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

REGION D
DMERC DIALOGUE
DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER

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CIGNA Government Services

CIGNA Medicare Has Changed Its Name To CIGNA Government Services, LLC

Effective May 24, 2005, CIGNA HealthCare Medicare Administration is now CIGNA Government Services, LLC. The name change better aligns CIGNA Government Services with the daily business it conducts as a contractor for government healthcare programs.

The name change will be phased in over an extended period of time. You will immediately notice the change on our Web site, publications, Interactive Voice Response (IVR) system, and in our telephone greeting. Many other items will be phased in over a period of time. Over the next six months you may still receive correspondence from us with our old name and logo as we complete the transition to our new name.

The dedicated staff at CIGNA Government Services remains committed to serving our provider, supplier, and beneficiary communities… just as we have for the last 40 years.

From the Medical Director…

Robert Hoover, Jr., MD, MPH

New Web Site For Physician Education: www.cignagovernmentservices.com/MDCorner

In mid-April, CIGNA Government Services launched M.D. Corner, a Web site devoted to physician education about durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). The site contains articles I've written for medical publications, local Part B carrier bulletins and state medical societies. Included on the home page for this site is the "Physician's Guide to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) which is a general overview of the Durable Medical Equipment Regional Carrier (DMERC) contractor system, policy development and Medicare benefit categories.

This site was developed to help medical equipment suppliers educate the physician community about various issues important to the DMEPOS industry. Information will be added periodically as topics of interest to treating physicians arise. In addition, I would appreciate any feedback or suggestions regarding enhancements for the site that would make it more useful to you. There's a link on the site for feedback so take a look and send me your comments and suggestions.

Subscribe to the CIGNA Government Services Electronic Mailing List

To receive automatic notification via e-mail of the posting of LCDs/Policy Articles, LMRPs, publications and other important Medicare announcements, subscribe to the CIGNA Government Services electronic mailing list at **www.cignagovernmentservices.com/mailer/subscribe.asp**.

In This Issue

MEDICAL POLICY

Durable Medical Equipment

Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep Apnea (OSA)

Medlearn Matters Article Number: MM3843

Provider Types Affected - Physicians, providers, and suppliers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs) and Fiscal Intermediaries (FIs) for OSA-related claims

Provider Action Needed

Providers need to be aware that on April 4, 2005, the Centers for Medicare & Medicaid Services (CMS) declared that the national coverage policy for CPAP therapy for OSA will remain unchanged. Unattended home sleep testing for the diagnosis of OSA is not considered reasonable and necessary.

Polysomnography must be performed in a facility-based sleep study laboratory, not in the home or a mobile facility.

Background

CR3843 is updating and confirming the National Coverage Determination (NCD) policy section 240.4 of the Medicare NCD Manual (Pub. 100-03), which states that polysomnography must be performed in a facility based sleep study laboratory, not in the home or a mobile facility.

The use of CPAP is covered under Medicare when used in adult patients with moderate or severe OSA for whom surgery is a likely alternative to CPAP. The use of CPAP devices must be ordered and prescribed by the licensed treating physician to be used in adult patients with moderate to severe OSA if either of the following criteria using the Apnea-Hyopopnea Index (AHI) is met:

• AHI greater than or equal to 15 events per hour, or

• AHI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke. The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of 2 hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected). Apnea is defined as a cessation of airflow for at least 10 seconds.

Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent oxygen desaturation.

Initial claims must be supported by medical documentation (separate documentation where electronic billing is used), such as a prescription written by the patient's attending physician that specifies:

• A diagnosis of moderate or severe obstructive sleep apnea, and
• Surgery is a likely alternative.

The claim must also certify that the documentation supporting a diagnosis of OSA (described above) is available.

Implementation - The implementation date of CR3843 is June 6, 2005.

Additional Information

The HCPCS codes that can be used for billing covered Medicare CPAP devices and various accessories are E0601, A7030-A7039, A7044-A7046, and E0561- E0562.

For complete details, please see the official instruction issued to your carrier/DMERC/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 CR3843 in the CR NUM column on the right, and click on the file for the desired CR. For additional information relating to this issue, please refer to your carrier/DMERC/intermediary. To find their toll free phone numbers go to: http://www.cms.hhs.gov/medlearn/tollnums.asp

Group 2 Support Surfaces And ICD-9 Codes

The following article is being republished to remind suppliers that CIGNA Government Services will begin editing claims for the proper ICD-9 code for dates of service on or after July 1, 2005.

According to the Pressure Reducing Support Surfaces - Group 2 local medical review policy (LMRP), coverage is considered for multiple pressure ulcers located on the trunk or pelvis. As of October 1, 2004, the ICD-9 diagnosis code for decubitus ulcer (707.0) requires 5th digit specificity. The 5th digit describes the specific location of the ulcer. Suppliers should ensure that the ICD-9 diagnosis code on the claim reflects the appropriate location of the decubitus ulcer. The following ICD-9 diagnosis codes are eligible for coverage. Claims for Group 2 support surfaces that do not include one of these diagnosis codes will be denied as not medically necessary.

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

The ICD-9 diagnosis code 707.00 (unspecified site) does not have sufficient specificity to determine coverage; therefore, claims listing code 707.00 will be denied as not medically necessary for dates of service on or after 07/01/2005. Please refer to the Pressure Reducing Support Surfaces - Group 2 LMRP for additional information on the coverage, coding and documentation of these items. The LMRP will be converted to a local coverage determination (LCD) and Policy Article in a future update and will reflect these changes.

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

Medlearn Matters Article Number: MM3705

Note: This article was revised on April 25, 2005, to show that the correct diagnosis codes are 250.00-250.93.

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

Provider Action Needed

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

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

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

Background

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

the C-peptide testing requirement for Medicare coverage of CSII pump therapy.

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

Levels need only be documented once in the patient's medical records.

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

Those billing for these services should note that Medicare carriers/intermediaries will accept, effective for services on or after December 17, 2004, CPT code 84681 (C-peptide) or CPT code 86337 (insulin antibodies) when diagnosis codes 250.00-250.93 are also reported on a claim.

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

From that web page, look for CR 3705 in the CR NUM column on the right, and click on the file for that CR. If you have questions regarding this issue, contact your carrier/intermediary on their toll free number, which is available at: http://www.cms.hhs.gov/medlearn/tollnums.asp

NOTE: These criteria have been added to the External Infusion Pump LCD and Policy Article posted on our Web site. Please refer to the LCD and Policy Article for more information on the coverage, coding and documentation requirements for these items.

Nebulizer Equipment And CERT Errors

A recent review of Comprehensive Error Rate Testing (CERT) program results showed that a significant percentage of errors in the Nebulizers and Nebulizer Drugs policy group were from suppliers who only bill for the nebulizer equipment. In these situations, the nebulizer is billed by one company and the drugs by a different supplier. However, one must remember that a nebulizer is covered only if it is medically necessary to administer a drug via the nebulizer.

With these CERT errors, the supplier billing the nebulizer equipment was not able to produce documentation to demonstrate that a covered drug was being administered and there was no billing for nebulizer drugs in Medicare's claim history for that beneficiary. Consequently, the claim for the nebulizer equipment was denied. Suppliers are reminded that the medical necessity for the nebulizer equipment is actually supported by documentation that the drug(s) being administered with the nebulizer equipment is medically necessary. Suppliers should obtain information from the patient's medical record that supports the medical necessity for the medications in order to support medical necessity for the nebulizer equipment. Claims for nebulizer equipment that are not supported by medical necessity for the drug(s) or for which there are no drugs in Medicare's claim history are subject to denial.

For more information on CERT errors, documentation tips, and policy information, please visit the CIGNA Government Services Region D Durable Medical Equipment Regional Carrier Web site at ww.cignagovernmentservices.com/dmerc.

Pharmacy

Immunosuppressive Drugs – DIF Reinstated; Supply Fee Revised

In March 2005, the DMERCs published a revised Immunosuppressive Drugs local coverage determination (LCD) that announced the elimination of the DMERC Information Form (DIF) effective for dates of service on or after July 1, 2005. Due to technical difficulties, the DIF will not be eliminated at that time. The DMERCs anticipate elimination of the DIF in the future and suppliers are urged to monitor DMERC publications and ListServ announcements for further details. In the meantime, suppliers must continue to submit DIFs with their claims as specified in the Documentation Requirements sec-

tion of the LCD.

In addition, there is a revision of the description of the supply fee (G0370) in the Policy Article. The April publication stated: "If two dosage strengths of the same drug are dispensed on the same day, a G0370 supply fee is payable for each one." This is revised to say: "If two dosage strengths of the same drug are dispensed on the same day, only one G0370 supply fee is payable." For example, if both 1 mg and 5 mg tablets of tacrolimus (J7507) are dispensed on the same day, only one unit of service for G0370 may be billed.

The Immunosuppressive Drugs LCD and Policy Article have been revised to reflect these changes and are posted at http://www.cignagovernmentservices.com/dmerc/lmrp_lcd/index.html and published in the July 2005 supplier manual revision.

General

Policies Revised

Effective for dates of service on or after July 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
- Eye Prostheses
- Glucose Monitors
- Home Dialysis Supplies and Equipment
- Immunosuppressive Drugs
- Intrapulmonary Percussive Ventilation System
- Mechanical In-exsufflation Devices
- Oxygen and Oxygen Equipment
- Pressure Reducing Support Surfaces – Group 1
- Refractive Lenses
- Speech Generating Devices
- Tracheostomy Supplies

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

Over the next year the DMERCs will convert all existing LMRPs into LCDs and policy articles. Until the conversion is complete the term LCD will refer to both standalone LCDs and the "reasonable and necessary" provisions of an LMRP. **Suppliers are strongly encouraged to read both the LCD and the policy article that accompanies the LCD for a full understanding of the coverage, coding and documentation requirements. A revision history field in each document provides summary details for each revision.**

COVERAGE AND BILLING

Durable Medical Equipment

Bathroom Aids – Raised Seats, Seat Lifts, And Lifts For Toilets

A raised toilet seat (E0244) is a device that adds height to the toilet seat. It is either fixed height or adjustable. It is either attached to the toilet or is unattached, resting on the bowl. (Note: A freestanding raised toilet seat supported by legs on the floor is coded as a commode. See accompanying article for information on coverage.)

A toilet seat lift mechanism is a device with a seat that can be raised with or without a forward tilt while the patient is seated, allowing the patient to ambulate once he/she is in a more upright position. It may be manually operated or electric. It is attached to the toilet. There is no specific code for these devices; therefore, code A9270 (noncovered item or service) must be used.

A patient lift for a toilet (E0625) describes a device with which the patient can be transferred from the toilet seat to another seat (e.g., wheelchair). It is used for a patient who is unable to ambulate. Devices billed with this code are attached to either the toilet, ceiling, floor, or wall of the bathroom.

None of these devices are primarily medical in nature; therefore, they do not meet the definition of durable medical equipment. They are statutorily noncovered – no benefit category.

Commodes – Coverage And Coding Clarification

When the seat pan of a commode is removed, the device can be placed over a toilet and serve as a raised toilet seat. However, if the device is only used in this way, the general coverage criteria of the Commodes policy are not met and the device is noncovered. In this situation, the appropriate HCPCS code for the commode is used and a GY modifier is added to the code and the

KX modifier is not used. This will result in a denial as statutorily noncovered – no benefit category.

A commode with seat lift mechanism is a free-standing device that has a commode pan and that has an integrated seat that can be raised with or without a forward tilt while the patient is seated. An integrated device is one which is sold as a unit by the manufacturer and in which the lift and the commode cannot be separated without the use of tools. Code E0169 may only be used for those devices that have an electric seat lift mechanism. Code E1399 must be used for a commode chair with an integrated non-electric seat lift mechanism. A commode with seat lift mechanism is intended to allow the patient to walk after standing. If the patient can ambulate, he/she would rarely meet the coverage criterion for a commode. Therefore, if the patient is capable of walking from the bed to the bathroom, a KX modifier must not be added to the code for the commode with seat lift mechanism.

These changes will be incorporated into the Commodes policy in a future revision.

Billing For Syringes Used In The Treatment Of End Stage Renal Disease (ESRD) Patients

Medlearn Matters Article Number: SE0527

Provider Types Affected - Physicians, providers, and suppliers billing carriers and intermediaries for ESRD services and supplies

Provider Action Needed - Providers billing HCPCS code A4657 for ESRD patients need to be aware of the proper use of this code when billing for syringes, especially when a pre-filled syringe is used in the administration of the drug contained in the syringe and no other syringe is used. In such instances, the supply charge associated with A4657 cannot be billed to Medicare.

Background

In some previous Change Requests (CRs) relating to ESRD, there was mention that Healthcare Common Procedure Coding System (HCPCS) code A4657 (syringe – with or without needle) was allowed for Epoetin (EPO). However, physicians, providers, and suppliers should note that pre-filled syringes with medications used to administer the drug to an ESRD patient should not be billed with HCPCS code A4657 to Medicare.

Also note that HCPCS code A4657 (syringe – with or without needle) should be billed only when an actual syringe is taken from the provider's supplies and used to administer the drug. Syringes that are pre-filled with medications should not require the use of another syringe to administer the medication.

When a drug is supplied in a pre-filled syringe (and no other syringe is used in the administration of the drug contained in the syringe) then the supply charge associated with HCPCS code A4657 cannot be billed to Medicare.

Only when a new syringe is used in the administration of the drug should HCPCS code A4657 be used. Note that this special edition article relates to billing for syringes used in the treatment of ESRD patients.

Additional Information

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

NOTE: Suppliers are reminded that modifier AX must be used when items are furnished in conjunction with home dialysis supplies and equipment and billed to the DMERC. Please refer to the Home Dialysis Supplies and Equipment medical policy for further details.

CPAP And RAD – Nasal Interfaces

There are two types of nasal interfaces that are used with a continuous positive airway pressure (CPAP) device or a respiratory assist device (RAD) – a nasal mask and cannula-type interface. Both of these are coded A7034 and the code includes the soft interface. Codes A7032 and A7033 describe replacement soft interfaces. Code A7032 is used for a nasal mask interface that goes around the nose, but not into the nostrils. The description for unit of service for this code is "each".

Code A7033 is used for a nasal cannula-type interface. This interface extends a short distance into the nostrils. The description for unit of service for this code is "pair". For some products, there are two physically separate cushions or "pillows" – one for each nostril. Two cushions/pillows equal one unit of service of A7033. For other products, the interface is a single piece with two protrusions that extend into the nostrils. One of these interfaces equals one unit of service of A7033.

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

Revised Manual Language To Item 24G (Days Or Units) CMS-1500 Instructions Regarding The Billing Of Oxygen And Oxygen Equipment

Medlearn Matters Article Number: MM3753

Provider Types Affected - Providers and suppliers billing carriers and Durable Medical Equipment Regional Carriers (DMERCs) for oxygen and oxygen equipment

Provider Action Needed

Impact to You - Suppliers and providers should note that this instruction is based on information contained in Change Request (CR) 3753 regarding revised manual language for oxygen billing instructions for CMS-1500 contained in the *Medicare Claims Processing Manual* (Pub. 100-04).

What You Need to Know - The language contained in Chapter 26, Section 10.4, Item 24G of the CMS-1500 claim form regarding the billing of oxygen claims is being revised, and the Item 24G billing requirements will include a reference to the actual oxygen billing instructions contained in Chapter 20, Section 130.6 of the *Medicare Claims Processing Manual*.

What You Need to Do - Please see the Background and Additional Information Sections of this instruction for further details regarding these changes.

Background

The *Medicare Claims Processing Manual* (Pub. 100-04) language contained in Chapter 26, Section 10.4, Item 24G provides an explanation of how to fill out Item 24G (Days or Units) of the CMS-1500 claim form, and the billing requirements for Item 24G can vary based on the type of service being billed.

The current language explaining the procedures for billing for oxygen is inaccurate and outdated and is removed by CR 3753. The language is being replaced with a direct reference to Chapter 20, Section 130.6 of the same manual that deals with billing for oxygen and oxygen equipment.

The following is the revised wording (bolded and italicized) that is being added to Item 24G (Pub. 100-04, Chapter 26, Section 10.4):

For instructions on submitting units for oxygen claims, see Chapter 20, Section 130.6.

The *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Section 130 (Billing for Durable Medical Equipment (DME) and Orthotic/Prosthetic Devices), Subsection 130.6 (Billing for Oxygen and Oxygen Equipment) can be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104c20.pdf

Implementation - The implementation date for this instruction is July 1, 2005.

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

From that web page, look for CR 3753 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

Rules For Maintenance And Servicing Claims

DMEPOS suppliers must not submit claims for maintenance and servicing until all claims for rental have been paid and six months have passed from the end of the final paid rental month. Furthermore, DMEPOS suppliers must not bill for maintenance and servicing codes on the same claim as codes for the rental itself.

