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…

Robert Hoover, Jr., MD, MPH

Medical Review Internet Site Receives Rave Reviews!!!

CIGNA Medicare DMERC Region D's Web site was the "buzz" at the recent MedTrade show in Orlando. For those of you that haven't visited the Region D Web site recently, you're missing out on some great resources. Based on data received from claims, progressive corrective action, probe review and the industry the Region D Medical Review staff has developed a number of tools to assist suppliers in submitting claims correctly. Submitting claims correctly means faster payment and fewer hassles with appeals.

What's new on the DMERC Region D Medical Review Web page?

- Documentation Checklists: These are designed to help with the intake process and ensure that your files contain the necessary documentation for claim submission. There are checklists for glucose monitors, ostomy supplies, oxygen and more.

- Netcourses: These are educational modules that are available 24/7 to assist suppliers and their staff on topics such as power mobility, support surfaces and oxygen. They are self-paced and are great resources for internal compliance training or new hire orientation.

- CERT information: The Comprehensive Error Rate Testing (CERT) program is designed to determine the amount of "errors" in the Medicare system. Many of the actions taken by medical review are based on CERT claims data. Find out more about CERT by accessing this information on the Web site.

- Frequently Asked Questions (FAQs): Medical Review staff periodically updates this site based on questions from customer service, provider education seminars and topics gleaned from industry publications. FAQ topics include respiratory assist devices, oxygen, support surfaces, progressive corrective action and more.

As one can see, there are many offerings of interest on the Region D Medical Review Web site. Suppliers are strongly encouraged to visit www.cignamedicare.com/dmerc/index.htm often to stay up-to-date on what's happening in Medical Review.

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MEDICAL POLICY

Pharmacy

Pancreatic Islet Cell Transplants – Correction

Effective for dates of service on or after October 1, 2004, Medicare will cover pancreatic islet cell transplants when conducted as part of a National Institutes of Health (NIH)-sponsored clinical trial. Medicare will pay for the routine costs, as well as transplantation and appropriate related items and services, for Medicare beneficiaries participating in an approved clinical trial. The term "routine costs" means reasonable and necessary routine patient care costs, including immunosuppressive drugs and other follow-up care, as defined in section 310.1 of the *National Coverage Determinations (NCD) Manual*.

Specifically, Medicare will cover transplantation of pancreatic islet cells, the insulin producing cells of the pancreas. Coverage will include the costs of acquisition and delivery of the pancreatic islet cells, as well as clinically necessary inpatient and outpatient medical care and immunosuppressants. For these patients, question #4 on the Immunosuppressive Drugs DMERC Information Form (DIF) should be answered "Yes" and in question #5, enter "8" (Reserved for Future Use). This is a correction to the instructions in the article entitled "MMA-Billing Requirements for Islet Cell Transplantation for Beneficiaries in a National Institutes of Health (NIH) Clinical Trial" that was posted on August 18th and published in the Fall 2004 Region D *DMERC Dialogue* which incorrectly stated the response to question #5 for this type of transplant should be "9" (Other).

Immunosuppressive drugs used following partial pancreatic tissue transplantation or islet cell transplantation performed outside the context of a clinical trial or performed before October 1, 2004 will continue to be noncovered. In these situations, question #4 must be answered "No" and in question #5, enter "9".

Refer to the article entitled "MMA-Billing Requirements For Islet Cell Transplantation For Beneficiaries In A National Institutes Of Health (NIH) Clinical Trial" published in the Fall 2004 Region D *DMERC Dialogue* for additional information about coverage and billing requirements.

Further details may be found in the Centers for Medicare & Medicaid Services (CMS) Internet-only manual Pub. 100-3, Section 260.3.1. This change will also be incorporated into an upcoming revision of the Immunosuppressive Drugs local coverage determination.

Durable Medical Equipment

CPAP And RAD – Clarification Of Apnea-Hypopnea Index

A revision of the medical policies on Continuous Positive Airway Pressure Devices (CPAP) and Respiratory Assist Devices (RAD) in the January 2005 *DMERC Region D Supplier Manual* updates includes a clarification of the definition of the Apnea-Hypopnea Index (AHI). It says that although there is a requirement for a minimum of two hours of recording time without use of a positive airway pressure device, the AHI is calculated based on the number of hours of sleep within that recording time. An example of the calculation is also included. The two policies were also converted into the new format of local coverage determinations (LCD) and

policy articles. The definition of the AHI can be found in the Appendices section of the LCDs.

Wheelchair Seating – Policy Revision

A revision of the DMERC local coverage determination (LCD) and policy article on Wheelchair Seating is included in the January 2005 *DMERC Region D Supplier Manual* update. That revision includes all of the following changes.

Effective for dates of service on or after January 1, 2005, all of the recently-established K codes for wheelchair cushions (except K0669) are being replaced with E codes.

2004 Code	Description	2005 Code
K0650	General use wheelchair seat cushion, width less than 22 inches, any depth	E2601
K0651	General use wheelchair seat cushion, width 22 inches or greater, any depth	E2602
K0652	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	E2603
K0653	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	E2604
K0654	Positioning wheelchair seat cushion, width less than 22 inches, any depth	E2605
K0655	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	E2606
K0656	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	E2607
K0657	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	E2608
K0658	Custom fabricated wheelchair seat cushion, any size	E2609
K0659	Wheelchair seat cushion, powered	E2610
K0660	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	E2611
K0661	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	E2612
K0662	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	E2613
K0663	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	E2614
K0664	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including mounting hardware	E2615
K0665	Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware	E2616
K0666	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware	E2617
K0668	Replacement cover for wheelchair seat cushion or back cushion, each	E2619

There is no grace period allowing use of these K codes for dates of service in 2005.

In addition, three new codes are being established for dates of service on or after January 1, 2005:

E2618 Wheelchair accessory, solid seat support base (replaces sling seat) for use with manual wheelchair or lightweight power wheelchair, includes any type mounting hardware
E2620 Positioning wheelchair back cushion, planar with lateral supports, width less than 22 inches, any height, including any type mounting hardware
E2621 Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware

Coding guidelines for these codes can be found in the policy article.

The revision also includes updates to the ICD-9 codes previously published.

Coverage criteria, coding guidelines, and documentation requirements relating to adjustable cushions, as described in the article entitled "Wheelchair Seating – Coding and Pricing Changes" in this issue, have been incorporated into the revised medical policy.

Refer to the Revision History Explanation sections at the end of the LCD and policy article for a listing of other changes.

General

Policies Revised

Effective for dates of service on or after January 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:

- ***Automatic External Defibrillators***
- ***Canes and Crutches***
- ***CPAP Devices***
- ***Patient Lifts***
- ***Respiratory Assist Devices***
- ***Refractive Lenses***
- ***Spinal Orthoses***
- ***Surgical Dressings***
- ***Wheelchair Seating***

Effective for dates of service on or after April 1, 2005, the ***Commodes*** policy has been converted from a LMRP to a LCD and policy article.

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 also 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.**

COVERAGE AND BILLING

Durable Medical Equipment

Wheelchair Seating – Coding And Pricing Changes

On July 1, 2004, new wheelchair cushion codes became effective. After coding the majority of cushions submitted for review, the SADMERC, DMERCs and CMS have determined that the code descriptions do not adequately describe some adjustable seat cushions.

Effective immediately, adjustable seat cushions will be removed from both the skin protection seat cushion codes (K0652, K0653) and the combination skin protection and positioning seat cushion codes (K0656, K0657). Adjustable cushions are those which have all of the characteristics of a skin protection seat cushion or skin protection and positioning seat cushion as described in the Coding Guidelines section of the Policy Article and are adjustable by addition or removal of significant quantities of air, liquid, gel, or other fluid medium in physiologically appropriate areas of the cushion to promote pressure reduction. Adjustable cushions will be coded K0108 (Wheelchair component or accessory, not otherwise specified) until such time as an acceptable code description and test requirements can be determined.

For products that have already been coded as K0652, K0653, K0656, or K0657, the SADMERC will determine which of the products are adjustable cushions and the revised determination will be posted on the SADMERC Web site by November 5 and a new Coding Verification Review letter will be sent to the manufacturer. Manufacturers of adjustable products that have not yet been coded will receive letters assigning their products to K0108. Once that coding determination is made by the SADMERC, those products may be submitted as K0108 for dates of service on or after July 1, 2004. Fee schedule amounts will be established for categories of similar adjustable products. The DMERCs will process the claims as any other K0108 with the allowed payment amounts being equal to the lower of the actual charge or the fee schedule amount.

The Web address for the SADMERC Product Classification List is www.palmettogba.com, then select Other Partners/SADMERC, then Product Classification List twice, then Wheelchair Cushions (new K codes).

If claims for products that are classified by the SADMERC as adjustable seat cushions have been sub-

mitted as K0652, K0653, K0656, and K0657 and paid based on the fee schedule amounts posted in early October, suppliers may request a payment adjustment beginning November 12 . The procedure for Region D is to submit the request in writing using the suggested Medicare Written Adjustment Request Form (located on the Web at http://www.cignamedicare.com/ dmerc/ resource.html). For adjustable cushions, the supplier will need to provide all of the details about the cushion as described in the next paragraph. Claims that were processed prior to early October were paid using individual consideration; those claims may not be submitted for a payment adjustment.

For an adjustable seat cushion to be covered, it must meet the coverage criteria (including ICD-9 codes) for a skin protection seat cushion or skin protection and positioning seat cushion (as applicable) as specified in the Wheelchair Seating Local Coverage Determination (LCD). If the criteria are not met but the coverage criteria for another type of cushion are met, payment will be based on the allowance for the least costly medically appropriate alternative; if the criteria for another type of seat cushion are not met, the provided cushion will be denied as not medically necessary. If the narrative coverage criteria have been met, a KX modifier should be added to code K0108. Claims for cushions billed with code K0108 must clearly state "cushion" and must include the name of the manufacturer, the product name, the model number, and the width of the cushion which was provided. This information should be entered in the narrative field of an electronic claim or attached to a hardcopy claim. Suppliers should make sure that the product name/number that they list exactly matches the complete product name/number that is listed in the Product Classification List on the SADMERC Web site. If a cushion submitted as K0108 has not received coding verification as such from the SADMERC, the claim line will be rejected or denied as incorrect coding.

There is no change in the coding of general use seat cushions (K0650, K0651), positioning seat cushions (K0654, K0655), custom fabricated seat cushions (K0658), general use back cushions (K0660, K0661), positioning back cushions (K0662-K0665), or custom fabricated back cushions (K0666). Those codes include both adjustable and nonadjustable cushions.

Effective immediately, the codes for custom fabricated seat cushions (K0658) and custom fabricated back cushions (K0666) will be paid on an individual consideration basis, rather than using the fee schedule allowances established in early October. All claims for codes K0658 and K0666 must include the manufacturer and model name/number of the product if applicable, or if not, a detailed description of the product that was provided. The submitted charge and the product description must include whatever mounting hardware is used for the cushion.

Fee schedule allowances for all codes other than K0658 and K0666 will be recalculated based on products that have received confirmation of coding from the SADMERC. This includes a recalculation of the allowances for codes K0652, K0653, K0656, and K0657 with the adjustable products removed. The new allowances will be effective on all claims for these codes that are processed on or after November 12, 2004.

If claims for codes K0650-K0666 are processed before November 12 and are paid based on the October fee schedule allowances, suppliers may request a payment adjustment beginning November 12. The procedure for Region D is to submit the request in writing using the suggested Medicare Written Adjustment Request Form (located on the Web at http://www.cignamedicare.com/ dmerc/resource.html). For custom fabricated cushions, the adjustment request must include the manufacturer and product name/number (if applicable) or a detailed description of the product. Claims that were processed prior to early October were paid using individual consideration; those claims may not be submitted for a payment adjustment.

A revision of the Wheelchair Seating LCD and Policy Article incorporating these changes will be published in the January 2005 *DMERC Region D Supplier Manual* update.

Wheelchair Options

Power Wheelchair Drive Control Systems - New Modifier

Codes E2320-E2331 describe nonstandard power wheelchair drive control interfaces. Effective for claims with dates of service on or after January 1, 2005, a new modifier has been created:

KC - Replacement of special power wheelchair interface

This modifier is added to the codes listed above if they are replacing an existing interface because of irreparable damage or a change in the patient's condition. The KC modifier must not be used when a nonstandard interface is provided at the time of initial issue of the wheelchair.

Nonstandard Seat Frame Dimensions - Captain's Seats

Codes E2340 - E2343 describe nonstandard seat frame widths or depths for power wheelchairs. These codes should only be used for wheelchairs which have a tubular seat frame. They may not be used with wheelchairs that have captain's seats. A seat width and/or seat depth of 20 inches or greater in a captain's seat should be billed with code K0108. The claim must indicate the fact that it is a captain's seat and must indicate the seat width and depth.

Orthotics/Prosthetics

Enteral Nutrition – Code Changes

Effective for dates of service on or after January 1, 2005, the following new codes have been established:

B4102 Enteral formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500ml = 1 unit

B4103 Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500ml = 1 unit

B4104 Additive for enteral formula (e.g. fiber)

B4149 Enteral formula, blenderized natural foods with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4157 Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4158 Enteral formula, for pediatrics, nutritionally complete with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit.

B4159 Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit

B4160 Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ ml) with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4161 Enteral formula, for pediatrics, hydrolyzed/ amino acids and peptide chain proteins includes fats carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4162 Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

The narrative description of the following existing codes has been revised effective for dates of service on or after January 1, 2005.

B4150 Enteral formula, nutritionally complete with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4152 Enteral formula, nutritionally complete calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4153 Enteral formula, nutritionally complete hydrolyzed proteins (amino acids and peptide chain) includes fats carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4154 Enteral formula, nutritionally complete special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/ or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit

B4155 Enteral formula, nutritionally incomplete/ modular nutrients, includes specific nutrients carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g. medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit

Codes B4151 and B4156 have been discontinued for claims with dates of service after December 31, 2004.

There is no grace period allowing use of these codes for dates of service in 2005. Manufacturers or suppliers of products that had been billed using those codes may request a new Coding Verification Review from the SADMERC. (Refer to the article entitled "Coding Assistance from the SADMERC" published in the Summer 2003 *DMERC Dialogue* for information about requesting a coding verification review.)

Codes B4102 and B4103 describe electrolyte-containing fluids that are noncovered by Medicare.

Code B4104 is an enteral formula additive. The enteral formula codes include all nutrient components, including vitamins, mineral, and fiber. Therefore code B4104 will be denied as not separately payable.

Code B4149 describes formulas containing natural foods that are blenderized and packaged by a manufacturer. Code B4149 must not be used for foods which have been blenderized by the patient or caregiver for administration through a tube. Self-blenderized formulas are noncovered by Medicare.

New codes B4149 and B4157-B4162 will require a Certificate of Medical Necessity (CMN); codes B4102-B4104 will not require a CMN.

Questions concerning the correct coding of specific enteral nutrition products should be directed to the SADMERC.

A revision of the Enteral Nutrition medical policy incorporating these codes will be published in a future supplier manual update.

Payment To Providers/Suppliers Qualified To Bill Medicare For Prosthetics And Certain Custom-Fabricated Orthotics

Medlearn Matters Article Number: MM3373

Provider Types Affected - Physicians, providers, and suppliers who bill durable medical equipment regional carriers (DMERCs)

Provider Action Needed - This instruction puts new edits in the Medicare claims processing system to look for specialty codes 51, 52, 53, 55, 56, and 57 when processing claims for prosthetics and custom-fabricated orthotics. These new edits will ensure that those providers specifying Prosthetist and Orthotist (P & O) on their enrollment application are the only entities billing Medicare for P & O supplies.

Claims listing specialty codes other than those just mentioned and representing billings for prosthetics and certain custom-fabricated orthotics will be denied by Medicare. If you did not enter the appropriate specialty code on the National Supplier Clearinghouse (NSC) application, you must reenroll with the NSC.

Any supplier qualified to distribute the prosthetics and customized-fabricated orthotics in question that did not select one of the covered specialties in its initial enrollment can submit a revised CMS 855S enrollment form to the NSC.

Background

Section 1834(h)(F) of the Social Security Act titled "Special Payment Rules for Certain Prosthetics and Custom-Fabricated Orthotics," states that no payment will be made for such items unless provided by a qualified practitioner. Currently, DMERCs are processing these claims from all enrolled and approved providers/suppliers without regard to specialty identified on the Enrollment Application Form (Form 855S).

Effective for claims with dates of service of July 1, 2005 or later, DMERCs will process claims for prosthetics and certain customized-fabricated orthotics only when the DMERC provider/supplier files show a specialty code that authorizes billing for prosthetics and these orthotics. The specialties identified as involving orthotics and prosthetics are as follows:

- Medical Supply Company with Certified Orthotist – Specialty Code 51
- Medical Supply Company with Certified Prosthetist – Specialty Code 52
- Medical Supply Company with Certified Orthotist and Prosthetist – Specialty Code 53
- Certified Orthotist – Specialty Code 55
- Certified Prosthetist – Specialty Code 56
- Certified Orthotist and Prosthetist – Specialty Code 57

This instruction puts new edits in the claims processing system to look for specialty codes 51, 52, 23, 55, 56, and 57. These new edits will ensure that those providers specifying P & O on their enrollment application are the only entities billing Medicare for P & O supplies.

