DMERC Dialogue

Durable Medical Equipment Regional Carrier (DMERC) Region D

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

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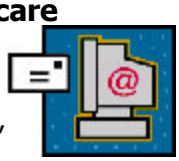

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From the Medical Director...

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Medical Review Strategy For Fiscal Year 2005

Each year the Centers for Medicare & Medicaid Services (CMS) require that Medical Review departments develop a strategy for actions to be taken in the coming fiscal year. The strategy must use data analysis to determine areas of vulnerability in the Medicare program with the primary goal of reducing the claim payment error rate. The claim payment error rate is determined using data obtained from the Comprehensive Error Rate Testing (CERT) program.

Over the past two years, suppliers have been informed in numerous *DMERC Dialogue* and CIGNA Medicare Web site articles about CERT and the importance of responding to requests for records from the CERT contractor, AdvanceMed. These efforts have paid off with a significant reduction in supplier errors, in large part thanks to the hard work of the supplier community in Region D. The gains in reducing the CERT error rate are appreciated by CIGNA Medicare and CMS; however, there is still work to be done.

In FY2005, which begins on October 1, 2004, CIGNA Medicare Medical Review will be concentrating educational and claim review activities on policy groups where the CERT error rate remains problematic. Through service-specific and provider-specific actions, educational offerings and policy development, CIGNA Medicare Medical Review will be concentrating on reducing the claim payment error rate in the following policy groups:

- Glucose Monitors
- Nebulizer Equipment and Drugs
- Wheelchairs (Manual and Power)
- Lower Limb Orthoses
- Enteral Nutrition
- Oxygen Equipment

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Cont'd

Medical Review Strategy For Fiscal Year 2005 (cont'd)

Suppliers engaged in dispensing items and services in these policy groups should pay particular attention to the *DMERC Dialogue* and the CIGNA Medicare Medical Review section of the Web site (www.cignamedicare.com/dmerc) for educational opportunities such as articles, documentation tools, Netcourses and Webinars. With your help, CIGNA Medicare can continue to improve the CERT error rate and achieve the goal of proper claim payment for all suppliers in Region D.

MEDICAL POLICY

Wheelchair Seating – Policy Revision

A revision of this policy is included in the October 2004 *DMERC Region D Supplier Manual* update.

As a result of the 2004 ICD-9 update, pressure ulcers are coded with 5 digit codes effective for dates of service on or after October 1, 2004. For skin protection seat cushions, the acceptable diagnoses will include 707.03, 707.04 and 707.05 – pressure ulcer of the lower back, hip, and buttock, respectively. These changes are included in the revised LCD (local coverage determination). Suppliers are reminded that there is no grace period for the use of the previous ICD-9 code (707.0). However, it should continue to be used on claims with dates of service prior to 10/1/04, regardless of the date of claim submission.

The Policy Article clarifies the distinction between seat inserts and solid support bases.

Suppliers are reminded that the grace period for use of previous codes for wheelchair seat and back cushions ends with claims with dates of service on or after 7/1/04 that are submitted on or after 10/1/04. The new codes for prefabricated seat cushions (K0650-K0657), prefabricated back cushions (K0660-K0665), and brand name custom fabricated seat and back cushions (K0658, K0666) may not be billed until the code for the product that was provided has been confirmed in a written coding verification review from the SADMERC. The results of these are posted on the SADMERC Web site. If a supplier chooses to submit a claim for a cushion before this has been obtained, code K0669 must be used and it will be denied as not medically necessary.

Specialty Nutrients - Documentation

According to the local medical review policy (LMRP) for Enteral Nutrition, coverage of special formulas (HCPCS Codes B4151, B4153-B4156) must be justified in each patient. Failure to substantiate the medical necessity of the special formula will result in payment according to the least costly alternative, B4150. The most common request in Region D is for specialty diabetic formulas such as Glucerna® and Diabetisource®. The documentation necessary to justify these special formulas was outlined in a December 1996 *DMERC Dialogue* article entitled "Category IV, V and VI Enteral Nutrients" (page 7):

1. Medical records documenting the medical condition requiring the Category IV/V/VI nutrient and the severity of that condition as shown by history, physical exam and diagnostic/laboratory studies.

2. The response of the medical condition to Category I or II nutrients as compared to the response to the prescribed Category IV/V/VI nutrient. If this comparison has not been made, the medical reason for its absence should be documented in the patient's medical record. The reason(s) should be individualized for the patient, not be a generalized statement such as the diagnosis.

In response to numerous questions on the coverage of these specialty nutrients, especially the diabetic formulas, the following additional specific documentation guidance is provided:

1. How long was the patient on a Category I nutrient?

2. Were different Category I formulas tried? What were they?

3. Were adjustments made in medications in an attempt to control blood sugars while on the Category I nutrient?

4. Is there documentation in the form of serial blood sugars, preferably one month prior to and after beginning usage of a Category IV diabetic formula, demonstrating improvement in glycemic control?

Providing this additional information will assist Medical Review staff in their review of these claims and help insure that proper claims payment is made.

MMA-Billing Requirements For Islet Cell Transplantation For Beneficiaries In A National Institutes Of Health (NIH) Clinical Trial

Medlearn Matters Article Number: MM3385

Provider Types Affected - All providers involved in an NIH sponsored clinical trial

Provider Action Needed

Impact to You - In the specific context of an NIH sponsored clinical trial: For services performed on or after October 1, 2004, Medicare will cover islet cell transplantation for trial participants (patients) with Type I diabetes. The islet cell transplant may be done alone or in combination with a kidney transplant. Immunosuppressive therapy to prevent rejection of the transplanted islet cells and routine follow-up care will be necessary for each trial participant.

What You Need to Know - Partial pancreatic tissue transplantation or islet cell transplantation performed outside the context of a clinical trial continues to be non-covered.

What You Need to Do - Please stay current on instructions pertaining to NIH sponsored clinical trials to ensure accurate claims processing.

Background - As a result of Section 733 of the Medicare Modernization Act (MMA), for services performed/discharged on or after October 1, 2004, Medicare will cover islet cell transplantation for patients with Type I diabetes who are participating in an NIH sponsored clinical trial.

For dates of service on and after October 1, 2004, for such beneficiaries, Medicare carriers will accept claims for islet cell transplantation with a type of service code of 2 and a HCPCS of G0341 (Percutaneous islet cell trans), G0342 (Laparoscopy islet cell trans), or G0343 (Laparotomy islet cell transp). Physicians should also use the QV modifier for islet cell transplantation and routine follow-up care related to this NIH trial.

Where beneficiaries are enrolled in a Medicare Advantage (MA) plan, Medicare carriers or intermediaries should make payment directly to providers of these islet cell transplants in accordance with Medicare payment rules, except that MA beneficiaries receiving the services are not responsible for the Part A and Part B deductibles. Such beneficiaries will be liable, however, for any applicable coinsurance amounts that the MA organization has in place for clinical trial benefits.

Providers billing Medicare intermediaries for these services should do so on an 11x type of bill. Such claims will be paid by the intermediary only for IPPS hospitals participating in the trial, and claims for beneficiaries in MA plans should also include condition code 30 so the deductible will not be applied. For fee-for-service beneficiaries, deductibles and coinsurance will apply.

Additional Information - The official instruction issued to the intermediary regarding this change can be found online, referenced via CR 3385, at: http://www.cms.hhs.gov/manuals/pm_trans/R261Cp.pdf

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

NOTE TO DMERC SUPPLIERS:

Per the above instructions, coverage will include the costs of acquisition and delivery of the pancreatic islet cells, as well as clinically necessary inpatient and outpatient medical care and immunosuppressants. For these patients, question #4 on the Immunosuppressive Drugs DMERC Information Form (DIF) should be answered "Yes" and in question #5, enter "9".

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

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

COVERAGE AND BILLING

Orthoses/Prostheses – Coding For Professional Services/ Fabrication Supplies

Codes L4205 (Repair of orthotic device, labor component, per 15 minutes) and L7520 (Repair of prosthetic device, labor component, per 15 minutes) may only be billed for time involved with the actual repair of an orthosis or prosthesis, respectively, or for medically necessary adjustments made more than 90 days after delivery.

Codes L4205 and L7520 must not be used to bill for time involved with other professional services including, but not limited to:

- Evaluating the patient
- Taking measurements, making a cast, making a model, use of CAD/CAM
- Making modifications to a prefabricated item to fit it to the individual patient
- Follow-up visits
- Making adjustments at the time of or within 90 days after delivery

Reimbursement for these services is included in the allowance for the HCPCS codes which describe the orthosis/prosthesis.

Similarly, codes L4210 (Repair of orthotic device, repair or replace minor parts) and L7510 (Repair of prosthetic device, repair or replace minor parts) must not be used for casting supplies or other materials used in the fitting or fabrication of an orthosis/prosthesis.

If a supplier decides to submit a claim for services/items that are included in the allowance for the orthosis/prosthesis, code L9900 (Orthotic and prosthetic supply, accessory and/or service component of another HCPCS L code) must be used. Code L9900 is denied as not separately payable.

Services or supplies associated with the provision of

plaster or fiberglass casts or splints are in the jurisdiction of the local carriers and fiscal intermediaries. Claims for these items may not be submitted to the DMERC.

Avoid Unnecessary Duplicate Denials

Items billed on separate lines under the same HCPCS code may cause the second line to deny as a duplicate. All charges and number of services for the same HCPCS codes should be billed on one line.

For example:

1. If the beneficiary receives two different kinds of ostomy supplies but they are both billed under A5061, combine the charges and total units and bill on one line.
2. If the beneficiary receives two different nutrient products but they are both billed under B4150, combine the charges and units and bill on one line.

This does not include rented or purchased items with RT/LT modifier. These may be on two lines.

For more information about duplicate claims, refer to the article entitled "Reminder to Stop Duplicate Billings" published in the Summer 2004 *DMERC Dialogue*.

Elimination Of Regulations For Written Statement Of Intent

Medlearn Matters Article Number: MM3310

Provider Types Affected - All Medicare Providers

Provider Action Needed

Impact to You - Effective with the claims filing period ending on December 31, 2004 and thereafter, Medicare will no longer accept Statements of Intent (SOIs) to extend the timely filing limit for filing initial claims.

What You Need to Know - Know the Medicare timely filing requirements for submitting claims. These requirements are in Chapter 1, Section 70 of the Medicare Claims Processing Manual, which may be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

What You Need to Do - To ensure accurate claims processing, please submit filings in a timely manner and make certain that you will no longer utilize SOIs.

Background - Medicare regulations at 42 CFR Part 424.45 allowed for the submission of written SOIs to claim Medicare benefits. The purpose of an SOI was to extend the timely filing period for the submission of an initial claim. An SOI, by itself, did not constitute a claim, but rather was used as a placeholder for filing a timely and proper claim.

A Final Rule published in the Federal Register, dated April 23, 2004, Volume 69, Number 79, pages 21963-21966, amended 42 CFR Part 424 by removing the SOI provision at 424.45, effective May 24, 2004. Therefore, for the claims filing period ending on December 31, 2004, and all periods thereafter, Medicare carriers, intermediaries, and Medicare Regional Offices will no longer accept SOIs to extend the timely filing period for claims.

Additional Information - If you have questions regarding this issue, you may also contact your carrier or intermediary by their toll free number. If you bill for Medicare Part A services, including outpatient hospital services, the toll free number for your carrier/intermediary may be found online at: http://www.cms.hhs.gov/providers/edi/anum.asp

If you bill for Medicare Part B services, the toll free number may be found online at: http://www.cms.hhs.gov/providers/bnum.asp

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via CR 3310, at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

On the above online page, scroll down while referring to the CR NUM column on the right to find the link for CR3310. Click on the link to open and view the file for the CR.

Medicare Contractor Annual Update Of The International Classification Of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

Medlearn Matters Article Number: MM3303

Provider Types Affected - Physicians, suppliers, and providers

Provider Action Needed

Impact to You - Medicare will soon issue the annual update of the *International Classification of Diseases,*

Ninth Revision, Clinical Modification (ICD-9-CM) to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2004.

