510, Q4054, and Q4055 are now provided. The revised payment limit for 90740, a vaccine, is based on 95% of the average wholesale price (AWP). The revised payment limits for the blood clotting factor codes includes the $0.14 per I.U. furnishing fee. The payment limits in Table 2 are for certain new drugs.

Table 1

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit	1Q05 Vaccine Limit
90740	Hepb vacc, ill pat 3 dose im	3 DOSE SCH	$113.91	$113.91	$113.91
J7190*	Factor viii	I.U.	$0.66	$0.66	
J7191*	Factor viii (porcine)	I.U.	$1.86	$1.86	
J7192*	Factor viii recombinant	I.U.	$1.06	$1.06	
J7193*	Factor ix non-recombinant	I.U.	$0.89	$0.89	
J7194*	Factor ix complex	I.U.	$0.63	$0.63	
J7195*	Factor ix recombinant	I.U.	$0.98	$0.98	
J7197*	Amtithrombin iii injection	I.U.	$1.72	$1.72	
J7198*	Anti-inhibitor	I.U.	$1.23	$1.23	
J7510	Prednisone oral per 5 mg	5 MG	$0.05	$0.05	
Q0187*	Factor viia recombinant	1.2 MG	$1,051.45	$1,051.45	
Q2022*	Von Willebrand Factr Cmplx per IU	I.U.	$0.86	$0.86	
Q4054	Darbepoetin alfa, ESRD use	1MCG	$3.54	$3.54	
Q4055	Epoetin alfa, ESRD use	1,000 units	$9.32	$9.76	

* The ASP-based payment allowance limit for blood clotting factors and the furnishing fee for the blood clotting factors do not apply to inpatient claims.

Table 2

HCPCS	Drug Name	Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit	1Q05 Vaccine Limit
J3490	Pegaptamib sodium	0.3 MG	$1,054.70	$1,054.70	
J9999	Histrelin implant	5 MG	$530.00	$530.00	
J9999	Natalizumab	5 MG	$31.94	$31.94	

Note: The absence or presence of a HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug or biological.

Implementation - The implementation date is February 4, 2005.

Additional Information - The official instruction issued to your carrier/intermediary regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp From that web page, look for CR 3728 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 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

HCPCS UPDATES

New G Codes For Dispensing/Supply Fees For Oral Anticancer, Oral Antiemetic, Immunosuppressive, And Inhalation Drugs

Effective for dates of service on or after January 1, 2005, the following new HCPCS codes have been added for dispensing/supply fees.

G0369 PHARMACY SUPPLY FEE FOR INITIAL IMMUNOSUPPRESSIVE DRUG(S) FIRST MONTH FOLLOWING TRANSPLANT
G0370 PHARMACY SUPPLY FEE FOR ORAL ANTI-CANCER, ORAL ANTI-EMETIC OR IMMUNO-SUPPRESSIVE DRUG(S)
G0371 PHARMACY DISPENSING FEE FOR INHALATION DRUG(S); PER 30-DAYS
G0374 PHARMACY DISPENSING FEE FOR INHALATION DRUG(S); PER 90-DAYS

Please refer to the respective local coverage determinations for additional information on the coverage, coding and documentation for oral anticancer, oral antiemetic, immunosuppressive and inhalation drugs.

New K Codes For Lower Extremity Prosthesis

The following new HCPCS code has been added effective for dates of service on or after April 1, 2005.

K0670 ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR (S), ANY TYPE

Please refer to the Lower Limb Prostheses Local Coverage Determination for additional information on the coverage, coding and documentation for lower limb prostheses.

APPEALS

More Appeals Changes

In the past few years several changes in the Medicare Appeals process have been implemented as a result of the Benefits Improvement and Protection Act (BIPA) and the Medicare Modernization Act (MMA). The changes so far are:

- To request an ALJ hearing there must be at least $100 in controversy. This amount was lowered from the $500 previously required.
- The first level of appeal is now Redetermination instead of Review. The time frame for the Carrier to complete a redetermination is 60 days.
- With the implementation of the Redetermination came the Medicare Redetermination Notice (MRN). The MRNs provide more information about the decision in a more user friendly format.

As a result of the BIPA and MMA legislation you will likely see the following additional changes in the second half of 2005 and 2006:

- All redetermination requests must be in writing. Telephone requests will not be accepted.
- The first level of appeal for all overpayment requests will be Redetermination.
- The second level of appeal will be Reconsideration (previously Carrier Hearing). Reconsiderations will be conducted by a Qualified Independent Contractor (QIC).
- All evidence must be presented before the reconsideration is issued. Additional or new evidence may not be submitted at the ALJ level unless you can demonstrate good cause for withholding the evidence from the QIC.

More specific information and instructions will be provided as these changes are implemented.

ELECTRONIC DATA INTERCHANGE (EDI)

April 2005 Update Of Health Care Claims Status Codes And Health Care Claims Status Category Codes For Use With The Health Care Claim Status Request And Response ASC X12N 276/277

Medlearn Matters Article Number: MM3566

Provider Types Affected - Physicians, providers, and suppliers

Provider Action Needed

Physicians, providers, and suppliers should note that this article and related CR 3566 provide information regarding updates to the Health Care Claims Status Codes and Health Care Claims Status Category Codes for use in requesting information about the status of claims with the Health Care Claim Status Request and Response ASC X12N 276/277 transactions. Effective April 1, 2005, Medicare carriers and intermediaries will use codes with the “new as of June 2004” designation and prior dates.

Background

The Health Insurance Portability and Accountability Act (HIPAA) directs that all health care plans to use national standards for the transfer of certain health care data. HIPAA requires all payers to use the applicable health care claims status category codes and health care claim status codes of the American National Standards Institute (ANSI) American Standards Committee (ASC) X12N. Medicare carriers and intermediaries must periodically update their claims system with the most current health care claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277 transaction. These transactions are used by providers to inquire about the status of claims they have submitted and by health plans to reply to such inquiries.

Medicare contractors (carriers, Durable Medical Equipment Regional Carriers, intermediaries, and Regional Home Health Intermediaries) must update their claims systems to ensure that the current version of these codes is used in their claim status responses. By April

4, 2005, Medicare contractors are to use the "new as of June 2004" or a prior date designation. These codes may be found at: http://www.wpc-edi.com/codes/Codes.asp

Not all of the codes apply to Medicare. Thus, Medicare contractors are not required to accommodate codes that do not apply to Medicare in their 277 responses.

Note: Medicare contractors must comply with the requirements contained in the version 4010A1 ASC X12 276/277 IG and must use valid Health Care Claim Status Category Codes and Health Care Claim Status Codes when sending 277 responses.

Additional Information

The *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 31 (ANSI X12N Formats), Section 20 (ANSI X12N 276/277 Claims Status Request/Response Transaction Standard), Subsection 20.7, has been revised. The revised manual page(s) are attached to the official instruction released to your Medicare carrier/intermediary. You may view that instruction at: http://www.cms.hhs.gov/manuals/pm_trans/R406CP.pdf

For additional information on claims status codes and claims status category codes, you may also refer to Medlearn Matters article MM3361, which is available at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3361.pdf

The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes found at: http://www.wpc-edi.com/codes/codes.asp

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

Carrier And DMERC 835 Flat File Change And Replacement Of Deactivated Reason Code A2

Medlearn Matters Article Number: MM3236

Note: This article was revised on December 6, 2004, to show that the deactivation of Reason Code A2 also applies to Medicare carriers.

Provider Types Affected - All providers who submit claims to Medicare carriers, including durable medical equipment regional carriers (DMERCs)

Provider Action Needed

Impact to You - This one-time notification informs you of the Deactivation of Reason Code A2 for carriers and DMERCs.

What You Need to Know - Providers should be aware of the flat file change and the deactivated reason code.

What You Need to Do - Be aware that Reason Code A2 is being replaced by Reason Code 121 (Indemnification Adjustment) as of January 3, 2005.

Background

CR 2657 has changed the 835 flat file for carriers and DMERCs to accommodate quantity in metric units, which may have up to seven numeric positions and up to three decimal points. The updated flat file is posted at: http://www.cms.hhs.gov/providers/edi/hipaadoc.asp

In addition, as noted above and effective as of January 1, 2005, Reason Code A2 will be replaced by Reason Code 121 (Indemnification Adjustment) on remittance advices.

Additional Information

The official instruction released to your carrier or DMERC may be found at: http://www.cms.hhs.gov/manuals/pm_trans/R103OTN.pdf

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

Guidance Regarding Elimination Of Standard Paper Remittance (SPR) Advice Notices In The Old Format

Medlearn Matters Article Number: SE0451

Note: This article was revised on November 19, 2004, to correct a typographical error in the third line of the Background section. Specifically, the phrase "date elements" was corrected to read "data elements."

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

Provider Action Needed - Be advised that only the most recent version of the Standard Paper Remittance (SPR) Advices will be used. The 835 version 4010A1 flat file is the appropriate format to produce SPRs. Also, no data may be included in paper remittance advices that are not included in an Electronic Remittance Advice (ERA).

Background

The Centers for Medicare & Medicaid Services (CMS) prohibits the inclusion of data in paper remittance advice notices that is not included in the ERA transactions. The most recent version of the SPR Advice and the ERA contain the same information in the comparable fields and data elements, including the same codes. The same flat file should be used to produce both the SPR and 835 version 4010A1 ERA.

CMS has issued a memorandum to all Medicare carriers and fiscal intermediaries, including Durable Medical Equipment Carriers (DMERCs) and Regional Home Health Intermediaries (RHHIs), stating that effective January 1, 2005, only the 835 version 4010A1 flat file is to be used to produce the SPRs; no other format for SPRs will be used.

Additional Information

Refer to Chapter 22 of the *Medicare Claims Processing Manual*, Publication 100-4, which can be found online at: http://www.cms.hhs.gov/manuals/104_claims/clm104c22.pdf.

Additional information regarding the Fiscal Intermediary Part A 835 flat file, including a sample of the most recent SPR format, is available in CR 3344. You may view that CR at: http://www.cms.hhs.gov/manuals/pm_trans/R252CP.pdf.

If you have any questions regarding receipt of or conversion to ERAs, please contact your carrier/intermediary. If you bill an intermediary, their number may be found at: http://www.cms.hhs.gov/providers/edi/anum.asp.

If you bill a carrier, their number may be found at: http://www.cms.hhs.gov/providers/edi/bnum.asp.