Maintenance and servicing for an item billed on the same claim with the rental of the same item will be denied. A claim must be resubmitted for the maintenance and servicing fee only.

Orthotics/Prosthetics

Skilled Nursing Facility Consolidated Billing As It Relates To Prosthetics And Orthotics

Medlearn Matters Article Number: SE0437

NOTE: This article was revised on February 18, 2005. Specifically, line 4 of the "Clarification" statement below was modified to say "These "excluded" services…." in-

stead of "These included services…" We regret the error.

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

Provider Action Needed - This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to prosthetics and orthotics for SNF residents.

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

Background

The SNF CB provision of the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432(b)) is a comprehensive billing requirement under which the SNF itself is responsible for billing Medicare for virtually all of the services that its residents receive. This billing requirement is similar to the billing requirement that has been in effect for inpatient hospital services since 1983.

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's residents (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list prosthetic devices among the services identified for exclusion, such items initially were categorically included within the scope of the CB provision.

However, effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F, Section 103) provided for the exclusion of certain additional types of services from SNF CB. These services are listed in a separate Medlearn Matters article, SE0431, which also provides an overview of SNF CB. This article can be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

The original statutory exclusions enacted by the BBA consist of a number of broad service categories and encompass all of the individual services that fall within those categories. By contrast, the additional exclusions enacted in the BBRA are more narrowly targeted, and apply only to certain specified, individual services within a number of broader service categories that otherwise remain subject to CB.

For customized prosthetic devices, the exclusion applies only to those individual items that the legislation itself specifically identifies by Healthcare Common Procedure Coding System (HCPCS) code, while all other items within this category remain subject to CB. The individual HCPCS codes by which the excluded services are identified appear in annual and quarterly CB updates. These CB updates can be found at: http://www.cms.hhs.gov/providers/snfpps/snfpps_pubs.asp

The BBRA Conference Committee report (H. Rep. 106-479) characterized the individual services that this legislation targeted for exclusion as "…high-cost, low-probability events that could have devastating financial impacts because their costs far exceed the payment [SNFs] receive under the prospective payment system…."

The BBRA also gives the Centers for Medicare & Medicaid Services (CMS) limited authority to identify additional prosthetic codes for exclusion, in response to developments such as major advances over time in the state of medical technology, or reconfigurations of the HCPCS codes themselves. When new HCPCS codes are established for excluded services, the new codes are communicated through the annual and quarterly CB updates.

Moreover, while Congress elected to exclude from CB certain specific customized prosthetic devices that meet the criteria discussed above regarding high cost and low probability, it declined to exclude other types of prosthetic devices, and also declined to exclude orthotics as a class.

In contrast to prosthetics, those items in the orthotics category tend to be more standardized and lower in cost. Further, even those customized items that fall at the high end of the orthotics category generally are still significantly less expensive and more commonly furnished in SNFs than customized items that fall at the high end

of the prosthetics category.

Accordingly, orthotics would not appear to meet the criteria of exceptionally high cost and low probability that served as the basis for the BBRA exclusions. Further, even if certain individual orthotic devices were to be identified as meeting these criteria, excluding them from the CB requirement could not be accomplished administratively, but would require further legislation by Congress to add this service category to the statutory exclusion list.

In addition, CMS notes that in contrast to prosthetics (where the needs of a patient with a missing limb can often be addressed only through the use of a single, particular type of customized device), it is often medically feasible to use a relatively inexpensive orthotic device in place of a more expensive one. Thus, CMS believes that the SNF PPS appropriately places the financial responsibility for such devices (along with the decision-making authority for selecting among them) with the SNF itself, because it may be possible to address a particular SNF resident's condition with equal efficacy by selecting among a broader range of orthotic devices.

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

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

It includes the following relevant information:

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

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

It includes the following relevant information:

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

Pharmacy

Anti-Cancer Chemotherapy For Colorectal Cancer

Medlearn Matters Article Number: MM3742

Provider Types Affected - Providers and suppliers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs), and fiscal intermediaries (FIs) for anti-cancer chemotherapy

Provider Action Needed

This article is based on information contained in Change Request (CR) 3742, which states that the Centers for Medicare & Medicaid Services (CMS) will cover the off-label use of Oxaliplatin (Eloxatin™), Irinotecan (Camptosar®), Cetuximab (Erbitux™), or Bevacizumab (Avastin™) in clinical trials identified by CMS and sponsored by the National Cancer Institute (NCI).

This national coverage decision does not:

- Modify existing requirements for coverage of these and other anti-cancer chemotherapeutic agents for FDA-approved indications or for off-label indications listed in an approved compendium; or
- Change existing coverage for any off-label uses of these drugs provided outside the clinical trials identified.

Medicare carriers, DMERCs, and intermediaries will continue to make local coverage determinations for medically accepted uses of off-label indications based on guidance provided by the Secretary of the Department of Health and Human Services (DHHS).

Background

On January 28, 2005, CMS announced a National Coverage Determination (NCD) covering the off-label use of certain colorectal anti-cancer drugs in identified clinical trials of colorectal cancer and other cancer types. These clinical trials study the use of one or more off-label uses of these four drugs in colorectal and other cancer types.

Note: The clinical trials for which these drugs and other items and services are covered appear in Appendix A in the NCD at the following CMS web site: http://

www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=90

Anti-cancer chemotherapeutic agents are eligible for coverage in a clinical trial setting when the following occurs:

- They are used in accordance with Food and Drug Administration (FDA)-approved labeling;
- Their use is supported in one of the authoritative drug compendia; or
- The Medicare contractor (carriers, Fiscal Intermediaries (FIs), DMERCs) determines an off-label use is medically accepted based on guidance provided by Secretary of DHHS.

Effective for services provided on or after January 28, 2005, CMS covers the following anti-cancer chemotherapeutic agents, which have been approved by the FDA for the treatment of colorectal cancer, when used in clinical trials identified by CMS and sponsored by the National Cancer Institute:

- Oxaliplatin (Eloxatin™)
- Irinotecan (Camptosar®)
- Cetuximab (Erbitux™)
- Bevacizumab (Avastin™)

Under the concept of linking Medicare coverage determinations to clinical studies, the investigational items and services provided in qualified scientific studies are covered (including clinical trials, practical trials, and systematic data collection systems) when:

- They provide for the accrual of supporting evidence of medical necessity; and
- They collect data to support decisions about whether or not a technology is reasonable and necessary.

Note: The list of identified clinical trials for which the routine costs of the items and services are covered appears in the Clinical Trials section of the following CMS web site: http://www.cms.hhs.gov/coverage

Non-routine clinical costs include items and services that are provided in either the investigational or the control arms of a clinical trial specified by CMS for coverage. The following non-routine items and services **are not covered** and include items and services:

- Provided solely to satisfy data collection, and that are not used in the direct clinical management of the patient;
- Provided solely to determine trial eligibility;
- Customarily provided by the research sponsors free-of-charge for any enrollee in the trial;
- That are statutorily excluded from Medicare coverage; or
- That do not fall into a benefit category.

This NCD, issued on January 28, 2005, does not withdraw Medicare coverage for items and services that may be covered according to the existing national coverage policy for Routine Costs in a Clinical Trial (See *National Coverage Determination Manual*, Section 310.1 at the following CMS web site: http://www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp

Note: The existing requirements for coverage of oxaliplatin, irinotecan, cetuximab, bevacizumab, or other anticancer chemotherapeutic agents for FDA-approved indications or for indications listed in an approved compendium are not modified.

Medicare contractors will continue to make reasonable and necessary coverage determinations under the Social Security Act (Section 1861(t)(2)(B)(ii)(II))based on guidance provided by CMS for medically accepted uses of off-label indications of Oxaliplatin, Irinotecan, Cetuximab, Bevacizumab, or other anticancer chemotherapeutic agents provided outside of the identified clinical trials appearing on the CMS website noted previously.

Some important points to remember when billing Medicare for these anti-cancer drugs are as follows:

- FIs will accept claims for these drugs on types of bill (TOB) 11x, 12x, 13x, 18x, 21x, 22x, 23x, and 85x. Revenue code 0636 should be used.
- When billing carriers, DMERCs and FIs, on a claim other than an inpatient claim, include the QR modifier to show the drug was furnished during a clinical trial.
- Claims submitted to FIs should also contain an ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position to show that the claim involves a clinical trial.
- When using the QR modifier, also be sure to include a HCPCS code of J9035, J9055, J9206, J9263, J8520, J8521, J9190, or J9201, as appropriate for the anti-cancer drug being billed.
- Providers are also to include a QR modifier when billing for nonroutine costs associated with these clinical trials.
- DMERCs will accept claims with HCPCS codes of J8520 and J8521 as clinical trial codes for **oral anticancer** drugs, when accompanied by the QR modifier to show use in a clinical trial.
- When billing for covered routine costs associated

with clinical trials as described in section 310 of the NCD Manual, be sure to include a QV modifier on the claim.
- Submit an appropriate cancer diagnosis code for the clinical trial on the claim.

Note: While this NCD is effective as of January 28, 2005, Medicare systems will be unable to process claims containing the QR modifier received before April 1, 2005. For that reason, do not send in claims for drugs or other nonroutine services covered under this NCD until April 1, 2005. Do not hold claims for nonroutine services containing the QV modifier associated with this NCD.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction includes the NCD section 110.17 and it may be viewed by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3742 in the CR NUM column on the right, and click on the file for that CR. You should see two versions of CR 3742 ob this web site. The version of CR 3742 with a transmittal number of R30NCD will contain the NCD information and the version with a transmittal number of R512CP will contain the Medicare claims processing instructions.

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

DuoNeb And Budesonide – Coding Clarification

A new code J7616 (albuterol, up to 5 mg, and ipratropium bromide, up to 1 mg, compounded inhalation solution, administered through DME) became effective for dates of service on or after January 1, 2005. DuoNeb is one example of J7616. DuoNeb contains 3.0 mg of albuterol sulfate (which is 2.5 mg of albuterol base) and 0.5 mg of ipratropium bromide in each unit dose vial. Therefore, 1 unit of service of J7616 is billed for 2 unit dose vials. Code J7616 may only be used when albuterol and ipratropium are provided in combination by a manufacturer or repackager in a vial with a single NDC number. Despite the narrative description of the code, J7616 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 must use codes J7613 for albuterol and J7644 for ipratropium with the appropriate modifier – KO, KP, or KQ. A KO, KP, or KQ modifier should not be used with code J7616.

Code J7617 (combination levalbuterol and ipratropium) is invalid for claim submission to the DMERC. That is because there is no such product provided by a manufacturer or repackager. For combination unit dose preparations compounded by pharmacies, suppliers must use codes J7614 for levalbuterol and J7644 for ipratropium with the appropriate modifiers – KP, KQ.

Code J7626 is used for unit dose vials of budesonide inhalation solution. Bill one unit of service for each vial dispensed, regardless of whether a 0.25 mg vial or a 0.5 mg vial is dispensed.

Intravenous Immune Globulin - New Codes

Effective for dates of service on or after April 1, 2005, codes J1563 and J1564 will no longer be valid for claim submission to Medicare. These codes will be replaced with HCPCS codes Q9941 – Q9944 for dates of service on or after April 1, 2005.

HCPCS CODE	LONG DESCRIPTOR
Q9941	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED, 1 G
Q9942	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED, 10 MG
Q9943	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, N0N-LYOPHILIZED, 1G
Q9944	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED, 10 MG

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided a new benefit for intravenous immune globulin (IVIG) administered in the home setting. This benefit was effective for claims with dates of service on or after January 1, 2004. In order for the IVIG to be covered, all of the following criteria must be met:

1. It is an approved pooled plasma derivative for the treatment of primary immune deficiency disease;
2. The patient has a diagnosis of primary immune deficiency disease (ICD-9 codes 279.04, 279.05, 279.06, 279.12, 279.2);

3. The IVIG is administered in the home; and
4. The treating physician has determined that administration of the IVIG in the patient's home is medically appropriate.

This benefit is limited to coverage of the medication.

If the IVIG is billed with a diagnosis code other than one of the covered diagnosis codes listed above and it is not administered with an infusion pump, the IVIG will be denied as noncovered.

If the IVIG is billed with a diagnosis code other than one of the covered diagnosis codes listed above and it is administered with an infusion pump, the IVIG will be denied as not medically necessary under the External Infusion Pumps policy.

Related equipment and supplies are not covered under the IVIG benefit. If the IVIG is not administered with an infusion pump, supplies will be denied as noncovered, i.e., no benefit category. If the IVIG is administered with an infusion pump, the pump and related supplies will be denied as not medically necessary – even if the IVIG itself is covered.

Coding Instructions:

IVIG not administered through an infusion pump – If supplies are billed, use HCPCS code A4223 for these noncovered items.

IVIG administered through an infusion pump – Use HCPCS codes A4221 and A4222 as appropriate for the related supplies.

IVIG must be dispensed and billed by a pharmacy or other entity licensed to dispense drugs. If an IVIG meets the coverage criteria for this benefit but it is not dispensed by an entity licensed to dispense drugs, it will be denied as not medically necessary. Further, in order for reimbursement to be made for IVIG, suppliers must bill assigned claims. Beneficiaries are ineligible to receive direct payment for this drug.

Lessons Learned From Albuterol/ Ipratropium Wide-Spread Probe

In 2004, insufficient or incomplete documentation accounted for the majority of nebulizer drug billing errors identified by the Comprehensive Error Rate Testing (CERT) contractor and confirmed in a recent Carrier wide-spread probe of HCPCS codes J7619, J7644 and J7621. In light of the findings from these reviews, we want to remind you that if requested by either the Carrier or the CERT contractor, you must produce copies of all documentation specified in the *DMERC Region D Supplier Manual*. Failure to produce this documentation in a timely manner can result in a revised determination to deny a previously paid claim and an overpayment assessment.

The Medical Review staff has developed a documentation checklist for nebulizer drugs that we encourage you to use when verifying the completeness of your beneficiary files. Copies of this checklist, plus checklists for other policy groups, can be obtained online at: http://www.cignagovernmentservices.com/dmerc/mr/CERT/doccheclists.html

The following "reminders" are based on specific errors identified in the Carrier's review of claims for HCPCS codes J7619, J7644 and J7621.

• If the drug is dispensed prior to obtaining a valid written order, make sure your file includes verification of the verbal order. The *DMERC Region D Supplier Manual* specifies that the following elements must be included in the verbal order:

- Description of the item
- Name of the beneficiary
- Name of the physician
- Start date of the order

Nebulizer drugs may be dispensed based on a verbal order. However, the supplier cannot bill Medicare and receive payment prior to obtaining a valid written order. Written orders must meet the requirements outlined in The CMS Manual System, Pub. 100-8 *Medicare Program Integrity Manual*, Chapter 5, Section 5.1.1.2. A written order for nebulizer drugs must include all of the following elements:

- Beneficiary's name;
- Name of the drug
- Concentration (if applicable)
- Dosage
- Frequency of administration
- Signature and date the order is signed.
- The start date of the order, if different from the signature date.

• Written orders for nebulizer drugs must also comply with the requirements outlined in the Documentation Requirements section of the Local Coverage Determination (LCD) for Nebulizers. One of these requirements mandates that the written order be renewed a minimum of once every 12 months.

• Items billed prior to the time that the supplier has a valid written order in the beneficiary's file must be billed with modifier EY.
• Whether or not to routinely obtain medical records is a business decision the supplier must make. The CMS Manual System, Pub. 100-8 *Medicare Program Integrity Manual*, Chapter 5, Section 5.2 states that the documentation in the patient's medical record does not have to be routinely sent to the supplier or to the DMERC. However, section 5.2.1 instructs that the supplier should obtain as much documentation from the patient's medical record as they determine they need to assure themselves that coverage criteria for an item have been met. In any event, if requested by the DMERC or CERT contractor, the supplier is required to obtain medical records that support that the item(s) in question meet Medicare medical necessity and statutory coverage criteria. If the information is not received when requested or the information in the patient's medical record does not adequately support the medical necessity for the item, the supplier is liable for the dollar amount involved unless a properly executed Advanced Beneficiary Notice (ABN) of possible denial has been obtained.
• The units billed should match the units prescribed by the treating physician. If either the CERT contractor or CIGNA Government Services' Medical Review staff review a claim, they check all aspects of the documentation. This means they check the units billed against the written order to make sure that what the physician ordered and what the supplier billed match. For example, if the physician ordered 2.5 mg. Albuterol QID (four times/day), any billed units over that amount would be denied in a postpay review of the claim. The formula used to calculate the correct number of units to bill is: # units per dose X # doses per day X # days per month

The *DMERC Region D Supplier Manual* states that 1 unit of Albuterol equals 1 milligram. So, if the supplier was billing for a month's supply of Albuterol based a QID frequency in a month with 31 days, the number of units billed should not be more than 310.