What You Need to Know - Remember that, as of October 1, 2004, Medicare no longer can provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes.

What You Need to Do - Be ready to use the updated codes on October 1, 2004. Refer to the *Background* and *Additional Information* sections of this article for further details regarding this instruction.

Background - This instruction is a reminder that Medicare carriers and intermediaries will use the annual *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* coding update effective for:

- Dates of service on or after October 1, 2004; and
- Discharges on or after October 1, 2004 for institutional providers.

The Centers for Medicare & Medicaid Services (CMS) has been evolving the use of ICD-9-CM codes as follows:

- Beginning in 1979, ICD-9-CM codes became mandatory for reporting provider services on Form CMS-1450.
- On April 1, 1989, the use of ICD-9-CM codes became mandatory for all physician services submitted on Form CMS-1500.
- Effective October 1, 2003, an ICD-9-CM code is required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59) (see Change Request (CR) 2725, dated June 6, 2003, at http://www.cms.hhs.gov/manuals/pm_trans/B03045.pdf).
- Effective for dates of service on and after October 1, 2004, CMS will no longer provide a 90-day grace period for physicians, practitioners and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR 3094 dated February 6, 2004 at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3094.pdf).

Updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment System and are effective each October first. Physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect beginning October 1, 2004.

After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following Website: http://www.cms.hhs.gov/medlearn/icd9code.asp. The update should be available at this site in June.

Implementation - The implementation date for this instruction is October 4, 2004.

Related Instructions - The *Medicare Claims Processing Manual*, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service) has been revised. The updated manual instructions are included in the official instruction issued to your carrier, and it can be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that Website, look for CR3303 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.

Additional Information - The new, revised, and discontinued ICD-9-CM diagnosis codes are posted annually on the following CMS Website: www.cms.hhs.gov/medlearn/icd9code.asp

Providers can view the new updated codes at this Website in June and providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

In addition, the National Center for Health Statistics (NCHS) also will place the new ICD-9-CM Addendum on their Website (www.cdc.gov/nchs/icd9.htm) in June, which is also available for providers to visit.

Medicare Beneficiaries In State Or Local Custody Under A Penal Authority

I. GENERAL INFORMATION

A. Background:

Under Sections 1862(a)(2) and (3) of the Social Security Act (the Act), the Medicare program does not pay for services if the beneficiary has no legal obligation to pay for the services and if the services are paid for di-

rectly or indirectly by a governmental entity. These provisions are implemented by regulations 42 CFR 411.4(a) and 411.4 (b), respectively.

Regulations at 42 CFR 411.4(b) state that "Payment may be made for services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met: (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody, and (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing the collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts."

A recent Office of Inspector General audit of Medicare payments identified a vulnerability for the Medicare trust fund with respect to this issue. The study identified payments for beneficiaries who, on the date of service on the claim, were in state or local custody under the authority of a penal statute. To address this vulnerability, CMS is establishing claim level editing using data received from the Social Security Administration (SSA).

Specifically, the data will contain the names of the Medicare beneficiaries and time periods where the beneficiary is in such state or local custody. This data will be compared to the data on the incoming claims. The Common Working File (CWF) will reject claims where the dates from the SSA file and the dates of service on the claim overlap. Any claims rejected by CWF will contain a trailer to the Medicare contractor indicating the date span covered.

B. Policy:

Exclusion from Coverage

Medicare excludes from coverage items and services furnished to beneficiaries in state or local government custody under a penal statute, unless it is determined that the state or local government enforces a legal requirement that all prisoners/patients repay the cost of all healthcare items and services rendered while in such custody and also pursues collection efforts against such individuals in the same way and with the same vigor as it pursues other debts. CMS presumes that a state or local government that has custody of a Medicare beneficiary under a penal statute has a financial obligation to pay for the cost of healthcare items and services. Therefore, Medicare denies payment for items and services furnished to beneficiaries in state or local government custody. Denial messages are:

> ANSI Reason code: CO 96 - Non covered charges.
>
> Remark code: N103 - Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.

However, providers and suppliers that render services or items to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact by appending the modifier referenced in section C below to the procedure code when submitting a claim.

Appeals

A party to a claim denied in whole or in part under this policy may appeal the initial determination on the basis that, on the date of service, (1) The conditions of 42 CFR 411.4(b) were met, or (2) The beneficiary was not, in fact, in the custody of a State or local government under authority of a penal statute.

C. Implementation:

Providers that render services to a prisoner or patient in a jurisdiction that meets the conditions of 42 CFR 411.4(b) should indicate this fact on the claim. Providers should use the following modifier:

> QJ - Services/items provided to a prisoner or patient in State or local custody, however, the State or local government, as applicable, meets the requirements in 42 CFR 411.4(b).

This modifier indicates that the provider has been instructed by the state or local government agency that requested the healthcare items or services provided to the patient that it is the policy of the State or local government that the prisoner or patient is responsible to repay the cost of medical services, and that it pursues collection of debts incurred for furnishing such items or services with the same vigor and in the same manner as any other debt.

October 2004 Quarterly Update Of Healthcare Common Procedure Coding System (HCPCS) Codes Used For Skilled Nursing Facility (SNF) Consolidated Billing Enforcement

Medlearn Matters Article Number: MM3348

Provider Types Affected - Institutional providers billing claims to the Medicare Fiscal Intermediaries (FIs). Physicians, practitioners, and suppliers billing Medicare carriers for services.

Provider Action Needed

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

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

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

Background - The Centers for Medicare & Medicaid Services (CMS) periodically updates the list of HCPCS codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (SNF PPS). Services appearing on this list submitted on claims to Medicare Fiscal Intermediaries (FIs) and Carriers, including Durable Medical Equipment Regional Carriers (DMERCs) will not be paid to any Medicare providers, other than a SNF, when included in SNF consolidated billing.

For non-therapy services, the SNF consolidated billing applies only when the services are furnished to a SNF resident during a covered Part A stay. However, the SNF consolidated billing applies to physical, occupational, or speech-language therapy services whenever they are furnished to a SNF resident, regardless of whether Part A covers the stay. Services excluded from the SNF consolidated billing may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay.

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

The codes below are listed as being added or removed from the annual update, mentioned above. Deletions from Major Category I F. below, specifically HCPCS code 36489, is being removed because the HCPCS was discontinued as of December 31, 2003. additions to what is noted as Major Category III below means these services may be provided by any Medicare provider licensed to provide them, **except a SNF,** and are excluded from SNF PPS and consolidated billing. Additions to therapy inclusions, Major Category V below, mean SNFs alone can bill and be paid for these services when delivered to beneficiaries in a SNF, whereas codes being removed from this therapy inclusion list now can be billed and potentially paid to other types of providers for beneficiaries NOT in a Part A stay or in a SNF bed receiving ancillary services billed on TOB 22x.

Outpatient Surgery and Related Procedures (Major Category I F., FI Annual Update, INCLUSION) - Remove 36489. **–** placement of cv catheter.

Note on Code above**:** Code discontinued effective December 31, 2003.

Customized Prosthetic Devices (Major Category III, FI Annual Update, EXCLUSION)

For FI claims processing, remove K0556*, K0557*, K0558*, K0559* - Addition to lower extremity, below knee/above knee, custom fab. **For carrier claims processing**, these codes will remain payable for dates of service prior to January 1, 2004.

Add L5673**** -** addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism

Add L5679**** - addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism

Chemotherapy Administration (Major Category III, FI Annual Update, EXCLUSION) - Remove 36489***** -** placement of cv catheter.

Notes on Codes above:
***** Codes were replaced by L5673, L5679, L5681 and L5683.
****** Codes are added to exclusion list retroactive to 1/1/04.
******* Code discontinued effective 12/31/03.

Therapies (Major Category V, FI Annual Update, for FI billing use revenues codes 42x (physical therapy), 43x (occupational therapy), 44x (speech-language pathology) - Remove G0295^ Electromagnetic stimulation, to one or more areas (Not covered by Medicare) (This code was not previously included on carrier coding files.)

Remove G0237^^ **-** Therapeutic procd strg endur
Remove G0238^^ **-** Oth resp proc, indiv
Remove G0239^^ **-** Oth resp proc, group
Remove G0302^^ **-** pre-op LVRS service
Remove G0303^^ **-** pre-op service LVRS 10-15dos
Remove G0304^^ **-** pre-op service LVRS 1-9dos
Remove G0305^^ **-** post-op service LVRS min 6dos

Add G0329^^^– electromagnetic therapy, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

Notes on Codes above**:**
^ This code was erroneously added to file. Code was not previously included on carrier coding files.
^^ These codes are not considered therapy codes and are not payable to a SNF. They were inadvertently added to the table.
^^^ This code was added to the therapy inclusion list effective July 1, 2004. (Information concerning this code was not received in time to issue a July 2004 update.)

Additional Information - Each January, separate instructions are published for FIs, Carriers and DMERCs for the annual notice on the SNF consolidated billing. The 2004 Annual Updates for FIs can be found on the CMS web site at: www.cms.hhs.gov/manuals/pm_trans/R19CP.pdf. This instruction is referred to as CR2926.

Overall information regarding SNF CB can be found at: http://www.cms.hhs.gov/medlearn/snfcode.asp.

Quarterly updates now apply to FIs, Carriers and DMERCs. There has been one joint FI/Carrier/DMERC quarterly update published subsequent to the 2004 Annual Updates. This update can be found at: www.cms.hhs.gov/manuals/pm_trans/R92CP.pdf That instruction is also known as CR3070.

The official instruction issued to your carrier regarding this change may be found by going to: http://www. cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR3348 in the CR NUM column on the right, and then click on the file for that CR.

Skilled Nursing Facility Consolidated Billing

Medlearn Matters Article Number: SE0431

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

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

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

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

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

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

• A potential for duplicate (Parts A/B) billing if both the SNF and outside supplier billed;
• An increased out-of-pocket liability incurred by the beneficiary for the Part B deductible and coinsurance even if only the supplier billed; and
• A dispersal of responsibility for resident care among various outside suppliers, which adversely affected quality (coordination of care) and program integrity, as docu-

mented in several reports by the Office of the Inspector General (OIG) and the General Accounting Office (GAO).

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

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

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

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

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

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

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

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

Physician "Incident To" Services - While CB excludes the types of services described above and applies to the professional services that the practitioner performs personally, **the exclusion does not apply to physician "incident to" services** furnished by someone else as an "incident to" the practitioner's professional service. These "incident to" services furnished by others to SNF residents are subject to CB and, accordingly, must be billed to Medicare by the SNF itself. Examples of

"incident to" services are laboratory tests or x-rays performed in the doctor's office.

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

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

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

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

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

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

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

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

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

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

medlearn/matters/mmarticles/2004/SE0439.pdf

• Skilled Nursing Facility Consolidated Billing as It Relates to Certain Diagnostic Tests http://www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0440.pdf

• Skilled Nursing Facility Consolidated Billing and "Incident To" Services (Services That Are Furnished as an Incident to the Professional Services of a Physician or Other Practitioner) (coming soon)

In addition, the CMS Medlearn Consolidated Billing Website can be found at: http://www.cms.hhs.gov/medlearn/snfcode.asp. It includes the following relevant information:

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

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

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

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

Medlearn Matters Article Number: SE0434

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.

Background - The original Balanced Budget Act of 1997 list of exclusions from the prospective payment system (PPS) and consolidated billing (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)). For an overview of SNF CB and a list of excluded services, see Medlearn Matters article SE0431 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 for it under Part B.

An SNF that elects to furnish EPO to a 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) and DPA (Darbepoetin Alfa, trade name Aranesp) are not separately billable when provided as treatment for any ill-

ness 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 for that beneficiary.

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 *Medicare Renal Dialysis Facility Manual*, Chapter II, Coverage of Services can be found at the following CMS Website: http://www.cms.hhs.gov/manuals/29_rdf/rd200.asp?#_1_1. You can find the *Medicare Benefit Policy Manual*, Pub. 100-02, Chapter 11, End Stage Renal Disease (ESRD), at the following CMS Website: http://www.cms.gov/manuals/102_policy/bp102index.asp. 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 Website: http://www.cms.gov/manuals/104_claims/clm104index.asp.