Elimination Of Paper Remittance Notices

Effective April 1, 2005, Region D DMERC will discontinue printing and mailing Medicare Remittance Notices to suppliers that are receiving Electronic Remittance Notices (ERNs) and are also utilizing Electronic Funds Transfer (EFT). If you need a paper copy of a Medicare Remittance Notice you may use the Interactive Voice Response (IVR) at 1.877.320.0390 to request one as needed. A paper copy will be mailed to you within three business days.

Please note this only applies to suppliers signed up for ERNs ***and*** EFT. We encourage all electronic submitters to utilize both our ERN option and to sign up for EFT. These options greatly reduce the amount of paper that your office will receive and increases the speed in which you will receive payment. You can sign up for these options by going to www.cignamedicare.com/eft and http://www.cignamedicare.com/edi/dmerc/forms.html for the customer profile.

New ANSI And NCPDP Edits Effective In April

Effective April 4, 2005, new Medicare claims processing edits will be put into production to reject inbound ANSI and NCPDP claims with invalid diagnosis codes. If the diagnosis codes are not effective on the FROM date of service billed, the claim will be rejected. This change will also affect claims that have diagnosis codes listed but not referenced to by any of the claim lines. For non-referenced to diagnosis codes on the claim, the claims processing system will take the earliest from date and latest from date listed on the claim and if the effective date of that non-referenced to diagnosis code falls outside of that range, the claim will be rejected.

HIPAA

Health Care Eligibility/Benefit Inquiry And Response

• The Centers for Medicare & Medicaid Services (CMS) has been working with its Medicare Fee-for-Service (FFS) Claims Processing Contractors to determine how to handle high volumes of X12 270/271 Health Insurance Portability and Accountability Act (HIPAA) transactions. The initial Medicare implementation of the HIPAA version of the 270/271 transactions will provide beneficiary eligibility information on a real time basis.

• Provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), present many new challenges for Medicare to provide improved access to information and better overall quality service.

• The CMS is making changes to its Information Technology (IT) infrastructure to address these needs. This new enterprise approach creates the necessary database and infrastructure to meet eligibility query capability for all customers and communications channels. These changes will not only satisfy the current demand for a fully functioning HIPAA compliant 270/271 eligibility transaction for FFS providers/submitters, but also over time will support a national provider telephone interactive voice response (IVR) as well as Internet eligibility queries.

- The new approach will be phased in starting May 2005. The CMS plans to begin testing with a limited number of vendors in early 2005.
- Under the HIPAA Contingency Plan announced September 23, 2003, Medicare will continue to provide eligibility information via current methods.

HIPAA 270/271 Q's and A's

Q1: When will the new infrastructure be available?

A1: It is expected to be available for use in May 2005. Initially the infrastructure will support HIPAA compliant 270/271 eligibility transactions in May 2005. Over time, CMS will make the infrastructure available for IVR and Internet eligibility inquiries.

Q2: Wasn't a HIPAA compliant 270/271 required in October 2003?

A2: Covered Entities (CE) were generally required to comply with HIPAA Transaction Standards, including 270/271, by October 16, 2003. The CEs have been permitted to adopt contingency plans, however, while they work toward full compliance with the Transaction Standards. The CMS' initial programming and system testing at multiple contractors revealed that the high volume of anticipated 270/271 transactions could create difficulties in handling these new queries and completing claims processing cycles. It was determined that a different architecture was necessary to process 270/271 for Medicare FFS customers. The updates to the system architecture will also serve to enable implementation of certain data requirements in the recently enacted Medicare prescriptions drug legislation. Until the new system is ready, CMS will continue to operate under its HIPAA Contingency Plan with respect to the 270/271 transaction.

Q3: Does CMS have plans to allow usage of the Internet for 270/271 transactions?

A3: Yes, we anticipate that we will allow usage of the Internet for 270/271 transactions; however; we will first concentrate on establishing a functional transaction via the Medicare Data Communication Network (MDCN).

Q4: How can providers/submitters get eligibility information until this infrastructure is available?

A4: Medicare will continue to provide eligibility information via legacy systems under its HIPAA Contingency Plan announced September 23, 2003. Providers/Submitters can continue to use current electronic queries, telephone IVR, and other methods currently offered by their local Medicare Carriers and Fiscal Intermediaries (FI) to obtain eligibility information. Medicare will continue to maintain these sources of eligibility data. Medicare contractors have also been notified that they should continue to give new providers and submitters access to eligibility data via these legacy systems and methods until notified that the 270/271 is approved for use.

Q5: How can providers/submitters obtain additional information concerning use of the 270/271 and eventual Internet access?

A5: Although the new infrastructure that will support the 270/271 for Medicare will use a central national Medicare eligibility database, and processing of these queries will bypass the current carriers, durable medical equipment regional carriers (DMERC), and FIs, Medicare plans to continue to use the provider newsletters and Web sites of the carriers, DMERCs and FIs to share information on availability, enrollment, Internet use, and other pertinent information about the 270/271.

Q6: Medicare has always supported batch transactions in the past. Will Medicare accept batch 270 queries as well as real-time queries?

A 6: The CMS plans to begin to accept batch 270 transactions in a later phase of implementation and will share information about that as soon as it is available.

Q7: Will Medicare furnish free software for use of the 270/271 by small providers?

A7: Medicare's Internet implementation of the 270/271 will include an interactive screen that can be used by providers to individually enter eligibility queries and receive real-time responses. Providers will not need to load 270/271 software on their Personal Computers (PCs) to submit 270 transactions or receive easy to read responses.

Q8: I already have 270/271 software as part of a suite of HIPAA software I purchased. Will I be able to use that software to automatically generate my 270s and submit them via the Internet?

A8: Yes. When available, our Internet system will be able to accept single, already formatted 270 compliant transactions in addition to those submitted via our eligibility screen.

Q9: Will clearinghouses be required to use the CMS' AT&T Global Network Service (AGNS)/MDCN intranet to submit 270 queries or will they also be allowed to use the Internet to submit and receive these queries?

A9: In May 2005, a small group of clearinghouses will initially be allowed to access the new system via the AGNS/MDCN network to assist us to validate performance. Upon satisfactory performance, other clearinghouses and providers that have accounts with AT&T resellers that would allow them to access the CMS' AGNS/MDCN communication network will also be permitted to submit 270s via that intranet. Once Internet access is available, users of the intranet will have the option to continue to use that access path, or to transfer to use of the Internet.

Q10: This is the first time CMS has supported Internet use for a HIPAA transaction. Will CMS begin to offer Internet access for other HIPAA transactions also?

A10: The CMS does plan to allow greater use of the Internet for multiple purposes. In addition to this 270/271 effort, several pilots are in place using the Internet to obtain claim status and other information. These pilots will assist us in expanding Internet services nationally.

MEDICARE SECONDARY PAYER (MSP)

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, Chapter 3, § 20.2.1, has been updated. Question 6 under Part VI – ESRD has been changed to reflect the appropriate follow up question.

This questionnaire may be used to help determine if Medicare is the primary or secondary payer. If no MSP data are found in the Common Working File (CWF) for the beneficiary, the provider still asks the questions found in § 20.1 and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process. Refer to **Appendix 2** at the back of this newsletter for the MSP Questionnaire.

MISCELLANEOUS

CMS Seeks Provider Input On Satisfaction With Medicare Fee For Service Contractor Services

Medlearn Matters Article Number: SE0513

Provider Types Affected - A sample of 8,200 (or 2 percent of) Medicare providers served by 12 Medicare Fee-for-Service contractors (carriers and fiscal intermediaries), including hospitals, Skilled Nursing Facilities (SNFs), rural health clinics, home health clinics, End-Stage Renal Disease (ESRD) facilities, physicians, non-physicians, Durable Medical Equipment (DME) suppliers, and ambulance service providers

Provider Action Needed

Impact to You - The Centers for Medicare & Medicaid Services (CMS) would like to provide a channel for you to voice your opinions about the services you receive from your Medicare Fee-for-Service (FFS) contractors (carriers and fiscal intermediaries, including Durable Medical Equipment Regional Carriers (DMERCs) and regional home health intermediaries (RHHIs)). The Medicare Contractor Provider Satisfaction Survey (MCPSS) will be CMS's initial effort to use provider satisfaction as a standard of measurement to evaluate our FFS contractors' performance.

CMS values the opinions of the Medicare physician and provider community and understands the important role that FFS contractors play in representing the Medicare program to providers. The MCPSS represents an important opportunity for you to be heard.

What You Need to Know - The first year of the MCPSS is a pilot. CMS has selected 12 FFS contractors to participate in the pilot: 4 Fiscal Intermediaries (FIs): AdminaStar Federal, Noridian Administrative Services L.L.C., Riverbend GBA, and Empire Medicare Services; 4 Carriers: National Heritage Insurance Company (NHIC), Wisconsin Physician Services (WPS), TrailBlazer Health, and Empire Medicare Services; 2 Durable Medical Equipment Regional Carriers (DMERCs): Health Now New York and AdminaStar Federal; and 2 Regional Home Health Intermediaries

(RHHIs): Palmetto GBA and Anthem Health Plans of Maine. A random sample of 8,200 providers (approximately 2% of providers) served by these twelve FFS contractors have been selected to participate in the pilot. If you have been selected, you should have received a notification packet with background information about the pilot, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet web site. The letter also includes a phone number that you can call to request a paper copy of the survey instrument to submit your responses by mail or fax, if you prefer to do so.

What You Need to Do - Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the time to complete and submit your survey responses as soon as possible. The data collection period for the pilot will continue through the end of March.

Background

On January 17, 2005, CMS launched a pilot of the MCPSS. The survey will give providers the opportunity to rate their Medicare contractor on seven administrative functions: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider reimbursement.

The survey contains a total of 76 questions and takes approximately 22 minutes to complete. Sampled providers will be able to access the survey on a secure Internet web site or may request a paper copy of the survey and submit via mail or fax. Data collection for the pilot will continue through March 2005.

CMS will use the results of the pilot to evaluate and refine the survey instrument, data collection procedures, analysis, and reporting of results for the national survey implementation. The results of the pilot will not be used to evaluate the Medicare contractors' performance. In the future, CMS plans to use the MCPSS to support and assist contractors in using provider feedback to identify and implement "best practices" and quality or process improvement initiatives.