2.5 (# units/milligrams/dose) X 4 (# doses/day) X 31 (# days/month) = 310

• Suppliers should be alert for beneficiaries receiving supplies from more than one company. This practice can also result in denials for billing excess units of service. For example, Supplier A bills for 200 units of J7619 on May 1st and Supplier B bills for 310 units on May 15th. If Supplier B's May 15th claim is randomly selected for review and the written order indicates a QID frequency, the reviewer may combine the total number of units billed by both suppliers to determine how many units should be allowed within a month's time. In that case, Supplier B would have 110 units approved and 200 units denied.
• Claims for more than the usual maximum replacement amount will be denied as not medically necessary unless the claim is accompanied by documentation which justifies a larger quantity in the individual case. Each claim must include documentation supporting the medical necessity for the higher utilization. This information must be attached to a hard copy claim or entered in the narrative field of an electronic claim. Additionally, there must be clear documentation in the patient's medical records corroborating the medical necessity of this amount.
• The pharmacist is responsible for assessing how much inhalation solution a patient is actually using. Considering this information, the pharmacist is responsible for assuring that the patient has used almost all of his/her supply on hand prior to dispensing a new supply.

Levalbuterol – Billing Guidelines

The unit of service for billing levalbuterol inhalation solution in unit dose vials (J7614) is 0.5 milligrams (mg). Levalbuterol is provided in dosages that are different. This difference has caused some confusion regarding the proper calculation for the number of units to be billed to Medicare. The number of units of service that must be billed on the claim are determined as follows:

1) Calculate the total milligrams of levalbuterol that are provided for the month. For example, Xopenex brand levalbuterol comes in unit dose vials each containing 0.31 mg, 0.63 mg, and 1.25 mg of levalbuterol. If 90 of the 0.63 mg vials are dispensed, then the number of milligrams dispensed is 90 x 0.63 = 56.7 mg.

2) Multiply the result from step 1 times 2 to determine the number of units of service (UOS). For example, 56.7mg x 2 UOS/mg = 113.4 UOS.

3) Round the result from step 2 up to the next highest whole number (if the result in step 2 is not already a whole number) and bill that number of units on the claim. For example, round 113.4 up to 114 UOS and bill that on the claim.

• DO NOT determine the number of UOS per vial and use that in the calculation. In the example given,
• DO NOT say that each 0.63 mg represents 2 UOS.
• DO NOT bill 180 UOS when 90 of the 0.63 mg vials are dispensed.

IMPORTANT NOTE: The amount of drug in a vial can be expressed as either levalbuterol or levalbuterol hydrochloride (HCl). The calculation used to determine the UOS must use the value for levalbuterol, NOT levalbuterol HCl. For example, Xopenex brand levalbuterol comes in unit dose vials containing 0.31 mg, 0.63 mg, and 1.25 of levalbuterol. (These correspond to 0.36 mg, 0.73 mg, and 1.44 mg of levalbuterol HCl, respectively.) The 0.36, 0.73, and 1.44 values must NOT be used in the calculation of units of service.

When claims are billed in NCPDP format using NDC numbers, different instructions may apply. Refer to the NCPDP Companion Document available through the CMS web site.

MMA - Supply Codes And Payments For Immunosuppressive Drugs

Medlearn Matters Article Number: MM3830

Provider Types Affected - Pharmacies, hospitals not subject to the Outpatient Prospective Payment System (OPPS), and Dialysis Facilities in the State of Washington billing Medicare for immunosuppressive drugs

Provider Action Needed

Impact to You - Effective January 1, 2005, Medicare pays a supplying fee for immunosuppressive drugs, oral anticancer chemotherapeutic drugs, and oral anti-emetic drugs used as part of an anti-cancer chemotherapeutic regimen in accordance with Section 303(e) (2) of the Medicare Modernization Act (MMA).

What You Need to Know - Most supplies of immunosuppressive drugs are billed to the Medicare Durable Medical Equipment Regional Carriers (DMERCs). However, Medicare Fiscal Intermediaries (FIs) will also pay for 30-day supplies of immunosuppressive drugs when provided by a dialysis facility in the State of Washington, or by hospital outpatient departments not subject to OPPS. When billing Medicare, both the drug and the supply fee must be billed on the same claim. If the supply fee is billed alone on the claim, it will be denied. Furthermore, you may only submit a claim for G0369 once per beneficiary per transplant.

What You Need to Do - To ensure accurate claims processing, review the information included here and stay current with instructions for Medicare dispensing/ supply fees.

Background

Section 303(e) (2) of the MMA implements a supplying fee for immunosuppressive drugs. Beginning January 1, 2005, Medicare pays a separately billable supplying fee of $24.00 to a pharmacy or other entity providing an immunosuppressive drug to a Medicare beneficiary.

These payments are generally made by the DMERC to the pharmacy. However, in the state of Washington, FIs pay the supplying fee to the dialysis facility that supplies immunosuppressive drugs to kidney transplant beneficiaries. In addition, FIs will pay this $24.00 supplying fee to non-OPPS hospitals supplying 30-day supplies of immunosuppressive drugs. The code for this supplying fee is G0370. The code description is as follows:

G0370 – Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s)

Effective January 1, 2005, Medicare pays a supplying fee of $50.00 to a pharmacy for the initial supplied prescription of immunosuppressive drugs to the patient during the first month following the transplant. The code for this supplying fee is G0369. This is a one-time payment per beneficiary, per transplant. The code description is as follows:

G0369 – Pharmacy supply fee for initial immunosuppressive drug(s) first month following transplant

Effective October 1, 2005 for claims submitted to DMERCs, edits will apply to the G0369 to ensure that only one such claim is paid per beneficiary for each transplant received by that beneficiary.

Note: You cannot bill both the G0369 and G0370 with the first prescription. G0369 must be billed within one (1) year of the date of the patient's discharge from the hospital stay during which the transplant was performed.

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

Additional Information

Beneficiaries are required to pay the normal co-pay and deductible on both the drug and the supplying fee. Your FI will process any adjustment requests you submit for immunosuppressive drugs with dates of service on and after January 1, 2005 and pay the supplying fee to the dialysis facility or non-OPPS hospital. For complete details of CR 3830, on which this article is based, please see the official instruction issued to your 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 3830 in the CR NUM column on the right, and click on the file for that CR. Additional information may also be found in Medlearn Matters Article MM3620, and the related CR 3620, which that addresses New Dispensing/Supply Fee Codes for Oral Anti-Cancer, Oral Anti-Emetic, Immunosuppressive, and Inhalation Drugs when billed to DMERCs. MM3620 may be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3620.pdf CR 3620 may be found at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp Once at that site, look for CR 3620 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 DMERC or FI at their toll free number, which you will find at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Nebulizer Drugs Dispensing Fee – Revision

In the article entitled "Dispensing Fees – Nebulizer Drugs" that was published in the April 2005 *DMERC Dialogue* (pg. 12), suppliers have questioned the statement that "The dispensing fee covers all nebulizer drugs provided by the same supplier during the 30 days (G0371) or 90 days (G0374) after the date of service of the dispensing fee – regardless of the number of drugs dispensed or the number of dispensing dates during that time." Some have interpreted this to mean that if a different supplier submits a claim during the same 30 or 90 day period, the second supplier's dispensing fee will be eligible for payment. This is not correct. Only one dispensing fee (G0371 or G0374) may be paid, regardless of how many suppliers bill the dispensing fee.

The Nebulizer and Nebulizer Drugs LCD and Policy Article will be revised in the future to reflect these changes.

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

Medlearn Matters Article Number: SE0434

Note: This article was revised on March 1, 2005 to delete the reference to Chapter 17 of the *Medicare Benefit Policy Manual* in the Additional Information section of the article.

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

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

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

Background

The original Balanced Budget Act of 1997 list of exclusions from the PPS and CB for SNF Part A residents specified the services described in section 1861(s)(2)(O) of the Social Security Act—the Part B erythropoietin (EPO) benefit. This benefit covers EPO and items related to its administration for those dialysis patients who can self-administer the drug, subject to methods and standards established by the Secretary for its safe and effective use (see 42 CFR 405.2163(g) and (h)). See Medlearn Matters Special Edition SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

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

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

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

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

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

Additional Information

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

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

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

You can find the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 8, Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims, at the following CMS web site: http://www.cms.hhs.gov/manuals/104_claims/clm104c08.pdf

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

It includes the following relevant information:

- General SNF consolidated billing information;
- HCPCS codes that can be separately paid by the Medicare carrier (i.e., services not included in consolidated billing);
- Therapy codes that must be consolidated in a 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 CMS Skilled Nursing Facility Prospective Payment System (SNF PPS) web site can be found at: http://www.cms.hhs.gov/providers/snfpps/cb

It includes the following relevant information:

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

General

Completion Of Section B Of The Certificate Of Medical Necessity Form

Section B of the Certificate of Medical Necessity (CMN) may not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed by the treating physician. Following are rules for completing the various fields in Section B.

a. **Estimated Length of Need** - This indicates the estimated length of need (the length of time (in months) the physician expects the patient to require use of the ordered item). If the treating physician expects that the patient will require the item for the duration of his/her life, 99 is entered. For recertification and revision CMNs, the

cumulative length of need (the total length of time in months from the initial date of need) is entered.

b. **Diagnosis Codes** - Listed in the first space is the ICD-9 code that represents the primary reason for ordering this item. Additional ICD-9 codes that would further describe the medical need for the item (up to 3 codes) are also listed. A given CMN may have more than one item billed, and for each item, the primary reason for ordering may be different. For example, a CMN is submitted for a manual wheelchair (K0001) and elevating leg rests (K0195). The primary reason for K0001 is stroke, and the primary reason for K0195 is edema.
c. **Question Section** - This section is used to gather clinical information regarding the patient's condition, the need for the DME, and supplies.
d. **Name of Person Answering Section B Questions** - If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician, or a physician employee) answers the questions in Section B, he/she must **print** his/her name, give his/her professional title, and the name of his/her employer, where indicated. If the treating physician answered the questions, this space may be left blank.

Correction To The Use Of Group Codes For The Enforcement Of Mandatory Electronic Submission Of Medicare Claims

Medlearn Matters Article Number: MM3815

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

Provider Action Needed

Providers and suppliers need to be aware of the Administrative Simplification Compliance Act (ASCA) that requires all expenses for items and services billed to the Medicare Program be submitted electronically. Unless there is an exception in place for a given provider, paper claims will be denied.

Background

Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires you—with limited exceptions—to submit all your initial claims for reimbursement under Medicare electronically, on or after October 16, 2003. Further, ASCA amendment to Section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

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 3815 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please refer to your local FI, Carrier, RHHI or DMERC. Their toll free phone numbers may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Importance Of Supplying Correct Provider Identification Information Required In Items 17, 17a, 24K, And 33 Of The Form CMS-1500, And The Electronic Equivalent

Medlearn Matters Article Number: SE0529

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

Provider Action Needed - The Centers for Medicare & Medicaid Services (CMS) would like to remind providers and their billing staffs of the importance of reporting the correct provider identification information in items 17, 17a, 24K, and 33 of the Form CMS-1500, or the electronic equivalent. This information is critical for accurate and timely processing and payment of your claims.

Additional Information

Please be aware of the following instructions:

Items 17 and 17a - On the Form CMS-1500, or electronic equivalent, the provider must submit the appropriate referring or ordering physician name in item 17, and the Unique Physician Identification Number (UPIN)

of that referring/ordering physician in item 17a. These are required fields when a service was ordered or referred by a physician. When a claim involves multiple referring and/or ordering physicians, you must prepare a separate claim submission for each ordering/referring physician.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Item 17a - Enter the UPIN of the referring/ordering physician listed in item 17.

- **Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders nonphysician services for the patient. See Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name and UPIN. This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- Diagnostic laboratory services,
- Diagnostic radiology services,
- Portable x-ray services,
- Consultative services, and
- Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list shall also show the ordering/referring physician's name and UPIN. For example, a surgeon shall complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned UPIN appear in items 17 and 17a.

When a service is incident to the service of a physician or non-physician practitioner, the name and assigned UPIN of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services must obtain a UPIN even though they may never bill Medicare directly. A physician who has not been assigned a UPIN must contact the local Medicare carrier to obtain the UPIN. A list of toll free numbers of the Medicare carriers is available at: http://www.cms.hhs.gov/medlearn/tollnums.asp

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN of the physician supervising the limited licensed practitioner must appear in items 17 and 17a.

When a patient is referred to a physician who also orders **and** performs a diagnostic service, a separate claim form is required for the diagnostic service. Enter the original ordering/referring physician's name and UPIN in items 17 and 17a of the first claim form. Enter the ordering (performing) physician's name and UPIN in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service).

Item 24K - Enter the **provider identification number (PIN)** of the performing provider of service/supplier in item 24K if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, or electronic equivalent, show the individual PIN of each performing provider in the corresponding line item. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in item 24K.

UPINs are not appropriate identifiers for item 24K.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. **This is a required field.**

For a provider who is **not** a member of a group practice (e.g., private practice), enter the PIN at the bottom of item 33 for paper claims. The PIN should be entered on the **left** side, next to the PIN# field.

If a group practice is billing, then the **group PIN** is to be placed in item 33 for paper claims. Enter the group PIN at the bottom of item 33 on the **right** side, next to the GRP# field. Enter the PIN for the performing provider of service/supplier who is a member of that group practice in item 24K.

Suppliers billing a DMERC will use the National Supplier Clearinghouse (NSC) number in this item.

NOTE: When implemented, the National Provider Identification (NPI) number will replace the PIN and UPIN. At that time, you will use the NPI number in items 17a, 24K, and 33.

The above instructions are included Chapter 26 of the *Medicare Claims Processing Manual*. That manual is available at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

The *Medicare Benefit Policy Manual* may be found at: http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp

And, if you have questions, please contact your carrier/DMERC at their toll free number, available at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Skilled Nursing Facility Consolidated Billing

Medlearn Matters Article Number: SE0431

NOTE: This article was revised on February 18, 2005. Specifically, line 4 of the "Clarification" statement below was modified to say "These "excluded" services…." instead of "These included services…" We regret this error.

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

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

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

Background

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

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

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

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

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

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

Conceptually, SNF CB resembles the bundling requirement for inpatient hospital services that's been in effect

since the early 1980s—assigning to the facility itself the Medicare billing responsibility for virtually the entire package of services that a facility resident receives, except for certain services that are specifically excluded.

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

Effective Dates

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

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

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

Excluded Services

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

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

Physician "Incident To" Services

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

In Program Memorandum (PM) Transmittal # A-98-37 (November 1998, reissued as PM transmittal # A-00-01, January 2000), CMS identified specific types of out-

patient hospital services that are so exceptionally intensive or costly that they fall well outside the typical scope of SNF care plans. CMS has excluded these services from SNF CB as well (along with those medically necessary ambulance services that are furnished in conjunction with them). These excluded service categories include:

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

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

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

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

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

Effects of CB

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

In addition, SNF CB:

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

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

- Skilled Nursing Facility Consolidated Billing as It Relates to Certain Types of Exceptionally Intensive Outpatient Hospital Services http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0432.pdf
- Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Service http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0433.pdf
- Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0434.pdf
- Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0435.pdf
- Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0436.pdf
- Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetics and Orthotics http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf
- Medicare Prescription Drug, Improvement, and Modernization Act – Skilled Nursing Facility Consolidated Billing and Services of Rural Health Clinics and Federally Qualified Health Centers http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0438.pdf
- Skilled Nursing Facility Consolidated Billing as It Relates to Clinical Social Workers http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0439.pdf
- Skilled Nursing Facility Consolidated Billing as It Re-

lates to Certain Diagnostic Tests http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0440.pdf
• Skilled Nursing Facility Consolidated Billing and "Incident To" Services (Services That Are Furnished as an Incident to the Professional Services of a Physician or Other Practitioner) (coming soon)

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

It includes the following relevant information:

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

The SNF PPS Consolidated Billing web site can be found at: http://www.cms.hhs.gov/providers/snfpps/cb It included the following relevant information:

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

Skilled Nursing Facility Consolidated Billing And Preventive/Screening Services

Medlearn Matters Article Number: SE0436

NOTE: This article was revised on February 18, 2005. Specifically, line 4 of the "Clarification" statement below was modified to say "These "excluded" services…." instead of "These included services…" We regret this error.

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

Provider Action Needed

This Special Edition is an informational article that describes SNF Consolidated Billing (CB) as it applies to preventive and screening services provided to SNF residents.