The CMS Medlearn Consolidated Billing Website can be found at: http://www.cms.hhs.gov/medlearn/snfcode.asp. It includes the following relevant information:

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

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

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

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

Medlearn Matters Article Number: SE0437

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.

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 Website can be found at: http://www.cms.hhs.gov/medlearn/snfcode.asp. It includes the following relevant information:

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

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

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

Skilled Nursing Facility Consolidated Billing L Codes – Durable Medical Equipment Regional Carrier And Fiscal Intermediaries

Medlearn Matters Article Number: MM3295

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

Provider Action Needed

Impact to You - As of April 1, 2004, suppliers cannot get paid for codes L5673 and L5679 for services provided to a beneficiary in a Part A SNF stay. These codes have replaced codes K0557 and K0558. Codes L5673 and L5679 were inadvertently left off the April 2004 quarterly update edits for SNF consolidated billing.

What You Need to Know - Once corrected, these codes will allow separate payment by Medicare Durable Medical Equipment Regional Carriers (DMERCs) and Fiscal

Intermediaries (FI) outside the perspective payment rate for Medicare beneficiaries in Part A SNF stays. These codes will be added to the October quarterly update. When claims for L5679 and L5673 are rejected, the following incorrect messages will appear on your statement: Remittance Advice American National Standards Institute (ANSI) Reason code 109 "Claims not covered by this payer/contractor. Claims must be sent to the correct payer/contractor;" and remark code MA101, "A SNF is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents." Since these codes were mistakenly not added to the edits for services that are separately payable outside of consolidated billing and the PPS rate, the provider or supplier should not contact the SNF for payment on these claims.

What You Need to Do - If your claim for L5679 or L5673 services is not paid from April 1 through September 30, 2004, notify your DMERC or intermediary and request they re-open the claim and use the appropriate override code to process your claim for payment.

Background - Due to an inadvertent programming error, Medicare systems will not process payments for HCPCS codes L5673 and L5679 as of April 1, 2004. These codes are described as follows:

• **L5673** - Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism, effective January 1, 2004.
• **L5679** - Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism, effective January 1, 2004.
• **L5673** and **L5679** replaced K0557 and K0558, which were terminated as of December 31, 2003.

K0557 and K0558 are defined as follows:

- K0557 - same definition as L5673, terminated December 31, 2003.
- K0558 - Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code K0556 or K0557), terminated December 31, 2003.

Where appropriate, Medicare has instructed your DMERC or intermediary to pay interest for delayed payments.

Additional Information - If you have any questions regarding this issue, please contact your DMERC or intermediary at their toll free number. If you do not have that number, you may find it at: http://www.cms.hhs.gov/medlearn/tollnums.asp. To view the instruction issued to your carrier/intermediary regarding this issue, please visit: http://www. cms. hhs.gov/manuals/transmittals/comm_date_dsc.asp. Scroll down the CR NUM column on the right and click on CR3295

Skilled Nursing Facility Consolidated Billing: Services Furnished Under An "Arrangement" With An Outside Entity

Medlearn Matters Article Number: MM3248

Provider Types Affected - Skilled Nursing Facilities (SNF), physicians, non-physician practitioners, suppliers, and providers.

Provider Action Needed

Impact to You – Affected providers should note that this instruction is being issued as a reminder of the applicable consolidated billing requirements that pertain to Skilled Nursing Facilities (SNF) and to the outside suppliers that serve SNF residents.

What You Need to Know - Whenever a SNF resident receives a service that is subject to SNF consolidated billing from an outside supplier, the Social Security Act requires the SNF and the supplier to enter into an "arrangement." Under an "arrangement," Medicare's payment to the SNF represents payment in full for arranged-for services and suppliers must look to the SNF (rather than to Medicare Part B) for their payment.

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

Background - The SNF consolidated billing provisions of the Social Security Act[1] place the Medicare billing responsibility for most of the SNF's residents' services with the SNF itself. In addition, Part A consolidated billing requires that an SNF must include on its Part A bill:

• Almost all of the services that a resident receives during the course of a ***Medicare-covered* stay**;
• **Except** for those services that are specifically ***excluded*** from the SNF's global prospective payment system (PPS) per diem payment for the covered stay. (These

"excluded" services remain separately billable to Part B directly by the outside entity that actually furnishes them.)

Also, Part B consolidated billing makes the SNF itself responsible for submitting the Part B bills for any ***physical, occupational, or speech-language therapy services*** that a resident receives during a ***noncovered*** stay.

Further, for any Part A or Part B service that is subject to SNF consolidated billing, the SNF must either:

• Furnish the service directly with its own resources, **or**
• Obtain the service from an outside entity (such as a supplier) under an "arrangement," as described in the Social Security Act.[2]

This "arrangement" must constitute a written agreement to reimburse the outside entity for Medicare covered services subject to consolidated billing, i.e., services that are reimbursable only to the SNF as part of its global PPS per diem or those Part B services that must be billed by the SNF.

Problematic Situations - There are various ***problematic situations*** in which an SNF resident receives a service from an outside supplier (or practitioner) that is subject to consolidated billing, in the absence of a valid arrangement between that entity and the SNF.

In some instances, the supplier may have been unaware that the beneficiary was in a Part A stay until its separate Part B claim was denied. In the absence of a written agreement, the supplier may have difficulty in obtaining payment from the SNF, even though the service at issue is a type of service that is Medicare covered and included in the SNF's global PPS per diem.

As discussed in greater detail below, such situations most commonly arise in one of the following scenarios:

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

Whenever a supplier furnishes services that are subject to consolidated billing in the absence of a written agreement with the SNF, the supplier risks not being paid for the services. In addition, the supplier in this situation might improperly attempt to bill Part B directly for the services. The inappropriate submission of a Part B bill for such services could result not only in Medicare's noncoverage of the services themselves, but also in the imposition of civil money penalties, as explained below.

Along with all of the other potentially adverse consequences of such practices, the SNF risks violating the terms of the Medicare provider agreement (which requires a SNF to have a valid arrangement in place whenever a resident receives services that are subject to consolidated billing from any entity other than the SNF itself).

In order to help prevent these types of problems from arising, ***this instruction is being issued as a reminder of the applicable consolidated billing requirements that pertain to SNFs and to the outside suppliers that serve SNF residents.***

Billing Arrangements - Under an arrangement as defined in the Social Security Act[3]**:**

• Medicare's payment to the SNF represents payment in full for arranged-for services; and
• Suppliers must look to the SNF (rather than to Part B) for their payment.

Further, in entering into such arrangements, the SNF cannot function as a mere billing conduit, and must exercise professional responsibility and control over the arranged-for service**.**[4] The long-term care (LTC) facility requirements for program participation further provide that under such an arrangement, the SNF must ***specify in writing*** that it assumes responsibility for the quality and timeliness of the arranged-for service.[5]

Medicare does not prescribe the actual terms of the SNF's written agreement with its supplier (such as the specific amount or timing of the supplier's payment by the SNF). These are arrived at through direct negotiation between the parties to the agreement. However, in order for a valid "arrangement" to exist for those services that are subject to consolidated billing, ***the SNF must have a written agreement in place with its supplie****r*, which specifies how the supplier is to be paid for its services. The existence of such an agreement also provides both parties with a means of resolution in the event that a dispute arises over a particular service.

If an SNF elects to obtain services that are subject to consolidated billing from an outside supplier, but fails to execute a written agreement with that supplier, then there is no valid arrangement for the services as contemplated under the Social Security Act.[6]

Not only would this potentially result in Medicare's

noncoverage of the particular services at issue, but the SNF would also risk being found in violation of the terms of its provider agreement. Under the Social Security Act, the SNF's provider agreement includes a specific commitment to comply with the requirements of the consolidated billing provision.[7]

Further, the Social Security Act imposes a civil money penalty on any person who knowingly and willfully presents (or causes to be presented) a bill or request for payment inconsistent with an arrangement or in violation of the requirement for such an arrangement.[8]

Accordingly, whenever an SNF elects to utilize an outside supplier to furnish a service that is subject to consolidated billing, the SNF must have a written agreement in place with that supplier. Conversely, whenever an outside supplier furnishes such a service to an SNF resident, it must do so under a written agreement with the SNF.

Problems with Arrangements - Problems involving the absence of a valid arrangement between an SNF and its supplier typically tend to arise in one of the following two situations:

• **The first problem scenario** occurs when an SNF elects to utilize an outside supplier to furnish a type of service that would be subject to Part A consolidated billing, but then fails to inform the supplier that the resident receiving the service is in a covered Part A stay.

This causes the supplier to conclude mistakenly that the service it furnishes to that resident is not subject to consolidated billing. Based on the inaccurate impression that the resident's SNF stay is noncovered, the supplier inappropriately submits a separate Part B claim for the service, and only learns of the actual status of the resident's Medicare-covered SNF stay when that Part B claim is denied. In this scenario, even though the supplier made reasonable efforts to ascertain from the SNF both the beneficiary's status as an SNF resident and the specific nature of the beneficiary's SNF stay, the information from the SNF (on which the supplier relied) proved to be inaccurate.

While it is recognized that inadvertent errors may occasionally occur in the course of furnishing such information, an SNF should not only make a good faith effort to furnish accurate information to its supplier, but should have a written agreement in place that provides for direct reimbursement of the supplier once such an error is called to its attention.

By contrast, in the scenario at issue, the SNF refuses to pay the supplier for the service even ***after*** being apprised of the inaccuracy of its initial information. As discussed previously, having a valid arrangement in place for the disputed service would not only ensure compliance with the consolidated billing requirements, but also would provide a vehicle for resolving the dispute itself.

• **The second problem scenario** involves a resident who temporarily departs from the SNF on a brief leave of absence, typically accompanied by a relative or friend. While briefly offsite, the resident (or the relative or friend, acting on the resident's behalf) obtains services that are subject to the consolidated billing requirement, but fails to notify the SNF.

As in the previous scenario, this results in the services being furnished to the resident by an outside entity in the absence of a valid arrangement with the SNF. In addition, such a practice impedes the SNF from meeting its responsibility to provide comprehensive oversight of the resident's care and treatment.

SNFs can act to prevent such problems from arising by ensuring that each resident (and, if applicable, his or her representative) is fully aware of the applicable requirements.

For example, the Medicare law[9] guarantees a beneficiary's free choice of any qualified entity that is willing to furnish services to the beneficiary. However, in selecting a particular SNF, the beneficiary has effectively exercised this right of free choice with respect to the ***entire package*** of services for which the SNF is responsible under the consolidated billing requirement, including the use of any outside suppliers from which the SNF chooses to obtain such services.

In addition, the Long Term Care (LTC) facility participation requirements[10] direct the SNF to advise each resident, on or before admission and periodically during the stay, of any charges for services not covered by Medicare.

In providing such advice periodically throughout each resident's stay, the SNF should take particular care to include any resident who is about to leave the facility temporarily, in order to ensure that the resident (and, if applicable, the resident's representative) understands the need to consult the SNF before obtaining any services offsite.

Moreover, while the SNF itself should take reasonable steps to prevent such problems from arising, the supplier is also responsible for being aware of and complying with the consolidated billing requirements.

This means that prior to furnishing services to a Medi-

care beneficiary, **the supplier should routinely ascertain whether the beneficiary is currently receiving any comprehensive Medicare benefits (such as SNF or home health benefits) for which Medicare makes a bundled payment that could potentially include the supplier's services.** If the supplier ascertains that a particular beneficiary is, in fact, a resident of an SNF with which the supplier does not have a valid arrangement in place, then the supplier should contact the SNF before actually furnishing services to that beneficiary.