Claims listing other specialty codes billing for prosthetics and certain custom-fabricated orthotics will be de-

nied, effective for claims with dates of service on or after July 1, 2005.

Any supplier qualified to distribute the prosthetics and customized-fabricated orthotics in question that did not select one of the covered specialties in its initial enrollment can submit a revised CMS 855S enrollment form to the National Supplier Clearinghouse.

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

Additional Information - The CMS 855 forms may be found at: http://www.cms.hhs.gov/providers/enrollment/forms/. If you have any questions regarding this issue, please contact your DMERC or intermediary at their toll free number. You may find that number at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

The *Medicare Claims Processing Manual* (Pub 100-04), Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DME/POS), Parenteral and Enteral) Section 130.1 (Provider Billing for Prosthetic and Orthotic Devices), has been revised to include a paragraph regarding editing for P & O claims. The updated manual instructions are included in the official instruction issued to your carrier, and can be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. Once at that site, scroll down the CR NUM column on the right and click on CR3373.

A comprehensive list of the HCPCS for customized orthotics and prosthetics that need to be used with these specialty codes can also be found at as an attachment to CR3373.

Pharmacy

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

Several suppliers have expressed confusion regarding the following statement in the Medlearn Matters article published in the Fall 2004 *DMERC Dialogue*, page 12:

"Thus, the law and implementing regulations permit the 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 for it under Part B."

This statement only relates to the fact that EPO is excluded from Skilled Nursing Facility (SNF) Consolidated Billing (CB) when provided by an outside provider. The drugs may be billed to the DMERC, but the KX modifier for coverage criteria should only be used if the specific criteria in the local medical review policy (LMRP) for Epoetin (EPO) are met. For example, a pharmacy who provides EPO to a Method II dialysis patient, but is not the supplier of the patient's dialysis supplies does not meet the criteria in the EPO LMRP; modifier KX must not be used and such claims are denied because there is no Medicare benefit category under which to cover the drug. Refer to the *DMERC Region D Supplier Manual,* Chapter 9, EPO policy for the coverage criteria.

Clarification Of Epoetin Alfa (EPO) Billing Procedures And Codes In ESRD

Medlearn Matters Article Number: SE0406

Provider Types Affected - Physicians, suppliers, and renal dialysis facilities (RDFs) caring for patients with End Stage Renal Disease (ESRD)

Provider Action Needed - Physicians, suppliers, and RDFs should note that this Special Edition provides an overview of the differences between Medicare's billing procedures and codes for ESRD.

Background

Epoetin Alfa (EPO) Billing Procedures and Codes

The Centers for Medicare & Medicaid Services (CMS) has assigned a new Healthcare Common Procedure Coding System (HCPCS) code (Q4055) for EPO, and the new HCPCS code (Q4055) is provided for ESRD EPO usage only. Also, CMS has deleted all the current "Q" codes (Q9920 through Q9940) established for ESRD patients on EPO. All other rules still apply for billing EPO for ESRD-related anemia.

Intermediaries pay for EPO to ESRD facilities as a separately billable drug to the composite rate. No additional payment is made to administer EPO, whether in a facility or a home. Medicare beneficiaries getting dialysis at home may choose between two methods of payment.

EPO payment is in addition to the composite rate and the following billing procedures are to be used for EPO administered in your facility. Identify EPO and the number of injections by:

- Revenue Code 634: EPO administration of **less than** 10,000 units; and
- Revenue Code 635: EPO administration of **equal to or more than** 10,000 units.

The following value codes should be used for reporting Hemoglobin and Hematocrit readings:

- Hemoglobin (Hgb) Reading: Value Code 48; and
- Hematocrit (Hct) Reading: Value Code 49.

In addition, use value code **68** for reporting the number of EPO units administered during the billing period. And, remember to include the HCPCS code Q4055 on the claim.

Summarizing for EPO

For dates of service on and after January 1, 2004, claims include the following:

- Bill Type = 721 (Clinic ESRD First Service to Last Service) or other bill type as applicable
- Revenue Code = 634 or 635 (according to units administered)
- HCPCS Codes = Q4055 (Required)
- Units = number of administrations (not to exceed 13 for a 30-day month or 14 for a 31-day month)
- Value Codes = 48 (hemoglobin reading) or 49 (hematocrit reading)
- Value Code = 68 (number of units of EPO administered)
- Reimbursement remains the same at $10.00 per 1,000 units.
- (Reference: CMS Pub. 100-4, Chapter 8, Section 60.4)

Example 1: The following numbers of EPO units were administered during the billing period 2/1/04 – 2/28/04:

Date	EPO Units	Date	EPO Units
2/1	3000	2/15	2500
2/4	3000	2/18	2500
2/6	3000	2/10	2560
2/8	3000	2/22	2500
2/11	2500	2/25	2000
2/13	2500	2/27	2000

Total: 102,500 units
HCPCS code: Q4055
Revenue Code: 634, 3 (number of administration dates)
HCPCS code: Q4055
Revenue Code: 635, 6 (number of administration dates)
Value Code: 68, 102,500
Value Code: 49, 30.9 (Hct)
(See ESRD Manual Section 60.)

If an electronic submitter has additional documentation, which Medicare may require, they can indicate "DOCUMENTATION AVAILABLE UPON REQUEST" in the narrative (NTE02) segment. If the additional documentation you have is needed for Medicare to make its payment determination, a development letter will be sent requesting the information. If the NTE02 segment does not indicate the availability of the additional documentation or the information is not returned in a timely manner, the claim will be returned as unprocessable.

Related Instructions

Change Request (CR) 2963, Transmittal 39, January 6, 2004 can be found at the following CMS web site: http://www.cms.hhs.gov/manuals/transmittals/comm/date_dsc_asp

CR 3037; Transmittal 36, December 24, 2003 can be found at the following CMS web site: http://cms.hhs.gov/manuals/pm_trans/R36OTN.pdf

CR 2984**,** Transmittal 118, March 5, 2004 can be found at the following CMS website: http://www.cms.hhs.gov/manuals/transmittals/cr_num_asc.asp

Additional Information

The Medicare Renal Dialysis Facility Manual, Chapter II, Coverage of Services can be found at the following CMS Website: 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 sites:

http://www.cms.gov/manuals/102_policy/bp102c11.pdf
http://www.cms.gov/manuals/102_policy/bp102c17.pdf

Lastly, see the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 8, Section 60.4 at the following CMS web site: http://www.cms/manuals/104_claims/clm104c08.pdf

Durable Medical Equipment Regional Carriers And VIPS, Processing National Drug Code Numbers

Medlearn Matters Article Number: MM3141

Provider Types Affected - Suppliers and Providers who bill Medicare Durable Medical Equipment Regional Carriers (DMERCs).

Provider Action Needed

Impact to You - Suppliers and providers who bill for medications using National Drug Codes (NDCs) on claims submitted to Medicare need to note this change.

What You Need to Know - Suppliers and providers should note that if an NDC has been de-activated, even for a short time, the related claim will be rejected if the date of service occurs during the time the code is deactivated or terminated.

What You Need to Do - Please refer to the *Background* and *Additional Information* sections of this instruction for further details.

Background - With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), DMERCs now receive many NDCs for drugs, and they must also be able to process the following formats:

- The National Council for Prescription Drug Programs (NCPDP) format;
- The X12N 837P format (claims, encounters, and coordination of benefits); and
- The National Standard Format (NSF) format.

DMERCs will receive monthly updates of the NDC crosswalk files from CMS, beginning in April, 2004. The DMERCs will use these updates in editing NDCs submitted on claims. Where a claim is submitted for an NDC and the date of service is during a time when the NDC is deactivated, terminated, or otherwise invalid, the CMERC will reject the claim back to the provider with remittance advice message M119 to indicate that the claim contains a "Missing/Incomplete/Invalid/Deactivated or withdrawn National Drug Code (NDC)."

Providers should note that if an NDC code has been deactivated, even for a short time, the claim line will be rejected if the date of service occurs during the time the code is deactivated/terminated.

Implementation - The implementation date for this instruction is April 5, 2004.

Additional Information - The official instruction issued to your carrier 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 CR3141 in the CR NUM column on the right, and click on the file for that CR.

Infusion Therapy – Billing For Denial

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

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

A Certificate of Medical Necessity (CMN) does not need to be submitted in this situation.

If the supplier elects to submit a claim, then code A4221 and/or A4223 must be used as appropriate for the infusion-related supplies. A4223 is a new code that is being established, effective for dates of service on or after January 1, 2005. The narrative for the new code is:

A4223 Infusion supplies, not used with external infusion pump, per cassette or bag (list drugs separately)

If the drug has a specific code, it must be used. If there is no specific code for the drug, it is submitted using code J3490 (unclassified drug); do not use J7799.

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

ation.

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

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

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

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

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

The modifier GY must not be used in these situations.

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

Nebulizer – New Inhalation Drug Codes

Effective for dates of service on or after January 1, 2005, six new codes have been established for albuterol, levalbuterol, and ipratropium inhalation solutions:

J7611 Albuterol, inhalation solution, administered through DME, concentrated form, 1mg
J7612 Levalbuterol, inhalation solution, administered through DME, concentrated form, 0.5mg
J7613 Albuterol, inhalation solution, administered through DME, unit dose, 1mg
J7614 Levalbuterol, inhalation solution, administered through DME, unit dose, 0.5mg
J7616 Albuterol, up to 5 mg and ipratropium bromide up to 1 mg, compounded inhalation solution, administered through DME
J7617 Levalbuterol, up to 2.5 mg and ipratropium bromide up to 1mg compounded inhalation solution, administered through DME

Codes J7618, J7619, and J7621 are discontinued for claims with dates of service after December 31, 2004. There is no grace period allowing use of these codes for dates of service in 2005.

Codes J7616 and J7617 may only be used when these drugs are provided in combination by a manufacturer or repackager in a vial with a single National Drug Code (NDC) number. DuoNeb is one example of J7616. Despite the narrative description of the code, J7616 and J7617 must not be used for inhalation solutions of these drugs that are compounded by pharmacies. For combination unit dose preparations compounded by pharmacies and for situations in which these drugs are provided in separate unit dose vials, suppliers should use codes J7613 for albuterol, J7614 for levalbuterol, and J7644 for ipratropium with the appropriate modifier – KO, KP, or KQ.

The KO, KP, and KQ modifiers should not be used with codes J7616 and J7617.

General

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

Medlearn Matters Article Number: MM3525

Provider Types Affected - Physicians, providers, home health agencies (HHAs), and suppliers

Provider Action Needed - The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing update effective January 1, 2005. Affected providers should be aware of these changes.

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

With the exception of therapies performed by physicians, supplies incidental to physician services, and supplies used in institutional settings, services appearing on this list that are submitted on claims to Medicare contractors will not be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA).

Medicare periodically publishes Routine Update Notifications, which contain updated lists of non-routine supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

Additional Information - This notification provides the annual HH consolidated billing update effective January 1, 2005. The following table describes the HCPCS codes and the specific changes to each that this notification is implementing on January 3, 2005:

Code	Description of Code	Type Change	Replacement Code or Code Being Replaced
Non-Routine Supplies			
A4347	Male external catheter	Delete	Replacement code: A4349
A4324	Male ext cath w/adh coating	Delete	Replacement code: A4349
A4325	Male ext cath w/adh strip	Delete	Replacement code: A4349
A4349	Male ext catheter, with or without adhesive, disposable, each	Add	Replaces codes: A4347, A4324, A4325
A7040	One way chest drain valve	Add	
A7041	Water seal drainage container and tubing for use with implanted chest tube	Add	
A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	Add	
A7527	Tracheostomy/laryngectomy tube plug/stop, each	Add	
Note: The following codes are not DMERC jurisdiction.			
Therapies			
97601	Wound care selective	Delete	Replacement codes: 97597, 97598
97597	removal of devitalized tissue from wound(s), selective debridement; surface area less than or equal to 20 square centimeters	Add	Replaces code: 97601
97598	removal of devitalized tissue from wound(s), selective debridement; total wound(s) surface area greater than 20 square centimeters	Add	Replaces code: 97601
97605	Negative pressure wound therapy(eg. vacuum assisted drainage collection); total wound(s) surface area less than or equal to 50 square centimeters	Add	
97606	Negative pressure wound therapy(eg. vacuum assisted drainage collection); total wound(s) surface area greater than 50 square centimeters	Add	

The last update to the HH consolidated billing was issued under Transmittal 226, CR 3350. This CR can be found at: http://www.cms.hhs.gov/manuals/pm_trans/R226CP.pdf. The official instruction issued to your carrier/intermediary (including Durable Medical Equipment Carriers (DMERCs) and Regional Home Health Intermediaries

(RHHIs)) 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 3525 in the CR NUM column on the right, and click on the file for that CR. If you have any questions regarding this issue, please contact your carrier/intermediary at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

Skilled Nursing Facility (SNF) Consolidated Billing

Medlearn Matters Article Number: SE0431

Provider Types Affected - All Medicare providers, suppliers, physicians, skilled nursing facilities (SNF), 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" section 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).

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 Medicare Part A 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 Medicare Part B, 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, which 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). This section of the law contains the SNF CB requirements. 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 became effective 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 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 tests 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 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** furnished 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.

Outpatient Hospital Services

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 are:

- Cardiac catheterization;
- Computerized axial tomography (CT) scans;
- Magnetic resonance imaging services (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 in order for an outside supplier to 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 Medlearn Consolidated Billing Website 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 Website 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).

Billing Reminder

Proper identification of the beneficiary is essential when billing a claim. Please use the beneficiary's name and Health Insurance Claim Number (HICN) as it appears on the beneficiary's Medicare card. An incorrect or incomplete beneficiary name or HICN can cause delay in claim processing or return of the claim.

MMA - Processing Part B Claims For The Indian Health Services (IHS)

Medlearn Matters Article Number: MM3288

Provider Types Affected - Indian Health Services, tribe and tribal organizations (non-hospital or non-hospital based) facilities

Provider Action Needed - This instruction notifies affected providers and suppliers that beginning January 1, 2005; IHS facilities can bill Medicare for other Part B services, such as Durable Medical Equipment (DME), prosthetics, orthotics, therapeutic shoes, clinical laboratory services, and ambulance services. Coverage of these other Part B items and service are for a five-year period beginning January 1, 2005.

Background - The Social Security Act (SSA) provides for payment to IHS facilities for services paid under the physician fee schedule. Additionally, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA, Section 630) allows IHS, tribe and tribal organization facilities to bill for other Part B services that are not covered under the SSA (Section 1848). Therefore, the Centers for Medicare & Medicaid Services (CMS) is amending the *Medicare Claims Processing Manual* (Pub 100-04), to allow IHS, tribe and tribal organization facilities to bill for all other Part B services that are not paid for under the physician fee schedule. (See the Additional Information section below.) This expansion of scope of services is for a five-year period beginning January 1, 2005.

IHS, tribe and tribal organization facilities may bill for all other Part B services that are not paid under the physician fee schedule and that are not included in the Medicare IHS all-inclusive rate. Specifically, for the five-year period beginning January 1, 2005, IHS, tribe and tribal organization facilities may bill Medicare for the following Part B services:

- DME
- Prosthetics and orthotics
- Prosthetic devices
- Surgical dressings, splints, and casts
- Therapeutic shoes
- Drugs (those normally billed under Part B and to DME Regional Carriers (DMERCs))
- Clinical laboratory services
- Ambulance services

IHS and tribally operated hospitals and clinics associated with hospitals that meet the definition of providerbased in regulations at 42 Code of Federal Regulations (CFR) 413.65, and are currently reimbursed under the all-inclusive rate for services paid under the physician fee schedule, will continue this practice. If and when these facilities decide to bill for items on the Durable Medical Equipment, Prosthetics, Orthotics, and Equipment (DMEPOS) fee schedule, they must enroll as a supplier through the National Supplier Clearinghouse (NSC) and bill the appropriate DMERC.

An IHS tribe or tribal organization facility **furnishing clinical laboratory services** must accomplish the following:

- Meet the applicable requirements of the Clinical Laboratory Improvement Amendment (CLIA) requirements as specified in 42 CFR, Section 493(f.f)
- Enroll with Trailblazers and bill that carrier

An IHS tribe or tribal organization facility **furnishing ambulance services** (which will be paid based on the ambulance fee schedule) must accomplish the following:

- Meet the requirements of 42 CFR, Section 410.41
- Enroll with and bill Trailblazers

Outpatient Clinics (freestanding) operated by the IHS and **furnishing DMEPOS** will:

- Enroll with the NSC as a "DME supplier"
- Comply with the supplier standards specified in 42 CFR, Section 424.57
- Submit all DMEPOS claims to the CIGNA DMERC, or (at the facility's option) submit DME claims to the appropriate DMERC based on current DME jurisdiction rules
- DMEPOS claims submitted to the DMERC must be billed with a place of service "12" (home).
- Claims submitted to the DMERC must have a specialty code from the NSC of "A9". The "A9" must not be transmitted as the "primary specialty" on DMEPOS claims.

Such outpatient clinics should note that to bill drugs to

DMERCs, the supplier must be a pharmacy and a pharmacy license must be on file with the NSC. The NSC will give the pharmacy supplier a specific identifier. Also, if claims are submitted to CIGNA, note that CIGNA will not perform any other DMERC functions for non-CIGNA claims. CIGNA will only route the non-CIGNA claims to the appropriate DMERC and that DMERC will be the point of contact for the supplier.