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

Additional Information

For questions or additional information about the MCPSS, please visit: http://www.cms.hhs.gov/providers/mcpss/default.asp

Correction To January 2005 Annual Update Of HCPCS Codes Used For Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

Medlearn Matters Article Number: MM3613

Provider Types Affected - Skilled Nursing Facility (SNF) and ambulance suppliers billing Medicare carriers or intermediaries for patients in a SNF stay

Provider Action Needed

Impact to You - Transmittal 360 (CR 3542) of the *Medicare Claims Processing Manual* (published on November 5, 2004) was the 2005 Skilled Nursing Facility annual update. CR 3613 provides a correction to the annual SNF CB update for calendar year 2005 by adding one code under Major Category I.H. (Ambulance Services) that was inadvertently omitted, namely A0999 – unlisted ambulance service.

What You Need to Know - HCPCS 53660, 95974, and G0168 had been reported twice in Major Category I.F. – this duplication of codes has also been corrected.

What You Need to Do - To ensure accurate claims processing, please review the information included here and stay current with instructions for SNF CB.

Additional Information - The official instruction issued regarding this change can be found at: http://www.cms.hhs.gov/manuals/pm_trans/R421CP.pdf. If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

The Centers For Medicare & Medicaid Services (CMS) Consolidation Of The Claims Crossover Process

Medlearn Matters Article Number: SE0504

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

Provider Action Needed - Physicians, providers, and suppliers should note that this special edition article is

to inform you of system changes to implement a switch from 1) Medicare intermediaries, carriers, and Durable Medical Equipment Regional Carriers (DMERCs) crossing supplemental claims to supplemental insurers to 2) a single entity, the Coordination of Benefits Contractor (COBC), doing the same from one location.

Background

The Centers for Medicare & Medicaid Services (CMS) is consolidating the Medicare claims crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA) initiative.

Currently, **supplemental payers/insurers** (including eligibility-file-based Medigap, Medicaid and employer plans) **must sign multiple crossover agreements** with Part A intermediaries and Part B carriers and Durable Medical Equipment Regional Carriers (DMERCs) to accomplish an automatic, or eligibility-file based, crossover to other insurers that pay after Medicare has made its payment decision on a claim.

In the future (under the new consolidated claims crossover process) **supplemental payers/insurers will sign one national crossover agreement** and work directly with the COBC (which represents CMS).

The supplemental payer/insurer will:

• Send eligibility files to identify its covered members, and
• Receive outbound HIPAA ANSI X-12N 837 Coordination of Benefits (COB) claims and National Council for Prescription Drug Programs (NCPDP) claims for use in calculating their secondary payment liability. On July 6, 2004, CMS began testing the consolidated crossover process with approximately ten supplemental payers/insurers.
Note the following:
• Testing is focused on the outbound HIPAA ANSI X-12 837N COB claims that are translated from
Medicare's Part A intermediary, Part B carrier, and DMERC processed claims.
• Initial -implementation will take place after successful testing is completed, and the 10 supplemental payers/insurers will be moved to full COBA crossover production through one entity, the COBC.
• Throughout the course of fiscal year 2005, CMS will begin transitioning all supplemental payers/insurers from the existing eligibility file-based crossover process to the national COBA process. Detailed requirements for 1) eligibility file-based crossover and 2) claim-based (mandatory Medigap) crossover were previously issued by CMS in Change Request (CR) 3109 (Transmittal 98), and CMS subsequently issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. Transmittal 138 may be accessed at: http://www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf

CR 3218 (Transmittal 138) provided:

• Major changes to many of the requirements previously published in CR 3109 (Transmittal 98) and
• Moved the implementation of claim-based crossover to a future date

Physician, Provider, and Supplier Action

NOTE: Physicians, providers, and suppliers will not need to take any new actions with respect to the COBA automatic (or eligibility-file-based) crossover process.

The key difference between the existing automatic crossover process and the new COBA automatic crossover process is that, when a supplemental payer/insurer provides CMS with specific claim types and member information for those claims they wish to receive, **the claims will be crossed over to the supplemental payers/insurers only after the claims have left the Medicare claims payment floor.**

Thus, **physician, provider, and supplier offices should receive payment and/or processing information** from a patient's supplemental payer/insurer **after the Medicare payment has been received** (once the supplemental payer/insurer has transitioned to the COBA crossover process).

Physicians, providers, and suppliers will be able to reference a listing of eligibility file-based COBA trading partners on the COBA portion of the following CMS COB web site as supplemental payers/insurers are scheduled to move to full eligibility-file-based crossover production under the COBC: http://www.cms.hhs.gov/medicare/cob/coba/coba.asp. (This listing is not currently available but will be available after supplemental payers/insurers have moved to full production with the COBC.)

Physicians, providers, and suppliers should note that the following important information will require your attention when a supplemental payer/insurer 1) has transitioned to the COBA eligibility-file-based crossover process and 2) is listed on the web site noted in the previous paragraph.

• Although the claim may cross to multiple supplemen-

tal payers/insurers, only one will print on your remittance advice. In this situation, if one of the supplemental payers/insurers is Medigap, the Medigap insurer will always print.
• Since payment from the supplemental payer/insurer should occur only after the Medicare payment has been issued, it is advised that you do not bill the supplemental payer/insurer for a minimum of 15 work days after receiving the Medicare payment. This will allow sufficient time for the claim to cross to the supplemental payer/insurer and the subsequent actions necessary to issue payment from the supplemental payer/insurer.
• In addition, prior to submitting a claim to the supplemental payer/insurer, it is advised that you use available self-service tools to research the status of your supplemental payment, e.g., the supplemental payer/insurer's website, claims automated "hot line," etc.
• There may be situations (such as claim errors related to HIPAA) that prevent the automatic crossover from occurring after you have received a Medicare remittance advice (electronic or supplemental paper) notifying you that the claim has crossed to the supplemental payer/insurer.
• Again, it is advised that you allow a minimum of 15 work days after Medicare payment has been issued before billing the supplemental payer/insurer to ensure that an automatic supplemental payment will not be issued. In addition, it is advised that you use the self-service tools of the supplemental payer/insurer to research the status of your supplemental claim prior to submitting it for supplemental payment.
• As a reminder, only the "official" Medicare remittance advice or HIPAA 835 Electronic Remittance Advice should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:
• You are billing the supplemental payer/insurer after the 15 work days from the Medicare- issued payment have expired, and
• You have used the available self-service tools to research the status of your supplemental payment.

Special Note for Physicians and Suppliers

Currently, Part B carriers and DMERCs assign identification numbers (known as In-key or OCNA numbers) to Medigap insurers that do **not** participate in the automatic, or eligibility-file-based, crossover process.

There are no current changes to this process and no current action is required of physicians, providers, and suppliers to change internal procedures related to Medigap claim-based crossovers.

Participating physicians and suppliers that bill Part B carriers and DMERCs for claim-based crossover will be informed approximately 90 days prior to implementing any changes to the claim-based crossover process. CMS expects this method of crossover to decrease sharply under the consolidated COBA crossover process, since most Medigap insurers will now have a single entity to which they can submit eligibility files to identify their covered members.

Related Instructions

On April 9, 2004, CMS issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. CR 3218 (Transmittal 138), may be viewed at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3218 in the CR NUM column on the right, and click on the file for that CR.

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

The Centers For Medicare & Medicaid Services (CMS) Doctors' Office Quality Information Technology Demonstrations: Providing Leadership In The Adoption Of Electronic Health Records

Medlearn Matters Article Number: SE0505

Provider Types Affected - All Providers

Impact on Providers - This article is informational only.

Background - Recent studies have highlighted the potential for Healthcare Information Technology (HIT) to improve the quality, safety, and efficiency of healthcare. Systems that enhance patient-clinician communication, access to patient information, as well as decision support and reference data hold the promise of improving the efficiency and effectiveness of healthcare delivery. Additionally, enhanced HIT infrastructure allows the implementation of improved tracking and surveillance applications, which are important in battling emerging

public health threats. The Medicare Modernization Act of 2003 encourages the use of HIT to manage the clinical care of beneficiaries.

Furthermore, there is great interest in the integration of HIT in healthcare systems by patients, payers, and health policy leaders alike. A recent Institute of Medicine (IOM) report, *Fostering Rapid Advances in Health*, called for significant reforms in the practice and organization of medicine and recommended that the U.S. Department of Health & Human Services (DHHS) undertake a number of demonstration projects to stimulate innovation in the adoption of HIT systems in healthcare.

Despite this momentum, physician offices remain largely unengaged in terms of their adoption and use of e-health technologies. Given that the bulk of patient care is provided in ambulatory settings, the lack of HIT integration precludes potentially significant improvements in quality and efficiency in the delivery of healthcare. Through its role as a major payer of healthcare services and sponsor of both the largest national quality improvement program in the Nation, and innovative disease management demonstrations, CMS is actively engaged in fostering IT integration in the Nation's health care system.

The CMS Doctors' Office Quality Information Technology (DOQ-IT) is a major project created to promote Electronic Health Records (EHR) in ambulatory care. This two-year Special Study demonstration is designed to improve quality of care, patient safety, and efficiency for services provided to Medicare beneficiaries by promoting the adoption of Electronic Medical Records (EMR)/ Electronic Health Records (EHR) and HIT in primary care physician offices. This demonstration involves 4 states: California, Arkansas, Massachusetts and Utah. Lumetra, the California Quality Improvement Organization (QIO), is the lead Medicare QIO and is coordinating the effort through the QIO program in the other three states.

The information gained from DOQ-IT will be used solely for the purposes of disseminating the use of HIT, and studying the role of HIT in improving healthcare delivery in the ambulatory setting. DOQ-IT will not be merged with any enforcement or program integrity efforts.

Additional Information

For additional information please see http://www.doqit.org or contact James Sorace MD at jsorace@cms.hhs.gov.

MMA – The Centers For Medicare & Medicaid Services (CMS) Recovery Audit Contract (RAC) Initiative

Medlearn Matters Article Number: SE0469

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 have been selected for pilot RACs that will begin during the first part of 2005 and 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 1) identifying underpayments and overpayments, and 2) 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).

A small percentage of claims (< 5 percent) are examined during medical review of claims performed by the MACs, and in annual studies of the Medicare program, claims payment error rates of between 6 percent and 10 percent have been identified. It is further estimated that in the last two fiscal years, billions of dollars have been inappropriately paid out by Medicare. There is growing concern that the Medicare Trust Funds may not be adequately protected against erroneous payment through current administrative procedures.