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

Additional Information - The *Medicare Claims Processing Manual,* Pub 100-04, Chapter 6 (SNF Inpatient Part A Billing), Section 10.3 (Types of Services Subject to the Consolidated Billing Requirement for SNFs) has been revised. The following new sections have also been added:

• Section 10.4 (Furnishing Services that are Subject to SNF Consolidated Billing Under an "Arrangement" with an Outside Entity);
• Subsection 10.4.1 (Written Agreement); and
• Subsection 10.4.2 (SNF and Supplier Responsibilities).

These revised/new portions of the manual are attached to the official instruction issued to your carrier regarding this change. That instruction (CR3248) may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR3248 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.

The *Medicare General Information, Eligibility, and Entitlement Manual,* Pub. 100-1, Chapter 5 (Definitions), Section 10.3 (Under Arrangements) can be found at the following CMS Online Manuals Website: www. cms.hhs.gov/manuals/cmsindex.asp.

[1] Social Security Act, Sections 1862(a)(18), 1866(a)(1)(H)(ii), and 1888(e)(2)(A).
[2] Social Security Act, Section 1861(w).
[3] Social Security Act, Section 1861(w).
[4] *Medicare General Information, Eligibility, and Entitlement Manual*, Pub. 100-1, Chapter 5 (Definitions), Section 10.3 (Under Arrangements).
[5] Code of Federal Regulations, 42 CFR 483.75(h)(2).
[6] Social Security Act, Section 1862(a)(18).
[7] Social Security Act, Section 1866(a)(1)(H)(ii), and the Code of Federal Regulations, 42 CFR 489.20(s).
[8] Social Security Act, Section 1866(g).
[9] Social Security Act, Section 1802.
[10] Code of Federal Regulations, 42 CFR 483.10(b)(6).

October 2004 Quarterly Update Of Home Health Common Procedure Coding System (HCPCS) Codes Used For Home Health Consolidated Billing Enforcement

Medlearn Matters Article Number: MM3350

NOTE: The DMERC does not have jurisdiction for the code included in this Home Health Consolidated Billing notice, G0329. This article is being published to provide information about the frequency of updates and the Web site resource for the home health consolidated billing master code list (see the Background and Additional Information sections).

Provider Types Affected - Physicians, practitioners, and suppliers billing Medicare carriers for services

Provider Action Needed

Impact to You - The HCPCS code **G0329** is being added to Home Health (HH) consolidated billing enforcement.

What You Need to Know - The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article reflects the October 2004 update.

What You Need to Do - Affected providers should be aware that **G0329** will not be separately payable for beneficiaries in a Home Health episode as of October 1, 2004.

Background - The Balanced Budget Act of 1997 required consolidated billing of all HH services while a beneficiary is under a HH plan of care authorized by a physician. As a result, billing for all such items and services is to be made to a single HHA overseeing that plan. This HHA is known as the primary agency for Home Health Prospective Payment System (HH PPS) for billing purposes.

Medicare periodically publishes Routine Update Notifications which contain updated lists of non-routine sup-

ply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes which Medicare also publishes annually. The lists may also be updated as frequently as quarterly if required by the creation of new HCPCS codes mid-year.

In this update, G0329, Electromagnetic Tx for Ulcers, is being added to enforcement of HH consolidated billing to reflect a mid-year update to the HCPCS lists. Claims for this code for services on or after October 1, 2004, will be subject to this enforcement.

Additional Information - This recurring update notification provides the quarterly HH consolidated billing update effective October 1, 2004. Quarterly updates were not needed for April or July 2004. This is the only quarterly update for calendar year 2004. The next changes to the HH consolidated billing code list will come with the annual update for calendar year 2005.

The full descriptor for G0329 is as follows:

G0329 Electromagnetic Tx for Ulcers - Electromagnetic therapy to one or more areas for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care as part of a therapy plan of care.

There is a home health consolidated billing master code list available on the CMS Web site. You may access this list by going to: http://www.cms.hhs.gov/providers/hhapps/#billing.

The official instruction issued to your carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR 3350 in the CR NUM column on the right, and click on the file for that CR.

Time Limit For Filing Claims

Claims for services provided between October 1, 2002 and September 30, 2003 must be received at the carrier by December 31, 2004. Claims that are not submitted within these time limits will be denied. Effective with the claims filing period ending on December 31, 2004 and thereafter, Medicare will no longer accept Statements of Intent (SOIs) to extend the timely filing limit for filing initial claims (see article entitled "Elimination of Regulations for Written Statement of Intent" in this issue.)

FEE SCHEDULE

Drug Pricing Update—Payment Limits For J7308 (Levulan Kerastick) And J9395 (Faslodex)

Medlearn Matters Article Number: MM3312

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

Provider Types Affected - Physicians, suppliers, and providers

Provider Action Needed

Impact to You - New payment limits have been set for HCPCS drug codes J7308 (Levulan Kerastick) and J9395 (Faslodex) when these codes are not paid on a cost or prospective payment basis.

What You Need to Know - Medicare Carriers are instructed to replace the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) payment limits for HCPCS drug codes J7308 (Levulan Kerastick) and J9395 (Faslodex) with the new rates listed in this instruction for dates of service on or after January 1, 2004.

What You Need to Do - Be aware of the new payment limits for these two codes.

Background - This article informs providers that Medicare carriers will apply new payment limits for these HCPCS codes (J7308 (Levulan Kerastick) and J9395 (Faslodex)) for claims processed with dates of service on or after January 1, 2004 and on or before December 31, 2004.

From January 1, 2004 through December 31, 2004, the Medicare payment limits for the specific HCPCS drug codes listed below (that are not paid on a cost or prospective payment basis) apply.

HCPCS	Short Description	Average Wholesale Price (AWP) %	2004 Payment Limit for Drugs (other than End Stage Renal disease (ESRD) drugs separately billed by independent ESRD Facilities and drugs infused through Durable Medical Equipment (DME)
J7308	Aminole-vulinic acid hcl top	85	$ 111.47
J9395	Injection, Fulvestrant	85	$ 81.57

Note: The payment limits listed in the table above supercede the payment limits published in Change Request 3105 (Transmittal 75) dated January 30, 2004, only for these particular HCPCS drug codes for this time period. Also note that the absence or presence of an HCPCS code and its associated payment limit does not indicate Medicare coverage of the drug.

Implementation - The implementation date for this instruction is July 25, 2004. The effective date of the change is January 1, 2004. However, Medicare contractors will not adjust any claims previously processed in order to apply these new payment limits unless the provider requests such an adjustment.

October Quarterly Update For 2004 Durable Medical Equipment, Prosthetics, Orthotics, And Supplies (DMEPOS) Fee Schedule

Medlearn Matters Article Number: MM3377

Provider Types Affected - Physicians, providers, and suppliers

Provider Action Needed - This instruction provides information for updating and implementing the October Quarterly 2004 fee schedule amounts for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). It implements fee schedule amounts for new codes and revises any fee schedule amounts for existing codes that were calculated in error.

Background - Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings (Socials Security Act, Sections 1834(a), (h), and (i)). In addition, payment on a fee schedule basis is required for Parenteral and Enteral Nutrition (PEN) by regulations contained in 42 CFR 414.102.

This instruction implements fee schedule amounts for new codes, deletes certain codes, and revises any fee schedule amounts for existing codes that were calculated in error in prior updates. Specifically, the changes for this update are as follows:

- **Codes A4363, E1400 thru E1404, K0137 thru K0139, K0168 thru K0181, K0190 thru K0192, K0277 thru K0279, K0284, K0400, K0417, K0419 thru K0439, and K0530** were deleted from the Healthcare Common Procedure Coding System (HCPCS) effective 12/31/1999. These codes were inadvertently included in the 2004 fee schedule file, and they **are being removed with this update.**
- Codes E1019 and E1021 are also being removed as they are not valid 2004 HCPCS codes.
- The 2004 Puerto Rico schedule amounts for **Codes A4351 and A4352** were based on incorrect pricing information. The Durable Medical Equipment Regional Carriers (DMERCs) must revise the base fee schedule amounts for these codes as part of the October quarterly update.
- **Codes K0630 thru K0649, representing Lumbar Sacral Orthosis products** were added to the HCPCS effective April 1, 2004 and their fee schedule amounts were implemented on July 1, 2004. However, the Centers for Medicare & Medicaid Services has determined that the fee schedule amounts for codes K0630, K0631, K0632, K0634, K0635, K0636, K0637, K0639, K0640, K0642, K0644, K0645, and K0646 were based on incorrect pricing information and has recalculated those fee schedule amounts. The revised amounts will be implemented on October 4, 2004 as part of this update.
- **Codes K0650 thru K0669** were added to the HCPCS effective July 1, 2004. Because data is not yet available, implementation of the fee schedule amounts for these items will be delayed until the January 2005 update.

Implementation - The implementation date for this instruction is October 4, 2004.

Additional Information - To view the official instruction issued to your DMERC or intermediary on this issue, please see: http://www.cms.hhs.gov/manuals/pm_trans/R272CP.pdf. Also, the quarterly update process for the DMEPOS fee schedule is located in Section 60 of Chapter 23 of the *Medicare Claims Processing Manual,* which may be found at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp. If you have any questions, please contact your DMERC or intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

October 2004 Fee Schedule Quarterly Update

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

Below are revised fees for Lumbar-Sacral Orthosis (LSO) HCPCS codes K0630 – K0649.

HCPCS codes K0633, K0638, K0641 and K0643 will remain as individual consideration (IC). When billing for codes that are listed as IC, the manufacturer's name, product number, and suggested retail price will be need to process the claim. The fees for HCPCS codes K0647, K0648 and K0649 did not change; therefore, refer to www.cignamedicare.com for the 2004 fees.

The following fees will be effective for claims processed on or after August 16, 2004, for dates of service on or after April 1, 2004.

States	K0630	K0631	K0637	K0640	K0642	K0644	K0645	K0646
AK	90.56	300.97	65.92	806.64	225.31	1315.77	1667.83	820.28
AZ	92.55	259.29	65.92	806.64	225.31	960.72	1422.21	820.28
CA	92.55	259.29	65.92	806.64	225.31	960.72	1422.21	820.28
HI	96.83	321.85	65.92	806.64	225.31	1406.97	1783.45	820.28
IA	90.57	232.39	67.21	822.39	229.72	805.71	1325.29	836.32
ID	90.97	241.43	65.92	806.64	225.31	830.31	1082.60	820.28
KS	90.57	232.39	67.21	822.39	229.72	805.71	1325.29	836.32
MO	90.57	232.39	67.21	822.39	229.72	805.71	1325.29	836.32
MT	85.88	194.47	68.41	837.17	233.84	720.54	1253.86	851.36
ND	85.88	194.47	68.41	837.17	233.84	720.54	1253.86	851.36
NE	90.57	232.39	67.21	822.39	229.72	805.71	1325.29	836.32
NV	92.55	259.29	65.92	806.64	225.31	960.72	1422.21	820.28
OR	90.97	241.43	65.92	806.64	225.31	830.31	1082.60	820.28
SD	85.88	194.47	68.41	837.17	233.84	720.54	1253.86	851.36
UT	85.88	194.47	68.41	837.17	233.84	720.54	1253.86	851.36
WA	90.97	241.43	65.92	806.64	225.31	830.31	1082.60	820.28
WY	85.88	194.47	68.41	837.17	233.84	720.54	1253.86	851.36

The following fees will be effective for claims processed on or after October 1, 2004, for dates of service on or after April 1, 2004.

States	K0632	K0634	K0635	K0636	K0639
AK	IC	43.27	61.25	322.98	127.26
AZ	IC	43.27	61.25	322.98	127.26
CA	IC	43.27	61.25	322.98	127.26
HI	IC	43.27	61.25	322.98	127.26
IA	IC	44.12	62.45	329.29	129.73
ID	IC	43.27	61.25	322.98	127.26
KS	IC	44.12	62.45	329.29	129.73
MO	IC	44.12	62.45	329.29	129.73
MT	IC	44.93	63.56	335.21	132.06
ND	IC	44.93	63.56	335.21	132.06
NE	IC	44.12	62.45	329.29	129.73
NV	IC	43.27	61.25	322.98	127.26
OR	IC	43.27	61.25	322.98	127.26
SD	IC	44.93	63.56	335.21	132.06
UT	IC	44.93	63.56	335.21	132.06
WA	IC	43.27	61.25	322.98	127.26
WY	IC	44.93	63.56	335.21	132.06

HCPCS UPDATES

Reminder - Elimination Of The 90-Day Grace Period For HCPCS Codes

The Health Insurance Portability and Accountability Act (HIPPA) Transaction and Code Set Rules requires suppliers to use the medical code set (HCPCS codes) that is valid at the time the service is rendered. Therefore, effective January 1, 2005 discontinued HCPCS codes will no longer have a 90-day grace period and will be returned as unprocessable or denied as incorrect coding.