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

Background

When the Skilled Nursing Facility (SNF) prospective payment system (PPS) was introduced in the Balanced Budget Act of 1997 (BBA, P.L. 105-33, Section 4432), it changed the way SNFs are paid, and the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns to the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. See Medlearn Matters article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This article can be found at: http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

The BBA identified a list of services that are excluded from SNF CB. These services are primarily those provided by physicians and certain other types of medical practitioners, and they can be separately billed to Medicare Part B carriers directly by the outside entity that furnishes them to the SNF's resident (Social Security Act, Section 1888(e)(2)(A)(ii)). Since the BBA did not list preventive and screening services among the services identified for exclusion, these services are included within the scope of the CB provision.

However, reimbursement for covered preventive and screening services, such as vaccines and mammographies, is subject to special billing procedures. As discussed in the May 12, 1998 Federal Register (63 FR 26296), since preventive services (such as vaccinations) and screening services (such as screening mammographies) do not appear on the exclusion list, they are subject to CB. Accordingly, if an SNF resident receives, for example, a flu vaccine during a covered Part A stay, the SNF itself is responsible for billing Medicare for the

vaccine, even if it is furnished to the resident by an outside entity.

Nevertheless, even though the CB requirement makes the SNF itself responsible for billing Medicare for a preventive or screening service furnished to its Part A resident, the SNF would not include the service on its Part A bill, but would instead submit a separate bill for the service. This is because the Part A SNF benefit is limited to coverage of "diagnostic or therapeutic" services (i.e., services that are reasonable and necessary to diagnose or treat a condition that has already manifested itself). (See Sections 1861(h) following (7), 1861(b)(3), and 1862(a)(1) of the Social Security Act.) Accordingly, the Part A SNF benefit does not encompass screening services (which serve to detect the presence of a condition while it is still in an early, asymptomatic stage) or preventive services (which serve to ward off the occurrence of a condition altogether). Such services are always covered under Part B, even when furnished to a beneficiary during the course of a covered Part A SNF stay. Under Section 1888(e)(9) of the Social Security Act, payment for an SNF's Part B services is made in accordance with the applicable fee schedule for the type of service being billed.

Additional Information

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

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

It includes the following relevant information:

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

The SNF PPS Consolidated Billing web site can be found at: http://www.cms.hhs.gov/providers/snfpps/cb It includes the following relevant information:

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

FEE SCHEDULE

July 2005 Quarterly DMEPOS Fee Schedule Update

The following list contains fees for the July 2005 quarterly update. HCPCS code E2618, which became effective on January 1, 2005, was originally individual consideration. The fee schedule amounts listed below have been established for 2005 dates of service. The fee schedule amount for HCPCS code K0670 is a revision of the fee that was established when the code became effective on April 1, 2005. The revised fee was implemented on May 10, 2005. We will not adjust claims that were processed between the effective dates of the codes and the implementation dates of these fees unless the supplier requests such an adjustment.

States	E2618NU	E2618RR	E2618UE	K0670
AK	$153.68	$15.37	$115.25	$14,631.97
AZ	$153.68	$15.37	$115.25	$14,631.97
CA	$153.68	$15.37	$115.25	$14,631.97
HI	$153.68	$15.37	$115.25	$14,631.97
IA	$153.68	$15.37	$115.25	$14,917.69
ID	$153.68	$15.37	$115.25	$14,631.97
KS	$153.68	$15.37	$115.25	$14,917.69
MO	$153.68	$15.37	$115.25	$14,917.69
MT	$153.68	$15.37	$115.25	$15,155.69
ND	$153.68	$15.37	$115.25	$15,155.69
NE	$153.68	$15.37	$115.25	$14,917.69
NV	$153.68	$15.37	$115.25	$14,631.97
OR	$153.68	$15.37	$115.25	$14,631.97
SD	$153.68	$15.37	$115.25	$15,155.69
UT	$153.68	$15.37	$115.25	$15,155.69
WA	$153.68	$15.37	$115.25	$14,631.97
WY	$153.68	$15.37	$115.25	$15,155.69

The following codes have been added to the July quarterly fee schedule. Please refer to the website http://cignagovernmentservices.com/dmerc/fsch/index.html under 3rd Quarterly update for the fees. These fees will be implemented on May 10, 2005 for dates of service in 2005:

L3000, L3001, L3002, L3003, L3010, L3020, L3030, L3040, L3050, L3060, L3070, L3080, L3090, L3100, L3140, L3150, L3160, L3170, L3300, L3310, L3330, L3332, L3334, L3340, L3350, L3360, L3370, L3380, L3390, L3400, L3410, L3420, L3430, L3440, L3450, L3455, L3460, L3465, L3470, L3480, L3500, L3510,

L3520, L3530, L3540, L3550, L3560, L3570, L3580, L3590, L3595, L3600, L3610, L3620, L3630 and L3640.

We will not adjust any claims that were processed for 2005 dates of service for these codes prior to the implementation dates of the fees unless the supplier requests such an adjustment.

Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

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

Medlearn Matters Article Number: MM3779

Note: This article was revised on May 11, 2005, to provide the correct code descriptors for K0731 and K0732.

Provider Types Affected

Physicians, suppliers, and providers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs) and/or Fiscal Intermediaries (FIs)

Provider Action Needed

This article is based on CR 3779 and provides specific information regarding the July quarterly update of the 2005 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Section 1834 (a), (h), and (i), and payment of a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

CR 3779 provides specific details regarding the July quarterly update for the 2005 DMEPOS fee schedule, which are as follows:

Batteries Used with Cochlear Implant Devices

Code **L8620** with the description of "Lithium Ion Battery for Use with the Cochlear Implant Device" was added to the HCPCS effective January 1, 2005. When the fee schedule amounts were calculated and implemented for this code on January 1, 2005, pricing information for the different types of batteries used with cochlear implant devices was not included.

The fee schedule amounts for **L8620** are being revised as part of the quarterly update to include pricing information for the different types of lithium ion batteries used with cochlear implant devices. CMS is revising the fee schedule for the code using the standard gap-filling process. Local carriers, therefore, do not need to gap fill fees for this code.

Note: Previously paid claims for **L8620 with dates of service from January 1, 2005 thru June 30, 2005** will be adjusted if resubmitted by suppliers as adjustments on or after July 1, 2005.

Code **L8620** is being made invalid for Medicare claims with the dates of service on or after July 1, 2005. The following codes are being added to the HCPCS effective for dates of service on or after July 1, 2005:

• **K0731**-Lithium Ion Battery for Use With Cochlear Implant Device Speech Processor, Other than Ear Level, Replacement, Each;

Short Description: Lith ion batt cid, non-ear level

• **K0732** Lithium Ion Battery for Use With Cochlear Implant Device Speech Processor, Ear Level, Replacement, Each;

Short Description: Lith ion batt cid, ear level

These codes are to be used to bill for replacement batteries previously coded under **L8620** that are furnished on or after July 1, 2005. Also, please note that codes **L8110** and **L8120** do not meet the Medicare definition of prosthetic devices.

Controlled Dose Inhalation Drug Delivery System

The following code is also added to the HCPCS on July 1, 2005 and is effective for claims with service dates on or after April 1, 2005:

K0730-Controlled Dose Inhalation Drug Delivery System.

Note: The allowed rental payment amount for this device is based on your Medicare contractor's individual consideration of each claim until fee schedule amounts can be established for this new code.

Code **K0670** was added to the HCPCS effective on April 1, 2005, but the fee schedule amount for K0670 was based on incorrect information and the amount is revised with this change. Your DMERC or FI will adjust previously processed claims for code K0670 with dates of service on or after April 1, 2005, but **only if you resubmit the claim for adjustment.**

Parenteral and Enteral Nutrition (PEN) Equipment and Supplies

There are no changes to the PEN fee schedule file for July 2005.

Implementation

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

Additional Information

The quarterly updates process for the DMEPOS fee schedule is located in the *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 60 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule), which can be reviewed at the following CMS web site: http://www.cms.hhs.gov/manuals/104_claims/clm104c23.pdf

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

From that web page, look for CR 3779 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please refer to your carrier/DMERC/intermediary. To find their toll free phone numbers go to: http://www.cms.hhs.gov/medlearn/tollnums.asp

MMA - April 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective April 1, 2005, And New January 2005 Quarterly ASP File

Medlearn Matters Article Number: MM3667

Provider Types Affected - All Medicare providers

Provider Action Needed

Impact to You - CR 3667 discusses updates to the new methodology of paying for Medicare Part B covered drugs not paid on the basis of cost or prospective payment.

What You Need to Know - Effective January 1, 2005, Part B covered drugs and biologicals (that are not paid on a cost or prospective payment basis) are paid based on the new Average Sales Price (ASP) drug payment system, described below.

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

Background

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

The ASP file, used in the ASP methodology, is based on data CMS receives quarterly from manufacturers. Each quarter, the Centers for Medicare & Medicaid Services (CMS) will update your carrier and Fiscal Intermediary (FI) payment allowance limits with the ASP drug pricing files based on these manufacturers' data.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP, and CMS will update the payment allowance limits quarterly. However, there are exceptions to this general rule as summarized below:

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

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

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

• For **influenza, pneumococcal, and hepatitis B vaccines** payment allowance limits are 95 percent of the AWP as reflected in the published compendia. **The payment allowance limits will be updated on a quarterly basis.**

• For **drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File** payment allowance limits are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing. In determining the payment limit based on WAC, carriers/FIs will follow the methodology specified in the *Medicare Claims Processing Manual* for calculating the AWP, but substitute WAC for AWP. Please see Pub. 100-04, Chapter 17 (Drugs and Biologicals) at the following CMS web site: http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf. The payment limit is 100 percent of the WAC for the lesser of the lowest brand or median generic. Your carrier or FI may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting carrier/FI or via posting an MS Excel file on the CMS web site. If the payment limit is available from CMS, carriers/FIs will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.

• For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File,** payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after December 1, 2004.

The April 2005 and new January 2005 ASP drug pricing files will contain three decimal places in the currency fields. In addition, the new January file contains revised payment limits for some drugs. The codes with a revised payment limit are identified in the column titled "Notes."

The absence or presence of a HCPCS code and its associated payment limit in the pricing files do 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 carrier/FI processing your claim will make these determinations.

In addition, your carrier or FI is required to accomplish the following:

• Use the April 2005 ASP and NOC drug pricing files to pay for Medicare Part B drugs effective April 1, 2005. This file shall be used for dates of service from April 1, 2005 through June 30, 2005;

• Determine for any drug or biological not listed in the ASP or NOC drug pricing files, the payment allowance limits in accordance with the policies described in this transmittal , CR 3539, dated October 29, 2004 (see http://www.cms.hhs.gov/manuals/pm_trans/R348CP.pdf), and CR3232, dated December 16, 2004 (see http://www.cms.hhs.gov/manuals/pm_trans/R397CP.pdf), and FIs should seek payment allowances from their local carrier;

• Use the new January 2005 ASP drug pricing file for (1) those claims where the carriers/FIs are asked to retroactively adjust claims processed with the original January 2005 file and (2) those claims with dates of service on or after January 1, 2005 and before April 1, 2005 that are processed after April 4, 2005. **Your carrier or FI shall not search and adjust claims that have already been processed unless brought to their attention**;

• Overlay the old January 2005 file with the new January 2005 file; and

• For any drug or biological for which they (your carrier or FI) calculates a payment allowance limit,
forward to CMS the following:

• The drug name,

• Dosage,

• Payment allowance limit, and

• National Drug Code (if available).

Note: The ASP and NOC drug pricing files will contain the 106 percent ASP, 106 percent WAC or WAC based payment allowance limits; therefore, no additional payment calculation is required by your carrier or FI. The

payment limits for the blood clotting factor codes includes the $0.14 per I.U. furnishing fee.

Additional Information

The new January 2005 and April 2005 ASP and NOC Pricing Files are available from the following CMS Website on or after March 17, 2005:
http://www.cms.hhs.gov/providers/drugs/asp.asp

You can find more information about the April 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective April 1, 2005, and New January 2005 Quarterly ASP File at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3667 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

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

Medlearn Matters Article Number: MM3783

Provider Types Affected - All Medicare 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 July 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) supplies 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:

• 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 payment 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.

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

• 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.

• The payment allowance limits for drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on the published Wholesale Acquisition Cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the carriers/intermediaries follow the methodology specified in Chapter 17, Drugs and Biologicals, of the Medicare Claims Processing Manual for calculating the Average Wholesale Price (AWP) but substitute WAC for AWP. Chapter 17 may be found at on the CMS web site at: http://www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf.

• The payment limit is 100 percent (100%) of the WAC for the lesser of the lowest brand or median generic. Carriers/intermediaries, at their discretion, may contact CMS to obtain payment limits for drugs not included in

the quarterly ASP or NOC files or otherwise made available by CMS on the CMS website. If the payment limit is available from CMS, carriers/intermediaries will substitute CMSprovided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting carrier/intermediary or via posting an MS Excel file on the CMS website.

• The payment allowance limits for new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106% of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.

• The payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare carrier/intermediaries will determine payment limits for radiopharmaceuticals based on invoice pricing.

Note: The absence or presence of a HCPCS code and its associated payment limit in the payment 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 carrier/intermediary processing the claim shall make these determinations.

Implementation

The implementation date is July 5, 2005. The July 2005 ASP and NOC drug pricing files will be used by your carrier/intermediary to pay for Medicare Part B drugs from July 1, 2005 through September 30, 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 3783 in the CR NUM column on the right and click on the file for that CR. Also if you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

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

Medlearn Matters Article Number: MM3584

Note: CR 3584 was reissued on March 18, 2005, and this article was revised on March 21, 2005 to reflect the new CR release date and transmittal number. No other changes were made to the article.

Provider Types Affected

Durable Medical Equipment (DME) Suppliers that bill Medicare DMERCs

Provider Action Needed

None, this article is informational only.

Beginning January 1, 2005, the payment limit for Part B drugs and biologicals will be based on the Average Sales Price (ASP). Drugs will be paid based on either the lower of the submitted charge or the ASP and will continue to be priced based on date of service.

To facilitate the implementation of this ASP pricing methodology, CR 3584, beginning on July 1, 2005, increases (to eight) the number of online fee screens/pricing files that DMERC systems must maintain in order to determine the amount to pay for fee-for-service drug claims. This increase will allow DMERCs to maintain 2 years of drug pricing files to facilitate the implementation of the ASP pricing methodology.

Additional Information

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

From that web page, look for CR 3584 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Oxygen And Oxygen Equipment 2005 Fee Schedule

In Joint Signature Memorandum (JSM-05177) dated January 13, 2005, DMERC's were instructed to pay claims for the stationary and portable oxygen HCPCS codes listed below using the 2004 fee schedule amounts pending clarification of pricing issues. The pricing issues for these codes have been resolved. The 2005 fee schedule amounts for these codes are listed below and are effective March 31, 2005 for dates of service on or after January 1, 2005.

States	E0424	E0431	E0434	E0439	E1390	E1391
AK	200.40	32.08	32.08	200.40	200.40	200.40
AZ	194.48	32.07	32.07	194.48	194.48	194.48
CA	200.41	32.07	32.07	200.41	200.41	200.41
HI	200.39	32.08	32.08	200.39	200.39	200.39
IA	200.32	32.07	32.07	200.32	200.32	200.32
ID	200.41	32.08	32.08	200.41	200.41	200.41
KS	200.41	31.06	31.06	200.41	200.41	200.41
MO	200.40	32.08	32.08	200.40	200.40	200.40
MT	200.41	30.57	30.57	200.41	200.41	200.41
ND	194.48	30.57	30.57	194.48	194.48	194.48
NE	200.40	32.07	32.07	200.40	200.40	200.40
NV	200.41	32.07	32.07	200.41	200.41	200.41
OR	194.48	32.08	32.08	194.48	194.48	194.48
SD	194.48	30.57	30.57	194.48	194.48	194.48
UT	200.38	32.08	32.08	200.38	200.38	200.38
WA	194.48	32.07	32.07	194.48	194.48	194.48
WY	195.73	30.57	30.57	195.73	195.73	195.73

HCPCS UPDATES

New HCPCS Codes For Intravenous Immune Globulin (IVIG)

Medlearn Matters Article Number: MM3745

Provider Types Affected - Physicians, providers, and suppliers billing Medicare for IVIG

Provider Action Needed

Impact to You - New HCPCS codes for IVIG will be effective April 1, 2005.

What You Need to Know - Effective April 1, 2005, for dates of service on or after April 1, 2005, codes J1563 and J1564 will no longer be paid by Medicare Fiscal Intermediaries (FIs) and carriers, including Durable Medical Equipment Regional Carriers (DMERCs). Codes J1563 and J1564 will be replaced with HCPCS codes Q9941 – Q9944.

What You Need to Do - These new HCPCS codes are needed to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG. Be sure to bill the new codes when providing these services.

Additional Information - Effective April 1, 2005, the following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG.