This pilot program is designed to determine whether the use of RACs will be a cost-effective means of adding resources to ensure correct payments are being made to providers. Contractors selected for this pilot program

will identify and collect Medicare claims overpayments that were not previously identified by the MACs. To accomplish this, the following is planned:

• There will be RACs for both Medicare Secondary Payer (MSP) and non-MSP claims and activity.
• Compensation for RACs will be provided through retention of a percentage of the overpayment recoveries.

The following provides additional details about the RACs pilot program:

• Claims reviewed by RACs will have been submitted to the carriers/intermediaries at least a year before to ensure that the ordinary processing will have been completed.
• RACs will 1) perform data analysis to identify areas of investigation, and 2) request claims history information from the carriers/intermediaries.
• Non-MSP RACs will identify and recover claims overpayments only. They will not be permitted to establish cost report overpayments.
• RACs will apply national coverage policies and Local Coverage Determinations (LCDs) that have been approved by the MACs.
• The collection policies to be applied by this pilot will be the same as those currently in effect for the carriers/intermediaries, including assessment of interest on the portion of any debt that is unpaid 30 days after issuance of the demand letter.
• No new policy will be applied. In addition:

  • Providers will be permitted to appeal any negative determinations to their MAC; and
  • If underpayments are determined; the information will be forwarded to the MACs for processing and payment.

CMS selected the following three states with the largest Medicare benefit payment amounts as the pilot states for the Recovery Audit Contracts:

• California
• Florida
• New York

CMS released a Request for Proposal (RFP) to interested qualified bidders and expects the contractor selections to be made in the beginning of 2005. It is expected that RACs will start work in May of 2005, and the duration of the pilot contracts will be three years.

Each of the three pilot states will have 1) one contractor for non-MSP claims overpayment recovery and 2) another (or possibly the same) contractor for MSP recoveries. To avoid a conflict of interest, current Medicare contractors are not eligible to bid on these contracts.

A complete evaluation of the pilot program will be made before extending it in the three designated states or to additional states.

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

Find out more about the Medicare Prescription Drug and Modernization Act of 2003 (MMA) at the following CMS web site: http://www.cms.hhs.gov/medicarereform/

In addition, Section 306 was taken from the MMA and is provided below:

House Rpt.108-181 - PROVIDING FOR CONSIDERATION OF H.R. 1, THE MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003, AND H.R. 2596, HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

SEC. 306. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL- The Secretary shall conduct a demonstration project under this section (in this section referred to as the 'project') to demonstrate the use of recovery audit contractors 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 B of title XVIII of the Social Security Act. Under the project-

(1) Payment may be made to such a contractor on a contingent basis;
(2) Such percentage as the Secretary may specify of the amount recovered shall be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and
(3) The Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION -

(1) SCOPE- The project shall cover at least 2 States

that are among the States with-

(A) The highest per capita utilization rates of Medicare services, and
(B) At least 3 contractors.

(2) DURATION - The project shall last for not longer than 3 years.

(c) WAIVER - The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS-

(1) IN GENERAL- The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has the appropriate clinical knowledge of and experience with the payment rules and regulations under the Medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS- The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY- In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, or under the Medicaid program under Title XIX of the Social Security Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD- A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT- The Secretary shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the Medicare program and recommendations on the cost-effectiveness of extending or expanding the project information means information about a conviction for a relevant crime or a finding of patient or resident abuse.

How To Locate Specific Transmittals/Change Requests (CRs) Of Interest That Are Posted On Centers for Medicare & Medicaid Services (CMS) Web Sites

Medlearn Matters Article Number: SE0506

Provider Types Affected - All Medicare physicians, providers, suppliers, and others who use the Medlearn Matters Articles and Related Change Request Information

Provider Action Needed - This Special Edition article has been written to assist physicians, providers, and suppliers in locating specific Change Requests of interest that CMS has issued and posted on its web site.

Background - CMS Program Transmittals/Change Requests (CRs) are used to communicate new or changed policies, and/or procedures that are being incorporated into a specific CMS program manual, and Medlearn Matters articles are written about selected CMS Transmittals/Change Requests to assist providers in understanding these transmittals. Each Medlearn Matters article usually has a section included at the end of the article titled *Additional Information* that includes a variation of the following statement:

For complete details (regarding this Change Request XXXX), please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

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

Note: The above web site **includes Transmittals/CRs issued for the current** year. Therefore, starting in January 2005, the above web site includes only those Transmittals/CRs with communication (comm.) release dates during calendar year 2005. However, if you scroll down to the end of the above web site page, you will find options for being redirected to web sites for Transmittals/

CRs issued in previous years (2000 through 2004). An abbreviated copy/view of the above CMS web site screen is shown below:

Medicare & Medicaid
2005 Program Transmittals/Program Memos
Table of Contents

SIZE	FILE	COMM DATE	MANUAL	SUBJECT	IMPLEMENTATION DATE	CR NUM
51 kb	R425CP	01/11/2005	PUB 100-04	Section 630 of the …	04/03/2005	3521
168 kb	R423CP	01/06/2005	PUB 100-04	Jan 2005 update of the ….	01/14/2005	3632

The files listed above are **PDF (Portable Document Format) files. In the past the transmittal cover page was all we were able to put on the Internet. PDF format enables us to put the entire transmittal on the Internet. You can view and print PDF files exactly as they were originally printed in paper form. To view these documents, you must have the Adobe Acrobat Reader, which can be downloaded at no cost at: Adobe Reader–Download http://www.adobe.com/products/acrobat/readstep2.html

2004 Transmittals | 2003 Transmittals | 2002 Transmittals | 2001 Transmittals

Accessing CRs released prior to January 1, 2005

If you want to review a Transmittal/CR with a release date in a previous year, you can select the desired year, and you will be redirected to one of the following web sites:

- 2004 - http://www.cms.hhs.gov/manuals/pm_trans/2004/transmittals/comm_date_dsc.asp
- 2003 - http://www.cms.hhs.gov/manuals/pm_trans/2003/transmittals/comm_date_dsc.asp
- 2002 - http://www.cms.hhs.gov/manuals/pm_trans/2002/transmittals/comm_date_dsc.asp
- 2001 - http://www.cms.hhs.gov/manuals/pm_trans/2001/transmittals/comm_date_dsc.asp
- 2000 - http://www.cms.hhs.gov/manuals/pm_trans/2000/transmittals/comm_date_dsc.asp

Once you have accessed the desired Transmittal/CR website, you can **sort** the Table of Contents (example shown above) by clicking your mouse on any column heading. To reverse the order of the sort for that column, click on the sort order icon (or). For some users, once you have accessed the desired Transmittal/CR web site, type Ctrl F (i.e., hold down the Control (Ctrl) key first, then press the 'f' key), and a 'Find' box will appear. Type the desired CR number in the 'Find What?' box, press the enter key, and you will be taken directly to the CR of interest which will be highlighted.

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

Provider Enrollment Fraud Alert

This is to inform you that Medicare is aware of an organized group who is representing themselves as either a Medicare Fraud Investigator; or a Medicare employee from the enrollment, claims or audit units. These callers tell the physician, or office personnel, that the Medicare computer system has had a malfunction and they need to update lost information. The callers may also say they need to update the physician's provider record. They then request via telephone or fax the following information:

- Copy of Physician's Drivers License;
- Copy of Physician's Social Security Number (SSN);
- Unique Physician Identification Number (UPIN);

- Verification of education;
- Verification of Practice Location;
- Copy of Physician's Medical License;
- Copy of Patient's Charts for a specific period of time.

Once the entity receives this information, they falsify enrollment data using the physician's name and request a change to their practice locations, telephone numbers, and pay-to-addresses.

The Centers for Medicare & Medicaid Services (CMS) has not suffered any computer system malfunction and are not calling providers requesting the above information be provided. If you should receive such a call, please try to verify the telephone number of the caller, and immediately notify your Medicare carrier that you suspect fraud.

The CMS is committed to protecting all Medicare providers/suppliers and to ensuring that only those qualified make changes to enrollment data. We believe that with your help we can target those unscrupulous individuals that are looking to take advantage of you and the Medicare trust fund.

Interest Payment On Clean Claims Not Paid Timely

Medlearn Matters Article Number: MM3557

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

Provider Action Needed

Physicians, providers, and suppliers should note that this article clarifies information relating to the calculation of interest due on claims not paid in a timely manner by Medicare.

Background

The *Medicare Claims Processing Manual* (Pub, 100-04, Chapter 1, Section 80.2.2) provides instructions for assessing and calculating interest due on non-periodic interim payment (PIP) claims not paid in a timely manner by fiscal intermediaries (FIs) and carriers. It states the following:

• Interest is required to be paid for clean claims not paid within 30 days after the day of receipt of a claim.

• Interest accrues until and including the day of late payment.

Related CR 3557 corrects Chapter 1, Section 80.2.2 of the *Medicare Claims Processing Manual*. For your convenience, the following revised language from Section 80.2.2 is provided with revisions in red (bold and italicized): "Interest must be paid on clean claims if payment is not made within the applicable number of calendar days *(i.e., 30 days)* after the date of receipt as described above. The applicable number of days is also known as the payment ceiling. For example, a clean claim received on October 1, 1993, must have been paid before the end of business on October 31, 1993. Interest is not paid on:

• Claims requiring external investigation or development by the provider's FI ***or carrier;***

• Claims on which no payment is due;

• Full denials;

• Claims for which the provider is receiving PIP; or

• Home Health Prospective Payment System (HH PPS) Requests for Anticipated Payment (RAPs).

Interest is paid on a per bill basis at the time of payment. Interest is paid at the rate used for §3902(a) of title 3l, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the applicable rate on the day of payment. This rate is determined by the Treasury Department on a 6-month basis, effective every January and July 1. For the correct rate, providers may access the Treasury Department web page http://www.publicdebt.treas.gov/opd/opdprmt2.htm for the correct rate. Also, the carrier or FI notifies the provider of any changes to this rate.

Interest is calculated using the following formula:

Payment amount x rate x days divided by 365 (366 in a leap year) = interest payment

The interest period begins on the day after payment is due and ends on the day of payment. Note that the example below is for one 6-month period in which the interest rate was 5.625 percent.

Milestones	Clean Paper Claim (in calendar days)	Clean Electronic Claim (in calendar days)
Date Received	November 1, 20001	November 1, 2001
Payment Due	*December 1, 2001*	*December 1, 2001*
Payment Made	December 4, 2001	December 4, 2001
Interest Begins	December 2, 2001	December 2, 2001
Days for Which Interest is Due	*3*	*3*
Amount of Payment	$100	$100
Interest Rate	5.625%	5.625%

See §80.2.1.1 for the definition of EMC and paper claims.