Clarification To CR 3069 – New "K" Codes For Wheelchair Cushions

Medlearn Matters Article Number: MM3289

Provider Types Affected - Durable medical equipment (DME) suppliers and Home Health Agencies

Provider Action Needed

Impact to You - Medicare may not reimburse you correctly for ordering or supplying wheelchair cushions for your Medicare patients if you don't use the correct codes on your claim.

What You Need to Know - As previously published in CR 3069, The Centers for Medicare & Medicaid Services (CMS) has established twenty new "K" codes for wheelchair cushions. Further, these new codes will be replacing 11 "E" codes and 3 "K" codes that CMS is discontinuing on July 1, 2004. You will be granted a 90-day grace period (from July 1, 2004 to September 30, 2004) to begin using the correct codes.

What You Need to Do - Make sure that your billing staffs are aware of these new and discontinued codes for wheelchair cushions you provide on or after July 1, 2004.

Background - This Change Request updates a previous one (CR 3069) that addressed codes for ordering or supplying wheelchair cushions. CMS has established twenty new "K" codes for wheelchair cushions.

Effective July 1, 2004, the codes shown in Table 1 will be added to the system.

Code #	Description	Short Descriptor
K0650	General use wheelchair seat cushion, width less than 22 inches, any depth	Gen w/c cushion width < 22"
K0651	General use wheelchair seat cushion, width 22 inches or greater, any depth	Gen w/c cushion width > 22"
K0652	Skin protection wheelchair seat cushion, width less than 22 inches, any depth	Skin protect w/c cush width < 22"
K0653	Skin protection wheelchair seat cushion, width 22 inches or greater, any depth	Skin protect w/c cush width > 22"
K0654	Positioning wheelchair seat cushion, width less than 22 inches, any depth	Position w/c cush width < 22"
K0655	Positioning wheelchair seat cushion, width 22 inches or greater, any depth	Position w/c cush width > 22"
K0656	Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth	Skin protect w/c cush width < 22"
K0657	Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth	Skin protect w/c cush width > 22"
K0658	Custom fabricated wheelchair seat cushion any size	Custom fabricated w/c cushion
K0659	Wheelchair seat cushion powered	Powered w/c cushion
K0660	General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware	Gen use back cushion width < 22"

Code #	Description	Short Descriptor
K0661	General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware	Gen use back cushion width > 22”
K0662	Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware	Position back cushion width < 22”
K0663	Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware	Position back cushion width > 22”
K0664	Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware	Position back post/lat width < 22”
K0665	Positioning wheelchair back cushion, posterior-lateral width 22 inches or greater, any height, including any type mounting hardware	Position back post/lat width > 22”
K0666	Custom fabricated wheelchair back cushion, any size, including any type mounting hardware	Custom fab w/c back cushion
K0667	Mounting hardware, any type, for seat cushion or seat support base attached to a manual wheelchair or lightweight power wheelchair, per cushion/base	Mount hardware man or light power w/c
K0668	Replacement cover for wheelchair seat cushion or back cushion, each	Replacement cover w/c seat cush
K0669	Wheelchair seat or back cushion, no written coding verification from SADMERC	W/c seat/back no CVR SADMERC

Table 1: New “K” Codes for Wheelchair Cushions

Additionally, Codes E0176, E0177, E0178, E0179, E0192, E0962, E0963, E0964, E0965, E1012, E1013, K0023, K0024 and K0114 are being eliminated and will be invalid for submission to Medicare on or after July 1, 2004.

You will be granted a 90-day grace period (from July 1, 2004 to September 30, 2004) to begin using the correct codes.

Additional Information - You can read this Change Request on the CMS Website at this address: http://www.cms.hhs.gov/manuals/transmittals/comm_ date_dsc.asp. Once at that site, look for CR3289 in the right hand column, CR NUM, and click on the files for that CR.

APPEALS

MMA - Implementation Of New Medicare Redetermination Notice

Medlearn Matters Article Number: MM2620

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

Provider Action Needed

Impact to You - The first level of appeal for fee-for-service has a new name. Starting in October, first level appeals will be called “Redeterminations.” You and your patients will receive a formal decision notification letter—the Medicare Redetermination Notice (MRN)—for any decision made on a request for redetermination made on or

after October 1, 2004.

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

What You Need to Do - The newly initiated Redetermination Appeals Process provides information in a more concise and understandable manner and has been well received by Medicare beneficiaries and providers in consumer testing. The Appeals Process provides for timely notification of beneficiaries and providers via the (MRN). Be sure to understand how these new procedures affect your appeal rights.

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

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

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

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

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

ELECTRONIC DATA INTERCHANGE (EDI)

Reporting Medicare Secondary Payer Information On The Health Insurance Portability And Accountability Act Of 1996 X12N 837, Created Via The Free Billing Software

Medlearn Matters Article Number: MM3284

Provider Types Affected - All providers who use free billing software from Medicare for HIPAA 837.

Provider Action Needed

Impact to You - All providers who use free (or low cost) billing software from Medicare for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 837 must receive a software upgrade related to Medicare Secondary Payer (MSP) from their carrier, durable medi-

cal equipment regional carrier, or intermediary. Changes included in the updated software will be required for electronic submission of such claims (when there is one primary payer to Medicare). ***Note that the HIPAA 837 does not accommodate the data Medicare needs when there is more than one primary payer. Providers must submit these types of MSP claims to Medicare on paper.***

What You Need to Know - Please be sure to submit claims in the correct format to avoid delays in claims processing.

What You Need to Do - If you use the billing software supplied by a Medicare carrier or intermediary, please obtain the required software upgrade after October 4, 2004 from your carrier/intermediary to ensure accurate electronic claims processing.

Additional Information - If you have questions regarding this issue, contact your carrier or intermediary on their toll-free number. If you bill for Medicare Part A services, including outpatient hospital services, the toll free number for your carrier/intermediary may be found online at: http://www.cms.hhs.gov/providers/edi/anum.asp

If you bill for Medicare Part B services, the toll-free number may be found at: http://www.cms.hhs.gov/providers/bnum.asp

The official instruction issued to the carrier/intermediary regarding this change can be found online, referenced via CR NUM 3284, at: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that page, scroll down the CR NUM column on the right to find CR3284 and click on the file for that CR.

Stratus Report Retention

Currently Stratus displays your uploaded and downloaded reports for seven days (including weekends and holidays), unless a download was attempted. If a download was attempted, the file will remain in your Stratus Network mailbox for only **TWO** days after the attempt. The time frame has changed for downloaded files only. Once you have downloaded your report(s) and the file has a .cp extension, it will only remain available to be downloaded for two more days.

CIGNA Medicare stores copies of your files for 30 days. If you need a file to be put back into your Stratus Network mailbox, please contact the EDI Department at 1.866.224.3094, option 1.

.cp - You will see this mask after the file has been successfully uploaded or downloaded. We recommend you search for the file on your computer before downloading files again.

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

Medlearn Matters Article Number: MM3361

Provider Types Affected - All providers

Provider Action Needed

Impact to You - The Health Insurance Portability and Accountability Act (HIPAA) requires all payers to use the applicable health care claims status category codes and health care claim status codes.

What You Need to Know - Medicare carriers and intermediaries must periodically update their claims system with the most current health care claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277.

What You Need to Do - Providers will need to be aware of the new codes that may appear on their response to a claims status inquiry.

Background - Medicare carriers and intermediaries must periodically update their claims system with the most current health care claims status category codes and health care claim status codes for use with the Health Care Claim Status Request and Response ASC X12N 276/277. Under HIPAA, all payers must use health care claims status category codes and health care claim status codes approved by the Health Care Code Maintenance Committee.

At each X12 trimester meeting (generally held in the months of February, June and October) the Committee may update the claims status category codes and health care claim status codes. Included in the code list are specific details, such as the date a code was added, changed, or deleted.

Per HIPAA (1996), health plans must be able to conduct the standard electronic transactions mentioned in the regulation. The named HIPAA transaction for claims status is the ASC X12N 276/277 4010A1 Health Care Claim Status Request and Response. The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes.

Medicare contractors are already using these code sets because of prior instructions. However, recently some new codes and code changes were made with the designation "new as of 2/04." Medicare carriers and intermediaries will start using the "new as of 2/04" codes as of January 3, 2005.

Additional Information - Claims Status codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-2, STC10-2 and STC11-2 composite elements. They indicate the detail about the general status communicated in the Claims Status Category Codes carried in STC01-1, STC10-1 and STC11-1. Claims status codes communicate information about the status of a claim, i.e., whether it's been received, pended, or paid. For users who are new to the Claim Status transaction, please review the 276/277 Implementation Guide for using claim status codes. The Claim Status transaction is not used as a financial transaction.

Claim Status Category codes are used in the Health Care Claim Status Notification (277) transaction in the STC01-1, STC10-1 and STC11-1 composite elements. They indicate the general category of the status (accepted, rejected, additional information requested, etc.), which is then further detailed in the Claim Status Codes carried in STC01-2, STC10-2 and STC11-2. The code sets for use with the 276/277 are the Health Care Claims Status Category Codes and Health Care Claim Status Codes found at: http://www.wpc-edi.com/codes/codes.asp

By January 3, 2005, Medicare carriers and intermediaries must have all applicable code changes and new codes that are posted on the web site with the "new as of 2/04" designation and prior dates available for use in production. The official instruction issued to your carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR 3361 in the CR NUM column on the right, and click on the file for that CR.

HIPAA

Additional Health Insurance Health Insurance Portability And Accountability Act (HIPAA) Coordination Of Benefits (COB) Information For Trading Partners

Professional Coordination of Benefits (COB) Companion Document

Issue	CMS COB Information
Capitalized data	The CMS will format COB data in upper case.
Gap Fill Data	The CMS uses gap fill data that complies with the IG syntax requirements with the understanding that the data may not appear valid. An inbound claim could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum and maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound X12N 837 COB transaction. The "gap fill" data meets the data element minimum length requirement of an outbound X12N 837 COB transaction if insufficient data are available for entry in a required data element. The selected values will not include any special characters, low values, high values, or "all spaces" and will be useable with every type of data where this situation could occur (decimal (R), identifier (ID), date (DT), etc.) except for alphanumeric (string) or numeric (Nn). The CMS will use Xs to gap fill alphanumeric data and 9s to gap fill numeric data. When inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the CMS will gap fill the phone number data element with "8009999999". The CMS shall not gap fill data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source.