HCPCS Code	Short Descriptor	Long Descriptor
Q9941	IVIG lyophil 1G	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED, 1G
Q9942	IVIG lyophil 10 MG	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED, 10 MG
Q9943	IVIG non-lyophil 1G	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, N0N-LYOPHILIZED, 1G
Q9944	IVIG non-lyophil 10 MG	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED, 10 MG

• Based on the above table, providers must bill Q9941 or Q9943, as appropriate, in place of J1563. Similarly, those providers should bill Q9942 or Q9944, as appropriate, instead of J1564.
• Payments for the new Q-codes can be found in the respective quarterly Medicare Part B drug pricing files posted on the CMS web site at: http://www.cms.hhs.gov/providers/drugs
• The Medicare Outpatient Code Editor (OCE) will be updated to include these coding changes upon installation of the April 2005 software version 6.1.
• The Outpatient Prospective Payment System (OPPS) for the new Q codes can be found in the April update of OPPS Addendum A and Addendum B on the hospital outpatient web site. OPPS payment is based on the Ambulatory Payment Classification (APC).
• Coverage requirements for IVIG can be found in Chapter 15 of the *Medicare Benefit Policy Manual*. This manual may be found at: http://www.cms.hhs.gov/manuals/102_policy/bp102index.asp . Additional information on IVIG may be found in Chapter 17 (Drugs and Biologicals), Section 80.6 of the *Medicare Claims Processing Manual* at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp
• The official instruction issued to your carrier 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 3745 in the CR NUM column on the right, and click on the file for that CR.
• For additional information relating to this issue, please refer to your local carrier or FI. You may find the toll free phone number for your local carrier at: http://www.cms.hhs.gov/medlearn/tollnums.asp

APPEALS

Helpful Appeals Tips

At CIGNA Government Services, the DMERC Appeals Department does everything possible to effectively process appeal requests from Medicare suppliers and beneficiaries. However, we have found that many appeal requests for diabetic supplies cannot be completed due to incomplete or missing information. Below are the most common pieces of documentation missing from appeal requests:

- Documentation indicating the frequency at which the patient was actually testing during the time period before the date of service on the claim. The source documentation must be one of the following:
  - o The treating physician's records that document the frequency at which the patient was actually testing or a copy of the patient's blood glucose test log, or
  - o The supplier's records such as a copy of the patient's blood glucose test log.
- A copy of the physician's order(s) for all items billed on the claim
- A copy of the treating physician's medical records relating to the items billed on the claim, including the specific medical reason for the prescribed frequency of testing.

Redetermination - Timely Filing Reminder

The first level in the appeal process is the redetermination level. Region D DMERC has found that 6% of redetermination requests are not filed timely by the requestor. A redetermination must be requested within 120 days of the initial determination date. The initial determination date is the date on the Medicare Remittance Notice (MRN) or the patient's Medicare Summary Notice (MSN). Redetermination requests made after the 120-day time limit will be dismissed for untimely filing if an explanation regarding the late filing is not included with the redetermination request. Redeterminations dismissed due to late filing do not have further appeal rights. Suppliers are encouraged to review claim denials upon receipt and, when appropriate, to file a request for appeal as quickly as possible. This should aid in reducing the volume of redetermination request that are dismissed by CIGNA Government Services.

ELECTRONIC DATA INTERCHANGE (EDI)

Electronically Requesting And Receiving Information Regarding Claims Using The ASC X12N276/277 Claims Status Inquiry/Response Transactions

Medlearn Matters Article Number: SE0524

Provider Types Affected - Physicians, providers and suppliers billing Medicare carriers and intermediaries.
Provider Action Needed

Impact to You - This special edition discusses how health care providers may want to implement the ASC

X12N 276/277 Claims Status Inquiry/Response Transactions and benefit by being able to request and receive the status of claims **in one standard format, for all health care plans**.

What You Need to Know - Implementing the ASC X12N 276/277 would make electronic claim status requests and receipt of responses feasible for small providers, and eliminate the need to:

• Maintain redundant software, and
• Send and review claim status requests and responses manually.

What You Need to Do - Providers who implement the ASC X12N 276/277 may create a more efficient follow up process and also achieve an increase in cash flow each month by greatly reducing the administrative costs incurred by supporting multiple formats and manually processing claim status requests.

Background - Even though there has been a significant increase in the number of providers who use electronic health care transactions, providers have faced the burden of sending information to various health plans in multiple formats. Even when different plans accept information in similar formats, they frequently have additional requirements that further complicate efficient information interchange. Consequently, providers have been burdened with additional administrative work in order to electronically process healthcare transactions (including claims status requests and responses). This has increased the costs and decreased the efficiency of processing claims status requests and responses.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes administrative simplification provisions meant to reduce and simplify the administrative demands faced by healthcare providers. HIPAA:

1) Directed the Federal government to adopt national standards for the transfer of certain health care data; and

2) Requires all payers to use national standard transaction formats and code sets, such as the health care claims status category codes and the health care claim status codes issued by the Claim Adjustment Status Code Maintenance Committee.

Medicare carriers and intermediaries must periodically update their claims system with the most current health care claim status codes for use with:

- The Health Care Claim Status Request (ASC X12N 276), and
- The Health Care Claim Response (ASC X12N 277).

The ASC X12N 276 (Claims Status Inquiry Transaction) is used to transmit request(s) for status of specific health care claim(s), and the ASC X12N 277 (Claims Status Response Transaction) can be used for any of the following:

- As a response to a health care claim status request (276);
- As a notification about health care claim(s) status, including front end acknowledgments; and
- As a request for additional information about a health care claim(s).

Most health care providers who are currently using an electronic format and who wish to request claim status electronically using the ASC X12N 276/277 may incur some conversion costs.

However, after implementation, providers will benefit by being able to request and receive the status of claims **in one standard format, from all health care plans**. This would make electronic claim status requests and receipt of responses feasible for small providers, and eliminate the need to:

- Maintain redundant software, and
- Send and review claim status requests and responses manually.

It is possible that providers who implement the ASC X12N 276/277 can create a more efficient follow up process and also achieve an increase in cash flow each month by greatly reducing the administrative costs incurred by supporting multiple formats and manually processing claim status requests.

It's time to start using this transaction.

Medicare can accept transmission of the ASC X12N 276 (your electronic request on the status of a previously submitted claim) and respond with an ASC X12N 277 (our electronic answer back to you**). Currently, CMS sends out over 10,000 responses (277s) per month, and you too can benefit from** this process. It could help you reduce the time required to follow up with Medicare as well as with any payer from 20 minutes to a few seconds.

Additional Information

An informative article entitled "Realizing Savings from the HIPAA Transaction Standards: How to Get There

from Here," which was prepared by Martin A. Brutscher, Partner, McBee Associates, Inc., can be reviewed at the following website: http://www.mcbeeassociates.com/HFMA_white_paper.pdf

The article shows the types of results that may be available to providers who implement the ASC X12N 276/277 as well as other HIPAA transactions.

Also, the *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 31 (ANSI X12N Formats), Section 20 (ANSI X12N 276/277 Claims Status Request/Response Transaction Standard) can be reviewed at the following Centers for Medicare & Medicaid Services (CMS) website: http://www.cms.hhs.gov/manuals/104_claims/clm104c31.pdf

The X12 276/277 version 4010A1 implementation guide, as well as the claim status codes and category codes, may be downloaded without charge at: http://www.wpc-edi.com/hipaa.

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

Update To The Healthcare Provider Taxonomy Codes (HPTC) Version 5.0

Medlearn Matters Article Number: MM3716

Provider Types Affected - Providers who bill Carriers including Durable Medical Equipment Regional Carriers (DMERCs)

Provider Action Needed

Impact to You - CMS has released the summary of changes reflected in the Health Care Provider Taxonomy Code (HCPT) list version 5.0. Medicare carriers and DMERCs will update their HPTC tables with this new version effective on April 1, 2005.

What You Need to Know - The Health Insurance Portability and Accountability Act (HIPAA) requires that submitted data, which is part of a named code set, be valid data from that code set. Claims accepted with invalid data are non-compliant.

What You Need to Do - Please review the information included here and stay current on all HIPAA requirements to assure timely processing of your claims.

Background - Under HIPAA, code sets that characterize a general administrative situation, rather than a medical condition or service, are referred to as non-clinical or non-medical code sets. The Provider Taxonomy code set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment, specifically within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care transaction.

HIPAA requires that submitted data, which is part of a named code set, must be valid data from that code set. The health care provider taxonomy is a named code set in the 837 professional implementation guide, thus carriers must validate the inbound taxonomy codes against their internal HPTC tables.

The HPTCs are updated twice per year, in April and October. The summary of changes for Version 5.0 is noted in the table below:

TYPE OF CHANGE	PROVIDER TAXONOMY VALUE CODE
Additions	• 390200000X • 261QM1103X • 291900000X • 332000000X • 341800000X • 3418M1120X • 3418M1110X • 3418M1130X
Revisions	• 261QM1101X • 261QM1100X • 261QM1102X • 2865M2000X • 2865X1600X • 3416A0800X • 3416L0300X • 3416S0300X
Inactivation (will be deleted in future version)	• 2865C1500X

The HPTC code list is available in two forms from the Washington Publishing Company: http://www.wpc-edi.com/codes/taxonomy

- A free Adobe PDF download or
- An electronic representation of the list which will facilitate automatic loading of the code set. This version is available for purchase.

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

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3716. 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/ DMERC at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

HIPAA

Claims Status Code/Claims Status Category Code Update

Medlearn Matters Article Number: MM3715
Provider Types Affected - All providers submitting Health Care Claim Status Transactions to Medicare carriers, including Durable Medical Equipment Carriers (DMERCs), and Fiscal Intermediaries (FIs)

Provider Action Needed - This is a reminder item regarding the periodic update of certain code sets used as a result of the Health Insurance Portability and Accountability Act (HIPAA). Effective July 1, 2005, the Medicare Claims processing system will update its lists of Health Care Claims Status Codes and Health Care Claims Status Category Codes with all applicable code changes posted online with the "new as of 10/04" and prior date designations.

Background

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

Claim Status Category Codes and Claim Status Codes are used in the Health Care Claim Status Response (277) transaction:

- Claim Status Category Codes indicate the general payment status of the claim.
- Claim Status Codes provide more detail about the status communicated in the general Claim Status Category Codes.

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

Additional Information

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

On the above page, scroll down the CR NUM column on the right to find the link for CR 3715. 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 intermediary at their toll free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

MEDICARE SECONDARY PAYER (MSP)

MMA - Clarification For Change Request (CR) 3267

Medlearn Matters Article Number: MM3729

Provider Types Affected - Hospitals and independent laboratories billing Medicare carriers or fiscal intermediaries (FIs) for laboratory services

Provider Action Needed - This article contains information provided in Change Request (CR) 3729 that clarifies policies previously issued in CR 3267 (Transmittal 228, July 16, 2004). It also informs hospitals and independent labs that 1) they may use collected and retained Medicare Secondary Payer (MSP) information for the billing of nonface-to-face reference lab services, and 2) they are required to collect MSP information from the beneficiary when billing for face-to-face encounters with Medicare patients for lab services.

Background

Treatment of hospitals for certain services under Medicare Secondary Payer (MSP) Provisions of the Medicare Prescription Drug Improvement & Modernization Act of 2003 (MMA) states: "(a) IN GENERAL. – The Secretary shall not require a hospital (including a criti-

cal access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare Secondary Payer provisions) in the case of reference lab services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory."

"(b) REFERENCE LABORATORY SERVICES DESCRIBED. – Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation."

The Centers for Medicare & Medicaid Services (CMS) **will not require independent reference laboratories to collect MSP** information in order to bill Medicare for reference laboratory services as described in subsection (b) above.

Therefore, pursuant to the MMA (Section 943), CMS **will not require hospitals to collect MSP information** in order to bill Medicare for reference laboratory services (as described in subsection (b) above). **This policy, however, will not be a valid defense to Medicare's right to recover when a mistaken payment situation is later found to exist.**

Therefore, in situations where hospital and independent labs have already collected and retained MSP information for beneficiaries, they may use the collected and retained MSP information for the billing of non-face-to-face reference lab services.

In addition, in situations when there is a face-to-face encounter with the beneficiary, hospitals and independent labs are required to collect MSP information from the beneficiary when billing for faceto-face lab services.

This clarification should have been made as part of CR 3267 (which clarified CR 3064, Transmittal 11, February 27, 2004).

Implementation - The implementation date for this instruction is June 6, 2005.

Additional Information - CR 3267 (Transmittal 228, July 16, 2004) can be reviewed at the following CMS web site: http://www.cms.hhs.gov/manuals/pm_trans/R228CP.pdf

CR 3064, Transmittal 11, February, 27, 2004) can be reviewed at the following CMS web site: http://www.cms.hhs.gov/manuals/pm_trans/R11MSP.pdf

The *Medicare Secondary Payer Manual* (Pub. 100-5) can be found at the following CMS web site: http://www.cms.hhs.gov/manuals/105_msp/msp105index.asp

The *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 26 (Completing and Processing Form CMS-1500 Data Set) provides instructions on how to process reference lab claims submitted on Form CMS-1500, and can be found at the following CMS web site: http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf

After you get to Chapter 26, click on Section 10.2 (Items 1-11 - Patient and Insured Information) in the Table of Contents. For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3729 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

MISCELLANEOUS

Centers For Medicare & Medicaid Services (CMS) Comprehensive Error Rate Testing (CERT) Program - The Importance Of Complying With Requests For Claim Documentation

Medlearn Matters Article Number: SE0526

Provider Types Affected - Medicare Fee-for-Service (FFS) physicians, providers and suppliers

Provider Action Needed

Impact to You - The net national claims error rate under CERT for fiscal year 2004 was 9.3 percent. A portion of this error rate was due to providers not sending requested supporting documentation to the designated

CERT contractor. Medicare FFS physicians, providers and suppliers must provide documentation and medical records that support their claims for covered Medicare services to the designated CERT contractor upon request. If you fail to submit documentation, the claim will be considered an error and you will receive a demand letter requesting refund of payment received for the '"erroneous" claim.

What You Need to Know - During a CERT review, you may be asked to provide more information related to a claim you submitted, such as medical records or certificates of medical necessity, so that the CERT review contractor (CRC) can verify that billing was proper. Be assured that forwarding specifically requested records to the designated CERT contractor does not violate privacy provisions under the Health Insurance Portability and Accountability (HIPAA) law.

What You Need to Do - If you receive a letter from CMS regarding a CERT request for medical documentation, you should respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. Physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor. This special edition article provides an overview of the CERT program and stresses the importance of providing the requested medical documentation for the CERT review.

Background

The Government Performance and Results Act of 1993 established performance measurement standards for Federal agencies. To achieve the goals of this Act, CMS established the Comprehensive Error Rate Testing (CERT) program in November 2003. The purpose of the CERT program is to measure and improve the quality and accuracy of Medicare claims submission, processing and payment. The results of these reviews are used to characterize and quantify local, regional and national error rate patterns. CMS uses this information to address the error rate through appropriate educational and interventional programs.

Methodology

The CERT program was originally administered by the Department of Health and Human Services, Office of the Inspector General (OIG) from 1996 - 2002. During this period, the OIG designed a sampling method that estimated only a national FFS paid claims error rate (the percentage of dollars that Medicare contractors erroneously allowed). Currently, CMS calculates a national paid claims error rate, a contractor specific error rate, services processed error rate (which measures whether the Medicare contractor made appropriate payment decisions on claims) and a **provider compliance error rate** (which measures how well providers prepared claims for submission). The CMS methodology includes:

- Randomly selecting a sample of claims submitted in a specific calendar year;
- Requesting medical records from providers who submitted the claims;
- Reviewing the claims and medical records to see if the claims complied with the Medicare coverage, coding, and billing rules; and
- **When providers fail to submit the requested documentation, treating the claims as errors and** sending the providers overpayment letters.

The designated CERT review contractor currently reviews over 140,000 randomly-selected claims and corresponding medical records each year, with a medical review staff that includes physicians and nurses who can use clinical judgment when necessary in reviewing medical records. Their medical review staff has access to national and local policies, contractor processing guidelines and automated edits.

If you fail to submit the requested information in a timely fashion, an "error" is registered against both the Medicare contractor (your Medicare Carrier or Fiscal Intermediary) and you, as the Medicare provider. (At this point, the CERT review contractor has no choice but to register the claim submission as "erroneous" because there is insufficient supporting documentation to determine otherwise.) These errors have a corresponding negative impact on the other error rates that are calculated under the CERT program.

Your Role Is Critical To Improvement

Our research has shown that providers do not comply with the requests for information because:

- They believe it is a violation of the Health Insurance Portability and Accountability Act (HIPAA) to send patient records to the designated CERT contractor; or
- They are unaware of the CERT process, and they may not appreciate the importance of cooperating in a timely fashion.