The following formula is used:

For the clean paper claim: $100 x .05625 x ***3*** divided by 365 = ***$0.0462*** or, ***$0.05*** when rounded to the nearest penny.

For the clean electronic claim: $100 x .05625 x ***3*** divided by 365 = ***$0.0462,*** or ***$0.05*** when rounded to the nearest penny.

When interest payments are applicable, the FI or carrier reports the amount of interest on each claim on the remittance record to the provider.

Additional Information - The official instruction issued to your carrier/intermediary regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/pm_trans/R416CP.pdf

Implementation Date - The implementation date for this instruction is January 25, 2005

MMA - Implementation Of Section 921 Of The Medicare Modernization Act (MMA) – Provider Customer Service Program

Medlearn Matters Article Number: MM3376

Provider Types Affected - Physicians, providers, and suppliers

Provider Action Needed - This instruction implements Section 921 of the Medicare Modernization Act (MMA). It creates the Provider Customer Service Program (PCSP) at most Medicare contractors. Collectively, carriers and fiscal intermediaries (FIs) are referred to as contractors or Medicare contractors. Because of funding limitations, the Centers for Medicare & Medicaid Services (CMS) is implementing this instruction in phases. Currently, only carriers and some FIs will be implementing this program in January 2005. Check with your carrier/FI to see if they are participating in the first phase.

Background - Medicare contractors are required to implement a PCSP designed to meet provider informational and educational needs.

The PCSP flows from provisions in Section 921 of the MMA that strengthen and enhance Medicare's ongoing efforts associated with provider inquiries and education. The PCSP is designed to improve accuracy, completeness, consistency, and timeliness by ensuring that providers' issues are addressed by staff with the appropriate levels of expertise.

The PCSP includes the following three principal components:

• Provider self-service technology
• Provider contact center (PCC)

• Provider outreach and education

Provider Self-Service Technology

• Self-service technology will enable the contact centers to handle the increasing volume of provider calls by allowing providers access to certain information without direct personal assistance from Medicare contractor staff. Contractors will require providers to use the interactive voice response (IVR) systems to access information about claims status, beneficiary eligibility, and remittance advice code definitions.

Provider Contact Center - The PCC will respond to inquiries from the following:

• Telephone calls
• Letters
• Faxes
• E-mails

Contractors will use an inquiry triage process for telephone inquiries to ensure that inquiries are answered by the staff with the appropriate expertise. Each contractor will organize its customer service representatives (CSRs) into at least two levels.

Inquiries that require even more specialized expertise or research or that just require significant additional time to resolve will be referred to a new group, the Provider Relations Research Specialists (PRRSs). The PRRS will provide clear and accurate written answers within 10 business days for at least 75 percent of cases referred by telephone CSRs, 20 business days for 90 percent of the cases referred by telephone CSRs, and 45 business days for 100 percent of all cases (referred by CSRs or from the general inquiries area). All general inquiries (letter, fax, and e-mail) will be answered within 45 business days.

Provider Outreach and Education - This component of the PCSP includes all provider outreach, education, and training activities that your carrier/FI currently performs, plus some additional requirements and activities. These new areas include:

• Training tailored for small providers and tailored to reduce the claims error rate
• Enhanced use of the Internet
• Local "Ask-the-Contractor" teleconferences and other new methods of communication

Small providers are defined by law as providers with fewer than 25 full-time equivalents or suppliers with fewer than 10 full-time equivalent staff. Contractors are required to identify providers meeting the definition of small providers and, beginning April 1, 2005, offer to all providers at least two educational programs tailored to the needs of the small providers/suppliers within their jurisdiction. Thereafter, contractors shall offer at least one additional event tailored to small providers per quarter with a minimum of six such events per state per federal fiscal year. (Thus, there may be more than one event in certain quarters of the year.)

Additional Information - For complete details, please see the official instruction issued to your contractor 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 3376 in the CR NUM column on the right, and click on the file for that CR. If you have any questions or want to take advantage of any opportunities under this expanded PCSP, visit the web site of your carrier/intermediary or call them at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

MMA - Section 706 - Implementation Of Coverage Of Religious Nonmedical Health Care Institution (RNHCI) Items And Services Furnished In The Home

Medlearn Matters Article Number: MM3529

Provider Types Affected - RNHCIs and Durable Medical Equipment (DME) Suppliers who may make arrangements with RNHCIs

Provider Action Needed - Effective January 1, 2005, RNHCIs may choose to provide certain Medicare items and RNHCI nursing services in a beneficiary's home. This RNHCI home service benefit is time-limited and will expire on December 31, 2006. Details of those services and how to bill Medicare for them are included in this article. RNHCIs should be familiar with these requirements in order to receive accurate and timely payment for these services.

Background - Section 706 of the MMA extends coverage to certain RNHCI items and services that are provided in a beneficiary's home.

Previously, beneficiaries with a RNHCI election only received coverage for inpatient services in a RNHCI. Those beneficiaries whose religious beliefs prevent them from receiving most medical services and who have an effective election are now eligible for specified home health benefits from a RNHCI.

Beginning April 4, 2005, RNHCIs may submit claims for specified DME and RNHCI nursing visits in the home, although coverage is available from January 1, 2005. Coverage is extended to specified DME items such as: canes, crutches, walkers, commodes, a standard wheelchair, hospital beds, bedpans, and urinals. The DME items are specified by Healthcare Common Procedure Coding System (HCPCS) code numbers and substitute codes may not be billed.

Total Medicare payments to all RNHCI providers nationwide for these items are limited to $700,000 per calendar year.

When RNHCIs offer home services to RNHCI beneficiaries they may order items and services without a physician order, but with the concurrence of the RNHCI utilization review committee. Receipt of these items and services from a RNHCI do not compromise the beneficiary's election for RNHCI care.

The RNHCI may establish a payment arrangement with one or more DME supplier to obtain any of the specified DME items. Items provided by a DME supplier dealing directly with the beneficiary are excluded. The RNHCI may provide RNHCI nursing services directly using their own staff or under an arrangement using independent RNHCI nurses. These services comprise the RNHCI home benefit. The RNHCI home benefit must exclude the same services that are excluded from home health benefit as defined in 42 CFR 409.49 and 42 CFR 403.768. Services provided by independent RNHCI nurses while working directly for the beneficiary are excluded.

Specific Billing Guidance - The specific billing guidance that RNHCIs need to follow to bill for these items and services are:

• RNHCIs should submit claims for specified DME items from the DME supplier only to the fiscal intermediary for the RNHCI, using type of bill (TOB) 43x.

It is crucial that the RNHCI stress to the DME supplier that the DME supplier must not bill these items to the DME regional carrier; such an action could terminate the beneficiary's election of RNHCI services.

• RNHCIs must submit claims for DME items using revenue codes 291 (rental), 292 (purchase- new) or 293 (purchase- used) only, reporting a HCPCS code, service units, and a date of service for each line item.
• RNHCIs may only provide DME items as specified by the following list of HCPCS:

Canes	• E0100 Cane, includes canes of all materials, adjustable or fixed, with tip • E0105 Cane, quad or three prong, includes canes of all materials, adjustable or fixed with tip
Crutches	• E0112 Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips • E0113 Crutch underarm, wood, adjustable or fixed, pair, with pad, tip and handgrip • E0114 Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips • E0116 Crutch underarm, other than wood, adjustable or fixed, with pad, tip and handgrip
Walkers	• E0130 Walker, rigid (pickup), adjustable or fixed height • E0135 Walker, folding (pickup), adjustable or fixed height • E0141 Walker, rigid, wheeled, adjustable or fixed height • E0143 Walker, folding, wheeled, adjustable or fixed height
Commodes	• E0163 Commode chair, stationary, with fixed arms • E0167 Pail or pan for use with commode chair
Wheelchairs	• K0001 Standard wheelchair
Hospital Beds & Accessories	• E0250 Hospital bed, fixed height, with any type side rails, with mattress • E0255 Hospital bed, variable height, hi-lo, with any type side rails, with mattress • E0260 Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress • E0275 Bed pan, standard, metal or plastic • E0276 Bed pan, fracture, metal or plastic • E0290 Hospital bed, fixed height, without side rails, with mattress • E0292 Hospital bed, variable height, hi-lo, without side rails, with mattress • E0325 Urinal; male, jug-type, any material • E0326 Urinal; female, jug-type, any material

• Payment to RNHCIs for these specified DME items will be made based on the DME fee schedule.
• Coinsurance applies to these items. Deductible does not apply to these items.
• RNHCIs must submit claims for RNHCI nursing visits on type of bill 43x using revenue code 57x, reporting each visit as a separate line item using HCPCS code G0156, service units, and a date of service for each line item.
• RNHCIs must report the nursing services in increments of 15 minutes, as defined by HCPCS code.
• Payment to RNHCIs for nursing visits will be made using the table of Metropolitan Statistical Area (MSA)-specific per-visit rates, which is shown in the *Additional Information* section below.

Additional Information - Payments made for nursing services are shown in the following table**:**

Facility Specific Per-Visit Rates for RNHCI Nursing Services for Services Provided in Calendar Year 2005

Facility MSA Area	2005 Wage Index Value	Facility Wage-Adjusted Labor Portion	Facility Non-Labor Portion	Total Facility Per-Visit Rate
1123	1.1290	31.04	8.32	39.36
1600	1.0851	29.83	8.32	38.16
1680	0.9626	26.46	8.32	34.78
1840	0.9753	26.81	8.32	35.13
1920	1.0054	27.63	8.32	35.95
2080	1.0904	29.98	8.32	38.30
3480	1.0039	27.60	8.32	35.92
4480	1.1732	32.25	8.32	40.57
5080	1.0076	27.70	8.32	36.02
5600	1.3586	37.36	8.32	45.68
5960	0.9742	26.78	8.32	35.10
7320	1.1267	30.98	8.32	39.30
7360	1.4712	40.45	8.32	48.77
8200	1.1078	30.46	8.32	38.78
8840	1.0971	30.16	8.32	38.48

Notes:

• National base RNHCI nursing rate is $35.81.
• Labor portions are calculated as follows: $35.81 x .76775 x facility's wage index value.
• Non-labor portions are calculated as follows: $35.81 x .23225 = $8.32.
• Facility per-visits rates are the sum of the labor and non-labor portions.