Professional Coordination of Benefits (COB) Companion Document (cont'd)

Issue	CMS COB Information
Admission Date	Admission Date - The admission date is required for all inpatient medical visits. Non-HIPAA claims do not capture this date. For COB purposes, the admission date will be gap-filled with the earliest date of service in loop 2400 when the inbound claim is non-HIPAA.
Accident Date	The accident date is required when the related causes code (CLM11) is equal to "AA" (auto accident), "AB" (abuse), "AP" (another party responsible)" or "OA" (other accident). Non-HIPAA claims do not capture this date. For COB purposes, the accident date will be gap-filled with the earliest date of service in loop 2400 when the inbound claim is non-HIPAA.
Ambulance Certification	Ambulance claims require ambulance certification data elements. Non-HIPAA claims do not have ambulance certification information. For COB purposes, these elements will be gap-filled with the following values when the inbound claim is non-HIPAA: CR103 = I, CR104 = A, CR105 = DH, CR106 = 1, CRC01 = 07, CRC02 = Y, CRC03 = 09
Medical Code Set Grace Period	The CMS will continue to allow a 90-day grace period for medical code sets for a limited time. The 90-day grace period for ICD9 will end for: - inpatient claims with a discharge date on or after October 1, 2004. - outpatient claims with date of service on or after October 1, 2004. The 90-day grace period for the HCPCS code set will end for claims with dates of service on or after January 1, 2005.
Should Verses Must Issues	In most instances the CMS interprets the IG 'required when' language to not mean 'reject if submitted when not required'. The CMS interprets the IG to mean the data is allowed even if not required.
Home Health Treatment Plan Certification (CR7)	Home Health Plan of Treatment (CR7) does not pertain to Medicare Part B. COB transactions being built from non-HIPAA claims will not contain the CR7 segment because the Medicare carrier does not have the information to populate the CR7 segment.
X12N 997 Acknowledgement	The CMS will not process an incoming X12 997. The CMS contractor may create and use its own proprietary report(s) for feedback purposes.
Destination Payer verses Other Payer	COB transactions are to contain the payer receiving the claim (the destination payer) in loops 2000B and 2010BB. If the "destination" payer is the same as the "other" payer, the CMS will not populate the 2320 loop. However, there may be instances where the formatting of the payer name is different, even if both payers are actually the same. In these instances the 2320 loop may be created. This issue will be corrected with the implementation of the National PlanID.
TaxID/SSN	When non-HIPAA inbound claims do not contain a required TaxID or SSN, and the CMS does not have a number on file, the CMS will populate the NM109 (Identification Code) with syntactically compliant (all 9s if NM108 = '24' and '199999999' if NM108 = '34') data to be sent on COB claims.
Provider Address Information	The CMS will populate the outbound COB files with the provider's first name, last name, middle initial, address, city, state and zip code that is present on CMS's provider files.
ICD9 Diagnosis Codes	COB transactions may contain invalid diagnosis codes until October 1, 2004. **NOTE:** There may be claims pending in the system with invalid diagnosis codes which were submitted prior to the new diagnosis edit. If those claims are flagged to cross over, they may contain invalid diagnosis codes after 10/1/2004.

National Council for Prescription Drug Program (NCPDP) Coordination of Benefits (COB) Companion Document

Issue	CMS COB Information
Capitalized data	The CMS will format COB data in upper case.
Gap Fill Data	The CMS uses gap fill data that complies with the IG syntax requirements with the understanding that the data may not appear valid. An inbound claim could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum and maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound NCPDP transaction. The "gap fill" data meets the data element minimum length requirement of an outbound NCPDP transaction if insufficient data are available for entry in a required data element. The selected values will not include any special characters, low values, high values, or "all spaces" and will be useable with every type of data where this situation could occur (decimal (R), identifier (ID), date (DT), etc.) except for alphanumeric (string) or numeric (Nn). The CMS will use "UNKNOWN" to gap fill alphanumeric data and zeros to gap fill numeric data to meet minimum length requirements. The CMS shall not gap fill data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source.
Medical Code Set Grace Period	The CMS will continue to allow a 90-day grace period for medical code sets for a limited time. The 90-day grace period for ICD9 will end for: - inpatient claims with a discharge date on or after October 1, 2004. - outpatient claims with date of service on or after October 1, 2004. The 90-day grace period for the HCPCS code set will end for claims with dates of service on or after January 1, 2005.
Medicaid	The following field must be submitted in order to allow Medicare to determine that a beneficiary has claim based Medicaid coverage and to specify where the coverage is: - The Group Id (301-C1) on the Insurance segment is not blank. - The two position state alpha code followed by the word "MEDICAID" must be submitted in the Group Id (301- C1) in the Insurance segment. **EXAMPLE: "XXMEDICAID"** such as NYMEDICAID or FLMEDICAID
Medigap	The following fields must be submitted in order to allow Medicare to determine that a beneficiary has Medigap coverage: - The Group Id (301-C1) on the insurance segment is not blank. - For Coordination of Benefits (COB) related to Medigap, the Patients Medigap Plan Id Number will be submitted in the Alternate Id (330-CW) in the Claim segment. - The Medigap Insurer Id (OCNA number) will be submitted in the Group Id (301-C1) in the Insurance segment. **NOTE:** Medigap takes priority when there is dual Medigap and Medicaid in a claim based situation.

National Council for Prescription Drug Program (NCPDP) Coordination of Benefits (COB) Companion Document (cont'd)

Issue	CMS COB Information
Other Payer Amount Paid qualifier field	The NCPDP has approved the following use of qualifiers for reporting Medicare COB amounts: "07" = Medicare Allowed Amount "08" = Medicare Paid Amount "99" = Deductible Amount "99" = Coinsurance Amount "99" = Co-Payment Amount NOTE: **The first occurrence of "99" will indicate the Deductible Amount.** The second occurrence of "99" will indicate the Coinsurance Amount. The third occurrence "99" will indicate the Co-Payment Amount.
NCPDP Data	CMS will send out on NCPDP COB, all data that is received on the inbound NCPDP claim regardless as whether Medicare needs the data to process the claim. Any extraneous non-Medicare data will be edited for syntax, but not data content.
Narrative Segment	The NCPDP standard contains a 500-position field in the Prior Authorization Segment that supports one occurrence of narrative information. Medicare COB may contain the following: - Certificate of Medical Necessity (CMN) or DMERC Information Form (DIF) - Narrative Supporting Documentation - Facility Name and Address - Modifiers for compound drugs Values for the narrative field that is being used to submit any of the information are as follows. CMN - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information. CNA - Indicates that the supporting documentation that follows is Medicare required CMN or DIF and narrative information. CFA - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information and Facility Name and Address. CNF - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Facility Name and Address. FAC - Indicates that the supporting documentation that follows is Medicare required Facility Name and address. FAN - Indicates that the supporting documentation that follows is Medicare required Facility Name and Address and narrative information. NAR - Indicates that the supporting documentation that follows is Medicare required Narrative Information. MMN - Indicates that the supporting documentation that follows is Medicare modifier information and CMN or DIF information. MNA - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and narrative information. MFA - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and Facility Name and Address. MNF - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and Facility Name and Address. MAC - Indicates that the supporting documentation that follows is Medicare modifier information and Facility Name and Address. MAN - Indicates that the supporting documentation that follows is Medicare modifier information, narrative information and Facility Name and Address. MAR - Indicates that the supporting documentation that follows is Medicare modifier information and narrative information. MOD - Indicates that the supporting documentation that follows is Medicare modifier information.

MISCELLANEOUS

CMS Creates Additional Supplier - Specific Web Pages

[The following article is being republished because the "NEW Provider Web Tools" were previously inadvertently omitted from the article in the July 2004 (Summer) *DMERC Dialogue*.]

The Provider Communications Group within the Center for Medicare Management has created additional provider and supplier-specific Web pages, and also has new Web page addresses and provider Web tools on the Centers for Medicare & Medicaid Services' (CMS) Web site (http://www.cms.hhs.gov/). CMS wants to ensure providers and health care practitioners have quick access to accurate Medicare program information. In keeping with this goal, the supplier-specific Web page listed below is a one-stop resource focused on the informational needs and interests of Medicare providers, including physicians and other practitioners.

The supplier-specific Web page can be accessed from http://www.cms.hhs.gov/suppliers.

Specialized information on these one-stop resource pages includes links to Federal Regulations and Notices, Transmittals/ Change Requests, and Frequently Asked Questions. General information includes links for Coverage, Coding, Program Integrity/ Medical Review and a wealth of other subjects that would be of interest to all audiences. Each page also has a *Highlights* section to emphasize important and timely information such as pertinent regulations, instructions, or conferences. Providers, physicians, and suppliers can now go to http://www.cms.hhs.gov/mailinglists to subscribe to ListServ for various Medicare audiences or categories.

NEW Provider/ Supplier Web Pages include:

http://www.cms.hhs.gov/providers/emtala - **Emergency Medical Treatment & Labor Act (EMTALA) —** Content includes Policy, Regulations, Manuals, Frequently Asked Questions and more.

http://www.cms.hhs.gov/providers/esrd.asp - **End-Stage Renal Disease (ESRD) Information Resource —** Content includes Regulations, Coverage, Billing, Demonstrations, CROWN, Forms, Network Organizations, Public Use Files, Publications, Dialysis Facility Compare, and more.

http://www.cms.hhs.gov/providers/pair - **Practice Administration Information Resource for Medicare —** Content includes up-to-date information and tools as they relate to Administrators, Coders, Billing Personnel, and others outside the traditional provider role.

http://www.cms.hhs.gov/suppliers/asc - **Ambulatory Surgical Centers (ASC) —** Content includes information on Enrollment/ Participation, Payment Rates, Regulations, and more.

http://www.cms.hhs.gov/providers/fqhc - **Federally Qualified Health Centers (FQHC) —** Content includes Regulations, HIPAA, Enrollment, Frequently Asked Questions, Forms, Manuals, Publications and more.

http://www.cms.hhs.gov/suppliers/dmepos - **Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) —** Content includes Billing Instructions, Coding, Payment, Medical Review information and more.

http://www.cms.hhs.gov/providers/hha - **Home Health Agencies (HHA) —** Content includes Regulations, Coding, Billing, Outcome and Assessment Information Set (OASIS) and Outcome-Based Quality Improvement (OBQI), and more.

http://www.cms.hhs.gov/providers/hospiceps - **Hospice —** Content includes Certification, Educational Articles, Frequently Asked Questions, Research and Statistics information and more.

http://www.cms.hhs.gov/providers/ipfpps - **Inpatient Psychiatric Facilities (IPF) Prospective Payment System (PPS) —** Content includes useful information related to the development of a PPS for Medicare inpatient psychiatric services, including Background and Coding information, the proposed Regulation and Assessment Tool and more.

http://www.cms.hhs.gov/suppliers/mammography - **Mammography Services –** Content includes Coding, Policies/ Regulations, helpful Resources and more.

http://www.cms.hhs.gov/providers/rh - **Rural Health Clinics —** Content includes Regulations, Enrollment, Coverage, Publications, Forms, Manuals, and more.

http://www.cms.hhs.gov/providers/snfpps - **Skilled Nursing Facilities (SNF) PPS —** Content includes Regulations, Publications, Rates and Indices, MDS, Swing Bed, Frequently Asked Questions and more.

NEW Provider Web Tools include:

http://www.cms.hhs.gov/physicians/mpfsapp - **Medicare Physician Fee Schedule Lookup —** View physician service information, geographic practice cost indices and payment policy.

NCCI Edits for Physicians: http://www.cms.hhs.gov/physicians/cciedits; NCCI Edits for Hospital Outpatient Departments: http://www.cms.hhs.gov/providers/hopps/cciedits - **National Correct Coding Initiative (NCCI) Edits —** The NCCI promotes uniformity among the contractors that process Medicare claims in interpreting Medicare payment policies. The edits are pairs of services that normally should not be billed by the same provider for the same patient on the same day.

http://www.cms.hhs.gov/medlearn/matters - **Medlearn Matters…Information for Medicare Providers —** This page includes links to educational articles and related Change Requests, in order to present consistent information to providers.

Additional pages are currently under development for anesthesiologists, surgeons and the Indian Health Service.

CMS Quarterly Provider Update

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 ListServ (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.

Correction Of Minor Errors And Omissions Without Appeals

Medlearn Matters Article Number: SE0420

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

Provider Action Needed - Understand the Medicare rules that enable you to correct minor errors and omissions on Medicare claims without having to go through the appeals process. This article will provide information needed to make such minor corrections to Medicare claims within existing procedures.