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

Additional Information - For complete details, including the revised sections of the *Medicare Claims Processing Manual*, please see the official instruction issued to your fiscal 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 3288 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.

FEE SCHEDULE

DMEPOS Fee Schedule Update For 2005

The 1st Quarter 2005 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule is available on our Web site at http://www.cignamedicare.com/dmerc/fsch/ index.html. Fees for the new 2005 HCPCS codes listed below are not yet available; therefore, they are not included in the 1st quarter fee schedule posted on the Web and are not included on the Winter 2005 publications CD-ROM. The 1st quarter fee schedule will be revised to include the new codes and posted on our Web site in mid-December 2004. The 1st Quarter 2005 DMEPOS fee schedule will apply to all claims with dates of service January 1, 2005 through December 31, 2005.

Section 302 (c)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires 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 Benefits (FEHB) plans surveyed by the OIG. This provision affects the following HCPCS codes: A4253, A4259, E0260, E0277, E0424, E0431, E0434, E0439, E0570, E1390, E1391, K0001, and K0011.

As of January 1, 2005, therapeutic shoes and inserts will be part of the DMEPOS fee schedule in accordance to Section 627 of the MMA. Refer to the Medlearn Matters article # MM3574 for more details regarding the calculation.

The fee schedule amounts for codes K0646 and K0648 have been revised effective January 1, 2005 by using the fee schedule amount for the previous code L0565.

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

- DME other than items classified as class III devices for the Food and Drug Administration (FDA) - 0%
- DME classified as class III devices by the FDA - 3.3%
- Prosthetic devices, prosthetics and orthotics - 0%
- PEN - 3.3%
- Surgical Dressings - 0%

CR = Capped Rental

FS = Frequently Serviced DME

IN = Inexpensive or Routinely Purchased DME

OS = Ostomy, Tracheostomy, or Urological Supply

PE = Enteral Nutrition

PO = Prosthetics and Orthotics

Code	Category
A4349	OS
A7527	OS
A7045	IN
B4102	PE
B4149	PE
B4157	PE
E0463	FS
E0464	FS
E1039	CR
E1841	CR
E2368	IN
E2369	IN
E2370	IN
E2601	IN
E2602	IN
E2603	IN
E2604	IN
E2605	IN
E2606	IN
E2607	IN
E2608	IN
E2611	IN
E2612	IN

Code	Category
E2613	IN
E2614	IN
E2615	IN
E2616	IN
E2618	IN
E2619	IN
E2620	IN
E2621	IN
L1932	PO
L2005	PO
L2232	PO
L4002	PO
L5685	PO
L5856	PO
L5857	PO
L6694	PO
L6695	PO
L6696	PO
L6697	PO
L6698	PO
L7181	PO
L8515	PO

MMA Drug Pricing Update – Payment Limit For J9045 (Carboplatin Injection) And J9310 (Rituximab Cancer Treatment)

Medlearn Matters Article Number: MM3419

NOTE: This article is being published as informational only for services billable by physicians and local carrier providers. DMEPOS suppliers should refer to the article entitled "New Basis for Medicare Drug Payment Amounts for DMERCs" (published in the April 2004 *DMERC Dialogue*) regarding pricing for drugs billable to the DMERC.

Provider Types Affected - Physicians, suppliers, and providers.

Provider Action Needed - Affected providers are advised that Medicare carriers are updating the payment limits (listed in this article) for HCPCS drug code J9045 (Carboplatin injection) and J9310 (Rituximab cancer treatment), effective with dates of service on or after April 1, 2004, and on or before December 31, 2004.

Background - The payment limits for Carboplatin injection and Rituximab cancer treatment, Medicare Part B drugs meeting the exceptions process described in Section 303(b) of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) are being updated for claims with such services provided between April 1, 2004 through December 31, 2004, inclusive. The old and new rates for J9045 (Carboplatin injection) and J9310 (Rituximab cancer treatment) with the new rate for dates of service on or after April 1, 2004 and on or before December 31, 2004 are as follows where payment is not made on a cost or prospective payment basis:

Status	HCPCS	Short Description	AWP %	2004 Payment Limit for Drugs (other than ESRD drugs separately billed by independent ESRD Facilities and drugs infused through DME)
OLD	J9045	Carboplatin injection	88	$137.54
NEW	J9045	Carboplatin injection	86	$135.15
OLD	J9310	Rituximab cancer treatment	81	$427.28
NEW	J9310	Rituximab cancer treatment	83	$438.38

The payment limits for J9045 and J9310 supercede the payment limits published in Change Request (CR) 3161 (Transmittal 119) dated March 15, 2004. 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 this instruction is September 24, 2004.

Additional Information - For complete details, please see the official instruction issued to your carrier 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 CR3419 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 - Instructions For Pricing Treprostinil (Q4077)

Medlearn Matters Article Number: MM3533

Provider Types Affected - All Durable Medical Equipment (DME) suppliers

Provider Action Needed

Impact to You - Medicare's Durable Medical Equipment Regional Carriers (DMERCs) will use the specific payment for Healthcare Common Procedure Coding System (HCPCS) drug code Q4077 (Treprostinil) located in the 2004 MMA Payment Limits Pricing File.

What You Need to Know - The 2004 pricing allowance for Q4077 is $61.75.

What You Need to Do - Make sure that your billing offices are aware of this instruction.

Background - This article and the related change request advise suppliers that the DMERCs will use the 2004 MMA Payment Limits Pricing File when pricing the drug Treprostinil (Q4077). That 2004 pricing allowance for Q4077 is $61.75 and is effective for claims with dates of service on or after January 1, 2004.

This change will ensure consistency among the four regional DMERCs and continuity of care for Medicare beneficiaries requiring Treprostinil.

NOTE: The DMERCs will not search their files to either retract payment for claims already paid or to retroac-

tively pay claims. However, contractors will adjust claims brought to their attention.

Implementation - The implementation date is November 29, 2004.

Related Instructions - The 2004 MMA Payment Limits Pricing File is available at: http://www.cms.hhs.gov/providers/drugs/default.asp.

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 3533 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 - January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective January 1, 2005

Medlearn Matters Article Number: MM3539

Provider Types Affected - All providers

Provider Action Needed - No provider action is necessary. This article is informational only and explains how Medicare pays for certain drugs that are not paid on a cost or prospective payment basis, effective January 1, 2005.

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 Average Sales Price (ASP) plus six (6) percent. The Centers for Medicare & Medicaid Services (CMS) will supply its carriers/intermediaries with the ASP drug pricing file for Medicare Part B drugs. The ASP is based on quarterly drug information supplied to CMS by drug manufacturers.

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

Exceptions - There are exceptions to this general rule, as summarized below:

1. The payment allowance limits for blood and blood products, with certain exceptions such as blood clotting factors, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the pay ment allowance limits for blood and products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
2. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005 will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003 regardless of whether or not the durable medical equipment is implanted. The payment allowance limits will not be updated in 2005.
3. The payment allowance limits for influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
4. The payment allowance limits for drugs not included in the ASP Medicare Part B Drug Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing.

Note that 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. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Implementation - The implementation date is January 3, 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 3539 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.

Note: The 2005 Average Sale Price (ASP) drug pricing file will be posted on the Region D Web site at http://www.cignamedicare.com/dmerc/fsch/ndex.html when it becomes available. Inclusion or exclusion of an ASP fee amount for a drug listed does not imply any health insurance coverage.

MMA - Reasonable Charge Update For 2005 For Splints, Casts, Dialysis Supplies, Dialysis Equipment, Therapeutic Shoes, And Certain Intraocular Lenses

Medlearn Matters Article Number: MM3430

Provider Types Affected - Physicians, providers, and suppliers.

Provider Action Needed - This instruction provides details regarding the calculation of reasonable charges for the payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year 2005.

Background - Payment on a reasonable charge basis is required for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses by regulations contained in 42 Code of Federal Regulations (CFR) 405.501.

This instruction provides details regarding the calculation of reasonable charges for payment of claims for **splints, casts**, dialysis supplies, dialysis equipment, **and intraocular lenses** furnished in calendar year 2005.

- 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.

For splints and casts the following applies:

- The 2005 gap-filled amounts will be based on the 2004 amounts increased by 3.3 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2003.
- **For splints and casts** furnished by hospital outpatient departments, payment is built into the Outpatient Prospective Payment System (OPPS) payment amounts.
- **For splint or cast materials,** payment is only made on a reasonable charge basis for splint or cast materials used by physicians or other practitioners to reduce a fracture or dislocation, and this payment is in addition to the payment made under the physician fee schedule for the procedure for applying the splint or cast.
- For **intraocular lenses (HCPCS codes of V2630, V2631, and V2632)**, payment is only made on a reasonable charge basis for lenses implanted at a physician's office.

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

Additional Information - For complete details, please see the official instruction issued to your carrier or DMERC regarding this change at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that Web page, look for CR3430 in the CR NUM column on the right, and click on the file for that CR. That CR has a detailed list of HCPCS codes for splints and casts with associated gap-filled payment amounts that your carrier will use in making payment in 2005 based on the lower of the actual charge or the gap-filled payment amount. If you have any questions, please contact your carrier or DMERC at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

2005 Reasonable Charge Codes

Payment on a reasonable charge basis is required for certain items by regulations contained in 42 CFR 405.501. As part of the development of reasonable charge data, the DMERCs will compute 2005 customary and prevailing charges for the codes identified below using actual charge data from July 1, 2003 through June 30, 2004. In addition, the DMERCs will compute the Inflation-Indexed Charge (IIC) amounts for 2005. The IIC update factor for 2005 is 3.3 percent.

Please refer to the *DMERC Region D Supplier Manual*, Chapter 12, page 2, for more information on how the reasonable charge is calculated.

Dialysis supplies and equipment HCPCS codes that are subject to reasonable charge calculation are listed below:

Dialysis Supplies Billed with AX Modifier

A4216, A4217, A4244, A4245, A4246, A4247, A4248, A4450, A4452, A4651, A4652, A4656, A4657, A4660, A4663, A4670, A4712, A4927, A4928, A4930, A4931, A6250, A6260

Dialysis Supplies Billed without AX Modifier

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

Dialysis Equipment Billed with AX Modifier

E0210NU, E1632, E1637, E1639

Dialysis Equipment Billed without AX Modifier

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

HCPCS UPDATES

2005 HCPCS Updates – New, Discontinued And Verbiage Changes

The following new codes are effective for dates of service on or after January 1, 2005. If these codes are billed before January 1, 2005 they will be returned as unprocessable or denied as an invalid code. For the full list of HCPCS codes, refer to the *DMERC Region D Supplier Manual*, Chapter 16, Level II HCPCS codes.

The appearance of a HCPCS code does not necessarily indicate coverage.

New HCPCS Codes

A4223 Infusion supplies, not used with external infusion pump, per cassette or bag (list drugs separately)
A4349 Male external catheter with or without adhesive, disposable, each
A4520 Incontinence garment, any type (e.g. brief, diaper), each
A4605 Tracheal suction catheter, closed system, each
A7045 Exhalation port with or without swivel used with accessories for positive airway devices, replacement only
A7527 Tracheostomy/laryngectomy tube plug/stop each
B4102 Enteral Formula, for adults, used to replace fluids and electrolytes (e.g. clear liquids), 500ml = 1 unit.
B4103 Enteral Formula, for pediatrics, used to replace fluids and electrolytes (e.g. clear liquids), 500ml = 1 unit
B4104 Additive for enteral formula (e.g. fiber)
B4149 Enteral Formula, blenderized natural foods with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4157 Enteral Formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4158 Enteral Formula, for pediatrics, nutritionally complete with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit.
B4159 Enteral Formula, for pediatrics, nutritionally complete soy based with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit
B4160 Enteral Formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 Kcal/ ml) with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4161 Enteral Formula, for pediatrics, hydrolyzed/ amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
B4162 Enteral Formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit
E0463 Pressure support ventilator, with volume control mode, may include pressure control mode, used with invasive interface (e.g. tracheostomy tube)

E0464 Pressure support ventilator, with volume control mode, may include pressure control mode, used with non-invasive interface (e.g. mask)
E0639 Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories
E0640 Patient lift, fixed system, includes all components/accessories
E0769 Electrical stimulation or electromagnetic wound treatment device, not otherwise classified
E0849 Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E1039 Transport chair, adult size, heavy duty, patient weight capacity 250 pounds or greater
E1229 Wheelchair pediatric size, not otherwise specified
E1239 Power wheelchair, pediatric size, not otherwise classified
E1841 Multi-directional static progressive stretch shoulder device, with range of motion adjustability, includes cuffs
E2205 Manual wheelchair accessory, handrim without projections, any type, replacement only, each
E2206 Manual wheelchair accessory, wheel lock assembly, complete, each
E2368 Power wheelchair component, motor, replacement only
E2369 Power wheelchair component, gear box, replacement only
E2370 Power wheelchair component, motor and gear box, combination, replacement only
E2601 General use wheelchair seat cushion, width less than 22 inches, any depth
E2602 General use wheelchair seat cushion, width 22 inches or greater, any depth
E2603 Skin protection wheelchair seat cushion, width less than 22 inches, any depth
E2604 Skin protection wheelchair seat cushion, width 22 inches or greater, any depth
E2605 Positioning wheelchair seat cushion, width less than 22 inches, any depth
E2606 Positioning wheelchair seat cushion, width 22 inches or greater, any depth
E2607 Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth
E2608 Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth
E2609 Custom fabricated wheelchair seat cushion, any size
E2610 Wheelchair seat cushion, powered
E2611 General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware
E2612 General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware
E2613 Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware
E2614 Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware
E2615 Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware
E2616 Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware
E2617 Custom fabricated wheelchair back cushion, any size, including any type mounting hardware
E2618 Wheelchair accessory, solid seat support base (replaces sling seat), for use with manual wheelchair or lightweight power wheelchair, includes any type mounting hardware
E2619 Replacement cover for wheelchair seat cushion or back cushion, each
E2620 Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware
E2621 Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware
J7343 Dermal and epidermal, tissue of non-human origin, with or without other bioengineered or processed elements, without metabolically active elements, per square centimeter
J7344 Dermal tissue, of human origin, with and without other bioengineered or processed elements, but without metabolically active elements, per square centimeter
J7518 Mycophenolic acid, oral, 180mg
J7611 Albuterol, inhalation solution, administered through DME, concentrated form, 1mg
J7612 Levalbuterol, inhalation solution, administered through DME, concentrated form, 0.5mg
J7613 Albuterol, inhalation solution, administered through DME, unit dose, 1mg

J7614 Levalbuterol, inhalation solution, administered through DME, unit dose, 0.5mg
J7616 Albuterol, up to 5mg and ipratropium bromide, up to 1mg, compounded inhalation solution, administered through DME
J7617 Levalbuterol, up to 2.5mg and ipratropium bromide, up to 1mg, compounded inhalation solution, administered through DME
J8501 Aprepitant, oral, 5 mg
L1932 AFO, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment
L2005 Knee ankle foot orthosis, any material, single or double upright, stance control, automatic lock and swing phase release, mechanical activation, includes ankle joint, any type, custom fabricated
L2232 Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only
L4002 Replacement strap, any orthosis, includes all components, any length, any type
L5685 Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each
L5856 Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor (s), any type
L5857 Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor (s), any type
L6694 Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism
L6695 Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism
L6696 Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)
L6697 Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695)
L6698 Addition to upper extremity prosthesis, below elbow/above elbow, lockmechanism, excludes socket insert
L7181 Electronic elbow, microprocessor simultaneous control of elbow and terminal device
L8515 Gelatin capsule application device for use with tracheoesophageal voice prosthesis, each
V2702 Deluxe lens feature

Discontinued Codes and Replacement HCPCS codes

The following codes will be deleted effective for dates of service on or after January 1, 2005. Reminder: the three month grace period no longer applies; therefore, if these codes are billed on or after January 1, 2005 they will be returned as unprocessable or denied as an invalid code.

Discontinued Deleted Codes	Replacement Crosswalk Codes
A4324	A4349
A4325	A4349
A4609	A4605
A4610	A4605
K0081	E2206
K0627	E0849
K0650	E2601
K0651	E2602
K0652	E2603
K0653	E2604
K0654	E2605
K0655	E2606
K0656	E2607
K0657	E2608
K0658	E2609
K0659	E2610
K0660	E2611
K0661	E2612
K0662	E2613
K0663	E2614
K0664	E2615
K0665	E2616
K0666	E2617
K0668	E2619
L5674	L5685
L5675	L5685
Q0182	J7343
Q0183	J7344

Discontinued Codes with no Replacement Codes

A4347	A4521	A4522	A4523	A4524
A4525	A4526	A4527	A4528	A4529
A4530	A4531	A4532	A4533	A4535
A4536	A4537	A4538	B4151	B4156
E0176	E0177	E0178	E0179	E0192
E0454	E0962	E0963	E0964	E0965
E1012	E1013	J3245	J3395	J7618
J7619	J7621	K0023	K0024	K0059
K0060	K0061	K0114	K0115	K0116
K0667	L2435	L5846	L5847	L5989
L8490				

Verbiage Changes for 2005

The following list contains HCPCS codes for which verbiage will be changed effective January 1, 2005. Refer to the *DMERC Region D Supplier Manual*, Chapter 16, HCPCS Coding section for the new verbiage.