The official instructions issued to your RNHCI fiscal intermediary are in two parts, one reflecting changes to the *Medicare Claims Processing Manual* and the other reflecting changes to the *Medicare Benefit Policy Manual*. The actual manual changes are attached to these instructions. To view the changes to the *Medicare Claims Processing Manual*, you may see CR3529, transmittal 357 at: http://www.cms.hhs.gov/manual/pm_trans/R357CP.pdf

View the changes to the *Medicare Benefit Policy Manual*, Transmittal 25 of CR 3529 at: http://www.cms.hhs.gov/manuals/pm_trans/R25BP.pdf

For additional information relating to this issue, please call your RNHCI intermediary at their toll free number.

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.

Unprocessable Unassigned Form CMS-1500 Claims

Medlearn Matters Article Number: MM3500

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

Provider Action Needed

No provider action is needed. This instruction makes necessary changes to assure consistency in the handling of Medicare Part B claims and that HIPAA noncompliant data is not transmitted to Coordination of Benefits (COB) trading partners.

Provider Impact

Formerly, unassigned claims were denied with appeal rights. However, this instruction notifies physicians, providers and suppliers that unassigned Centers for Medicare & Medicaid Services (CMS) Form 1500 claims and electronic interface equivalents that are incomplete or contain invalid information will be returned as unprocessable to the submitters for correction or resubmission. It is important to note that as an unprocessable, when the claim is returned, there are no appeal rights. When the claims are corrected and then processed, electronic crossover claims can be sent to COB trading partners that are HIPAA compliant and the COB secondary payer claims can be processed for Medicare beneficiaries.

Background

The *Medicare Claims Processing Manual* (Pub. 100-04) provides instructions for handling Medicare claims, including Part B Form CMS-1500 claims that have incomplete or invalid information. Such claims are to be returned without appeal rights. See Pub. 100-04, Chapter 1 (General Billing Requirements), Section 80.3.1 (Incomplete or Invalid Claims Processing Terminology) at: http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf.

Currently, the instructions for Form CMS-1500 claims are:

- Specified to apply only to assigned Part B claims, and
- Silent as to unassigned CMS-1500 claims.

As a result, many Part B carriers and DMERCs have been denying unassigned CMS-1500 claims with appeal rights and not returning these claims as unprocessable without appeal rights. In addition, when denying these claims, the carriers/DMERCs have been sending to COB secondary payers electronic crossover claims containing Health Insurance Portability and Accountability Act of 1996 (HIPAA) noncompliant claims data (such as diagnosis codes and procedure codes that are not part of the standard code sets). Under HIPAA rules, COB trading partners are not required to process claims that are not HIPAA compliant, and in claims with multiple service lines, the entire claim might be rejected. The inclusion of HIPAA noncompliant data has resulted in some COB trading partners refusing to process such crossover claims for Medicare beneficiaries.

Implementation - The implementation date for this instruction is July 5, 2005.

Additional Information

The *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 1 has been revised and is included as an attachment to the official instruction released to your carrier. You may view that instruction at: http://www. cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3500 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 found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Unsolicited/Voluntary Refunds

Medlearn Matters Article Number: MM3274

Provider Types Affected - All Medicare providers

Provider Action Needed - Providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Background

Medicare carriers and intermediaries receive unsolicited/voluntary refunds from providers. These voluntary refunds are not related to any open accounts receiv-

able. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related CR 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.

Additional Information

If you have any questions regarding this issue, contact your carrier or intermediary at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Remittance Advice Remark Code And Claim Adjustment Reason Code Update

Medlearn Matters Article Number: MM3636

Provider Types Affected - All Medicare providers

Provider Action Needed

Impact to You

The July 2004 through October 2004 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. Your Medicare carrier or fiscal intermediary must use the latest approved and valid codes in 835 transactions, corresponding standard paper remittance advice, and coordination of benefits transactions.

What You Need to Know

The most current and complete code list will be found online at: http://www.wpc-edi.com/codes

Please note that in case of a discrepancy, the code text included on this Washington Publishing Company (WPC) web site will supersede any corresponding text in a Medicare CR.

What You Need to Do

The above noted codes are updated three times a year. Please advise your billing staff to stay current with the latest approved and valid codes, in accordance with effective and implementation dates, to ensure correct interpretation of the electronic or paper remittance advice notices sent by Medicare.

Background

The Remittance Advice Remark Code list is one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). This list is maintained by The Centers for Medicare & Medicaid Services (CMS) and is updated three times a year. The Health Care Claim Adjustment Codes are maintained by the Claim Adjustment Reason Code and Status Code Maintenance Committee. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and decides on any additions, modifications, or retirement of reason codes. This updated list is also posted three times a year. The complete list of current codes is available online at the WPC web site: http://www.wpc-edi.com/codes

Here is a summary of the current updates.

New Remark Codes

New codes from N247 to N344 have been created to replace a number of generic remark codes, or to enable some existing codes to be split to better reflect their lowest component. This has been done to resolve some provider complaints that it is difficult for them to correlate certain remark codes with segments and data elements submitted on their corresponding claims. Codes with multiple meanings have been split, and new code(s) added to report each of the multiple bits of information previously included in a single message. For example,

• M45 (Missing/incomplete/invalid occurrence codes or dates) has been modified to mean "Missing/incomplete/invalid occurrence code(s)," and N299 (Missing/incomplete/invalid occurrence date(s)) has been added to address the date portion of the prior message.

• MA29 has been deactivated entirely and codes N256, N258, N261, N264, N266, N269, N279, N281, N285, N289, N292, N294, and N296 have been added to convey distinct types of information previously conveyed in MA29.

The following is a list showing the new codes and the source code that has been modified/split to create the new code:

New Code	Split from Existing Code
N299	M45
N300	M46
N301	M51
N302	M74
N303	MA66
N304	N57

Modified Remark Codes

The following table reflects modified remark codes:

Code	Current Modified Narrative	Modification Date
M67	Missing/incomplete/invalid other procedure code(s).	12/2/04
M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment.	12/2/04
M45	Missing/incomplete/invalid occurrence code(s).	12/2/04
M46	Missing/incomplete/invalid occurrence span code(s).	12/2/04
M51	Missing/incomplete/invalid procedure code(s).	12/2/04
MA66	Missing/incomplete/invalid principal procedure code.	12/2/04
MA121	Missing/incomplete/invalid x-ray date.	12/2/04
N31	Missing/incomplete/invalid prescribing provider identifier.	12/2/04
N57	Missing/incomplete/invalid prescribing date.	12/2/04

Deactivated Remark Codes

Codes M57, M68, M108, M110, M120, M128, MA29, MA38, MA 52, MA82, MA105, MA127, and N145 have been deactivated.

New Reason Codes

Code 165 has been added as of October 2004 and its narrative is “Payment denied/reduced for absence of, or exceeded referral.”

Additional Information

The most recent changes approved for the Remittance Advice Remark Codes and the Claim Adjustment Reason Codes can be found in the official instruction issued to your carrier or fiscal intermediary, including Durable Medical Equipment Regional Carriers (DMERCs). That official instruction is found in CR 3636, which is available at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that page, scroll down the CR NUM column on the right to find the link for CR 3636. Click on the link to open and view the file for the CR. The CR attachments also include information on the process of the decision making process that updates the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. It also includes a table of changes; however, please note that the most current and complete list is online at the WPC web site. This CR includes changes made only from July through October of 2004. If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll free number at: http://www.cms.hhs.gov/medlearn/tollnums.asp

NOTE: The updates referenced above are detailed in the following article.

Update To The American National Standard Institute (ANSI) Codes

New Remittance Advice Remark Codes

N246 State regulated patient payment limitations apply to this service.
N247 Missing/incomplete/invalid assistant surgeon taxonomy.
N248 Missing/incomplete/invalid assistant surgeon name.
N249 Missing/incomplete/invalid assistant surgeon primary identifier.
N250 Missing/incomplete/invalid assistant surgeon secondary identifier.
N251 Missing/incomplete/invalid assistant attending physician taxonomy.
N252 Missing/incomplete/invalid attending provider name.
N253 Missing/incomplete/invalid attending provider primary identifier.
N254 Missing/incomplete/invalid attending provider secondary identifier.
N255 Missing/incomplete/invalid billing provider taxonomy.
N256 Missing/incomplete/invalid billing provider/supplier name.
N257 Missing/incomplete/invalid billing provider/supplier primary identifier.
N258 Missing/incomplete/invalid billing provider/supplier address.
N259 Missing/incomplete/invalid billing provider/supplier secondary identifier.
N260 Missing/incomplete/invalid billing provider/supplier contact information.
N261 Missing/incomplete/invalid operating provider name.
N262 Missing/incomplete/invalid operating provider primary identifier.
N263 Missing/incomplete/invalid operating provider secondary identifier.
N264 Missing/incomplete/invalid ordering provider name.
N265 Missing/incomplete/invalid ordering provider primary identifier.
N266 Missing/incomplete/invalid ordering provider address.
N267 Missing/incomplete/invalid ordering provider secondary identifier.
N268 Missing/incomplete/invalid ordering provider contact information.
N269 Missing/incomplete/invalid other provider name.
N270 Missing/incomplete/invalid other provider primary identifier.
N271 Missing/incomplete/invalid other provider secondary identifier.
N272 Missing/incomplete/invalid other payer attending provider identifier.
N273 Missing/incomplete/invalid other payer operating provider identifier.
N274 Missing/incomplete/invalid other payer other provider identifier.
N275 Missing/incomplete/invalid other payer purchased service provider identifier.
N276 Missing/incomplete/invalid other payer referring provider identifier.
N277 Missing/incomplete/invalid other payer rendering provider identifier.
N278 Missing/incomplete/invalid other payer service facility provider identifier.
N279 Missing/incomplete/invalid pay-to provider name.
N280 Missing/incomplete/invalid pay-to provider primary identifier.
N281 Missing/incomplete/invalid pay-to provider address.
N282 Missing/incomplete/invalid pay-to provider secondary identifier.
N283 Missing/incomplete/invalid purchased service provider identifier.
N284 Missing/incomplete/invalid referring provider taxonomy.
N285 Missing/incomplete/invalid referring provider name.
N286 Missing/incomplete/invalid referring provider primary identifier.
N287 Missing/incomplete/invalid referring provider secondary identifier.
N288 Missing/incomplete/invalid rendering provider taxonomy.
N289 Missing/incomplete/invalid rendering provider name.
N290 Missing/incomplete/invalid rendering provider primary identifier.
N291 Missing/incomplete/invalid rendering provider secondary identifier.
N292 Missing/incomplete/invalid service facility name.
N293 Missing/incomplete/invalid service facility primary identifier.
N294 Missing/incomplete/invalid service facility primary address.
N295 Missing/incomplete/invalid service facility secondary identifier.