Medicare beneficiaries have consented to the release of medical information necessary to process their Medicare claims. **Providers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.** Be

assured that forwarding specifically requested records to the designated CERT contractor does not violate HIPAA Privacy statutes.

If You Receive A Letter From CMS Regarding A CERT Medical Review…

1. Don't ignore it! Respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. The letter will provide a clearly defined list of the documentation required and where to submit the information.
2. Include any additional material that you believe supports the service(s) billed to the Medicare program.
3. Make sure your address files and telephone numbers that are on file with your carrier or fiscal intermediary are accurate to ensure that CERT documentation requests are received and allow time for you to respond timely.
4. Remember that physicians, providers and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.

Additional Information

In an effort to assist Medicare physicians, providers and suppliers with CERT compliance, we have several resources available to explain the CERT process and how your responsiveness is in everyone's best interest.

- CERT Web page (http://www.cms.hhs.gov/cert)
- CERT Newsletters (http://www.cms.hhs.gov/cert/letters.asp)
- A designated telephone number for Medicare physicians, providers and suppliers for general information and questions regarding the CERT initiative — (804) 864-9968.

In addition, we are preparing a series of Fact Sheets, Frequently-Asked Questions, and future Medlearn Matters articles to provide further guidance regarding the CERT process.

REMEMBER:

Review can result in identification of overpayments as well as underpayments.

If CERT changes the payment decision on your claim by denying or reducing payment, you can still file an appeal with your Medicare contractor.
It is in everyone's interest to code and pay claims correctly. Your support of this process helps protect the solvency of the Medicare Program.

Your cooperation also allows your Medicare contractor to provide individualized education to you on your specific CERT errors.

CMS Announces The National Provider Identifier (NPI) Initiative

Just released!! The CMS Administrator has announced a May 23, 2005 start of enumeration for the National Provider Identifier (NPI). The NPI is the standard unique health identifier for health care providers that was adopted by the Secretary of Health and Human Services under the Health Insurance Portability and Accountability Act of 1996. The Administrator's announcement letter informs health care providers about the NPI, describes three ways to obtain an NPI, and gives them guidance as to what they should do once they have obtained their NPI. The letter, which also provides contacts and resources should health care providers have questions about the NPI, can be viewed at http://www.cms.hhs.gov/hipaa/hipaa2/npi_provider.asp on the CMS Website.

Read the following Medlearn Matters article for more information.

CMS Announces The National Provider Identifier (NPI) Enumerator Contractor And Information On Obtaining NPIs

Medlearn Matters Article Number: SE0528

Provider Types Affected - All health care providers - Medicare and non-Medicare

Provider Action Needed - Learn about the NPI and how and when to apply for one.

Background

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a new health care identifier for use in the HIPAA standard transactions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the National Provider Identifier (NPI) as this identifier.

The NPI must be used by covered entities under HIPAA (generally, health plans, health care clearinghouses, and health care providers that conduct standard transactions). The NPI will identify health care providers in the electronic transactions for which the Secretary has adopted standards (the standard transactions) after the compliance dates. These transactions include claims, eligibility inquiries and responses, claim status inquiries and responses, referrals, and remittance advices.

The NPI will replace health care provider identifiers that are in use today in standard transactions. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting HIPAA standard transactions with multiple health plans.

All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.
Important Note: While you are urged to apply for an NPI beginning May 23, 2005, the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006.

NPI Enumerator Contract Awarded

Recently, the CMS announced the selection of Fox Systems, Inc. as the contractor, to be called the Enumerator, to perform the support operations for the NPI project.

Fox Systems, Inc. will process NPI applications from health care providers and operate a help desk to assist health care providers in obtaining their NPIs.

Who may apply for the NPI?

All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and group practices are eligible to apply for and receive an NPI. Note: All health care providers who transmit health information electronically in connection with any of the HIPAA standard transactions are required by the NPI Final Rule to obtain NPIs. This is true even if they use business associates such as billing agencies to prepare the transactions.

The NPI Application Process

Health care providers may begin applying for an NPI on May 23, 2005. Once the process begins, it will be important to apply for your NPI before the compliance date of May 2007 because health plans could require you to use your NPI before that date.

You will be able to apply for your NPI in one of three ways:

1. You may apply through an easy-to-use Web-based application process, beginning May 23, 2005. The web address will be https://nppes.cms.hhs.gov, but please note — the web site is not available until May 23, 2005.

2. Beginning July 1, 2005, you may complete a paper application and send it to the Enumerator. A copy of the application, including the Enumerator's mailing address (where you will send it) will be available on https://nppes.cms.hhs.gov or you can call the Enumerator to receive a copy. The phone number is 1-800-465-3203 or TTY 1-800-692-2326. But remember, paper applications may not be submitted until July 1, 2005.

3. With your permission, an organization may submit your application in an electronic file. This could mean that a professional association, or perhaps a health care provider who is your employer, could submit an electronic file containing your information and the information of other health care providers. This process will be available in the fall of 2005.

You may apply for an NPI using only one of these methods. When gathering information for your application, be sure that all of your information, such as your social security number and the Federal Employer Identification Number, are correct. Once you receive your NPI, safeguard its use.

If all information is complete and accurate, the Web-based process could result in you being issued a number within minutes. If there are problems with the information received, it could take longer . The paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

The transition from existing health care provider identifiers to NPIs will occur over the next couple of years. Each health plan with which you conduct business, including Medicare, will notify you when it will be ready to accept NPIs in standard transactions like claims. You can expect to hear about the importance of applying for an NPI from a variety of sources. Be clear that you only

have to apply for, and acquire, one NPI. Your unique NPI will be used for all standard transactions, Medicare and non-Medicare.

Please be particularly aware that applying for an NPI does not replace any enrollment or credentialing processes with any health plans, including Medicare.

Additional Information

For additional information on NPIs:

• Visit http://www.cms.hhs.gov/hipaa/hipaa2 on the web.
• Beginning May 23, 2005, visit https://nppes.cms.hhs.gov or call the Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.
• For HIPAA information, you may call the HIPAA Hotline: 1-866-282-0659, or write to AskHIPAA@cms.hhs.gov on the web.

Coordination Of Benefits Agreement (COBA) Detailed Error Report Notification Process

Medlearn Matters Article Number: MM3709

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

Provider Action Needed - This instruction includes information contained in Change Request (CR) 3709 which directs Medicare Contractors (carriers, intermediaries, and Durable Medical Equipment Regional Carriers [DMERCs]) to issue special automated correspondence from their internal systems to physicians, providers, and suppliers informing them that claims that were expected to be crossed over to supplemental payers/insurers (as indicated on a previous Remittance Advice) were not crossed.

Background

Through the national COBA process, Medicare will automatically cross claims over to a supplemental payer/insurer that may pay after Medicare has made its payment decision on the claim. There may be situations (such as claim errors related to HIPPA) that prevent Medicare from crossing a claim over to the supplemental payer/insurer.

In those situations where Medicare is unable to cross the claim, CR 3709 directs Medicare Contractors to issue special automated correspondence to notify physicians, suppliers, and providers when claims previously selected for crossover by Medicare were subsequently unable to be crossed to the supplemental payer/insurer.

The correspondence sent to the physician, supplier, or provider will contain specific claim information, including the Internal Control Number (ICN)/Document Control Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (if the letter is from an intermediary and the claim was for Part A services), Patient Control Number (if present on the claim), beneficiary name, date of service, and the date the claim was processed. In addition, the letter will include the following message: "The above claim(s) was/were not crossed over to the patient's supplemental insurer due to claim data errors." Upon receipt of such correspondence, the physician, supplier, or provider is advised that the claim is not being crossed automatically and the provider may take appropriate action to obtain payment from the supplemental payer/insurer.

Implementation - The implementation date for CR 3709 is July 5, 2005.

Additional Information - Complete details of the COBA Error Notification process are included in the official instruction issued to your carrier/DMERC/intermediary. That instruction may be viewed at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3709 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Medicare Announces Delay In Processing Certain Claims No Later Than April 18, 2005

Medlearn Matters Article Number: SE0531

Provider Types Affected - All physicians and providers billing Medicare carriers and all providers billing Medicare fiscal intermediaries (FIs) for services paid under the Outpatient Prospective Payment System (OPPS)

Provider Action Needed - No action is needed. This article is informational only, but affected providers should

be aware that this article discusses circumstances that may cause a slight delay in receiving payment from Medicare for some of your claims.

Additional Information

The Centers for Medicare & Medicaid Services (CMS) recently advised Medicare carriers, including durable medical equipment regional carriers (DMERCs) and FIs that certain Medicare systems are being changed on April 18, 2005. Further, CMS advised that certain claims affected by these system changes may not be processed until those system changes are implemented no later than April 18.

As a result, CMS instructed carriers and FIs to hold these claims and not process them until the system changes are in place. The types of claims affected by this CMS action are as follows:

Claim Types	Medicare will Begin Holding on:	Medicare will Begin Processing the Claims no later than:	Change Request Involved	Provider Types Affected
Claims Affected by Type of Service (TOS) Changes (see note 1. below)	April 1, 2005	April 18, 2005	CR3788 (see note 2. below)	Those billing Medicare carriers for affected services
Anti-Cancer Chemotherapy for Colorectal Cancer Claims	April 1, 2005	April 18, 2005	CR3742 (See note 2. below)	Those billing Medicare carriers, DMERCs, or FIs for affected services
PET for Brain, Cervical, Ovarian, Pancreatic, Small Cell Lung, and Testicular Cancers Claims	April 1, 2005	April 18, 2005	CR3741 (see note 2. below)	Those billing carriers or FIs for affected services
Holding of Implantable Automatic Defibrillator (IAD) Claims	April 1, 2005	April 18, 2005	N/A	Those billing intermediaries for these services
Outpatient Prospective Payment System Claims	April 1, 2005	April 18, 2005	N/A	Those providers billing intermediaries for services paid under the OPPS

1. TOS is an indicator that the carrier places on the Form CMS-1500 paper form or electronic format. The indicator is mainly used for data purposes. However, in some instances it affects payment. All HCPCS codes have a corresponding TOS indicator.

2. To view a CR, visit 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 of the file for the CR you are interested in viewing.

If you have any questions related to any of these issues, please contact your carrier, DMERC, or intermediary at their toll free number, which is available at: http://www.cms.hhs.gov/medlearn/tollnums.asp

MMA - The Facts For Providers Regarding The Medicare Prescription Drug Plans That Will Become Available in 2006

The Second in a Series of Medlearn Matters Articles for Providers on Medicare's New Prescription Drug Coverage

Medlearn Matters Article Number: SE0502

Provider Types Affected - All Medicare providers and their staff

Provider Action Needed

This special edition article provides updated information regarding the Medicare Prescription Drug Plans that will be available to Medicare beneficiaries in 2006. This new benefit was established by the Medicare Modernization

Act (MMA), which was enacted in 2003.

This new drug coverage requires every Medicare beneficiary to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Because of this, we're looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients. Help can be as simple as referring them to CMS beneficiary educational resources such as 1-800-MEDICARE and http://www.medicare.gov. It is important to encourage your patients to learn more about the new coverage as it may save them money on prescription drug costs.

The Basic Plan

Beginning January 1, 2006, new Medicare prescription drug plans will be available to all people with Medicare. Insurance companies and other private companies will be working with Medicare to offer these drug plans and negotiate discounts on drug prices. These plans are different from the Medicare-approved drug discount cards that phase out by May 15, 2006, or when a beneficiary's enrollment in a Medicare prescription drug plan takes effect, if earlier. The cards offered discounts, while the plans offer insurance coverage for prescription drugs.

Medicare prescription drug plans provide insurance coverage for prescription drugs, and like other insurance plans, participating beneficiaries will pay:

- A monthly premium (generally around $37 in 2006), and
- A share of the cost of their prescriptions (with costs varying depending on the drug plan chosen by the beneficiary).

In addition, drug plans can vary depending on the following:

- What prescription drugs are covered,
- How much the beneficiary pays, and
- Which pharmacies the beneficiary can use.

All drug plans will provide a standard level of coverage which Medicare will set. However, for a higher monthly premium, some plans might offer more coverage, and additional medications. When a Medicare beneficiary joins a drug plan, it is important that they choose one that meets their prescription drug needs.

The following Qs and As provide key information that might be of interest to you, your staff, or your patient.

When can your patients enroll in this new plan?

If a beneficiary currently has Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance), the beneficiary can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006.

In general, a beneficiary can join or change plans once each year between November 15 and December 31. If they join a Medicare prescription drug plan:

- By December 31, 2005, their coverage will begin on January 1, 2006, and
- After December 31, 2005, their coverage will be effective the first day of the month after the month they join.

Even if a beneficiary does not use many prescription drugs now, they still should consider joining a plan. If they don't join a plan by May 15, 2006, and they don't have a drug plan that covers as much or more than a Medicare prescription drug plan, they will have to pay more each month to join later.

What if the Medicare beneficiary cannot pay for a Medicare prescription drug plan?

Some people with an income at or below a set amount and with limited assets (including their savings and stocks, but not counting their home) will qualify for extra help.

The exact income amounts will be set in early 2005. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions.

The type of extra help received will be based on income and assets. If they think they may qualify for extra help, they can sign up with the Social Security Administration (SSA) or their local Medicaid office as early as the summer of 2005.

Will this new plan work with other Medicare coverage that your patients may have?

Yes, Medicare prescription drug plans work with all types of Medicare health plans, and there will be:

- Medicare prescription drug plans that add coverage to the Original Medicare Plan (these plans will be offered by insurance companies and other private companies), and
- Medicare prescription drug plans that are a part of Medicare Advantage Plans (like HMOs), in some areas.

If a Medicare beneficiary has 1) a Medigap policy with drug coverage or 2) prescription drug coverage from an employer or union, they will get a detailed notice from their insurance company or the employer or union informing them whether or not their policy covers as much or more than a Medicare prescription drug plan.

This notice will explain their rights and choices.

If a Medicare beneficiary's employer or union plan covers as much as or more than a Medicare prescription drug plan, they can:

- Keep their current drug plan. If they join a Medicare prescription drug plan later, their monthly premium won't be higher, or
- Drop their current drug plan, and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

If a Medicare beneficiary's employer or union plan covers less than a Medicare prescription drug plan, they can:

- Keep their current drug plan, and join a Medicare prescription drug plan to give them more complete prescription drug coverage; or
- Keep their current drug plan. However, if they join a Medicare prescription drug plan later, they will have to pay more for the monthly premium; or
- Drop their current drug plan and join a Medicare prescription drug plan. However, they may not be able to get their employer or union drug plan back.

Further Information

- In mid-2005, SSA will send people with certain incomes information about how to apply for extra help in paying for their prescription drug costs.
- The information contained in this article is based on a fact sheet for beneficiaries. To obtain a copy of this fact sheet for your patients, visit: http://www.medicare.gov/Publications/Pubs/pdf/11065.pdf

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

You can also find additional information regarding prescription drug plans at: http://www.cms.hhs.gov/pdps/

Further information on CMS implementation of the MMA can be found at the following CMS web site: http://www.cms.hhs.gov/medicarereform/

MMA - Your Important Role

#3: Information for Providers, Physicians, Pharmacists and Their Staffs About Medicare Prescription Drug Coverage

Medlearn Matters Article Number: SE0520

Provider Types Affected - Medicare physicians, institutional providers, pharmacists, and any staff who have contact with Medicare beneficiaries

Provider Action Needed

Impact to You - On January 1, 2006, a new benefit will be available to the 41 million Americans who receive health insurance coverage through the Medicare program. Medicare Prescription Drug Plans will help reduce the cost of prescription drugs. Your patients may ask you about this new benefit.

What You Need to Know - We need your help to make sure Medicare patients know about and understand this new benefit—information is just a click away. Through Medlearn Matters articles, we will give you access to various levels of information. You decide the level of involvement you want to have in helping Medicare patients.

What You Need to Do - Stay informed, visit: http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the web. This web site includes links to all articles in this series and information providers need about the new coverage. At a minimum, refer your Medicare patients to 1-800-MEDICARE and http://www.medicare.gov on the Web.

Background - You and your staff are trusted sources of information for your patients. You may be the first source of information that Medicare beneficiaries use to explain Medicare Prescription Drug Coverage. Please encourage your Medicare patients to learn more abou t this new coverage because it may save them money on prescription drugs. **If a beneficiary fails to actively choose a prescription drug plan, they may miss out on cost savings for prescription drugs.**

Medicare Prescription Drug Coverage will:

- Help pay for prescriptions;
- Provide extra help for people with limited income and resources; and
- Cover brand name and generic drugs.

CMS will include Medicare Prescription Drug Coverage

details in the *2006 Medicare & You Handbook*, and send it to beneficiaries in October 2005.