A4222	A4332	A5119	B4150	B4152
B4153	B4154	B4155	E0450	E0461
E0625	E0951	E0952	E0955	E0956
E0957	E0967	E0978	E0986	E1010
E1011	E1014	E1038	E1225	E1226
J0150	J0152	J1564	J2324	K0669
L1820	L2035	L2036	L2037	L2038
L2039	L2320	L2330	L2755	L2800
L4040	L4045	L4050	L4055	L6890
L6895	L7180	V2745		

2005 Healthcare Common Procedure Coding System (HCPCS) Annual Update Reminder

Medlearn Matters Article Number: MM3422

Provider Types Affected - Physicians, providers, and suppliers

Provider Action Needed - This instruction is a reminder that the complete HCPCS file is updated and released annually by the Centers for Medicare & Medicaid Services (CMS) to the Medicare contractors. The 2005 version of the HCPCS file contains existing, new, revised, and discontinued HCPCS codes for 2005. Your Medicare contractor will use the file for processing claims for services on or after January 1, 2005.

All Medicare physicians, providers, and suppliers: there is no longer a 90-day grace period for billing discontinued HCPCS codes as of January 1, 2005.

Background

Medicare providers submitting claims to Medicare contractors for Part B services use a HCPCS code to indicate the service that was provided. HCPCS consist of Level I codes, which are the American Medical Association's (AMA's) Current Physician Terminology Codes (CPT-4) and Level II codes, which are alphanumeric and maintained by CMS.

The alpha-numeric index and the table of drugs will be posted to the CMS Web site by the end of October. The CMS Web site address for that posting will be: http://www.cms.hhs.gov/providers/pufdownload/default.asp#alphanu

There is no longer a 90-day grace period for discontinued codes in order to be compliant with HIPAA standards. To view further information regarding the elimination of this 90-day grace period, see the *Medlearn Matters* article MM3093, which may be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3093.pdf

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier and fiscal 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 CR3422 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

Note: Effective January 1, 2005, discontinued HCPCS codes will be returned as unprocessable or denied as incorrect coding.

APPEALS

MMA-Implementation Of New Medicare Redetermination Notice

Medlearn Matters Article Number: MM2620 (Revised)

Providers Affected - All Medicare physicians, providers, and suppliers.

Provider Action Needed

Impact to You - Redeterminations are the new first level of appeal for fee-for-service appeals. You and your patients will receive a formal notification letter, the Medicare Redetermination Notice (MRN), for any decision made on a request for redetermination made on or after October 1, 2004.

What You Need to Know - Contractors who judge these redetermination appeals must make their decisions within 60 days as a result of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and must then notify the providers and beneficiaries involved via the Medicare Redetermination Notice (MRN). This document describes the redetermination process, explains the results of the Medicare appeal, and provides information about how to file an appeal regarding Medicare's decision.

What You Need to Do - The newly initiated Redetermination Appeals Process provides for timely notification of beneficiaries and providers via the Medicare Redetermination Notice (MRN). Be sure to understand how these new procedures affect your appeal rights.

Background - The Medicare claims appeal process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, section 521). Section 1869 (a)(3)(C)(ii) required contractors to mail a written notification of the redetermination decision to the parties of an appeal. This section was then amended by MMA [Sections 1869 (a)(5) and 1869 (a)(4)(B)] to include specific requirements for the notices themselves. The requirements ensure that claim appellants receive complete, accurate and understandable information about their redetermination decisions, as well as information explaining the process of further appeals.

CMS has provided a model cover letter and a Medicare Redetermination Notice to serve as guidelines for Medicare carriers and intermediaries who make the redeterminations. The MMA also ensures that redetermination decisions are made in a timely manner by requiring that 100% of redeterminations must be completed and mailed within 60 days of the receipt of the request. [Section 940(a)(1)]

Additional Information - The MRN must be written in language that is clear and understandable to the beneficiary and must be printed legibly on white paper using black ink. The MRN include specific required elements such as the sections outlined below:

- An *Introductory* section.
- A *Summary Statement* about the appeal decision.
- A *Summary of the Facts* section including information specific to the appeal and background information.
- A *Decision* section stating whether the claim is covered by Medicare and whether the beneficiary is Responsible for payment.
- An *Explanation of the Decision* section outlining the logic and specific reasons that led to the redetermination. This must include relevant clinical or scientific evidence used in making the redetermination.
- A *Who is Responsible for the Bill* section with information on limitation of liability, waiver of recovery, and physician/supplier refund requirements.
- A *What to Include in Your Request for Independent Appeal* section to explain what policy was used to make the decision and identify specific documentation required to appeal at the Independent Appeal Level.
- An *Additional Relevant Information* section to present any additional relevant information, not including any sensitive medical information.
- A section on *Important Information About Your Appeal Rights* including contact information and an explanation of the next level of the appeal process.

The official instruction, including a copy of a model MRN, issued to your carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/pm_trans/R97CP.pdf

ELECTRONIC DATA INTERCHANGE (EDI)

Communications Software Supported (HyperTerminal)

Effective October 31, 2004, DMERC EDI will only support the communications software "HyperTerminal." You may continue to use whatever communications software currently being used. Region D DMERC EDI is not requiring you to upgrade or change your software. Beginning November 1, 2004, if you have issues with the communications software and it's not HyperTerminal, then you will need to use other resources to resolve the issues. The Region D DMERC EDI Department does not support scripted communications software, you will need to seek assistance from your software vendor.

Durable Medical Equipment Carrier – Revision To CR 2631 For Durable Medical Equipment Carriers Only

Medlearn Matters Article Number: MM3261

Provider Types Affected - Durable medical equipment suppliers

Provider Action Needed

Impact to You - Effective April 1, 2005, instead of the 2010AA Billing Provider loop to document place of service (POS) in your Durable Medical Equipment Carrier (DMERC) claims, you must use the 2420C Service Facility loop (line level) or 2310D (claim level). If you use the 2010AA loop and not one of these latter two loops, your claims will be returned as unprocessable when the place of service is other than home.

What You Need to Know - In your DMERC claims, if the place of service reported in either the 2300.CLM05 or the 2400.SV105 is anything other than Home - 12 (or CMS equivalent POS codes of 4-homeless shelter, 13-assisted living, and 14-group home), the Medicare claims processing system will only use the 2420C and 2310D loops to make the appropriate place of service determination. The Medicare System will not use the 2010AA loop to determine the valid place of service in these instances.

What You Need to Do - Make sure that your billing staff knows that, on your DMERC claims, they must use the 2420C and 2310D loops (and not the 2010AA Billing Provider loop) to document the place of service when that place is other than the home of the beneficiary.

Background

This article addresses Change Request 3261 that revises an earlier one (CR 2631). CR 2631 (Transmittal 1813B3, dated August 1, 2003) implemented procedures to follow when the POS on your claim is other than home (Code – 12 or equivalent as mentioned earlier).

It required that, on version 4010/4010A of the ASC X12N 837 electronic claim format, you provide the name, address, and zip code of the location where the service was performed, for all claims received on or after April 1, 2004. More specifically, it required that Billing Provider loop 2010AA always be completed, and was to be heavily relied on to serve as the documentation of a valid place of service.

The problem with this requirement in CR 2361 is that if the POS is not actually "home," the 2010AA loop billing may not be where the service was provided. It could actually be supplier information and not the place of service.

Although all claims must have a completed 2010AA Billing Provider loop, beginning April 1, 2004, this does not ensure that your claim has been properly submitted, because the Billing or Pay To Provider's location may not be where the services were rendered.

Therefore, in order to process claims correctly, the following change must be made for DMERC claims only:

• The Medicare system will not use the 2010AA loop to make the appropriate facility determination. It will only use the 2420C and 2310D loops to determine POS. Requirements for the required information for these two loops are not being changed with these instructions.

• The Medicare system will provide edits that require you to supply complete facility information at either the 2310D or the 2420C loops if the place of service reported in either the 2300.CLM05 or the 2400.SV105 is other than Home – 12 (or the equivalent POS codes as determined by CMS). If you don't, the claim will be returned to you with the appropriate remarks code as stated in CR2631.

NOTE: The Medicare Standard System first looks to the line item/2420C and then looks to the claim item/2310D for POS information. Currently, it then looks to the Header Information at 2010AA.

Implementation Date- The implementation date for these changes will be April 4, 2005.

Additional Information - You can find CR 3261 by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR 3261 in the CR NUM column on the right, and click on the file for that CR number. The revised pages of the online manual Pub 100-4, Chapter 1, Section 10 are attached to that CR. In addition you can find CR 2631 at: http://www.cms.hhs.gov/manuals/pm_trans/R1813B3.pdf. Finally, 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.

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

Medlearn Matters Article Number: SE0451

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 date elements, including the same codes. The same flat file is supposed to 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 and regional home health intermediaries, 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, the number may be found at: http://www.cms.hhs.gov/providers/edi/bnum.asp.

Inappropriate Access To Or Use Of Electronic Data Interchange (EDI) Transaction Data By Third Party Entities

Medlearn Matters Article Number: SE0461

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

Provider Action Needed

Impact to You - Failure to abide by Medicare security requirements for EDI access could lead to suspension of EDI capabilities.

What You Need to Know - This article clarifies and reminds affected physicians, providers, and suppliers of existing Medicare requirements and prohibitions concerning use of EDI numbers and passwords.

What You Need to Do - Be sure you and your third party partners are aware of and abide by these requirements to protect your EDI access and to maintain your ability to submit timely claims to Medicare.

Background - Medicare contractors (carriers and intermediaries) support electronic data interchange (EDI) to enable providers, either directly or through third party agents to:

- Verify patient eligibility to determine if a claim should be submitted to Medicare;
- Submit claims to Medicare electronically;
- Determine the status of a previously submitted claim; and
- Post adjudication decisions and payments to patient accounts.

It is important to note that these functions are **the only functions** for which a provider or a third party entity is entitled to send EDI transactions directly to Medicare contractors (carriers, DMERCs, or fiscal intermediaries) or receive EDI transactions directly from Medicare contractors.

Third-party entities that request permission to access Medicare EDI records directly generally fall into one of the following categories:

1. A clearinghouse as defined by the Health Insurance Portability and Accountability Act (HIPAA) that transfers and may translate claim, eligibility, claim status, and/or payment and remittance advice data for EDI transactions being transmitted between providers and one or more Medicare contractors;
2. An agent a provider has hired to prepare claims and possibly other EDI transactions for submission to one or more Medicare contractors, and possible posting to patient records/provider accounts of eligibility, claim status, and adjudication/payment data issued by one or more Medicare contractors;
3. A clearinghouse as in #1 above that also performs agent services as in #2 above; and
4. A third party that does not perform clearinghouse or agent services as described in #1-3, but that may want direct access to outbound Medicare EDI transactions for alternate functions. Entities included in this category include collection agents in pursuit of delinquent beneficiary payments to providers and vendors that market payment data analysis services to providers that serve Medicare patients.

Third parties in categories 1, 2, and 3 perform functions that qualify them for direct access to Medicare contractor EDI systems. If a provider elects to use the services of a third party to perform permitted Medicare EDI functions, the provider must complete an EDI Agreement and furnish the Medicare contractor with a signed authorization specifying the EDI services each third party may perform on their behalf. The third party must comply with existing requirements to obtain their own EDI number and password from the Medicare contractor that services each provider being represented.

Medicare contractors can issue EDI numbers and passwords to category 1, 2, and 3 entities and permit them to submit and/or obtain EDI data directly to/from the Medicare contractor EDI systems. Third parties in category 4 do not perform functions that qualify them for direct access to Medicare systems, and may not be issued EDI numbers or passwords.

Medicare requires that providers and third party entities to which EDI numbers and passwords are issued protect the security of those numbers and passwords to prevent use by unauthorized individuals. Furthermore, providers and third party entities of any category are prohibited from accessing Medicare systems using an EDI number or password not directly issued to them by a Medicare contractor.

This instruction is being issued to clarify and remind affected parties of existing CMS requirements and prohibitions concerning access to and use of EDI numbers and passwords.

Issues - Although they may qualify for direct access to Medicare contractor EDI systems, the read, write and use rights vary for entities in categories 1, 2, and 3. Third parties in categories 2 or 3 are allowed to review data within transactions, whereas category 1 entities are limited to review of “electronic envelope” data that contains routing information for the transactions. Some category 1 entities may be confused regarding this limitation.

The Centers for Medicare & Medicaid Services (CMS) recently discovered that at least one third-party entity in category 4 has been using EDI numbers and passwords furnished them by providers to download electronic remittance advice (ERA) transactions for those providers. The data **was not being used** to post adjudication and payment data to patient accounts, but was being used solely for automated analysis to detect information such as payment patterns and to generate reports. The providers were using the paper remittance advice notices they received, and not the ERAs, to post their accounts. CMS has been advised that other companies may also be marketing similar services and may be using EDI numbers and passwords issued to providers to obtain outbound EDI transactions from Medicare contractor systems for use in ways other than intended by Medicare.

CMS Policy - The following manual instructions contain CMS requirements that apply to these issues:

- The *Medicare Claims Processing Manual* (Pub. 100-04, Chapter 24 (EDI Support Requirements) contains CMS requirements for EDI access. This

can be accessed at: http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf

- The *Business Partners Systems Security Manual* (BPSSM) (Appendix A, Section 2.9.10 of the Core Security Requirements (CSR)) contains further requirements applicable to use of passwords issued to permit system access. These can be found at: http://www.cms.hhs.gov/manuals/117_systems_security/117_systems_security_atchA.pdf. These password requirements apply to entities to which Medicare contractors issue passwords, as well as to Medicare contractors themselves.
- The *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 24 (EDI Support Requirements), Section 90 contains instructions concerning mandatory electronic submission of claims to Medicare as required by ASCA. This information is available at: http://www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf.
- The *Medicare Claims Processing Manual* (Pub.100-04), Chapter 1 (General Billing Requirements), Section 80 (Carrier and FI Claims Processing Timeliness) contains Medicare's payment floor requirements at: http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf

In regard to access policies for entities in categories 1-4:

- Category 1 third parties that transfer EDI data to and/or from providers, but do not translate that data into or from a format that complies with the HIPAA requirements are **not permitted** to:
  - Open the electronic envelope of the transmitted data; or
  - Generate reports that include data from within those transmission envelopes.
- Category 2 and 3 agents **are permitted** to:
  - Open the electronic envelopes of the transmitted data; and
  - Use the data for analysis and generation of reports for the providers they serve, in addition to use of that data to prepare beneficiary claims, determine claim status or Medicare eligibility, and/or to post adjudication and payment data to patient accounts.
- Category 4 third parties may use data prepared by Medicare, but the following requirements must be met as conditions for use:
  - The data must be forwarded to the entity by the provider;
  - A signed agreement must be in effect between the provider and the entity in which the provider authorizes the entity to use the data and specifying how the data may and may not be used;
  - The entity has furnished the provider with a signed confidentiality agreement that meets Medicare's and HIPAA's privacy and security requirements for protection of personally identifiable beneficiary health data;
  - The provider has notified the patients that their personally identifiable health data will be shared with the entity and how it will be used; and
  - The provider agrees not to furnish data to the entity for any patients who object.
- A category 4 entity:
  - May **not** be given an EDI number or password for direct access to Medicare data; and
  - Is never permitted to use a provider's EDI number or password for that or any other purpose.

  As stated in the CSRs in BPSSM section 2.9.10, passwords (1) are "unique for specific individuals," (2) must be "controlled by the assigned user and [are] not subject to disclosure."

Contractor Actions if Improper Access is Identified

In the event a Medicare contractor becomes aware that improper access has been given, appropriate termination of EDI capabilities and notification must occur. For example:

- If an entity, previously issued an EDI number and password, falls under category 4, the Medicare contractor must immediately disable the EDI number and password of that entity, and then notify the entity and the provider why this has been done.
- If a third party entity is using a provider's EDI number and password to access Medicare systems, the Medicare contractor must immediately disable the EDI number and password, and then contact that provider by mail or phone to make them aware of Medicare's requirements and prohibitions.

During this contact, and while the EDI number and password are disabled, the Medicare contractor will remind the provider that:

- Loss of EDI privileges could result in termination of Medicare payment since the Administrative Simplification Compliance Act (ASCA) prohibits payment of claims submitted on paper that should have been submitted to Medicare electronically;

and
- In those cases when ASCA permits claims to be submitted on paper, payment is delayed as result of the lengthier payment floor that applies to paper claims.

Additional Information - Providers can review appropriate requirements by checking the Web sites mentioned above.

Remember: The law requires most providers to bill Medicare electronically and EDI access is crucial to that process. Protect your access and protect your patients' confidentiality by abiding by Medicare's privacy and security requirements.

If you have any questions regarding this issue, contact the EDI department of your carrier/intermediary at their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, that number may be found at: http://www.cms.hhs.gov/providers/edi/anum.asp. If you bill for Medicare Part B services, that number may be found at: http://www.cms.hhs.gov/providers/edi/bnum.asp.

Invalid Diagnosis Code Editing – Second Phase

Medlearn Matters Article Number: MM3260

Provider Types Affected - All physicians, providers, and suppliers who bill Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

Impact to You - New edits will be added to the Medicare claims processing systems to prevent acceptance of inbound claims with invalid diagnosis codes.