Background - Section 937 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Public Law 108-73, requires the Secretary of the Department of Health and Human Services to establish a process for physicians, providers, and suppliers to correct minor errors and omissions in claims without pursuing the formal appeals process. The Centers for Medicare & Medicaid Services (CMS) currently provides the following ways to make such corrections:

1. Correcting Incomplete or Invalid Claims Submissions

Medicare instructions currently provide an opportunity for physicians, suppliers, and providers to correct errors or omissions in a submitted claim without the need to initiate a formal appeal, such as a review or, reconsideration. These processes are outlined in the *Medicare Claims Processing Manual, Pub. 100-4,Chapter 1 - General Billing Requirements, section 80.3.2 - Handling Incomplete or Invalid Claims* and *Section 70.2.3.1 - Incomplete or Invalid Submissions*.

The instructions provide the rationale for determining whether a claim (Forms CMS-1450, CMS-1500 or their electronic equivalent) is considered complete for processing purposes and outlines the actions to be taken by contractors upon receipt of incomplete or invalid claim submissions.

Basically, the instructions identify incomplete claims as ones submitted with required information missing, such as the provider's name. Invalid submissions also

are claims that contain complete and required information, but the information is illogical or incorrect (e.g., incorrect HIC# or invalid procedure code) or the information does not conform to required claim formats.

The following definitions may be applied to determine whether data on submitted claims are incomplete or invalid:

• **Required** – Any data element that is needed in order to process the submission, such as provider name.

• **Not Required** – Any data element that is optional or is not needed to process the submission, such as the patient's marital status.

• **Conditional** – Any data element that must be completed if other conditions exist (e.g., if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim). If these conditions exist, the data element becomes required.

Based on these instructions, if a claim is submitted with missing or incorrect information for certain specified items, it is considered to be unprocessable and is to be "returned" to the provider. Returning a claim as unprocessable does not mean that every claim is physically returned to the provider. The terms "return as unprocessable" or "return to provider" refer to the many processes utilized for notifying the provider or supplier of service that their claim cannot be processed, and that it must be corrected or resubmitted.

Different contractors use various techniques for returning claims as unprocessable. Following are just two examples:

• If incomplete or invalid information is detected at the front-end of claims processing, the claim may be returned to the provider identifying the error(s) and explaining how to correct the errors prior to resubmission.

• If incomplete or invalid information is detected at the front-end of the claims processing system, the claim may be suspended and developed; requested corrections and/or medical documentation must be submitted within a 45-day period. After the requested information is received, the claim is processed. Otherwise, the suspended portion is returned and the supplier or provider of service is notified by means of the remittance advice.

Under these instructions, carriers and fiscal intermediaries (FIs) typically either suspend claims with defective data for development and correction by the provider or send the claim back to the provider, noting the missing or incorrect items, for correction and resubmission. Claims submissions that are returned to the provider are not considered claims under Medicare regulations. Therefore, neither of these processes allows for the initiation of an appeal.

For more details on these sections, you may view Chapter 1, Sections 70.2.3.1 and 80.3.2, of the *Medicare Claims Processing Manual,* Pub. 100-04, at: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Once at that site, scroll down to Chapter 1 and click on the file type you wish to download.

2. Correcting Mistakes in Previously-Processed Claims

Another process a provider can use is the Adjustment Request Process. Adjustment requests are the most common mechanism for FIs to change a previously accepted bill. The Adjustment Payment Process is outlined in the *Medicare Claims Processing Manual,* Pub. 100-4, Chapter 3 - Inpatient Hospital Billing,section 50, Adjustment Bills. **Adjustments are required when bills have been accepted and posted in error to a particular record.**

You may also view this section of the manual to obtain further details on adjustments by going to: http://www.cms.hhs.gov/manuals/104_claims/clm104index.asp

Once at that page, scroll down to Chapter 3 and click on the type of file you wish to download.

3. Reopening Claims

A third process that providers can use is the Reopening Process. Section 1869(b) (1) (G) of the Act provides for the reopening and revision of any initial determination according to guidelines prescribed by the Secretary. The *Medicare Claims Processing Manual,* Pub. 100-4, Chapter 29 - Appeals of Claims Decisions, section 60.27 - Reopening and Revision of Claims Determinations and Decisions, distinguishes the reopening process from the appeals process.

The purpose for a reopening should be to change the determinations or decisions that result in either overpayments or underpayments. Reopenings have been misconstrued as a level of the appeals process. A reopening is not an appeal right; it is a discretionary action as defined under 42 CFR 405.841.

Requests for adjustments to claims resulting from clerical errors must be handled through the reopening process. The request must be made within one year from

the date of the notice of the initial determination. A provider has a four-year timeframe to initiate a reopening after the date of the initial determination if good cause exists.

4. Correcting HIPAA Compliance Issues

The fourth process relates to CMS's existing process for evaluating a claim's HIPAA compliance. This process can be found in the *Medicare Claims Processing Manual,* Pub. 100-4, Chapter 24 - EDI Support Requirements, sections 30.6 - Translators; 70.1 - FI Requirements; and 70.2 - Carrier/DMERC Requirements.

Currently, Medicare contractor translators validate the syntax compliance of the X12N 837 standard. The entire file will be rejected when the file is syntactically incorrect. The contractor will send to the provider the X12N 997 Functional Acknowledgment to report the syntax errors. If the file is syntactically correct, HIPAAimplementation guide-compliance validation of the X12N 837 is performed. Compliance validation edits check for required loops and segments, appropriate segments within a loop, valid calendar dates, qualifiers, and so on. Individual claims are rejected to the provider when they contain errors. The errors are then reported on contractor specific error reports.

To view the manual sections on reopening information or for the HIPAA information, use the same Web address as provided above and scroll to Chapters 29 and 24, respectively. Once at each chapter, select the version of the file you wish to review.

Additional Information - If you encounter problems or have any questions, please contact your carrier or FI on their toll-free number. If you do not have that number, you may find it at: http://www.cms.hhs.gov/medlearn/tollnums.asp

Correcting Minor Errors Through The Adjustment Process

Claim adjustment is a process the supplier should utilize to correct minor errors (e.g. clerical errors, omissions, etc) on a previously processed claim without pursuing the formal appeals process. A claim adjustment is not an appeal right; it is a discretionary action by the contractor whether or not to reopen a claim for correction. The request for adjustment must be made within one year from the date of the notice of the initial determination. A Written Adjustment Request Form has been created to ensure your request is handled properly. (See Appendix A-1)

Electronic Funds Transfers (EFT) - Three Most Common Errors

The latest Authorization Agreement for Electronic Funds Transfer (EFT) [Form CMS-588 (09/03)] was introduced in the *DMERC Dialogue*, General Release 04-1, Winter 2004 (January). It has been six months since the enforcement of the required use of the new form. Most suppliers have done well in completing the new two page form, but some suppliers are experiencing delays in the process due to common errors. The purpose of this article is to assist the supplier community to avoid these errors and, in turn, alleviate the most common delays associated with EFT setup.

Error # 1 - Use of the incorrect Authorization Agreement Version

Some suppliers are still trying to use previously published versions of the EFT agreement. Be sure the Authorization Agreement being completed is Form CMS-588 with a revision date of September 2003 (09/03) found at www.cignamedicare.com/eft and www.cms.hhs.gov/forms/. The cutoff for older versions was January 1, 2004. Previous versions are unacceptable and will be returned to the supplier.

Error # 2 - Authorization Statement Completed Incorrectly

On the first page of the new authorization agreement (toward the bottom) under the heading "Authorization" is a statement with a blank that must be completed by the supplier. This blank should be completed with the name of the Medicare contractor or carrier. Following are acceptable names for Region D: Region D DMERC, DMERC Region D, CIGNA Medicare, or CIGNA Region D DMERC. Do not put the name of the supplier, supplier's owner, or Centers for Medicare & Medicaid Services (CMS) in this blank. These responses will cause the form to be returned to the supplier for additional information or correction.

Error #3 - Incorrect Verification Documentation for Routing/Account Numbers

The supporting documentation for banking information MUST come in one of the following forms:

- Voided Check with pre-printed information on it (company, name, address, etc.)
- Pre-printed deposit slip
  -OR-
- Confirmation letter of account information on bank letterhead - dated within the last year.

Copies of checks or deposit slips are not acceptable. Magnetic Ink Character Recognition (MICR) Check Printing Specification sheets are not acceptable.

To avoid delays in setup of an EFT authorization agreement, read and follow the two page instructions included with the application carefully. Make sure the information on supporting bank documentation matches the information entered on the agreement and verify the routing number with the financial institution. Finally, have the authorization signed by an Authorized/Delegated Official whose name is on file with the National Supplier Clearinghouse.

Long Term Care Hospital Prospective Payment System - Revised Fact Sheets

Revised fact sheets on Long Term Care Hospital Prospective Payment System are now available on the Medicare Learning Network Web site at www.cms.hhs.gov/medlearn/ltchpps.asp. The fact sheets are: 1) Updated Final Rule Fact Sheet; 2) Short-Stay Outliers Fact Sheet; 3) Interrupted-Stay Fact Sheet; and 4) High Cost Outliers Fact Sheet

Rural Health Fact Sheets

Four new rural health Fact Sheets that contain rural health information, definitions, helpful rural health resources, and Medicare Prescription Drug, Improvement and Modernization Act of 2003 enhancements (if applicable) are now available on the Medicare Learning Network Website at www.cms.hhs.gov/medlearn/pubs.asp. The Fact Sheets are entitled: 1) Rural Health Clinic; 2) Sole Community Hospital; 3) Federally Qualified Health Center; and 4) Critical Access Hospital Program

MMA - National 1-800-MEDICARE (1-800-633-4227) Implementation (Section 923(d) Of MMA)

Medlearn Matters Article Number: MM3195

Provider Types Affected - All providers.

Provider Action Needed

Impact to You - Medicare carriers (including DMERCs) and fiscal intermediaries will no longer maintain their own individual **beneficiary** toll-free telephone numbers. Instead, all beneficiary calls should be directed to 1-800-MEDICARE (1-800-633-4227).

What You Need to Know - Effective June 1, 2004, carriers and FIs will begin to transition to **1-800-MEDICARE (1-800-633-4227)** for all beneficiary questions that pertain to Medicare claims and services. The Centers for Medicare & Medicaid Services (CMS) will contact each carrier/FI on an individual basis to provide the specific migration/implementation date for that contractor (phase-in is planned for June - July 2004). As calls come in to the new centralized number, questions regarding specific claims will be routed to the appropriate Medicare carrier/FI for response.

What You Need to Do - Medicare carriers/FIs will publish the new beneficiary toll-free telephone number on Medicare Summary Notices (MSNs), beneficiary correspondence, Medicare Redetermination Notices (formerly, appeals letters) and, if applicable, on Medicare beneficiary websites. On or after August 1, 2004, **when you advise your patients to call Medicare with questions, direct them to 1-800-MEDICARE. However, for calls regarding eligibility status or claims status, and other provider-initiated inquiries, providers should continue to use the existing provider toll-free numbers.**

Background - The change in policy, driven by the Medicare Modernization Act (MMA) of 2003 (section 923 (d)), requires all Medicare carriers/FIs to use one number—**1-800-MEDICARE (1-800-633-4227)**—for all Medicare questions from beneficiaries. By providing a single call-in number, Medicare aims to improve customer telephone service by connecting callers quickly with the correct Medicare contractor for their case and question, thereby reducing the number of calls and referrals overall.

Currently, an internal CMS workgroup is developing standard operating procedures for processes and exceptions to this new policy. All procedures will be communicated to contractors as soon as final decisions are made.

Additional Information - The official instruction issued to your carrier regarding this change may be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp. From that web page, look for CR 3195 in the CR NUM column on the right, and click on the file for that CR number.

Also, remember that 1-800-MEDICARE is for beneficiary-initiated calls. Providers calling Medicare should continue using the numbers currently in use. If you do not have that number, you may find it at: http://www.cms.hhs.gov/tollnums.asp

OIG Alert About Charging Extra For Covered Services

Medlearn Matters Article Number: SE0421

Provider Types Affected - Physicians, suppliers, and providers

Provider Action Needed - Participating physicians, suppliers, and providers who consider charging Medicare patients additional fees should be mindful that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance.

Background - On March 31, 2004, the Office of the Inspector General (OIG) issued an Alert that focused on physicians charging extra for services covered by Medicare. The Alert noted that these extra contractual charges beyond Medicare's deductible and coinsurance constituted a potential assignment violation.