Your Role and Involvement – You Choose

Your interest may range from wanting basic to detailed information on this coverage. For example, if you work in a rural locale, or in areas that serve a large population of beneficiaries with limited income and resources, you may have a greater interest in counseling your patients.

- **Basic** - You know that Medicare Prescription Drug Coverage exists and where to send people to learn about benefit details. You may display a poster (available later this spring) in your office or clinic, and make beneficiary-focused materials available in your office.
- **Intermediate** - You know more about Medicare Prescription Drug Coverage, such as:
  - How beneficiaries can enroll;
  - Co-payment amounts;
  - Where to find additional help for people with limited income and resources;
  - Where to find information on the following web sites:

    http://www.medicare.gov
    http://www.cms.hhs.gov/medlearn/drugcoverage.asp

  - How to answer the basic questions.
- **Advanced** - You know detailed information about Medicare Prescription Drug Coverage and the plans available in your area. You, or someone on your staff, can answer detailed questions about the drug benefit. In some cases, you or your staff may counsel beneficiaries on their particular situation and the options that will work best for them.

To Stay Updated on New Information and Educational Resources

• Pay attention to correspondence from your national professional associations—they are part of the information stream from CMS to the community of professionals who serve people with Medicare; sign up for their listservs and read their newsletters.
• Keep current with information from your Medicare fee-for-service claims processing contractor; bookmark their website, read their bulletins, and register to receive electronic listserv messages.
• Bookmark and visit the provider educational web page on Medicare Prescription Drug Coverage, http://www.cms.hhs.gov/medlearn/drugcoverage.asp on the web.
• Register to receive listserv email messages to alert you when new *Medlearn Matters* articles have been released on the new drug benefit (and other Medicare information); register at http://www.cms.hhs.gov/medlearn/matters on the web.
• Participate in CMS Open Door Forums, to hear from and ask questions of CMS leadership on topics of interest to your particular provider type; for information about these forums visit http://www.cms.hhs.gov/opendoor on the web.

Get Your Staff Involved - In addition, inform members of your staff who interact with Medicare patients every day about the information in this article:

- Physicians – supply this information to nursing and front office staff.
- Hospitals - supply this information to nursing, discharge planning, financial, and emergency room staff.
- Pharmacists - supply this information to your pharmacy technicians and front counter staff.

If you or your staff are willing to further advise and counsel people with Medicare, CMS will have tools to help you do this on http://www.cms.hhs.gov/partnerships (toolkit available by April 1, 2005).

Summary - CMS asks you to:

• Respond to questions from your patients in a way that encourages them to seek more information from the Medicare Program;
• Inform members of your staff who interact with Medicare patients about the information resources available to them, and where they may refer patients to learn more about Medicare Prescription Drug Coverage; and
• At a minimum, refer your Medicare patients who are looking for information on Medicare Prescription Drug Coverage to 1-800-MEDICARE or http://www.medicare.gov on the web.

Modified Edits For Matching Claims Data To Beneficiary Records

Medlearn Matters Article Number: SE0516

Note: This article was revised on April 22, 2005, to show that claims that fail the matching edits will not be denied, but will be determined unprocessable and returned to the provider.

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

Provider Action Needed

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

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

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

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

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

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

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

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

Population-Based Disease Management - Use Of Group Health Plan Payment System For Medicare Disease Management Demonstration Serving Medicare Fee For Service Beneficiaries

Medlearn Matters Article Number: SE0519

Provider Types Affected - All Medicare providers

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) has begun a Medicare Disease Management Demonstration to improve care for chronically ill Fee-For-Service Medicare beneficiaries who suffer from advanced stage heart disease or diabetes. The Disease Management Organization, LifeMasters, is currently enrolling beneficiaries in Florida.

This Disease Management Organization is not an HMO, but is being paid, using the CMS Group Health System/MMCS, to pay a fixed monthly payment for disease management services as an "OPTION 1" cost plan or as an "OPTION 4" plan, which will be a phase in over the next few months. "OPTION 4" means the same as "OPTION 1" but will reference "Chronic Care Organizations" and will also help to differentiate the demonstration enrollees from an HMO enrollee.

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

LifeMasters = H5413 (plan number) in the Medicare systems

Reminder: The Medicare beneficiaries participating in the Medicare Disease Management Demonstration are NOT enrolled in an HMO; they should be treated as

traditional Fee-For-Service beneficiaries. No referrals for care are needed and **all Fee-For-Service claims will be processed** under traditional Medicare payment rules.

Background - This population based demonstration is intended to evaluate how disease management services can improve the health outcomes of Medicare beneficiaries diagnosed with advanced-stage illness from congestive heart failure, diabetes, or coronary heart disease. Up to 30,000 eligible Medicare Fee-For-Service beneficiaries will be enrolled in the treatment arm of the study during the three-year project in Florida.

The project will help Medicare:

- Find better ways to improve the quality of life for people with diabetes and chronic heart disease;
- Determine the benefits of disease management programs for chronically ill persons; and
- Find ways to make these services available to people with Medicare.

The disease management participants will receive disease management services in addition to their usual Medicare benefits. All participants remain in the traditional Fee-For-Service Medicare program under the care of their own doctor. The program is voluntary and the decision whether or not to participate does not affect Medicare benefits.

Demonstration Location

Florida – LifeMasters will be providing services to 30,000 eligible Medicare beneficiaries with congestive heart failure, diabetes, and coronary heart disease in Florida. (Questions? Call 1-888-716-2838).

Medicare Eligibility File Inquiry Screens

When confirming eligibility of a beneficiary participating in the Medicare Disease Management Demonstration, Medicare systems screens will display a line item indicating enrollment in an "Option 1" HMO Cost Plan or an "Option 4" plan. The definition of Option 1 means that Medicare is still primary and Fee-For-Service benefits are covered; no referrals for care are needed. Claims continue to be processed by Medicare as primary under the traditional Fee-For-Service program. **Even though this demonstration is coded with an HMO plan number, the beneficiaries are not enrolled in an HMO.** Beneficiaries or providers calling to confirm Medicare eligibility should be informed that they/the patient are Medicare eligible and that they are Fee-for-Service beneficiaries, not enrolled in an HMO cost plan.

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.

Region D Publications Distribution Options

CIGNA Government Services is pleased to offer suppliers more options for receiving quarterly publications. Suppliers with multiple sites and multiple supplier numbers may now eliminate publication distribution to some or all of their sites by opting to have one CD-ROM mailed to their corporate address. The corporate office may then disseminate the publications to the site locations. The CD-ROM will be mailed to the "Mail To" corporate address on the supplier enrollment application.

Multiple-site suppliers may choose to eliminate all supplier numbers with the same "Mail To" address from the CD-ROM mailing. Secondly, multiple-site suppliers may choose to eliminate the CD-ROM mailing only for the

supplier numbers listed.

DMERC Region D quarterly publications are distributed via Internet (www.cignagovernmentservices.com) and CD-ROM. The CD-ROM is mailed to all suppliers with billing activity for the previous 12 months unless the supplier designates an alternate distribution as described below.

Supplier publications distribution options are as follows:

- Opt-out of the CD-ROM distribution – suppliers will receive a paper copy of the DMERC Dialogue.
- Opt-in – suppliers that previously opted-out may return to receiving the CD-ROM.
- Eliminate CD-ROM distribution to multiple sites – the CD-ROM will be mailed to the supplier's corporate address.

Supplier requests for an alternate distribution may be submitted via the DMERC Region D Publications Designation Form (included as an appendix in this issue) or by submitting a written request on the supplier's letterhead. The written request must contain all information included on the form. Requests must be submitted to: CIGNA Government Services, Communications Department, Two Vantage Way, Nashville, TN 37228 or by fax: 615.782.4445.

Reporting Address And Other Changes To The National Supplier Clearinghouse (NSC)

Suppliers must notify the National Supplier Clearinghouse (NSC) of **any changes** that occur after the initial application is filed, including changes to their "Mail to" and "Pay to" addresses. Changes must be submitted on the CMS-855S Application Form which can be obtained by contacting a NSC representative toll-free at 866.238.9652 or downloaded from www.palmettogba.com. The form must be mailed to:

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

Reminder

Previously, the DMERC used "return service requested" envelopes only when mailing checks to suppliers allowing the U.S. Postal Service to return undeliverable Medicare checks. Because some suppliers get paid through electronic funds transfer (EFT), there may be cases where a supplier does not have a correct address on file, but continues to receive payments through EFT. Effective October 1, 2002, the DMERC uses "return service requested" envelopes for all hardcopy Medicare Remittance Notices (MRNs) in addition to using them for hardcopy checks.

When the post office returns an MRN, the DMERC follows the same procedure as with returned checks. The DMERC notifies the NSC and cease generating any more payments to the supplier until the supplier furnishes a new address and that address is verified by the NSC. The NSC maintains/updates the supplier's records and provides the information to the DMERC.

Supplier Email Inquiries

The CIGNA Government Services Online Help Center at http://www.cignagovernmentservices.com/dmerc/resource.html affords suppliers the option of submitting inquiries via email. Most email inquiries received can be responded to by email. However, responses that require information that is personal or sensitive in nature (claim specific information, supplier numbers, Medicare numbers, etc.) cannot be answered by email.

Submitting an email inquiry using the Online Help Center is quick and easy. Simply select the link "Inquiries or Comments" under the heading "Contact Us." *Note: In order to continue submission of your inquiry, you will be asked to acknowledge that you have read and understood CIGNA Government Services' Disclaimer.* Next, you will be asked to complete your contact information, select a topic, and type your inquiry or comment. Press "Send" to submit your inquiry.

As a contractor for the Centers for Medicare & Medicaid Services (CMS), CIGNA Government Services is required to abide by CMS regulations to respond to supplier Web site inquiries within 45 business days of receipt. As part of our commitment to provide a high level of customer service, we will make diligent attempts to respond to your inquiry prior to the 45-business day standard.

Unprocessable Unassigned Form CMS-1500 Claims

Medlearn Matters Article Number: MM3500

NOTE: This article was revised on March 18, 2005 because CR 3500 was reissued. The only changes to the article are to show the new CR release date and transmittal number. No other changes were made to the article.

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

Provider Action Needed - No provider action is needed. This instruction makes necessary changes to ensure consistency in the handling of Medicare Part B claims and to ensure that HIPAA noncompliant data is not transmitted to Coordination of Benefits (COB) trading partners.

Provider Impact - Formerly, unassigned claims were denied with appeal rights. However, this instruction notifies physicians, providers, and suppliers that unassigned Centers for Medicare & Medicaid Services (CMS) Form 1500 claims and electronic interface equivalents that are incomplete or contain invalid information will be returned as unprocessable to the submitters for correction or resubmission. It is important to note that as an unprocessable, when the claim is returned, there are no appeal rights.

When the claims are corrected and then processed, electronic crossover claims can be sent to COB trading partners that are HIPAA compliant and the COB secondary payer claims can be processed for Medicare beneficiaries.

Background

The *Medicare Claims Processing Manual* (Pub. 100-04) provides instructions for handling Medicare claims, including Part B Form CMS-1500 claims that have incomplete or invalid information. Such claims are to be returned without appeal rights. See Pub. 100-04, Chapter 1 (General Billing Requirements), Section 80.3.1(Incomplete or Invalid Claims Processing Terminology) at: http://www.cms.hhs.gov/manuals/104_claims/clm104c01.pdf

Currently, the instructions for Form CMS-1500 claims are:

- Specified to apply only to assigned Part B claims, and
- Silent as to unassigned CMS-1500 claims.

As a result, many Part B carriers and DMERCs have been denying unassigned CMS-1500 claims with appeal rights and not returning these claims as unprocessable without appeal rights.

In addition, when denying these claims, the carriers/DMERCs have been sending to COB secondary payers electronic crossover claims containing Health Insurance Portability and Accountability Act of 1996 (HIPAA) noncompliant claims data (such as diagnosis codes and procedure codes that are not part of the standard code sets).

Under HIPAA rules, COB trading partners are not required to process claims that are not HIPAA compliant, and in claims with multiple service lines, the entire claim might be rejected. The inclusion of HIPAA noncompliant data has resulted in some COB trading partners refusing to process such crossover claims for Medicare beneficiaries.

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

Additional Information - The *Medicare Claims Processing Manual* (Pub. 100-04), Chapter 1, has been revised and is included as an attachment to the official instruction released to your carrier. You may view that instruction at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that web page, look for CR 3500 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC at their toll-free number found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Use Of Group Health Plan Payment System For Medicare Disease Management Demonstration Serving Medicare Fee For Service Beneficiaries

Medlearn Matters Article Number: SE0425

Note: This article was revised on March 10, 2005 to add "OPTION 4" as a code to help differentiate the demonstration enrollees from an HMO enrollee.

Provider Types Affected - All Medicare providers

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) has begun a four-state Medicare Disease Management Demonstration to improve care for chronically ill Fee-For-Service Medicare beneficiaries who suffer from advanced stage heart disease or diabetes. The Disease Management Programs that are currently enrolling beneficiaries are: CorSolutions in Louisiana; XLHealth in Texas and HeartPartners in California and Arizona.

These Disease Management Organizations are not HMOs, but are being paid, using the CMS Group Health System/MMCS to pay a fixed monthly payment for disease management services as an "OPTION 1" cost plan or as an "OPTION 4", which will be a phase in over the next few months. "OPTION 4" means the same as "OPTION 1" but will reference "Chronic Care Organizations." "OPTION 1" and "OPTION 4" are used to help differentiate the demonstration enrollees from an HMO enrollee.

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. The organizations and their respective plan numbers are:

- HeartPartners = SeniorCo identified as H5408 in Medicare systems
- CorSolutions identified as H1902 in Medicare systems
- XLHealth identified as H4519 in Medicare systems

Reminder: The Medicare beneficiaries participating in the Medicare Disease Management Demonstration are NOT enrolled in an HMO; they should be treated as traditional Fee-For-Service beneficiaries. No referrals for care are needed and a**ll Fee-For-Service claims will be processed** under traditional Medicare payment rules.

Background

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 mandated this demonstration to evaluate how disease management services, combined with a prescription drug benefit, can improve the health outcomes of Medicare beneficiaries diagnosed with advanced-stage illness from congestive heart failure, diabetes, or coronary heart disease. Up to 30,000 eligible Medicare Fee-For-Service beneficiaries will be enrolled in the treatment arm of the study during the three-year project in California, Arizona, Louisiana, and Texas.

The project will help Medicare:

- Find better ways to improve the quality of life for people with diabetes and chronic heart disease;
- Determine the benefits of disease management programs for chronically ill persons; and
- Find ways to make these services available to people with Medicare.

Participants will be assigned to either a disease management group or a usual care group. The disease management group will receive disease management services and prescription drug benefits in addition to their usual Medicare benefits at no additional cost except for a modest co-payment for prescription drugs.

All participants remain in the traditional Fee-For-Service Medicare program under the care of their own doctor. The program is voluntary and the decision whether or not to participate does not affect Medicare benefits.

Demonstration Locations

Louisiana - CorSolutions will be providing services to 5,000 Medicare beneficiaries with congestive heart failure, diabetes, and/or coronary heart disease residing in the Shreveport – New Orleans corridor of Louisiana. (Questions? Call 1-800-917-2204).

Texas - XLHealth will be providing services to 10,000 Medicare beneficiaries with congestive heart failure (CHF), cardiovascular disease (CVD), or diabetes with co-morbidities of CHF, CVD or lower extremity complications in Texas. (Questions? Call 1-888-284-0001).

California and Arizona - HeartPartnersSM (collaboration among PacifiCare Health Systems, Qmed, and Alere Medical) will be providing services to 15,000 Medicare beneficiaries with congestive heart failure in California and Arizona. (Questions? Call 1-866-242-3432).

Medicare Eligibility File Inquiry Screens

When confirming eligibility of a beneficiary participating in the Medicare Disease Management Demonstration, Medicare systems screens will display a line item indicating enrollment in an "Option 1" HMO Cost Plan. The definition of Option 1 means that Medicare is still primary and Fee-For-Service benefits are covered; no referrals for care are needed. Claims continue to be processed by Medicare as primary under the traditional Fee-For-Service program. Even though these demonstrations are coded with an HMO plan number, the beneficiaries are not enrolled in an HMO. Beneficiaries or providers calling to confirm Medicare eligibility should be informed that they/the patient are Medicare eligible and that they are Fee-for-Service beneficiaries, not enrolled in an HMO cost plan.

Frequently Asked Questions

1. Please tell me about the new supplying fee for immunosuppressive drugs.

   ANSWER: Effective January 1, 2005 Medicare will pay a supplying fee of $24.00 to a pharmacy for each supplied prescription of immunosuppressive drugs, oral anti-cancer drugs, and oral anti-emetic drugs under procedure code G0370.