What You Need to Know - Diagnosis codes must always be valid on the date that the service was provided. Medicare systems will reject claims with diagnosis codes that were not valid on the
date of service.

What You Need to Do - As Medicare strengthens its edit processes to detect and reject claims with invalid diagnosis codes, ensure that your billing staff know the rules for diagnosis codes and that they submit diagnosis codes that are in compliance with HIPAA.

Background - To edit diagnosis accurately codes for validity, Medicare systems will apply date range edits to ensure that diagnosis codes are valid for the period of time for which they are reported on claims sent to Medicare. These edits will apply whether or not Medicare actually uses the reported diagnosis code in its claims processing.

HIPAA rules require that Medicare make sure that such codes are HIPAA-compliant, especially because these codes are passed on to other payers under Medicare's Coordination of Benefits processes. To be compliant, the diagnosis code must be valid on the date for which it is reported. These policy changes include validation of diagnosis codes on the National Council for Prescription Drug Program (NCPDP) claims and on 837 professional claims.

Additional Information - Additional information regarding this topic can be found in Transmittal 86 (CR 3050). The official instruction issued to your carrier 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 3260 in the CR NUM column on the right, and click on the file for that CR.

Line Level Medicare Secondary Payer Claims

In order to correctly submit an electronic claim containing line level Medicare Secondary Payer (MSP) information, we would like to draw your attention to a requirement from the 837 Implementation Guide.

On page 332 of the ANSI 837 Professional Implementation guide, loop 2320 note states; "Required if claim has been adjudicated by payer identified in this loop". The loop referred to in this note is the Other Subscriber loop. This loop is used to provide the name, address and identification number of the person that subscribes to the primary insurance plan. The note in the Implementation Guide is referring to the claim level Payer Paid Amount, or the total amount paid on this claim by the primary payer. This amount should be included with your line level MSP claims. If it is not included, it may cause the claim to be rejected or processed incorrectly.

The claim level payer paid amount must be reported and should reflect the total amount paid by the primary payer. Just as all the service line charges must equal the total claim charges , the line level payer paid amounts must equal the claim level payer paid amount.

Please contact your software vendor regarding your software's ability to include this amount for line level

MSP claims submitted electronically in the ANSI 837 format.

New ANSI And NCPDP Edits For Duplicate Files

New edits will be made effective January 3, 2005 to prevent duplicate batches of claims from being accepted by CIGNA Medicare. For ANSI files, the edit is 20268. This edit looks at the create date, the sender identification number and the interchange control number. If these three items are the same as a previous batch of claims accepted by CIGNA Medicare, the file will be rejected. For NCPDP claims, the edit is 65082. This edit looks at the create date, the sender identification number and the batch number. If these three items are the same as a previous batch of claims accepted by CIGNA Medicare, the file will be rejected.

Verify with your software vendor that the program you are using will comply with these changes.

New Free Billing Software – Express Plus

The Centers for Medicare and Medicaid Services (CMS) has required that carriers update their free billing software in order to allow for the transmitting of Medicare Secondary Payer (MSP) claims electronically. In an effort to create more standardization, we have partnered with another DMERC to provide the free billing software, *Express Plus*. *Express Plus* is produced by AdminaStar Federal Region B DMERC and is also used by HealthNow, NY, Inc. Region A DMERC.

Express Plus has been developed based on the requirements of the HIPAA-standard ANSI X12N version 4010A1 format. *Express Plus* is specifically designed for building and transmitting your health care claims (ANSI X12N 837) to Medicare in the 4010A1 format. *Take note … Any* stored data from *DMACS32* (NSF version) or *DMACS*-837 (ANSI version) will not convert to the *Express Plus* software. After installing the new program, all your data will need to be re-entered.

Following are the system requirements for Express Plus.

System Requirements

A valid copy of the software: A company/business with multiple computer systems, that will be using Express Plus from the same office, only needs one copy of the software to install on all systems in that office. If you have multiple offices we recommend that you have one copy of the program per office.
Computer: 386 processor or greater, IBM compatible computer, with Windows 98 or greater
Hard Drive Space: 50 megabytes
Total Memory (RAM): 64 megabytes
Available Memory: 512K
Modem: 9600 or greater baud rate modem
Printer: Any make or model

We have provided the necessary requirements to operate the Express Plus software program. However, due to the ever-changing environment within the computer industry and the variety of computer systems available today, we cannot guarantee the operation of our current program on all computers.

CIGNA Medicare cannot guarantee the functionality of the software on a network, nor will we support the program when operated across a network.

If you are an existing DMACS-32 or DMACS-837 user, you are not required to test. However, we encourage you to test to become familiar with the new program and prior to transmitting production claims. If you currently use DMACS-32 or DMAC-837, you may bypass the testing process and move directly into transmitting your production claims.

As a reminder, the use of the free billing software is not a requirement. Suppliers can choose from a variety of software options by reviewing our Certified Vendor List. You may view the most current vendor list at http://www.cignamedicare.com/edi/dmerc/vendorlist.html. The Certified Vendors offer a variety of services that may better suit the needs of your company. We encourage you to evaluate the goals and requirements for your company when determining which software package will best fit the needs of your business. The CMS has developed guidelines to assist in choosing a vendor. You may view the guidelines at http://www.cignamedicare.com/edi/vendor_lists/dmerc/guidelines.pdf.

How to Apply for Express Plus

To apply for Express Plus, simply complete the DMERC EDI Customer Profile. You may access this form via the CIGNA Medicare Web site, under EDI Forms. The software is free, with a $5.00 shipping and handling fee.

Note: Current DMACS32 or DMACS-837 software users will be mailed a copy of the software by mid-October 2004.

Requirement To Use Most Current Version Of Free Billing Software

As part of the Centers for Medicare & Medicaid Services' (CMS) continuing efforts to achieve greater standardization in Medicare claims processing, CMS is requiring the use of the most current HIPAA-compliant free-billing software by all providers/suppliers that use free-billing software furnished by a Medicare contractor. To that end, Medicare carriers and fiscal intermediaries are to require providers that use free-billing software to use only the most current version of their software and eliminate use of prior versions within 90 days of issuance of this notification.

Effective, January 3, 2005 CIGNA DMERC will only support the most current version of the free billing software, *Express Plus* version 4.2.4. All versions of DMACS (NSF or ANSI) will no longer be supported as of January 3, 2005. If you would like to obtain a copy of the *Express Plus* free billing software, you may request a copy by completing the DMERC EDI Customer Profile at http://www.cignamedicare.com/edi/dmerc/forms.html.

Sharing Of ID Number And Passwords

The Centers for Medicare & Medicaid Services (CMS) regulations do not allow ID numbers and passwords to be shared per the CMS Medicare Claims Processing Manual, Chapter 24, Section 80.1 (Carrier or FI Data Security and Confidentiality Requirements) as it allows unauthorized access to protected health information. The sharing of ID numbers or passwords is strictly prohibited. If unauthorized use of an ID number or password is suspected, the ID number and password may be revoked. In addition, if a violation of privacy is found, civil and/or criminal penalties may apply.

Medicare does allow for a clearing house or billing service to access systems to obtain data for a provider electronically if the use is for claims-related purposes. (Claims-related purposes are considered verification of a beneficiary's Medicare eligibility to determine if the beneficiary's claim should be sent to Medicare, submission of a claim to Medicare, submission of a claim status request to Medicare, and receipt of a remittance advice containing the adjudication decision and payment data for a claim for posting to patient account receivable records.) However, the third party must obtain their own ID number and password and must ensure that the appropriate documentation is on file for both the third-party as well as the supplier. The third-party is not to use the data for non-claims related purposes.

CIGNA encourages all entities who have signed the Electronic Data Interchange (EDI) Enrollment Form with CIGNA to review the agreement and comply with all requirements as set forth. If you have any questions or if you need to report unauthorized use, please contact the EDI Department at 866.224.3094 (toll-free), option 1.

MEDICARE SECONDARY PAYER (MSP)

Clarification Of Medicare Secondary Payer (MSP) Rules In Relation To A Temporary Leave Of Absence

Medlearn Matters Article Number: MM3447

Provider Types Affected - All providers.

Provider Action Needed

Impact to You - MSP rules state that if an employee retains their employment status, Medicare remains the secondary payer.

What You Need to Know - There has been confusion regarding MSP rules when an employee takes a company-approved leave of absence. Because the employee still has employee status, health coverage through their employer is retained.

What You Need to Do - Stay current with rules pertaining to employees and retained employment rights to ensure accurate billing and claims processing. This article clarifies that Medicare remains a secondary payer for employees on an approved leave of absence.

Background - Examples of retained employment rights can include: company-approved temporary leave of absence for any reason, furlough, temporary layoff, sick leave, short-term or long-term disability, leave for teachers and seasonal workers who normally do not work year round, and for employees who have health coverage that extends beyond or between active employment periods. The employees in the latter category are sometimes referred to as having an "hours bank" arrangement.

Additional Information - You may also refer to the revised Publication 100-05, Chapter 1, Section 50B, which is part of the official instruction issued to your carrier/intermediary regarding this change. That instruction may 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 3447. 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 or fiscal intermediary at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

MISCELLANEOUS

Application Of The Medicare Secondary Payer For The Working Aged Provision To Former Spouses And The Medicare Secondary Payer For The Disabled Provision To Former Spouses And Certain Family Members With Coverage Under The Federal Employees Health Benefits (FEHB) Program

Medlearn Matters Article Number: MM3120

Provider Types Affected - All Medicare providers

Provider Action Needed - This is an informational article to alert providers that former spouses of certain federal employees, former employees, or annuitants, may qualify to enroll in a health benefits plan under the Federal Employees Health Benefit Plan (FEHB) and the correct order of payment.

A determination has been made that Medicare will be the primary payer for such former spouses, once they are entitled to Medicare based on age or disability.

Background

Certain former spouses of people who have Federal Employees Health Benefits are entitled to coverage under the Spouse Equity Act because their divorce decree gives them the right to a portion of a future retirement annuity and/or to a survivor annuity, and because their former spouse is either an active worker, someone who is entitled to a future annuity, or is an annuitant.

The Medicare law in Section 1862 (b)(1)(A) of the Social Security Act, states that Medicare is secondary payer for individuals age 65 or over who have group health coverage by virtue of their own or a spouse's current employment status. The question was raised as to whether FEHB coverage provided to former spouses under the Spouse Equity Act is secondary to Medicare under this provision. Also, the question has been raised as to whether FEHB coverage provided to the spouse and family members under the Spouse Equity Act is secondary to Medicare under the disability provision.

Under the Spouse Equity Act, the individual is no longer on the former spouse's policy. The coverage is considered to be a separate, self-only policy, i.e., not dependent coverage but a policy separate from the former spouse. The employer makes no contributions to the coverage. Since the language in the Spouse Equity Act gives the former spouse the right to enroll in FEHB whether or not the spouse himself or herself is enrolled, the FEHB former spouse coverage is not considered employment based. Consequently, Medicare is the primary payer for the former spouse, once they are entitled to Medicare under the working aged provision. Under the Medicare secondary for the disabled provision, Medicare would be primary for the former spouse as well as any covered family members since the coverage is not considered employment based.

Additional Information

The official instruction issued to your carrier 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 3120 in the CR NUM column on the right, and click on the file for that CR.

Changes To Checks Mailed To Suppliers

In the coming months, CIGNA Medicare will be changing the color of the paper stock it uses for checks mailed to suppliers. The blue/green checks currently being used will be replaced with checks that are white. Please make a note of this upcoming change.

Important News About Flu Shots For Medicare Beneficiaries

Medlearn Matters Article Number: SE0464

Provider Types Affected - Physicians, providers, and suppliers

Provider Action Needed - This instruction provides important information to physicians and other providers regarding flu vaccinations for Medicare beneficiaries for the 2004 – 2005 influenza season. Despite the flu vaccine shortage, Medicare beneficiaries are being encouraged to obtain the flu vaccine from their regular physician.

Background - One of the principal pharmaceutical companies manufacturing flu vaccine was unable to provide the quantity of vaccine needed for this flu season, and this caused the flu vaccine supply to be reduced by almost one half of the expected amount. **This shortage does not, however, include pneumococcal vaccine.**

Because of the limited availability of flu vaccines this season, the Centers for Disease Control and Prevention (CDC) is recommending that individuals be given priority for getting the flu vaccine who are 1) at high risk for serious flu complications; or 2) in contact with people at high risk for serious flu complications. Individuals in the following groups are included in the high-risk category, and they should receive a flu vaccination this season:

- Individuals age 65 or older
- Individuals with a chronic condition such as heart or lung disease
- Nursing home residents
- Pregnant women
- Health care workers who provide direct patient care
- Infants and toddlers ages 6-23 months
- Children on aspirin therapy
- Individuals who care for or live with infants younger than 6 months of age.

Please note that CDC also recommends that the majority of individuals with Medicare should not take FluMist because it is approved only for people ages 5 - 49. The only Medicare beneficiaries who should take FluMist are healthy disabled persons ages 5 - 49.

These recommendations and other information for health care professionals, including Qs & As developed by CDC, can be found at: http://cdc.gov/flu/ on the web.

Medicare Billing for Flu Vaccines

Because Medicare beneficiaries generally fall into this high-risk category, they are being encouraged to obtain the flu vaccine from their regular physician. Beneficiaries can receive a flu vaccine from any licensed physician or provider. However, the billing procedure will vary depending on whether the physician or provider is enrolled in the Medicare Program.

If you are a Medicare-enrolled physician or provider and have the flu vaccine available, you must bill Medicare for the cost of the vaccine and the beneficiary will pay nothing; i.e., there is no deductible or coinsurance payment. Medicare rules require you to bill the Medicare Program on an assignment basis. Please remember that Medicare allows for roster billing when you administer flu vaccine to a number of beneficiaries at one location (e.g., a physician's office).

The specific rules to follow for roster billing can be found in Chapter 18, Section 10.3 of the Claims Processing Manual, at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp.

If you do not have the vaccine available, you should refer your patients to 1-800-MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048) or to http://www.medicare.gov where they can get the phone number for their state health department. Health departments throughout the United States are attempting to ensure that as many high-risk individuals as possible will get a flu vaccine.

If you are not a Medicare-enrolled physician or provider who gives a flu vaccine to a Medicare beneficiary, you can ask the beneficiary for payment at the time of service. The beneficiary can then request Medicare reimbursement. Medicare reimbursement will be approximately $18 for each flu vaccine.

To request reimbursement, the beneficiary will need to obtain and complete form CMS 1490S by calling 1-800-MEDICARE, or they may access and download the form at http://www.cms.hhs.gov/forms on the web.

In order to receive reimbursement, you will need to provide the beneficiary with a receipt for the flu vaccine that has the following information written or printed on it:

- The doctor's or provider's name and address
- Service provided ("flu vaccine")
- Date flu vaccine received
- Amount paid.

If you are currently not enrolled in Medicare but want to enroll to bill Medicare directly for the flu vaccine, your enrollment application will be expedited. CMS 855 enrollment applications and carrier contact information can be found on the following CMS website: http://www.cms.hhs.gov/providers/enrollment.

Additional Information - Please note that beneficiaries have been advised to contact the Inspector General's hotline at 1-800-HHSTIPS (1-800-447-8477) to file a complaint if they believe their physician or provider charged an unfair amount for a flu vaccine. If your patients have questions regarding flu vaccine, please refer them to http://www.medicare.gov on the web or 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877- 486-2048.

Information And Education Resources For Medicare Providers, Suppliers, And Physicians

Medlearn Matters Article Number: SE0454

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

Provider Action Needed - This article is informational only and is intended to notify Medicare physicians and other providers about the information and education resources that the Centers for Medicare & Medicaid Services (CMS) have developed to help meet their Medicare business needs.

Background - One of the goals of CMS is to give Medicare's 1.2 million physicians and other providers the information they need to understand the program, be aware of changes, and bill correctly. By making information and education resources easily accessible, understandable, and as timely as possible, physicians and other providers will be better able to submit bills correctly the first time, receive reimbursements more quickly, and spend less time dealing with paperwork. All of this can result in more time to spend on patient care. We are committed to accomplishing this goal by offering Medicare physicians and other providers a variety of educational products and services and using various information delivery systems to reach the broadest and most appropriate audiences possible.

Three-Pronged Provider Information and Outreach Approach - CMS relies on the cooperative efforts of its Medicare contractors, Regional Offices, and Central Office provider communications staff to deliver a seamless information and outreach approach to Medicare physicians and other providers.

1) Medicare Contractors - Medicare contractors, also called fiscal intermediaries and carriers, serve as the primary point of contact for most Medicare physicians and other providers. These contractors provide toll-free telephone lines for inquiries, conduct outreach and education, and often interact with local professional associations. Their outreach and education activities include in-person seminars, bulletins and newsletters, speaker appearances, and quick dissemination of timely information via web sites and provider-specific electronic listservs (mailing lists).

If you have questions about the Medicare Program, you should first get in touch with your fiscal intermediary or carrier. To find fiscal intermediary and carrier contact information, please visit: http://www.cms.hhs.gov/medlearn/tollnums.asp.