N296 Missing/incomplete/invalid supervising provider name.
N297 Missing/incomplete/invalid supervising provider primary identifier.
N298 Missing/incomplete/invalid supervising provider secondary identifier.
N299 Missing/incomplete/invalid occurrence date(s).
N300 Missing/incomplete/invalid occurrence span date(s).
N301 Missing/incomplete/invalid procedure date(s).
N302 Missing/incomplete/invalid other procedure date(s).
N303 Missing/incomplete/invalid principal procedure.
N304 Missing/incomplete/invalid dispensed date.
N305 Missing/incomplete/invalid accident date.
N306 Missing/incomplete/invalid acute manifestation date.
N307 Missing/incomplete/invalid adjudication or payment date.
N308 Missing/incomplete/invalid appliance placement date.
N309 Missing/incomplete/invalid assessment date.
N310 Missing/incomplete/invalid assumed or relinquished care date.
N311 Missing/incomplete/invalid authorized to return to work date.
N312 Missing/incomplete/invalid begin therapy date.
N313 Missing/incomplete/invalid certification revision date.
N314 Missing/incomplete/invalid diagnosis date.
N315 Missing/incomplete/invalid disability from date.
N316 Missing/incomplete/invalid disability to date.
N317 Missing/incomplete/invalid discharge hour.
N318 Missing/incomplete/invalid discharge or end of care date.
N319 Missing/incomplete/invalid hearing or vision prescription date.
N320 Missing/incomplete/invalid Home Health Certification Period.
N321 Missing/incomplete/invalid last admission period.
N322 Missing/incomplete/invalid last certification date.
N323 Missing/incomplete/invalid last contact date.
N324 Missing/incomplete/invalid last seen/visit date.
N325 Missing/incomplete/invalid last worked date.
N326 Missing/incomplete/invalid last x-ray date.
N327 Missing/incomplete/invalid other insured birth date.
N328 Missing/incomplete/invalid Oxygen Saturation Test date.
N329 Missing/incomplete/invalid patient birth date.
N330 Missing/incomplete/invalid patient death date.
N331 Missing/incomplete/invalid physician order date.
N332 Missing/incomplete/invalid prior hospital discharge date.
N333 Missing/incomplete/invalid prior placement date.
N334 Missing/incomplete/invalid reevaluation date.
N335 Missing/incomplete/invalid referral date.
N336 Missing/incomplete/invalid replacement date.
N337 Missing/incomplete/invalid secondary diagnosis date.
N338 Missing/incomplete/invalid shipped date.
N339 Missing/incomplete/invalid similar illness or symptom date.
N340 Missing/incomplete/invalid subscriber birth date.
N341 Missing/incomplete/invalid surgery date.
N342 Missing/incomplete/invalid test performed date.
N343 Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.
N344 Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.

Note: New codes from N247 to N344 have been created to replace a number of generic remark codes or to enable some existing codes to be split to better reflect their lowest component. This has been done to resolve some provider complaints that it is difficult for them to correlate certain remark codes with segments and data elements submitted on their corresponding claims. Codes with multiple meanings have been split, and new code(s) added to report each of multiple bits of information previously included in one message. For example:

1. M45 (Missing/incomplete/invalid occurrence codes or dates) has been modified to mean "Missing/incomplete/invalid occurrence code(s)," and N299 (Missing/incomplete/invalid occurrence date(s)) has been added to address the date portion of the prior message; and

2. MA29 has been deactivated entirely and codes N256, N258, N261, N264, N266, N269, N279, N281, N285, N289, N292, N294, and N296 have been added to convey distinct types of information all previously conveyed in MA29. (Since MA29 has been deactivated, this change has not been included in the "split from" listing below.)

In a departure from normal practice, the replacement codes are not listed in the comment section for this update due to their large number. Following is a list showing the new codes and the source code that has been modified/split to create the new code.

New Code	Split from Existing Code
N299	M45
N300	M46
N301	M51
N302	M74
N303	MA66
N304	N57

Revised Remittance Advice Remark Codes

M67 Missing/incomplete/invalid other procedure code(s).
M74 This service does not qualify for a HPSA/Physician Scarcity bonus payment.
M45 Missing/incomplete/invalid occurrence code(s).
M46 Missing/incomplete/invalid occurrence span code(s).
M51 Missing/incomplete/invalid procedure code(s).
MA66 Missing/incomplete/invalid principal procedure code.
MA121 Missing/incomplete/invalid x-ray date.
MA122 Missing/incomplete/invalid initial treatment date.
N31 Missing/incomplete/invalid prescribing provider identifier.
N57 Missing/incomplete/invalid prescribing date.
M57 Missing/incomplete/invalid provider identifier.
M68 Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.
M108 Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.
M110 Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.
M120 Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.
M128 Missing/incomplete/invalid date of the patient's last physician visit.
M128 Missing/incomplete/invalid provider name, city, state, or zip code.
MA29 Missing/incomplete/invalid provider name, city, state, or zip code.
MA38 Missing/incomplete/invalid birth date.
MA52 Missing/incomplete/invalid date.
MA82 Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.
MA105 Missing/incomplete/invalid provider number for this place of service.
MA127 Reserved for future use.
N145 Missing/incomplete/invalid provider identifier for this place of service.

New Health Care Claim Adjustment Reason Code

165 Payment denied/reduced for absence of, or exceeded referral.

Frequently Asked Questions

1. Are Certificates of Medical Necessity (CMNs) required for repairs?

   ANSWER: There is a chart in the supplier manual, Chapter 3 pages 5-6, which identifies when new CMNs or orders are needed and when the original CMN or order will be adequate for repairing or replacing durable medical equipment.

2. Could you please define the initial date on a CMN?

   ANSWER: The "initial Date" found in section A of the CMN is either the specific date that the treating physician gives as the start of medical necessity or, if the physician does not give a specific date, the "Initial Date" is the date of the order. *(CMS Pub. 100.08, Medicare Program Integrity Manual, Chapter 5 Section 1.1.4.2)*

3. Can Medicare pay for oxygen contents for patient owned equipment?

   ANSWER: Yes, according to the Oxygen and Oxygen Equipment Llocal Medical Review Policy (LMRP), oxygen contents are separately payable only when coverage criteria for home oxygen have been met and they are used with a patient owned stationary gaseous or liquid system, respectively.

4. What is the time limit for filing claims?

   ANSWER: For dates of service between October 1, 2003 and September 30, 2004, claims must be received at the carrier by December 31, 2005. Claims that are not submitted within these time limits will be denied. This information is provided in Chapter 6 of the supplier manual and on page 19 of the Fall 2004 *DMERC Dialogue*.

5. Can a physician's assistant write a prescription for a Medicare patient?

   ANSWER: Per Chapter 3 of the supplier manual, a nurse practitioner, physician assistant or clinical nurse specialist may give the verbal order and sign the written order if all of the following conditions are met: a) they are treating the beneficiary for the condition for which the item is needed; b) they are practicing independently of a physician (applies only to nurse practitioners and clinical nurse specialists; physician assistants must be practicing under the supervision of an MD or DO); c) they bill Medicare for other covered services using their own provider number; and d) they are permitted to do all of the above in the state in which the services are rendered.

6. I have an oxygen patient that was previously enrolled in a Medicare HMO and is now covered through traditional fee-for-service (FFS) Medicare. Does the oxygen test date on the initial CMN still have to be within 30 days of the date on the CMN?

   ANSWER: There is an exception for patients who were on oxygen in the Medicare HMO and who transition to the fee-for-service Medicare. For those patients, the blood gas study does not have to be obtained 30 days prior to the Initial Date, but must be the most recent test obtained while in the HMO.

7. Is the 90 day grace period still in effect for old HCPCS codes?

   ANSWER: The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rules require suppliers to use the medical code set (HCPCS codes) that is valid at the time the service is rendered. Therefore, effective January 1, 2005, HCPCS codes will no longer have a 90-day grace period and will be returned as unprocessable or denied as incorrect coding.

Frequently Asked Questions (cont'd)

8. Who approves the changes on the CMN, the supplier or physician?

   ANSWER: If there is a change made to any section of the CMN, the physician must signify approval of the change by making a line through the error, inserting the corrected information then initialing and dating the correction. *(CMS Pub. 100-8, Medicare Program Integrity Manual, Chapter 5)*

9. We are new to the DMERC process, can you tell me the difference between being a participating and non-participating supplier?

   ANSWER: A Medicare participating supplier is one who voluntarily enters into an agreement to accept assignment for all services furnished to Medicare beneficiaries during a 12-month period, beginning January 1 of each year. Suppliers who choose not to sign the participation contract are referred to as non-participating suppliers. Non-participating suppliers may choose to accept assignment on a claim-by-claim basis except where CMS regulations require mandatory assignment (i.e., Medicare covered drugs, home dialysis equipment and supplies, etc.). Accepting assignment means accepting the Medicare approved amount as payment in full. Participation status is part of the enrollment process through the National Supplier Clearinghouse. *(DMERC Region D Supplier Manual, Chapter 2)*

10. Is there a change to the fee schedule for Therapeutic Shoes for Persons with Diabetes?

    ANSWER: Yes, according to the Winter 2005 *DMERC Dialogue* the following information is stated: "For therapeutic shoe HCPCS codes A5500, A5501, A5503-A5507, K0628, and K0629 the Medicare Modernization Act of 2003 (MMA, Section 627) changes the payment methodology from reasonable charge to the prosthetic and orthotic fee schedule. Further information on the pricing update for therapeutic shoes will be provided in a separate article for the 2005 update of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule."