   Medicare will pay a supplying fee of $50.00 to a pharmacy for the initial supplied prescription of immunosuppressive drugs to the patient during the first month following the transplant under procedure code G0369. This is a one-time payment per beneficiary, per transplant.

   ("MMA - New Dispensing/Supply Fee Codes for Oral Anti-Cancer, Oral Anti-Emetic, Immunosuppressive, and Inhalation Drugs," Spring 2005 DMERC Dialogue, page 42)

2. What are Medicare's guidelines regarding starting a new capped rental period?

   ANSWER: For an item described by the same code, a new capped rental period would begin if there has been an interruption in the medical necessity for the item and the interruption lasted for 60-plus consecutive days. For an item described by a different code, a new capped rental period would begin if there is a substantive change in the patient's condition that necessitates a significantly different item. The claim for these items must include documentation not limited to: a description of the patient's prior medical condition that necessitated the previous item; a statement explaining when and why the medical necessity for the previous item ended; and, a statement explaining the patient's new or changed medical condition and when the new need began. This information must be entered in the NTE segment of an electronic claim, or attached to a paper claim.

   (DMERC Region D Supplier Manual, Chapter 3, pages 10-12)

3. Please help me understand the time requirement listed on a sleep study for a CPAP. Does the patient have to be asleep for 120 minutes?

   ANSWER: No. There is a two-hour (120 minutes) minimum requirement for total recording time off of the CPAP device; however, the patient is not required to be asleep during the entire test. The number of episodes recorded while the patient is asleep must meet the criteria explained in the "Indications and Limitations of Coverage and/or Medical Necessity" section in the CPAP LCD to qualify for coverage.

   (Continuous Positive Airway Pressure System (CPAP) Local Coverage Determination, http://www.cignagovernmentservices.com/dmerc/lmrp_lcd/index.html)

4. An oxygen patient was in a skilled nursing facility under a Part A stay for 10 days last month. Can I still bill for that month of oxygen?

   ANSWER: Yes. If the beneficiary is in a Part A covered stay, but not for the entire month, the discharge date becomes the new anniversary date for subsequent claims. In this situation, the supplier must submit a new claim using the date of discharge as the "from" date. Suppliers should note in the NTE segment (field 19 for paper claims) that the patient was in a SNF, resulting in the need to establish a new anniversary date.

   (DMERC Region D Supplier Manual, Chapter 5, page 10)

Frequently Asked Questions (cont'd)

5. What do I need to send to CIGNA Government Services as a supplier when I want to voluntarily refund an overpayment?

ANSWER: The Voluntary Overpayment Form must be completed and accompanied with a refund check made payable to Connecticut General Life Insurance Company (CGLIC) and mailed to DMERC, PO Box 10927, Newark, NJ 07193-0927.

(DMERC Region D Supplier Manual, Chapter 12, page 4)

6. Please tell me about the new dispensing fee for inhalation drugs.

ANSWER: Effective January 1, 2005 Medicare will pay a dispensing fee of $57.00 to a pharmacy for a 30-day period of inhalation drugs furnished through DME regardless of the number of shipments or drugs dispensed during that time. Only one dispensing fee payment will be made for the 30-day supply under procedure code G0371. Please note that Medicare includes the cost of compounding drugs in the dispensing fees.

Effective January 12, 2005 Medicare will pay a dispensing fee of $80.00 to a pharmacy for each dispensed 90-day period of inhalation drugs furnished through DME regardless of the number of shipments or drugs dispensed during that time. Only one dispensing fee payment will be made for the 90-day supply under procedure code G0374. Please note that Medicare includes the cost of compounding drugs in the dispensing fees.

("MMA - New Dispensing/Supply Fee Codes for Oral Anti-Cancer, Oral Anti-Emetic, Immunosuppressive, and Inhalation Drugs," Spring 2005 DMERC Dialogue, page 42)

7. What happens if a supplier does not have proof of delivery of equipment provided to Medicare patients?

ANSWER: If a supplier does not have proof of delivery, such claimed items and services shall be denied and overpayments recovered.

(DMERC Region D Supplier Manual, Chapter 3, page 8)

8. I discovered that I have billed over 15 months for an E0471. Since that is a capped rental item, I need to request an overpayment letter. Is that correct?

ANSWER: No. The respiratory assist device with backup (code E0471), falls under the payment category of items requiring Frequent and Substantial Servicing DME. Items in this category are paid on a rental basis until the medical necessity ends.

(DMERC Region D Supplier Manual, Chapter 5, page 1)

9. Is a sling included in the allowance for a patient lift if both items are provided at the same time?

ANSWER: Yes.

(Patient Lifts Policy Article, http://www.cignagovernmentservices.com/dmerc/lmrp_lcd/index.html)

10. Can the treating physician's signature and date on a CMN be stamped?

ANSWER: No.

(DMERC Region D Supplier Manual, Chapter 4, page 4)

DMERC Region D Publications Designation Form

DMERC Region D quarterly publications are distributed via Internet (www.cignamedicare.com) and CD-ROM. The CD-ROM includes the *DMERC Dialogue*, *DMERC Region D Supplier Manual* and update and various other supplier resources. Suppliers may choose to receive a paper copy of the *DMERC Dialogue* only in lieu of a CD-ROM.

Suppliers with multiple sites and supplier numbers may choose to eliminate publication distribution to some or all of the sites by designating that one CD-ROM be mailed to the supplier's corporate address. The CD-ROM will be mailed to the designated "Mail To" address for the corporate office on the supplier's enrollment application.

Complete the applicable section(s) below to **change** the method of publications distribution preferred. You may also submit your request in writing on your company letterhead to: CIGNA Government Services, Communications Department, Two Vantage Way, Nashville, TN 37228 or by fax: 615.782.4445.

Request for Paper Copy – DMERC Dialogue (Opt-Out of CD-ROM distribution)

_____
SUPPLIER NUMBER

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

Reason for requesting paper version:
- ☐ No personal computer
- ☐ No CD-ROM drive
- ☐ Prefer paper copy
- ☐ Other _____

(List additional supplier numbers to be included in this request on the back of this form.)

Request for CD-ROM (Opt-In or return to CD-ROM distribution)

_____
SUPPLIER NUMBER

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

(List additional supplier numbers to be included in this request on the back of this form.)

Request for elimination of CD-ROM distribution to multiple sites-Corporate address designation

_____
SUPPLIER NUMBER TO REMAIN ON PUBLICATIONS MAIL LIST

_____
SUPPLIER NAME

_____
ADDRESS

_____ _____ _____
CITY STATE ZIP

- ☐ Eliminate CD-ROM for all supplier numbers with the same "mail to" address shown on this form. [When this option is selected all newly assigned supplier numbers will be included in this request.]
- ☐ Eliminate CD-ROM only for the supplier numbers listed on the back of this form.

(List supplier numbers to be excluded from the publications mail list on the back of this form.)

DMERC REGION D

DMERC Region D Publications Designation Form (cont'd)

List additional supplier numbers to be included in the request on the front of this form.

SUPPLIER NUMBER(S):

SUPPLIER NUMBER(S):

The privacy of our customers is important to CIGNA Government Services. Personally identifying information that is collected will be used only in connection with the specified request. CIGNA Government Services will protect all personally identifying information, sensitive and non-sensitive, that you share with us.

DMERC Region D Publication Order Form

Name:

Company Name:

Address:

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

Email:

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

Subscription (4 quarterly publications) $40.00

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

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

Individual Publication Requests

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

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

Subtotal **$_____**

CD-ROM ($10.00 each)

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

Subtotal **$_____**

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

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

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

Subtotal **$_____**

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

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

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

Total Amount Due **$_____**

Payment/Order Information

Checks or money orders should be made payable to CIGNA Government Services. Send completed order form and payment to:

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

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

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

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

(Rev. 07/2005)

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MEDICARE REDETERMINATION REQUEST FORM

DATE_____

Mail To: CIGNA Government Services
DMERC Region D
P. O. Box 22995
Nashville, TN 37202

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

TYPE OF CLAIM: ☐DME ☐ Oxygen ☐ Supplies ☐ Orthotics ☐ Prosthetics ☐ ESRD ☐ PEN ☐ IV Therapy
☐ Other _____

CLAIM INFORMATION ☐ Assigned ☐ Non-Assigned

Service Date	HCPCS	Charge(s)	Claim Control Number	Denial Reason/ ANSI Code	Date of Initial Determination

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

Please see the Summer 2000 *DMERC Dialogue* for additional documentation requirements.

_____ CMS 1500 Claim Form
_____ Medicare Summary Notice
_____ Advance Beneficiary Notice
_____ Medicare Remittance Notice
_____ Certificate of Medical Necessity
_____ Medical Documentation
Other_____

CONTACT INFORMATION

PROVIDER: (Contact Name and Signature)	BENEFICIARY: (Contact Name – Please Print)
Phone # ( )	Phone # ( )

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MEDICARE WRITTEN ADJUSTMENT REQUEST FORM

Mail To: CIGNA Government Services
DMERC Region D
P. O. Box 690
Nashville, TN 37202

DATE_____

PROVIDER INFORMATION	BENEFICIARY INFORMATION
Name	Name
Provider #	Medicare #
Address	Address
Phone # Area Code ( )	Phone # Area Code ( )

TYPE OF CLAIM: ☐ DME ☐ Oxygen ☐ Supplies ☐ Orthotics ☐ Prosthetics ☐ ESRD ☐ PEN ☐ IV Therapy
☐ Other _____

Service Date	HCPCS	Claim Control Number	Date of Initial Determination

REASON FOR REQUEST

SUPPORTING DOCUMENTATION

_____ CMS 1500 Claim Form
_____ Certificate of Medical Necessity
_____ Medical Documentation
_____ Medicare Remittance Notice
_____ Advance Beneficiary Notice
_____ Other_____

CONTACT INFORMATION

PROVIDER: (Contact Name and Signature)	BENEFICIARY: (Contact Name – Please Print)
Phone # ( )	Phone # ( )

(Rev. 07/01/2005)

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0626

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

Reason for Submission:
- ❑ New EFT Authorization
- ❑ Revision to Current Authorization *(i.e. account or bank changes)*
- ❑ EFT Termination Request

Chain Home Office:
- ❑ Check here if EFT payment is being made to the Home Office of Chain Organization *(Attach letter Authorizing EFT payment to Chain Home Office)*

Physician/Provider/Supplier Information

Physician's Name _____

Provider/Supplier Legal Business Name _____

_____

Chain Organization Name _____

Home Office Legal Business Name *(if different from Chain Organization Name)* _____

_____

Tax ID Number: *(Designate SSN* ❑ *or EIN* ❑*)* __ __ __ __ __ __ __ __ __

Doing Business As Name _____

Medicare Identification Number (*OSCAR, UPIN, or NSC only*) _____

Depository Information (Financial Institution)

Depository Name _____

Account Holder's Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number *(nine digit)* __ __ __ __ __ __ __ __ __

Depositor Account Number _____

Type of Account *(check one)* ❑ Checking Account ❑ Savings Account

Please include a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead with this agreement for verification of your account number.

Authorization

I hereby authorize the Medicare contractor, _____, hereinafter called the COMPANY, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the said Physician/Provider/Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions.

FORM CMS-588 (09/03)

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and such manner as to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it. The COMPANY will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the COMPANY an updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name *(Print)* _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature _____ Date _____

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

Furnishing information is voluntary, but without it we will not be able to process your electronic funds transfer.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

Instructions for Completing the Authorization Agreement for EFT

The following instructions will guide you through the EFT Authorization process. If you are submitting multiple requests, a separate Authorization Agreement must be completed for each provider identification number (OSCAR, UPIN, or NSC). All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made. In the meantime, all payments will be mailed via hard copy checks directly to the "Pay To" address that the Medicare contractor currently has on file. Please contact the Provider Enrollment Unit to verify the "Pay To" address. This agreement must be completely filled out. Omission of any information will delay the processing of your request. If you have any questions, please contact your Medicare contractor. For a list of contractors see www.cms.hhs.gov/providers/enrollment/contacts/.

Please indicate your reason for completing this form: New EFT authorization; Change to your account information; or Termination of your EFT authorization.

If you are authorizing EFT payments to the Home Office of a Chain Organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the Home Office of the Chain Organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

Enter the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier as reported to the Internal Revenue Service (IRS). The account to which EFT payments are made must exclusively bear the Name of the Physician or Individual Practitioner, or the Legal Business Name of the person or entity enrolled with Medicare.

For EFT payments to the Home Office of a Chain Organization, the depository account must be established in the legal business name of the Home Office, and must match the Home Office name provided above on this form, as well as the Home Office name provided in the appropriate sections of the relevant Form CMS-855 (Provider/Supplier Enrollment Application).

Enter your Tax Identification Number as reported to the IRS. If the business is a corporation, provide the Federal Employer Identification Number (EIN), otherwise provide your SSN.

Enter your Medicare Identification Number. If you are a Part A Provider, or certified Supplier this will be your 6-digit OSCAR number. If you are enrolled as an individual practitioner or a group practice this will be the 6-position alphanumeric UPIN. If you are enrolled as a supplier of durable medical equipment, this will be the 10-digit National Supplier Clearinghouse number.

Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds), address, name of a contact person, and contact person's telephone number.

Enter your electronic Routing Transit Number, Account Number, and the type of account in which deposits will be made (Checking or Saving). Attach a voided check, preprinted deposit slip, or confirmation of account information on bank letterhead for verification of your account number. The documentation on bank letterhead should confirm the name on the account, electronic routing transit number, account number and type, and the bank officer's name and signature.

If you do not submit this information, your EFT Authorization Agreement will be returned without further processing.

Read the Authorization carefully. By your signature on this form you are certifying:

1. That the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider/Supplier;
2. The Physician/Provider/Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions;
3. That all arrangements between the depository and the said Physician/Provider/Supplier are in accordance with all applicable Medicare regulations and instructions;
4. The effective date of the EFT authorization; and
5. That you will notify the Medicare contractor regarding any changes in the account in sufficient time to allow the contractor and the depository to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on Form CMS-855 which the Medicare contractor has on file.

Mail this form with the original signature (no Fax signatures can be accepted) to the Medicare Contractor that services your geographical area. For a listing of contractors, see www.cms.hhs.gov/providers/enrollment/contacts/.

Customer Service Available

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

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

Paper Claim Submission & Written Inquiries:
CIGNA Government Services
DMERC Region D
PO Box 690
Nashville TN 37202

Review Requests:
CIGNA Government Services
DMERC Reviews
PO Box 22995
Nashville TN 37202

Hearing Requests:
CIGNA Government Services
DMERC Hearings
PO Box 22263
Nashville TN 37202

Local Medical Review Policies (LMRPs), Local Coverage Determinations (LCDs), and Policy Articles

LMRPs, LCDs and Policy Articles are available to view and download on the CIGNA Government Services Web site (http://www.cignagovernmentservices.com/dmerc/lmrp_lcd/index.html) and the Centers for Medicare & Medicaid Services (CMS) Web site (http://www.cms.hhs.gov/coverage). Region D maintains paper copies of current, previously revised, or retired policies. Paper copies of policies are available upon request by writing to: CIGNA Government Services, DMERC Region D, ATTN: Elesha Campbell, P.O. Box 690, Nashville, TN 37202; or call 866.243.7272.

Requests may also be made by contacting the CIGNA Government Services Online Help Center at http://www.cignagovernmentservices.com/dmerc/resource.html. Requests for retired policies must include the name of the policy and the date the desired policy was in effect. In addition, you must provide a contact name, phone number and an address to which the policy may be mailed. CIGNA Government Services regrets we will not be able to fax or e-mail copies of the retired policies to the requester.

Supplier Application Packages and Changes of Address—If you need a supplier number application package or if you have questions concerning supplier number requirements, contact the National Supplier Clearinghouse (NSC) at the following: National Supplier Clearinghouse, PO Box 100142, Columbia SC 29202-3142, Phone: 866.238.9652, Web site: www.palmettogba.com.

Also, remember that no checks will be issued if the address on file with the NSC is different than any forwarding order on file with the U.S. Postal Service. Please notify the NSC if you have an address change or are planning to move in the near future.

EDI—For information on implementing electronic claim transmission, including testing procedures, call our EDI representatives at 866.224.3094, or send us e-mail at www.cignagovernmentservices.com/customer_service.

Coding Questions—The Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) answers coding questions. Call 877.735.1326.

Overpayments/Refunds—When refunding a check, make it payable to CGLIC - Medicare and send it to:

CIGNA Federal Insurance Benefits—DMERC
PO Box 10927
Newark NJ 07193–0927

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CIGNA Government Services
DMERC Region D
PO Box 690
Nashville TN 37202

Region D DMERC Serves. . .

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

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

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