2) CMS Regional Offices - Staff at CMS' Regional Offices provide oversight of Medicare contractors and play a key role in resolving issues that physicians and other providers cannot get resolved. Our Regional Offices are active with the physician and other provider communities at State and local levels through their relationships with State and local associations and big billers, and through outreach activities such as hosting provider-oriented meetings and furnishing speakers at professional conferences.

CMS Regional Offices are located at various locations around the country. You can find their contact information at: http://www.cms.hhs.gov/about/regions/professionals.asp.

3) CMS Central Office in Baltimore, Maryland - The provider communications staff at the CMS Central Office work closely with both Medicare contractor and Regional Office staff to ensure that consistent and coordinated Medicare information and resources are available to all physicians and other providers. Education and outreach activities from the CMS Central Office are generally targeted to national associations with consistency and timeliness as our top priorities. Given the hectic schedules of today's health care professionals, most of our current initiatives are aimed at fostering a "self-service" environment so that physicians and other providers can access information and education 24 hours a day, 7 days a week. As a result, we have significantly increased the use of the Internet as a key tool for continuous-improvement customer service.

Our efforts have resulted in a variety of products and services, such as:

• **Medlearn Matters Articles** ~ One of the best sources for the latest Medicare information is "Medlearn Matters…Information for Medicare Providers" national articles, which are available at http://www.cms.hhs.gov/medlearn/matters. These articles are designed to give physicians and other providers and their staff easy to understand information related to new and recently changed Medicare rules and policies. The articles are written in consultation with clinicians and billing experts and focus on how these changes affect physician and other provider business functions. On the Medlearn Matters Web page, you'll find a searchable table for easy access to each article and its corresponding Program instructions, if applicable. You can join the Medlearn Matters listserv to receive electronic notification when new articles are released. Medicare contractors also publish Medlearn Matters articles in their bulletins and on their web sites. This Central Office initiative serves to enhance and support contractors' local provider education efforts by promoting the availability of nationally consistent educational materials.

• **Medicare Learning Network** ~ The Medlearn Matters articles are part of a broader inventory of physician and other provider educational products found under the Medicare Learning Network. The Medicare Learning Network is the brand name for official CMS physician and other provider educational products and is designed to promote national consistency of Medicare provider information developed for CMS initiatives. Products range from web-based training courses, comprehensive training guides, brochures, and fact sheets to CD-ROMs and videos. All MLN products are free of charge and can be ordered or downloaded from the Medlearn Web page located at http://www.cms.hhs.gov/medlearn, which also gives easy access to other resources such as educational web guides, electronic listservs, and provider-specific web pages. Check back often for the latest products, resources, and provider-oriented links.

• **CMS Provider Web Pages** ~ CMS has designed provider-specific web pages to assist individual physician and other provider types in obtaining information relevant to them more quickly. These web pages are a customized, one-stop web-based resource for the provider, supplier, and physician audience that also includes highlights on items such as new regulations and hot topics, links to general information on enrollment, billing, conditions of participation, publications, education, data, and statistics, and links to "specialty" information. For example, the Medicare Physician Web Page at http://www.cms.hhs.gov/physicians includes links to the Medicare Physician Fee Schedule Look-Up Tool, National Correct Coding Initiative edits, Practicing Physicians Advisory Council, Physicians Regulatory Issues Team, Medicare Coverage Database, and the CMS Online Manual. We also have Specialty Physician Web Pages where we will continue to add links of special interest to physician specialties. The first Specialty Physician Web Page, "Medicare Information for Anesthesiologists," is available at http://www.cms.hhs.gov/physicians/anesthesiologist/default.asp.

From the CMS Home Page at http://www.cms.hhs.gov, you can access select physician and other provider pages from the "Professionals" drop-down menu. You can also see a complete listing of available provider and supplier web pages by clicking on http://www.cms.hhs.gov/providers or http://www.cms.hhs.gov/suppliers. All pages have a comment section for you to electronically submit suggestions. We are always adding new pages, so check the site often.

• **Other Popular Provider Web Pages** ~ In addition to the pages mentioned above, other frequently visited pages include the CMS Online Manual System at http://www.cms.hhs.gov/manuals; the CMS Quarterly Provider Update at http://www.cms.hhs.gov/providerupdate, which gives a listing of regulations and major policies currently under development during the quarter, regulations and major policies completed or cancelled, and new or revised manual instructions; the Medicare Coverage Homepage at http://www.cms.hhs.gov/coverage, which contains complete coverage information including links to CMS coverage databases, frequently asked questions, and "What's New" lists.

• **Listserv Messages** ~ CMS has a number of listservs that transmit important Medicare notices and reminders to subscribers. For example, listservs have been established for most provider-specific web pages as well as for updates on the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the Medicare Learning Network, and the Quarterly Provider Update. To view and subscribe to one or more listserv, please visit http://www.cms.hhs.gov/mailinglists.

• **Open Door Forums** ~ CMS is very interested in hearing from and interacting with the physicians and other providers who deliver quality health care to our nation's beneficiaries. We continue to emphasize our responsiveness through an ongoing series of Open Door Forums that provide an environment for interactive dialogue. Forums are chaired by senior-level Agency officials and co-chaired by CMS Regional Office officials. For more information, please visit http://www.cms.hhs.gov/opendoor.

• **Exhibit Program** ~ CMS hosts exhibit booths at provider, supplier, and physician association meetings. The CMS Exhibit Program provides an excellent opportunity for CMS Central and Regional Office staff to have

direct contact with the Medicare provider, supplier, and physician community to listen to issues, concerns, and challenges and to share timely and relevant information. If you are interested in having a CMS exhibit at your national conference, please contact David Clark at dclark@cms.hhs.gov.

Physician and Other Provider Feedback

Although we try our best to be responsive to the Medicare physician and other provider community's education and information needs, we can't do it alone. Your feedback on the effectiveness and usefulness of our educational resources is very important to us as it helps ensure that we are "getting it right." Please submit your comments or suggestions at http://www.cms.hhs.gov/providers by selecting "Feedback" from the blue template located at the top of the page. There is also a feedback link on the Medlearn Web Pages for your suggestions on new educational products at http://www.cms.hhs.gov/medlearn/suggestform.asp. We look forward to hearing from you.

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

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

A. Covered Services

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

1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;
2. Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;
3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or
4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.

B. Billing of Covered Services

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

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

MMA - Use Of Group Health Plan Payment System To Pay Capitated Payments To Chronic Care Improvement Organizations Serving Medicare Fee-For-Service Beneficiaries Under Section 721 Of The MMA

Medlearn Matters Article Number: MM3410

Providers Affected - Physicians, providers, and suppliers

Provider Action Needed

Impact to You - The Centers for Medicare & Medicaid Services (CMS) will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (Section 721 of the Medicare Modernization Act [MMA]) in which private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional Fee-For-Services (FFS) Medicare program.

What You Need to Know - With the exception of how CMS is paying these private organizations, beneficiaries enrolled in these programs will be considered covered under the traditional Medicare FFS program for all other purposes. Beneficiaries will only receive coordinated care/disease management services from these chronic care organizations and they are not restricted in any way on how they receive their other Medicare services.

What You Need to Do - See the *Background* and *Additional Information* sections for more information on this notification.

Background - This instruction notifies providers that CMS will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (Section 721, MMA) in which private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional FFS Medicare program.

In order to implement these large programs most efficiently, CMS plans to accomplish the following:

- Each program will be assigned a new option code (designated as "Option Code 4" in this instruction); and
- Each organization will be set up as an "Option 4 Chronic Care Organization" in Medicare's Group Health System/PICS, which is otherwise used for Medicare Advantage (formerly Medicare + Choice) health plans.

By enrolling beneficiaries in these "Option Code 4" Chronic Care Organizations, CMS will be able to pay the organizations a fixed monthly amount for each beneficiary. Also, as an "Option Code 4" Chronic Care Organization," CMS can continue processing all FFS claims under traditional Medicare payment rules.

With the exception of how CMS is paying these organizations, beneficiaries enrolled in these programs will be considered covered under the traditional Medicare FFS program for all other purposes. Beneficiaries will only receive coordinated care/disease management services from these chronic care organizations. They are not restricted in any way on how they receive their other Medicare services.

Because the Group Health Plan system/MMCS is being used to pay demonstration sites, when a provider makes an inquiry to certain Common Working File (CWF) screens, it appears that the beneficiary is enrolled in a Health Maintenance Organization (HMO), when they are eligible for coverage under the traditional Medicare FFS program.

To avoid this confusion about a beneficiary's access to services when providers or others check beneficiary eligibility on CWF provider inquiries, **this instruction directs the CWF to suppress any reference to HMO information on provider inquiries for beneficiaries enrolled in these programs.**

In the event the provider is advised by the beneficiary or through some other means that the beneficiary is enrolled with one of these Chronic Care Organizations, the providers should treat the beneficiary as an ordinary FFS beneficiary who requires no referral from the Chronic Care Organizations to receive services in a FFS setting.

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

Additional Information - For complete details, please see the official instruction issued to your carrier or fiscal 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 CR3410 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.

Message To Pharmacists Regarding Medicare Approved Discount Drug Card Automatic Enrollment

Dear Pharmacist –

As a pharmacy that participates in the Medicare-approved drug card program, you are aware of the savings that are available to people who enroll in Medicare. In October, more than a million people with Medicare will be getting the attached "Important Message from Medicare" and a Medicare-approved drug discount card in the mail. People receiving this important message are likely to qualify for up to $1,200 in credits from Medicare to help pay for their prescription drug costs.

These people will also receive a Medicare-approved drug discount card that they will be able to begin using on November 1, 2004.

The purpose of this letter is to enlist your support in assisting people with Medicare who come to you with questions about this "Important Message from Medicare" and need additional information about how to apply for the $1,200 credit potentially available to them through the Medicare-approved drug card. The attached copy of the important message will help you answer these questions (see Appendix A-1). Assisting a beneficiary could be as simple as instructing him or her to call either the company shown on the card or 1-800-MEDICARE (1-800-633-4227). The beneficiary will be asked during this call if he or she has any other health insurance that includes prescription drug coverage, as well as some additional eligibility questions to see if he or she qualifies for more help.

We have also enclosed a flyer appropriate for public display in your pharmacy (see Appendix A-2). The purpose of this flyer is to encourage people who may qualify for the $1,200 credit to call and find out if they are eligible to receive this important benefit. If you need any additional information or resources, please visit www.cms.hhs.gov/partnerships; click on the box on the far right with the "Medicare RX" symbol.

We appreciate your help in this important effort. Questions from people with Medicare may be directed to 1-800-MEDICARE (1-800-633-4227 or TTY 1-877-486-2048).

MMA - New Medicare-Approved Drug Discount Cards And Transitional Assistance Program: A Summary For Pharmacists And Other Pharmacy Professionals

Special Edition Article Number: SE0423

Note: This article was revised on October 27, 2004 to correct the web address for State Health Insurance Counseling and Assistance Programs (SHIPs).

Provider Types Affected - Pharmacists and other pharmacy professionals

Provider Action Needed - Understand the Medicare-Approved Drug Discount Cards and Transitional Assistance Program that begins in 2004 to help Medicare beneficiaries save on prescription drugs.

Background - As part of the Medicare Modernization Act of 2003 (MMA), the Medicare-Approved Drug Discount Cards and Transitional Assistance Program begins in 2004 to help Medicare beneficiaries save on prescription drugs. Medicare will contract with private companies to offer new drug discount cards until a Medicare prescription drug benefit starts in 2006. A discount card with Medicare's seal of approval can help Medicare beneficiaries save on prescription drug costs. This article is designed to give an overview of the new Medicare-Approved Drug Discount Cards and Transitional Assistance Program. It will also explain where you may refer Medicare beneficiaries for information on selecting and enrolling in the drug discount card program that best suits their needs.

Medicare-Approved Drug Discount Cards

- Open enrollment started in May 2004
- Available to qualified beneficiaries regardless of income
- Represent a variety of discount and drug options from private companies
- Available to beneficiaries eligible for or enrolled in Medicare Part A or enrolled in Medicare Part B, **unless** receiving outpatient prescription drug coverage through State Medicaid programs
- May charge an annual enrollment fee of no more than $30, which may be paid by Medicare for some low-income beneficiaries
- Do **not** require that beneficiaries purchase discount drugs through mail-order pharmacies

Provide beneficiaries the ability to use their discount cards in pharmacies near their homes.

Transitional Assistance Program

Beneficiaries with the greatest need will have the greatest help available to them. Individuals with an annual income in 2004 of no more than $12,569 if single or $16,862 if married, and individuals receiving help from their state in paying their Medicare premiums or cost sharing, may qualify for a $600 credit on their discount card to help pay for prescription drugs. These income limits change every year. Residents of Puerto Rico or a U.S. territory are not eligible for the $600 credit from Medicare. However, they may be eligible for similar assistance provided by the territory in which they reside. Beneficiaries cannot qualify for the $600 if they already have outpatient prescription drug coverage from certain other sources.

Special Concerns of Pharmacists and Other Pharmacy Professionals About the Drug Discount Cards

Some pharmacy associations have expressed concerns about how the Medicare-approved drug discount cards

will affect the role of pharmacists and other pharmacy professionals in patient interaction. Because beneficiaries are more apt to seek out their local pharmacists or pharmacy professionals for advice, Medicare believes that the discount cards may allow the further development of relationships with Medicare beneficiaries. In fact, educational materials will remind beneficiaries to consider the importance of the relationship with their pharmacist or other pharmacy professional when selecting a discount card. Private companies are required to offer discount cards that give consumers in urban, suburban, and rural areas the option to use their cards in pharmacies near their homes.

Where Do I Refer Medicare Beneficiaries for Information on Prescription Drug Discount Programs?

In addition to the Medicare-approved drug discount cards, there are other programs available that provide assistance in paying for prescription drugs. Alternatives such as individual state pharmacy assistance programs and manufacturers' discount programs may be a better fit for certain individuals.

Medicare recognizes that pharmacists and other pharmacy professionals have limited time available to counsel beneficiaries. The following resources are available to help individuals with questions about the Medicare-approved drug discount cards:

The 1-800-MEDICARE (1-800-633-4227) Toll-Free Call Center

This Call Center is available 24 hours a day and 7 days a week. It connects beneficiaries with customer service representatives who can answer questions and perform price comparisons for discount cards and other assistance programs. Beneficiaries should prepare a list of current prescription drugs and dosages prior to contacting the Call Center. Beneficiaries may request a copy of their individualized price comparison results. TTY users should call 1-877-486-2048.

The Prescription Drug and Other Assistance Programs Web Site at Medicare.gov http://www.medicare.gov/AssistancePrograms/home.asp

For beneficiaries who use the Internet, this site features eligibility, enrollment, and price comparison information for each available discount card in a particular area, as well as their state pharmacy assistance programs. It also has a tool that helps beneficiaries determine the best savings program based on their prescription drug needs.

Medicare's Guide to Choosing a Medicare-Approved Drug Discount Card http://www.medicare.gov

This resource provides beneficiaries with information on choosing a card, enrolling, and submitting complaints. This guide also includes sample enrollment forms and worksheets to assist beneficiaries in selecting the discount card that is right for them.

State Health Insurance Counseling and Assistance Programs

Beneficiaries may also contact their SHIP counselor for information on prescription drug cost assistance programs. To find the telephone number for the nearest SHIP, call 1-800-MEDICARE (1-800-633-4227) or visit http://www.medicare.gov/contacts/Static/SHIPs.asp?dest=NAV on the Web.

Information Resources for Pharmacists and Other Pharmacy Professionals

- Download a free patient-education brochure at http://www.medicare.gov (or call 1-800-MEDICARE to order a limited number of free copies).
- Read The Medicare-Approved Drug Discount Cards and Transitional Assistance Program - A Brochure for Pharmacists and Other Pharmacy Professionals at http://www.cms.hhs.gov/medlearn.
- Attend CMS Open Door Forums in person or by telephone (toll-free). These forums address concerns and issues of the pharmaceutical industry. Visit http://www.cms.hhs.gov/opendoor for further details.
- Visit http://www.cms.hhs.gov/medicarereform for the latest information on MMA.

MMA - Medicare-Approved Drug Discount Cards And Transitional Assistance Program: A Summary Of New Initiative Of Interest To Pharmacists And Pharmacy Professionals

Medlearn Matters Article Number: SE0458

Provider Types Affected - Pharmacists and other pharmacy professionals

Provider Action Needed - This instruction provides important information on a new initiative to increase enrollment of low-income Medicare beneficiaries in a Medicare-Approved drug discount card and $600 credit.

Background - In an earlier Medlearn Matters article (SE 0422), an overview of the Medicare-approved Drug Discount Card Program was provided.

(See SE0423 at: http://www.cms.hhs.gov/medlearn/matters/mmarticle/2004/SE0423.pdf.)

This program is authorized by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). The program is designed to help people who are covered by Medicare with the cost of prescription drugs, and the regulation outlining the new drug discount card program is the first action resulting from the MMA. It emphasizes the importance of eliminating the practice of Medicare beneficiaries having to pay full price for prescription drugs. Beginning in May 2004, individuals began enrolling in the program.

Seniors and individuals with disabilities will be able to use these cards to save 10 to 15 percent on their total drug costs, with savings of up to 25 percent or more on individual prescriptions. All Medicare beneficiaries, except those who already have Medicaid outpatient drug coverage, will be able to enroll in Medicare-approved drug discount card programs with benefits beginning in June 2004, and continuing until the Medicare prescription drug benefit is implemented in 2006.