LOOK-UP TABLE FOR CALCULATING BENEFICIARY CO-PAYMENT FOR ANTIVIRAL INFLUENZA TREATMENT

MEDICARE ALLOWED PAYMENT AMOUNT		$0.76	$0.76	$1.32	$5.43	$1.65	$2.17	$6.99
(includes 5% or 10% reduction from AWP)					(per 10mg)			
A	B	C	D	E	F	G	H	I
Plan Name	Dnum	AMANTADINE 100MG CAPSULE	AMANTADINE 100MG TABLET	FLUMADINE 100MG TABLET	RELENZA 5MG DISKHALER	RIMANTADINE 100MG TABLET	SYMMETREL 100MG TABLET	TAMIFLU 75MG GELCAP
Anthem Drug Discount Card	D7000	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
MedCare USA, Powered by MedImpact	D7001	0.0864	0.2113	0.4195	0.4901	0.3227	0.2451	1.2622
aClaim RxSavings Club	D7002	0.0871	0.1680	0.4147	0.4689	0.2567	0.2545	1.3328
AmeriHealth RxSavings	D7005	0.1082	0.2089		0.4954		0.2545	1.2831
InStil Health Solutions	D7007	0.0864	0.2113	0.4195	0.4901	0.3227	0.2451	1.2622
HealthSpring of Alabama Prescription Advantage	D7008	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
HealthSpring of Illinois Prescription Advantage	D7009	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
HealthSpring Prescription Advantage	D7010	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
Texas HealthSpring Prescription Advantage	D7011	0.0994	0.2112	0.4195	0.4765	0.3224	0.2574	1.2562
Horizon RxSavings	D7013	0.1082	0.2089		0.4954		0.2545	1.2831
Priority Plus	D7015	0.0871	0.1680	0.4290	0.4932	0.2567	0.2633	1.2685
PBM Plus Senior Care	D7016	0.1181	0.2401	0.4767	0.5561	0.3024	0.2925	1.5320
The Pharmacy SmartCard	D7017	0.0560	0.1300	0.4147	0.5182	0.2750	0.2423	1.3328
myPharmaCare	D7019	0.1028	0.2089	0.4147	0.4787	0.3187	0.2423	1.3328
Liberty Prescription Discount Card	D7020	0.0933	0.1800	0.4147	0.4787	0.2750	0.2423	1.2348
ScriptSave Premier	D7021	0.1119	0.2161	0.4290	0.5063	0.3300	0.2507	1.3137
Blue Cross Blue Shield of Alabama's BlueRx	D7027	0.0889	0.2089	0.4147	0.4787	0.2794	0.2545	1.2348
Aetna Rx savings Card (SM)	D7028	0.1119	0.2161	0.4290	0.5063	0.3300	0.2507	1.3137
RxSavings distributed by Reader's Digest	D7029	0.1119	0.2161		0.5483		0.2779	1.4171
RxSavings distributed by Reader's Digest	D7029	0.1121	0.2401		0.5956		0.2925	1.4937
RxSavings distributed by MCS Life Insurance Company	D7030	0.1121	0.2401		0.5956		0.2925	1.4937
Anthem Drug Discount Card VA	D7031	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card NH	D7032	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card CO	D7033	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card IN	D7034	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card ME	D7035	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card KY	D7036	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card OH	D7037	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Anthem Drug Discount Card CT	D7038	0.0746	0.1440	0.4147	0.4689	0.2200	0.2423	1.2348
Preferred Prescription Discount Card	D7041	0.0965	0.2089	0.4147	0.4703	0.3190	0.2545	1.2140
Prescription Discount Card	D7042	0.0965	0.2089	0.4147	0.4799	0.3190	0.2545	1.2377
BlueSaver Premier	D7043	0.1095	0.2113	0.4195	0.4944	0.3227	0.2451	1.2831
First Health Services Medicare Drug Discount Card	D7046	0.1119	0.1920	0.4290	0.5360	0.2934	0.2633	1.3788
First Health Services Medicare Drug Discount Card	D7046	0.1119	0.2161	0.4290	0.5360	0.3300	0.2633	1.3788
ArgusRx	D7047	0.0933	0.1800	0.4147	0.4753	0.2750	0.2545	1.2225
RxSavings	D7049	0.1119	0.2161		0.5483		0.2779	1.4171
RxSavings	D7049	0.1121	0.2401		0.5956		0.2925	1.4937
RxSavings distributed by BlueCross BlueShield of Tennessee	D7057	0.1082	0.2089		0.4954		0.2545	1.2831

(cont'd next page)

LOOK-UP TABLE FOR CALCULATING BENEFICIARY CO-PAYMENT FOR ANTIVIRAL INFLUENZA TREATMENT (cont'd)

MEDICARE ALLOWED PAYMENT AMOUNT		$0.76	$0.76	$1.32	$5.43	$1.65	$2.17	$6.99
(includes 5% or 10% reduction from AWP)					(per 10mg)			
A	B	C	D	E	F	G	H	I
Plan Name	Dnum	AMANTADINE 100MG CAPSULE	AMANTADINE 100MG TABLET	FLUMADINE 100MG TABLET	RELENZA 5MG DISKHALER	RIMANTADINE 100MG TABLET	SYMMETREL 100MG TABLET	TAMIFLU 75MG GELCAP
RxSavings distributed by BlueCross BlueShield of South Carolina	D7058	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Wellmark BlueCross BlueShield	D7060	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Fidelis Care New York	D7062	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by OSF HealthPlans	D7063	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Premier Plus	D7064	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Texan Plus	D7066	0.1082	0.2089		0.4954		0.2545	1.2831
RxSavings distributed by Mennonite Mutual Aid Association	D7068	0.1119	0.2161		0.5483		0.2779	1.4171
RxSavings distributed by UCare Minnesota	D7069	0.1082	0.2089		0.4954		0.2545	1.2831
EnvisionRx Plus	D7070	0.1057	0.2041	0.4290	0.4867	0.3117	0.2507	1.3788
Rx Savings Access Card	D7071	0.1082	0.2089	0.4147	0.4786	0.3190	0.2423	1.2348
Pharmacy Care Alliance (Option A)	D7072	0.1011	0.2160	0.4290	0.4884	0.3297	0.2632	1.2869
Pharmacy Care Alliance (Option B)	D7073	0.1011	0.2160	0.4290	0.4884	0.3297	0.2632	1.2869
AARP Prescription Discount Card	D7074	0.1011	0.2280	0.4529	0.5182	0.3480	0.2779	1.3635
SHL RxCard	D7075	0.1028						1.3328
ScripSolutions Freedom	D7076	0.1095	0.2113	0.5638	0.5144	0.3224	0.2574	1.2501
ScripSolutions Choice	D7077	0.1095	0.2113	0.5638	0.5144	0.3224	0.2574	1.2501
ScripSolutions Choice	D7077	0.1095	0.2113	0.5638	0.5144	0.3224	0.2574	1.2501
American Advantage-Med	D7079	0.1004	0.2089	0.4243	0.4924	0.3190	0.2479	1.2885
American Prescription Plan	D7080	0.1119	0.2161		0.5483		0.2779	1.4171
PrimeScript	D7081	0.1082	0.2089	0.4290	0.5182	0.3190	0.2633	1.3328
SXC Health Solutions, Inc.	D7082	0.0933	0.1800	0.4147	0.4787	0.2750	0.2423	1.2348
Walgreens Health Initiatives Prescription Discount Drug Card	D7083	0.0995	0.1920	0.4147	0.4742	0.2934	0.2545	1.2228
Walgreens Health Initiatives Prescription Discount Drug Card	D7083	0.1244	0.2401	0.4767	0.5956	0.3748	0.2925	1.5320
PrecisionDiscounts (Option A)	D7084	0.0746	0.1755	0.4290	0.4966	0.2748	0.2633	1.2808
Public Sector Partners Prescription Drug Discount Card	D7086	0.0933	0.1800	0.4147	0.5182	0.2750	0.2423	1.2103
Rx for Less delivered through UPMC for Life	D7087	0.1095	0.2113	0.4195	0.4872	0.3227	0.2574	1.3482
Sav-Rx Med-Advantage Prescription Discount Card	D7088	0.1004	0.2089	0.4243	0.4882	0.3190	0.2479	1.2801
U Share Prescription Drug Discount Card	D7089	0.0965	0.2089	0.4147	0.4703	0.3190	0.2545	1.2140
Community Care Rx	D7090	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Community Care Rx	D7090	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Criterion Advantage	D7091	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Criterion Advantage	D7091	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Golden Buckeye	D7092	0.0884	0.1637	0.4147	0.4935	0.3024	0.2423	1.3328
Advantra X-tra Drug Discount Card Program	D7095	0.1082	0.2089		0.4954		0.2545	1.2831
BD Advantage Drug Discount Card	D7096	0.1119	0.2161				0.2779	1.4171

Medicare Secondary Payer (MSP) Questionnaire

Patient Name _____ Date: _____
HICN: _____

Part I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes Date benefits began: _____(CCYY/MM/DD)

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: _____(CCYY/MM/DD)

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: _____(CCYY/MM/DD)

___ No **GO TO PART III**

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:

_____
_____
_____

___ No Date of retirement:_____(CCYY/MM/DD)
___ No Never employed

2. Is your spouse currently employed?

___ Yes

Name and address of spouse's employer:

_____
_____
_____

___ No Date of retirement:_____(CCYY/MM/DD)
___ 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. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE LOWING INFORMATION.**

Name and address of GHP:

_____
_____
_____

Policy identification number: _____
Group identification number: _____
Name of policyholder: _____
Relationship to patient: _____

___ No **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Part V - Disability

1. Are you currently employed?

___ Yes

Name and address of your employer:

_____
_____
_____

___ No Date of retirement:_____(CCYY/MM/DD)

2. Is a family member currently employed?

___ Yes

Name and address of your employer:

_____

_____

_____

___ No

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. Does the employer that sponsors your GHP employ 100 or more employees?

___ Yes

STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.

Name and address of GHP:

_____

_____

_____

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

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?

Name and address of GHP:

_____

_____

_____

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

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:_____(CCYY/MM/DD)

___ No

3. Have you received maintenance dialysis treatments?

___Yes Date dialysis began:_____(CCYY/MM/DD)

If you participated in a self-dialysis training program, provide date training started:
_____(CCYY/MM/DD)
___ No

4. Are you within the 30-month coordination period?
___ 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 **STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

6. Was the initial entitlement to Medicare (including simultaneous 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**.

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 Medicare
DMERC Region D
PO Box 690
Nashville TN 37202

Review Requests:
CIGNA Medicare
DMERC Reviews
PO Box 22995
Nashville TN 37202

Hearing Requests:
CIGNA Medicare
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 Medicare Web site (http://www.cignamedicare.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 Medicare, 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 Medicare Online Help Center at http://www.cignamedicare.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 Medicare 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.cignamedicare.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
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