Medicare beneficiaries will be allowed to enroll in only one drug card program at a time. The cost of enrollment can be no more than $30 annually, and beneficiaries can change cards during an open enrollment period prior to 2005 or under special circumstances. Beginning in 2006, all people with Medicare will have access to a voluntary prescription drug benefit.

Transitional Assistance Program

A key part of the Medicare-approved prescription drug discount card program is a **subsidy of up to $600 a year** for eligible low-income beneficiaries. Individuals may qualify for the $600 credit on their discount card to help pay for prescription drugs if they:

- Have an annual income in 2004 of no more than $12,569 if single or $16,862 if married; and
- Receive help from their state in paying their Medicare premiums or cost sharing.

Note that these income limits can change every year. Also, residents of Puerto Rico or a U.S. territory are not eligible for the $600 credit from Medicare. However, they may be eligible for similar assistance provided by the territory in which they reside. Beneficiaries cannot qualify for the $600 if they already have outpatient prescription drug coverage from certain other sources.

Current Initiative

The Centers for Medicare & Medicaid Services (CMS) current initiative creates a streamlined Medicare- approved drug discount card enrollment process for about 1.1 million beneficiaries who receive help from their state in paying their Medicare premiums or cost sharing. These state programs are called Medicare Savings Programs. Starting in mid-October, these beneficiaries will receive an enrollment kit in the mail from a Medicare-approved drug discount card sponsor. The enrollment kit will contain a discount card with a Medicare-approved logo, a member handbook, a discount drug list, and pharmacy directory. An enclosed letter will explain to the beneficiary his or her assignment to a Medicare-approved drug discount card and eligibility for a $600 credit, and information about the right to decline or switch to a different Medicare-approved drug discount card. The letter instructs the beneficiary to call either the company offering the discount card or 1-800-MEDICARE (1-800-633-4227).

On November 1, 2004, the beneficiary can begin using the card to obtain discounts. In order to get the $600 credit, the beneficiary must call 1-800-MEDICARE or to the card sponsor's toll free number. On the call, the beneficiary completes the attestation for the $600 credit.

Beneficiaries who wish to choose a different card can call 1-800-MEDICARE to learn about their other choices.

If a beneficiary is not eligible for the $600 credit because of other prescription drug coverage, he or she has the option to keep the drug card and benefit from any associated discounts. In this instance, the beneficiary would be responsible for paying the enrollment fee.

Beneficiaries who wish to decline enrollment in the card must call the drug card sponsor at the toll free number.

As a result of this new program for enrollment in the drug card program, all beneficiaries in Medicare Savings Programs can start getting large savings on their drug costs.

Additional Information

Where to Refer Medicare Beneficiaries for Information on Prescription Drug Discount Programs

In addition to the Medicare-approved drug discount

cards, there are other programs available that provide assistance in paying for prescription drugs. Alternatives such as individual state pharmacy assistance programs and manufacturers' discount programs may be a better fit for certain individuals. Medicare recognizes that pharmacists and other pharmacy professionals have limited time available to counsel beneficiaries. The following resources are available to help individuals with questions about the Medicare- approved drug discount cards:

• The 1-800-MEDICARE (1-800-633-4227) Toll-Free Call Center:

Beneficiaries can get information about how the discount drug card program operates, who can qualify and how to join, as well as some comparative information on card sponsors at 1-800 MEDICARE (1-800-633-4227; TTY users should call 1-877-486-2048).

This Call Center is available 24 hours per day, 7 days per week, and it connects beneficiaries with customer service representatives who can answer questions and perform price comparisons for discount cards and other assistance programs. Beneficiaries should prepare a list of current prescription drugs and dosages prior to contacting the Call Center. Also, beneficiaries may request a copy of their individualized price comparison results. Customer service representatives will also be able to refer to appropriate sponsor or other resources (such as, make appropriate referrals for eligibility determination or to their State Pharmacy Assistance Program).

• The Prescription Drug and Other Assistance Programs Web site at: http://www.medicare.gov/AssistancePrograms/home.asp

At this site, beneficiaries can find eligibility, enrollment, and price comparison information for each available discount card in a particular area, as well as their state pharmacy assistance programs. It also has a tool that helps beneficiaries determine the best savings program based on their prescription drug needs. The negotiated prices displayed will be a drug's maximum price for an approved sponsor's service area. Actual prices may vary, but will not be more than the posted prices.

• Medicare's Guide to Choosing a Medicare-Approved Drug Discount Card:

This resource can be found at: http://www.medicare.gov/publications. It provides beneficiaries with information on choosing a card, enrolling, and submitting complaints. This guide also features sample enrollment forms and worksheets to assist beneficiaries in selecting the discount card that is right for them.

• State Health Insurance Counseling and Assistance Programs (SHIP):

Beneficiaries may also contact their SHIP counselor for information on prescription drug cost assistance programs. To find the telephone number for the nearest SHIP, call 1-800-MEDICARE (1-800-633-4227) or visit: http://www.medicare.gov/contacts/Static/SHIPs.asp?dest=NAV

For More Information

The following information resources are available for pharmacists and other pharmacy professionals:

- Download a free patient-education brochure at http://www.medicare.gov (or call 1-800-MEDICARE to order a limited number of free copies).
- Read the materials on the Medicare-Approved Drug Discount Cards and Transitional Assistance Program web page, at http://www.cms.hhs.gov/medlearn/drugcard.asp. This page includes a variety of useful publications.
- Attend CMS Open Door Forums in person or by telephone (toll-free). These forums address concerns and issues of the pharmaceutical industry. Visit http://www.cms.hhs.gov/opendoor for further details.
- Visit http://www.cms.hhs.gov/medicarereform for the latest information on MMA.

MMA - Medicare Replacement Drug Demonstration

Medlearn Matters Article Number: SE0443 revised

IMPORTANT: This is an updated version of this article. The article has been revised to reflect two additional drugs (Somavert and Mesnex) that are covered under this demonstration, as noted in the revised table that starts on page 4, and to announce that there are still many enrollment slots available. It is not too late to request or submit an application!

We need your help to reach beneficiaries who could benefit from this demonstration. These beneficiaries include people who have been diagnosed with rheumatoid arthritis, multiple sclerosis, osteoporosis, pulmonary hypertension, secondary hyperparathyroid-

ism, Paget's Disease, Hepatitis C, CMV retinitis, or certain kinds of cancer. If you treat Medicare beneficiaries who currently use or could benefit from the drugs listed in the table starting on page 4, Medicare may be able to help them pay for these drugs.

Provider Types Affected

All Medicare physicians and providers but we are especially interested in reaching out to physician specialists in family practice, internal medicine, geriatrics, rheumatology, oncology and neurology, as well as pharmacists, nurse practitioners, hospital outpatient departments, cancer and infusion centers, and group practice administrators.

Provider Action Needed

Impact to You - A new demonstration mandated under Section 641 of the Medicare Modernization Act allows up to 50,000 people with Medicare who have certain life-threatening diseases to obtain specified drugs they can take themselves at home for their condition.

What You Need to Know - A signed physician certification will need to be filled out for any of your patients who are: applying to participate in this demonstration. By signing this certification, you are certifying that the patient has the condition indicated and you have prescribed or intend to prescribe a coverable drug for this condition in accordance with the demonstration requirements. Your signed certification is necessary for the patient's application to participate in the demonstration to be considered complete. **For your convenience, physician certification forms may also be faxed to (410) 683-2933. Please note** that nurse practitioners who write prescriptions for these coverable drugs may also sign the certification form.

What You Need to Do - Review the list below of coverable conditions and drugs available under this demonstration. If you have any patients you think might be interested and eligible to apply, **let them know**. Be aware that both Fee-for-Service and Medicare Advantage beneficiaries are eligible to apply for the demonstration. If they would like to request an application or have any questions related to the demonstration, or need assistance completing the application, they can call a toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387). There is also helpful information on our web site (www.medicare.gov), including an application package that can be downloaded.

Note to Hospitals: Please share this information with staff who come into contact with Medicare beneficiaries who may be eligible for this demonstration (e.g., social workers or staff who assist with Medicaid eligibility determinations).

Background

The Medicare Replacement Drug Demonstration is a time-limited Medicare demonstration that will cover certain drugs and biologicals that are prescribed as replacements for existing covered Medicare drugs and biologicals before Medicare's prescription drug program begins in 2006. This demonstration was authorized by Section 641 of the Medicare Modernization Act.

The Centers for Medicare & Medicaid Services (CMS) has contracted with TrailBlazer Health Enterprises, a Medicare carrier, to assist in implementing the demonstration. TrailBlazer will manage the eligibility determination and enrollment process as well as coordinate outreach efforts to beneficiary advocacy groups, physicians, and others interested in this demonstration. TrailBlazer has sub-contracted with Caremark to administer the drug benefit.

Medicare realizes the important role drugs play in treating serious diseases. When Medicare first began, drugs played a much smaller role in medical care. Only drugs that are administered in a physician's office have been covered under Medicare Part B. In recent years, many new medications have been developed that replace some of these drugs, allowing patients with serious and life-threatening illnesses to take these drugs in their own home. For a beneficiary to be eligible for this demonstration, he or she must meet the following criteria:

- Beneficiary must have Medicare Part A and Part B.
- Medicare must be the beneficiary's primary health insurance.
- Beneficiary must reside in one of the 50 states or the District of Columbia.
- Beneficiary must have a signed certification form from his/her doctor stating that he/she has prescribed or intends to prescribe for the beneficiary one of the covered medications for the specified condition.
- The beneficiary may not have any other insurance that has comprehensive drug coverage (such as Medicaid, an employer or union group health plan, or TRICARE) that would cover this medication.

The table below shows the drugs and conditions that will be covered under the demonstration.

DRUGS COVERED UNDER THE MEDICARE REPLACEMENT DRUG DEMONSTRATION
(updated August 9, 2004)

Demonstration Covered Indication	Drug/Biological—Compound Name (Brand Name)
Rheumatoid Arthritis	Adalimumab (Humira) Anakinra (Kineret) Etanercept (Enbrel)
Multiple Sclerosis	Glatiramer acetate (Copaxone) Interferon beta –1a (Rebif, Avonex) Interferon beta –1b (Betaseron)
Osteoporosis (patient must be homebound)	Calcitonin – nasal (Miacalcin – nasal)
Pulmonary Hypertension	Bosentan (Tracleer)
Secondary Hyperparathyroidism Paget's Disease	Doxercalciferol (Hectoral) Alendronate (Fosamax) Risedronate (Actonel)
Hepatitis C	Pegylated interferon alfa-2a (Pegasys) Pegylated interferon alfa-2a (PEG-Intron)
CMV Retinitis	Valcyte (Valganciclovir)
Acromegaly Anti-Cancer Cutaneous T-cell Lymphoma	Pegvisomant (Somavert) Bexarotene (Targretin)
Non-small cell lung cancer	Gefitinib (Iressa)
Epithelial ovarian cancer	Altretamine (Hexalen)
Chronic Myelogenous Leukemia GI Stromal Tumor Multiple Myeloma	Imatinib Mesylate (Gleevec) Imatinib Mesylate (Gleevec) Thalidomide (Thalomid)
Breast Cancer	Hormonal therapy
Stage 2-4 only	Anastrozole (Arimidex) Exemestane (Aromasin) Letrozole (Femara) Tamoxifen (Nolvadex) Toremifene (Fareston)
Prophalactic agent to reduce ifosfamide-induced hemorrhagic cystitis	Mesna-oral tablest (Mesnex)

For more information on this demonstration, please visit www.medicare.gov or call our toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387) between 8 am and 7:30 pm Eastern time, Monday – Friday.

You can also use the toll-free number if you have questions about the demonstration or the application.
We also have a beneficiary brochure available that describes the demonstration and its benefits. Copies of the brochure can be requested at: outreach.mrdd@trailblazerhealth.com.

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.

Treatment Of Obesity

Medlearn Matters Article Number: MM3502

Provider Types Affected - All Providers.

Provider Action Needed - No action is necessary. This article is informational only. Current language in the National Coverage Determinations (NCD) Manual states that "obesity itself cannot be considered an illness." This language is being removed as a result of a recent decision by the Secretary of Health and Human Services. The change in the manual language will not directly affect current Medicare coverage of obesity treatments. Treatments for obesity alone remain non-covered and treatments of diseases resulting in or exacerbated by obesity remain unchanged.

Providers should note, however, that removal of the language does permit interested parties to submit NCD requests for anti-obesity interventions to the Centers for Medicare & Medicaid Services to determine if scientific and medical evidence demonstrate their effectiveness in improving Medicare beneficiaries' health outcomes.

Background

Nationally Covered Indications - Services performed in connection with the treatment of obesity are covered by Medicare only when such services are an integral and necessary part of a course of treatment for diseases such as hypothyroidism, Cushing's disease, hypothalamic lesions, cardiovascular diseases, respiratory diseases, diabetes, and hypertension.

Nationally Noncovered Indications - The treatment of obesity alone (i.e., where obesity cannot be shown to be an integral part of a disease process) is not considered reasonable and necessary for the treatment of an illness or injury and is not covered under the Medicare program. Supplemental fasting is not covered under the Medicare program as a general treatment for obesity.

Other - Supplemented fasting with adequate monitoring of the patient is eligible for a local coverage determination at the discretion of your Medicare contractor where weight loss is necessary before surgery to ameliorate the complications posed by obesity when it coexists with pathological conditions such as cardiac and respiratory diseases, diabetes, or hypertension (and other more conservative techniques to achieve this end are not regarded as appropriate).

Implementation - The implementation date for this instruction is October 1, 2004.

Additional Information - The official instruction issued to your Medicare contractor regarding this change may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR 3502 in the CR NUM column on the right and click on the file for that CR. Attached to CR 3502 is the actual revised language for the Medicare NCD Manual. If you have any questions, please contact your Medicare contractor at: http://www.cms.hhs.gov/medlearn/tollnums.asp.

Update To Medicare Deductible, Coinsurance, And Premium Rates For Calendar Year (CY) 2005

Medlearn Matters Article Number: MM3463

Provider Types Affected - Physicians, providers, and suppliers

Provider Action Needed - This instruction updates Medicare deductibles, coinsurance, and premium rates for CY 2005.

Background - Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) or Part A benefits without a premium payment. The Social Security Act provides that

certain aged and disabled persons who are not insured may voluntarily enroll, but they are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. **When voluntary enrollment takes place more than 12 months after a person's initial enrollment period for HI benefits, the monthly premium is increased by 10 percent.**

Under the Supplementary Medical Insurance (SMI) plan or Part B, all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay) that are set by statute. **When SMI enrollment by a beneficiary takes place more** than 12 months after the initial enrollment period, the monthly premium increases by 10 percent for each full 12-month period during which the individual could have been enrolled, but was not.

Beneficiaries who use covered Part A services may be subject to deductible and coinsurance requirements.

Inpatient Hospital Services - A beneficiary is responsible for an inpatient hospital deductible amount for inpatient hospital services furnished in a spell of illness (which is deducted from the amount payable by the Medicare program to the hospital).

- **More than 60 Days.** When a beneficiary receives such services for more than 60 days during a spell of illness, he/she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per day for the 61st-90th day spent in the hospital.
- **After the 90th Day.** An individual has 60 lifetime reserve days of coverage, which he or she may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one half of the inpatient hospital deductible.
- **Skilled Nursing Facility (SNF) (21st through 100th day).** A beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of SNF services furnished during a spell of illness.

For CY 2005, the premium, deductible, and coinsurance amounts are as follows:

Year 2005 Medicare Part A Deductible, Coinsurance, and Premium Amounts:

- Deductible: $912.00 per benefit period
- Coinsurance:
  $228.00 a day for days 61-90 in each period
  $456.00 a day for days 91-150 for each lifetime reserve day used
  $114.00 a day in a SNF for days 21-100 in each benefit period
- Premium per month:
  $375.00 for those who must pay a premium
  $412.50 for those who must pay both a premium and a 10 percent increase
  $206.00 for those who have 30-39 quarters of coverage
  $226.60 for those with 30-39 quarters of coverage who must pay a 10 percent increase

Year 2005 Medicare Part B Deductible, Coinsurance, and Premium Amounts:

- Deductible: $110.00 per year
- Coinsurance: 20 percent
- Premium per month: $78.20

The following table compares Medicare Part A Deductible, Coinsurance, and Premium Amounts for Years 2001 through 2005:

Year	Inpatient Hospital Deductible, 1st 60 Days ($)	Inpatient Hospital Coinsurance, 61st – 90th Days ($)	60 Lifetime Reserve Days Coinsurance ($)	SNF Coinsurance ($)
2001	792	198	396	99.00
2002	812	203	406	101.50
2003	840	210	420	105
2004	876	219	438	109.50
2005	912	228	456	114

Implementation

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

Related Instructions

CR 3121 (Transmittal 3), "New Part B Annual Deductible," was issued on March 12, 2004. CR 3121 updated the 2005 Part B deductible based on section 629 of the Medicare Prescription Drug, Improvement and Modernization Act. The same information held in CR 3121 is being communicated in CR 3463. Therefore, CR 3463 is replacing CR 3121 to prevent unintended consequences that may result from implementing both CR 3463 and CR 3121 together.

Additional Information

The Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01), Chapter 3 (Deductibles,

Coinsurance Amounts, and Payment Limitations) has been revised and the updated manual instructions are attached to the official instruction released to your carrier/intermediary. You may view that instruction by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that Web page, look for CR3463 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.

Remittance Advice Remark Code And Claim Adjustment Reason Code Update

Medlearn Matters Article Number: MM3466

Provider Types Affected - All providers

Provider Action Needed

Impact to You - The June 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.

What You Need to Know - The most current and complete list will be found online at: http://www.wpc-edi.com/codes/Codes.asp.

Please note that in case of a discrepancy, the code text included on the Washington Publishing Company (WPC) Web site will supersede any corresponding text in a CR.

In addition, with respect to Health Care Claim Adjustment Reason Codes, few temporary reason codes (D16-D20) were added for the cases where commercial payers do not make use of the available remark codes when the reason code used is too generic to help providers decide on the follow-up action. ***Medicare will not use these new temporary reason codes but rather will continue the current use of the combination of reason and appropriate remark codes.***

What You Need to Do - The above noted codes are updated three times a year. Please advise billing staff to stay current with the latest approved and valid codes, in accordance with effective and implementation dates, to ensure accurate Medicare claims processing.

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 complete list of current codes is available online at the WPC web site: http://www.wpc-edi.com/codes/Codes.asp.

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. The updated list is posted three times a year and the complete list of current codes is available online at the WPC web site: http://www.wpc-edi.com/codes/Codes.asp.

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 3466, 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 3466. Click on the link to open and view the file for the CR.

The CR attachments also include information on the process of decision making that results in updates to 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 March through June 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

N217 We pay only one site of service per provider per claim.
N218 You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing for the time period specified in the contract or coverage manual.
N219 Payment based on previous payer's allowed amount.
N220 See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute.
N221 Missing Admitting History and Physical report.
N222 Incomplete/invalid Admitting History and Physical report.
N223 Missing documentation of benefit to the patient during initial treatment period.
N224 Incomplete/invalid documentation of benefit to the patient during initial treatment period.
N225 Incomplete/invalid documentation/orders/notes/summary/report/invoice.
N226 Incomplete/invalid American Diabetes Association Certificate of Recognition.
N227 Incomplete/invalid Certificate of Medical Necessity.
N228 Incomplete/invalid consent form.
N229 Incomplete/invalid contract indicator.
N230 Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.
N231 Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
N232 Incomplete/invalid itemized bill.
N233 Incomplete/invalid operative report.
N234 Incomplete/invalid oxygen certification/re-certification.
N235 Incomplete/invalid pacemaker registration form.
N236 Incomplete/invalid pathology report.
N237 Incomplete/invalid patient medical record for this service.
N238 Incomplete/invalid physician certified plan of care.
N239 Incomplete/invalid physician financial relationship form.
N240 Incomplete/invalid radiology report.
N241 Incomplete/invalid Review Organization Approval.
N242 Incomplete/invalid x-ray.
N243 Incomplete/invalid/not approved screening document.
N244 Incomplete/invalid pre-operative photos/visual field results.
N245 Incomplete/invalid plan information for other insurance.

NOTE: New codes from N225 to N245 have been created by splitting 21 existing codes to help automate provider action. The rationale for splitting these codes is that if a document is missing, the provider action would involve sending the document to Medicare. On the other hand, if the document sent is incomplete/invalid, providers need to research and rectify before sending the corrected document to Medicare. This is a different action than just sending the missing document. Medicare contractors must use the new codes as appropriate in lieu of the existing codes.

For example if the consent form is incomplete/invalid, use code N228, and N3 only if it is missing. Following is a list showing the new codes and the source code that has been split to create the new code:

New Code	Split from existing Code
N225	N29
N226	M142
N227	M60
N228	N3

New Code	Split from existing Code
N229	N190
N230	M124
N231	M130
N232	N26
N233	M29
N234	M19
N235	M132
N236	M30
N237	M127
N238	M141
N239	M131
N240	M31
N241	N175
N242	N40
N243	N146
N244	N178
N245	MA92

Revised Remittance Advice Remark Codes

M19	Missing oxygen certification/re-certification.
M29	Missing operative report.
M30	Missing pathology report.
M31	Missing radiology report.
M60	Missing Certificate of Medical Necessity.
M73	The HPSA/Physician Scarcity bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components.
M74	This service does not qualify for a HPSA/Physician Scarcity bonus payment.
M124	Missing indication of whether the patient owns the equipment that requires the part or supply.
M127	Missing patient medical record for this service.
M130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
M131	Missing physician financial relationship form.
M132	Missing pacemaker registration form.
M141	Missing physician certified plan of care.
M142	Missing American Diabetes Association Certificate of Recognition.
MA92	Missing plan information for other insurance.
N3	Missing consent form.
N26	Missing itemized bill.
N29	Missing documentation/orders/notes/summary/report/invoice.
N40	Missing x-ray.
N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay.
N127	This is a misdirected claim/service for a United Mine Workers of America (UMWA) beneficiary. Please submit claims to them.
N137	The provider acting on the Member's behalf, may file an appeal with the Payer. The provider, acting on the Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The address may be obtained from the State Insurance Regulatory Authority.
N146	Missing screening document.
N175	Missing Review Organization Approval.
N178	Missing pre-operative photos or visual field results.
N190	Missing contract indicator.

Retired Remittance Advice Remark Codes

M35 Missing/incomplete/invalid pre-operative photos or visual field results.
M58 Missing/incomplete/invalid claim information. Resubmit claim after corrections.
MA51 Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
N38 Missing/incomplete/invalid place of service.
N66 Missing/incomplete/invalid documentation.

New Health Care Claim Adjustment Reason Codes

163 Claim/Service adjusted because the attachment referenced on the claim was not received.
164 Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.
D16 Claim lacks prior payer payment information.
D17 Claim/Service has invalid non-covered days.
D18 Claim/Service has missing diagnosis information.
D19 Claim/Service lacks Physician/Operative or other supporting documentation.
D20 Claim/Service missing service/product information.

NOTE: New reason codes (D16-D20) were added at the request of a group of health care industry professionals who identified some situations, that happen frequently, where there is no current reason code available. For these situations, remark codes are available, but commercial payers may not use the available remark codes. The suggestion was to create a few "temporary" reason codes that would be deactivated in the next version, and could be used in lieu of remark codes. Payers currently using the appropriate combination of reason and remark codes, do not have to switch and start using the new reason codes. **Medicare will continue using the combination of reason and appropriate remark code as is currently done, and not use the new temporary reason codes.**

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Frequently Asked Questions

1. What DMEPOS items does Medicare Part B cover for a beneficiary in a skilled nursing facility (SNF) outside of a Part A covered stay?

   ANSWER: The following DMEPOS items/services may be covered by Medicare Part B for a beneficiary in a SNF outside of a Part A covered stay:

   - Prosthetics, orthotics and related supplies
   - Urinary incontinence supplies
   - Ostomy supplies
   - Surgical dressings
   - Oral anticancer drugs
   - Oral antiemetic drugs
   - Therapeutic shoes for persons with diabetes
   - Parenteral/enteral nutrition (including E0776XA, the IV pole used to administer parenteral/enteral nutrition)
   - ESRD – dialysis supplies only
   - Immunosuppressive drugs

   (DMERC Region D Supplier Manual, Chapter 5, page 8)

2. Where in the supplier manual can I locate instructions on how to bill for upgraded equipment?

   ANSWER: Information regarding billing upgraded equipment is not currently available in the supplier manual. It will be included in a future update.

   Information regarding billing upgraded equipment was published in the article entitled "New Procedures to Use the ABN Form for DMEPOS Upgrades" in the *Region D DMERC Dialogue, Winter 2002, page 18.*

   We also offer a NetCourse titled "Advanced Beneficiary Notice (ABN)" on the Web at http://www.cignamedicare.com/webtraining/Logon.asp. The last portion of the Netcourse provides information about upgrades and examples for completing the CMS-1500 claim form.

3. What is the protocol to have a claim adjusted if it was processed incorrectly?

   ANSWER: If a claim was processed incorrectly due to carrier error, please contact Customer Service in writing or by phone (866.243.7272).

   If a claim was processed incorrectly due to incorrect/invalid information submitted by the supplier, additional information may be submitted for adjustment.

   Refer to the following articles for more information about claim adjustments (reopenings):

   1. "Correcting Minor Errors Through The Adjustment Process" (*Region D DMERC Dialogue*, Fall 2004, page 33)
   2. "Correction of Minor Errors and Omissions Without Appeals" (*Region D DMERC Dialogue*, Fall 2004, page 31)
   3. Frequently Asked Questions - # 7 (*Region D DMERC Dialogue,* Summer 2003, page 30)
   4. "How Do You Address Inquiries and Appeals?" (*Region D DMERC Dialogue,* Spring 1999, page 9)

Frequently Asked Questions (cont'd)

4. Is it the supplier's responsibility to replace capped rental equipment on maintenance and servicing that the patient has lost?

   ANSWER: Medicare will pay for a new piece of equipment which can be rented from the same supplier or a new supplier. No further charges can be billed to the beneficiary and no further maintenance and servicing charges can be billed to Medicare for the previous equipment.

   (CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 5, Section 5102.E.6 & DMERC Region D Supplier Manual, Chapter 5)

5. Is a new Certificate of Medical Necessity (CMN) needed for enteral nutrition if the beneficiary changes doctors?

   ANSWER: In the case of a change in doctor, supplier, or calories per day, a Revised CMN is required and is kept in the supplier's files.

6. Why was the payment reduced on a hospital bed from the previous month?

   ANSWER: A hospital bed falls within the capped rental DMEPOS Fee Schedule Payment Category. Payment for items in this category is reduced by 25% beginning with the fourth month of the capped rental period and thereafter.

   Other circumstances can alter the fee schedule allowance. For instance, if the beneficiary's state of residence changes. Fee schedule amounts may vary from state-to-state.

7. Can a supplier use a sleep study that is more than a year old for a Continuous Positive Airway Pressure (CPAP) device that is being prescribed for the first time today?

   ANSWER: Yes

8. How can a supplier avoid having claims denied for billing to the incorrect region?

   ANSWER: This can be avoided by verifying the beneficiary's current address. The beneficiary's state of residence on file with the Social Security office determines the DMERC region that should be billed.

9. Will Medicare cover an E0277 pressure reducing surface if Medicare was not billed for a hospital bed?

   ANSWER: Yes, if the coverage criterion are met.

10. Why haven't I heard anything on the redetermination request that I submitted?

    The timeframe for completion of a redetermination request is 60 days from the date of its receipt by the DMERC.

    ("MMA-Implementation of New Medicare Redetermination Notice" – Region D DMERC Dialogue, Fall 2004, page 23 & DMERC Region D Supplier Manual, Chapter 13)

An Important Message from Medicare…

Medicare now offers Medicare-approved drug discount cards that can help you pay for prescription drugs. We are writing to you because Medicare records show you very likely qualify for a $600 credit in 2004 and another $600 next year. You can use this $1,200 credit to pay for your prescriptions this year and next. To make it as easy as possible for you to get this Medicare benefit, included in this package is a Medicare-approved discount drug card from [Company Name].

Here's what you need to do NOW to get the $1,200 credit:

Call [Company Name] at 1-xxx-xxx-xxxx or 1-800-MEDICARE (1-800-633-4227) as soon as possible. TTY users should call 1-877-486-2048. If you don't call one of these numbers, you will not receive this benefit.

When you call, you will be asked:

- if you have any other health insurance with prescription drug coverage, and
- for other information that will help us find out if you qualify for even more help.

If you don't want to be in this card, call [Company Name] at **1-xxx-xxx-xxxx** as soon as possible. TTY users should call 1-XXX-XXX-XXXX. If you want to choose another Medicare-approved drug discount card, contact **1-800-MEDICARE (1-800-633-4227)**. An operator can also tell you about other cards that are available to you.

Remember, you must call NOW to get the $1,200 credit. If you qualify, the enclosed card is free.

Si desea información en español sobre las tarjetas de descuento para recetas médicas aprobadas por Medicare, llame al 1-800-MEDICARE (1-800-633-4227).

Prescription Drug Savings from Medicare

1-800-MEDICARE (1-800-633-4227)

www.medicare.gov

Watch Your Mail...

More than a million people with Medicare will be getting an Important Message from Medicare and a Medicare approved drug discount card in the mail this October. If your State helps pay your Medicare premiums or deductibles, watch your mail for this Important Message from Medicare.

Call Today...

It's easy. If you receive an Important Message from Medicare in the mail, you are likely to qualify for up to $1,200 in credits to use for your prescription drug costs. Just call the toll-free phone number in the letter and answer a few questions. There are no enrollment forms to complete. Don't wait—call today.

Start Saving...

You will also receive a Medicare-approved drug discount card and information about how to use it. You can start using your card as early as November 1, 2004 to save on your prescription drugs.

For more information about Medicare-approved drug discount cards, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web.

CMS

Completion of Medicare Certificates of Medical Necessity

Dear Physician:

Certificates of Medical Necessity, commonly known as CMNs, are documents used by the DMERCs to assist in gathering information about the medical necessity of an item. It is your responsibility to determine both the medical need for, and the utilization of, all healthcare services.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) are *your partners* in caring for *your patient.* They will not receive payment for their services until you return the completed, signed and dated CMN. If you have ordered equipment or supplies as part of your patient's treatment plan, completing the CMN accurately and in a timely manner helps insure that your treatment plan will be carried out. Moreover, your cooperation is a legal requirement as outlined in the Social Security Act, the law governing Medicare. Section 1842(p)(4) of the Act provides that:

> *[i]n case of an item or service…ordered by a physician or a practitioner…but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.*

Remember, everyone has tight cash flow these days – help your DMEPOS supplier continue good service to your patients by prompt completion and return of the CMN.

Sincerely,

Robert D. Hoover, Jr., MD, MPH
Durable Medical Equipment Regional Carrier
Medical Director

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DMERC Region D Publication Order Form

Name:

Company Name:

Address:

City:	**State:**	**Zip:**

Email:

Note: Government agencies, state associations, CMS, CIGNA employees and other insurance companies do not need to submit payment.

Subscription (4 quarterly publications) $40.00

Region D *DMERC Dialogue*_____ (quantity) ***Subtotal*** **$_____**

CD-ROM _____ (quantity) (Includes *DMERC Dialogue*, *DMERC Region D Supplier Manual* and updates and various other materials.) ***Subtotal*** **$_____**

Individual Publication Requests

Region D *DMERC Dialogue** **($10.00 each issue)** (*Previous issues may include the supplier manual update.)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

CD-ROM ($10.00 each)

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

DMERC Region D Supplier Manual
$40.00 per manual _____(quantity) ***Subtotal*** **$_____**

DMERC Region D Supplier Manual Update* **($10.00 each)** (*Previous updates may include the *DMERC Dialogue.)*

	Qty.	Year		Qty.	Year
Spring	_____	_____	Fall	_____	_____
Summer	_____	_____	Winter	_____	_____

Subtotal **$_____**

NOTE: Beginning Spring 2003, hardcopies of supplier manual updates are no longer mailed and must be downloaded from our Web site at http://www.cignamedicare.com/dmerc/dmsm/index.html. (Also, hardcopies are not available for the Summer and Fall 2002 updates, please download from the Web.)

DMERC DMEPOS Fee Schedule* ($10.00 each) (*DMERC DMEPOS suppliers do not need to submit payment for the fee schedule unless ordering more than one copy.)

Quantity_____ Year _____ ***Subtotal*** **$_____**

Total Amount Due **$_____**

Payment/Order Information

Checks or money orders should be made payable to CIGNA HealthCare Medicare Administration. Send completed order form and payment to:

Connecticut General Life Insurance Company
Attn: DMERC Publication Fulfillment Center
P. O. Box 360295
Pittsburgh, PA 15251-0295

If your order does not require a payment, send the completed order form to:

CIGNA Medicare
Attn: DMERC Region D Publications
P. O. Box 690
Nashville, TN 37202

If you have not billed CIGNA Medicare within the last 12 months, you will not be included on the current publication mailing list and will not receive your complementary CD-ROM or hardcopy *DMERC Dialogue*. Region D publications are available at http://www.cignamedicare.com/dmerc/index.html.

(Rev. 10/2004)

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Customer Service Available

Telephone Inquiries—Customer Service Agents are available from 8:00 am to 6:00 pm CST, Monday through Friday. The Interactive Voice Response (IVR) System is available any time as long as the mainframe system is functional.

IVR System*:* 877.320.0390 ***Supplier Help Line****:* 866.243.7272 ***Beneficiary Help Line****:* 1-800-MEDICARE (1-800-633-4227, Ask for Medical Supplies)

Paper Claim Submission & Written Inquiries:
CIGNA 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
Newark NJ 07193–0927

CIGNA HealthCare
Medicare Administration

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DMERC Region D
PO Box 690
Nashville TN 37202

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

The *DMERC Dialogue*, together with occasional special releases, serves as legal notice to suppliers concerning responsibilities and requirements imposed upon them by Medicare law, regulations, and guidelines.

CIGNA Medicare does not review or control the content and accuracy of Web sites referenced in this newsletter (except the CIGNA Medicare Web site) and is therefore not responsible for their content and accuracy.