In the Alert, the OIG reminded Medicare participating physicians of the potential liabilities posed by billing Medicare patients for services that are already covered by Medicare. Charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for services already paid for by Medicare.

Medicare participating providers can charge Medicare beneficiaries extra for items and services that are not covered by Medicare. In addition, participating providers may charge beneficiaries for any Medicare deductibles and coinsurance without violating the terms of their assignment agreements.

However, when participating providers request added payment for covered services from Medicare patients, they are liable for substantial penalties and exclusion from Medicare and other Federal health care programs. The special services for added payment are known by various names and may include "concierge care," "boutique medicine," "retainer practice," or "platinum practice."

For example, the OIG recently alleged that a physician violated his assignment agreement when he offered his patients, including Medicare beneficiaries, a "Personal Health Care Medical Care Contract" that required payment of an annual $600 fee. The physician characterized the services to be provided under the contract as "not covered" by Medicare, and the services offered under this contract included:

• Coordination of care with other providers;

• A comprehensive assessment and plan for optimum health; and

• Extra time spent on patient care.

The OIG alleged that based on the specific facts and circumstances of this case, at least some of these contracted services were already covered and reimbursable by Medicare. Therefore, OIG alleged that each contract presented to this physician's Medicare patients constituted a request for payment for already covered services, other than the coinsurance and deductible, and was therefore a violation of the physician's assignment agreement. To resolve these allegations, the physician agreed to pay a settlement amount to the OIG, and to stop offering these contracts to his patients.

Participating physicians, suppliers, and providers who consider charging Medicare patients additional fees are reminded that they are subject to civil money penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance.

Note that a participating provider is a provider of Medicare covered items and services who agrees to accept the Medicare-approved charge for all covered services to Medicare patients. A participating provider "accepts assignment" for all Medicare-payable services.

Also note that non-participating providers may also be subject to penalties and exclusion for overcharging beneficiaries for covered services. This is true whether the provider accepts assignment for a given service or not, in which case the provider's charge is limited to the "limiting charge."

Related Instructions - The Physicians Information Resource for Medicare website is extensive and includes information about Medicare Participation, Participating Physician Directory, Policies and Regulations, including the CMS Quarterly Provider Update, Medicare Coverage Issues Manual, Medicare National Determination Manual, Physician Fee Schedule, Practicing Physician Advisory Council, Medicare Learning Network, and much more. This website can be found at: http://www.cms.hhs.gov/physicians/

Additional Information - The OIG Alert, dated March 31, 2004 and titled "OIG Alerts Physicians About Added Charges for Covered Services," can be found at the following website: http://oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf

Payment To Bank

Medlearn Matters Article Number: MM3079

Provider Types Affected - Providers and suppliers.

Provider Action Needed - Become familiar with the revised policy regarding Medicare payments to be sent to a bank in the name of a provider/supplier.

There is a change in the policy allowing Medicare to send a payment to an individual provider or supplier's bank account for deposit.

If certain conditions are met, payments from Medicare to a provider or supplier may be sent to the provider's bank (or similar financial institution) for deposit into the provider's account. Please refer to the *Background* section for a review of these conditions.

Follow these revised criteria if you want Medicare to deposit payments directly into your bank account.

Background - Medicare payments may be sent to a bank (or similar financial institution) to be deposited into a provider/supplier's account so long as the following requirements are met:

• The bank may provide financing to the provider/supplier as long as the bank states in writing, in the loan agreement, that it waives its right of offset. (This allows the bank to lend money to the provider as well as deposit money from Medicare into the provider/supplier's account.)
• The bank account is in the provider/supplier's name and only the provider/supplier may issue instructions on that account.
• The bank should only be bound by the provider/supplier's instructions.
• No other agreement that a provider/supplier has with a third party can have any influence on the account. In other words, if a bank is under a standing order from the provider/supplier to transfer funds from the provider/supplier's account to the account of a financing entity in the same or another bank and the provider/supplier rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the provider/supplier's agreement with the financing entity.

Irrespective of the language in any agreement a provider/supplier has with a third party that is providing financing, that third party cannot purchase the provider/supplier's Medicare receivables.

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

Procedures For Re-issuance And Stale Dating Of Medicare Checks

Medlearn Matters Article Number: MM2951

Provider Types Affected - Physicians, suppliers, and providers

Provider Action Needed

Impact to You - The Centers for Medicare & Medicaid Services (CMS) is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

What You Need to Know - This instruction updates the Medicare Financial Management Manual (Pub. 100-06) and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding CMS procedures for re-issuance and stale dating of Medicare checks.

What You Need to Do - Be aware of these instructions in the event you have a problem in the future regarding lost, stolen, defaced, mutilated, destroyed, forged, or uncashed checks from your Medicare carrier/intermediary.

Background - This instruction updates the Medicare Financial Management Manual (Pub. 100-06) and incorporates Change Request (CR) 1364 (Transmittal AB-01-122, September 10, 2001) regarding the CMS procedures for re-issuance and stale dating of Medicare checks, which expired in September 2002. Legal authority for the CMS re-issuance and stale dated check policy is contained in Medicare regulations published at 42 CFR 424.352.

Introduction - As part of the CMS effort to improve financial reporting, CMS is clarifying the policy for reissuing, stale dating, and reporting outstanding Medicare checks.

Re-issuing Medicare Checks - In December 1993, CMS issued 42 Code of Federal Regulations (CFR) Subpart M – Replacement and Reclamation of Medicare Payments 424.352: Intermediary and carrier checks that are lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. All Medicare contractors must re-issue checks in accordance with 42 CFR 424.352.

The provisions of this regulation require that a Medicare contractor (fiscal intermediary or carrier) perform certain tasks upon notification by a payee that a check has been lost, stolen, defaced, mutilated, destroyed, or paid on forged endorsements. These tasks are as follows:

A. The Medicare contractor must contact the financial institution on which the check was drawn to determine whether the check has been negotiated.

B. If the check **has** been negotiated:

1. The Medicare contractor will provide the payee with a copy of the check and other pertinent information (such as a claim form, affidavit, or questionnaire to be completed by the payee) required to pursue the claim in accordance with State law and commercial banking regulations.

2. To pursue the claim, the payee must examine the check and certify (by completing the claim form, affidavit, or questionnaire) that the endorsement is not the payee's.

3. The claim form and other pertinent information are sent to the Medicare contractor for review and processing of the claim.

4. The Medicare contractor reviews the payee's claim. If the Medicare contractor determines that the claim appears to be valid, it forwards the claim and a copy of the check to the issuing bank. The Medicare contractor takes further action to recover the proceeds of the check in accordance with State law and regulations.

5. Once the Medicare contractor recovers the proceeds of the initial check, the Medicare contractor issues a replacement check to the payee.

6. If the bank of first deposit refuses to settle on the check for good cause, the payee must pursue the claim on his or her own, and the Medicare contractor will not re-issue the check to the payee.

C. If the check has not been negotiated:

1. The Medicare contractor arranges with the bank to stop payment on the check; and

2. Except as provided in paragraph (D) of 42 CFR 424.352, the Medicare contractor re-issues the check to the payee.

D. No check may be reissued under (C)(2) unless the claim for a replacement check is received by the contractor no later than one year from the date of issuance of the original check, unless State law (including any applicable Federal banking laws or regulations that may affect the relevant State proceeding) provides a longer period, in which case that State law will apply.

Medicare contractors may receive requests for re-issuance of Medicare checks that are older than one year. Based on 42 CFR 424.352 (summarized above), Medicare contractors should inform beneficiaries and providers/ physicians/ suppliers regarding the possibility that State law may provide a more favorable time frame for re-issuance. Requests for re-issuance based on State law should be forwarded by Medicare contractors to their Regional Office. The Regional Office will work with the Regional Office General Counsel to resolve these requests on a case-by-case basis.

Medicare contractors regularly receive requests for re-issuance of Medicare checks that are older than one year. Under 42 CFR 424.352 many of these requests must be denied. However, 42 CFR 424.352 applies **only** to checks that have been lost, stolen, defaced, mutilated, destroyed, or paid on a forged endorsement. Accordingly, Medicare checks that are in the physical possession of the payee, have not been defaced or mutilated, and have not been negotiated are not subject to the one-year time limit for re-issuance required by 42 CFR 424.352 (d). Therefore, if the criteria below are met, such checks may be re-issued by the Medicare contractor even if they are older than one year. The criteria are:

1. The payee (beneficiary, physician, supplier, provider, etc.) and/or authorized representative can present the physical check;

2. The Medicare contractor can confirm that the check was not previously reissued; and

3. Re-issuance is not barred by a Federal and/or State statute of limitations.

Any questions that the Medicare contractors have regarding application of the above criteria should be forwarded to their Regional Office. The Regional Office will work with the Regional Office General Counsel to resolve the questions.

Stale Dating of Checks - Medicare contractors are expected to continuously review all outstanding checks, take the appropriate action to stale date checks in conformance with Federal and/or State/local banking regulations, and adjust financial reporting for these actions. Medicare contractors must advise their financial institution of the change in the status of a check.

Outstanding checks are checks that have been issued as payment for Medicare benefits and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Checks are "voided" by rendering them non-negotiable either physically or by placing a stop payment on them.

Stale dated checks are checks that have reached a specific age from date of issue (e.g., one year from the date of issuance) and have not been presented for payment to a financial institution and subsequently drawn from the Medicare trust funds. Additionally, once a check has been stale dated and is no longer negotiable, the financial institution must be notified in writing.

Undeliverable Checks - Medicare providers, physicians, suppliers, and beneficiaries are responsible for providing their Medicare contractor with their current and accurate mailing address.

The Medicare contractors must comply with the policy established by the "Do Not Forward (DNF) Initiative." This policy requires Medicare contractors to re-issue the check based on the receipt of updated verified address information per Form CMS-855; and if no updated address information has been submitted, then Medicare contractors must void any returned checks. Checks voided due to DNF may be re-issued in accordance with the instructions in the preceding section titled "Re-issuing Medicare Checks."

Implementation - The implementation date for this instruction is August 16, 2004.

Related Instructions - The Medicare Financial Management Manual, Pub. 100-06, Chapter 5 (Financial Reporting/ Section 420-Procedures for Re-issuance and Stale Dating of Medicare Checks) is new. These updated manual instructions will be incorporated into the new Internet-only Office of Financial Management Manual, but are available now as part of the official instruction issued to your carrier/intermediary.

This instruction (CR2951) can be found by going to: http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp.

From that web page, look for CR2951 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.

Reminder To Providers To Supply Information To Medicare's Comprehensive Error Rate Testing (CERT) Program

Medlearn Matters Article Number: M2976

Provider Types Affected - All Medicare providers.

Provider Action Needed - Providers are reminded that they must comply with requests from Medicare contractors for medical records needed for the CERT program.

Background - The CERT program produces national, contractor-specific, and service-specific paid claim error rates, as well as a provider compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The provider compliance error rate is a measure of the extent to which providers are submitting claims correctly. The program uses independent reviewers to review representative random samples of Medicare claims (including both paid claims and denied claims) to ensure that the decision was appropriate.

The CERT process begins at the Affiliated Contractor (AC) — your Medicare carrier or intermediary processing site — where claims have entered the Medicare claims processing system. The CERT contractor randomly selects and extracts claims from the claims processing system each day. The CERT contractor obtains medical records from providers (or from the AC, if the AC had previously subjected the claim to manually medical review).

The CERT contractor requests medical records from providers in a written format, including a checklist of the types of documentation required. In addition, the CERT contractor follows up on written requests with phone calls to providers. Providers must submit documentation to the CERT Operations Center via fax or by mail at the number/address specified in the *Additional Information* section below.

Although providers are required to send documentation to support claims as part of the CERT process, many providers do not comply with this requirement. Providers may believe that it is a HIPAA violation to send patient records to CERT, they may not understand the CERT process, or they may not understand the importance of sending documentation in a timely fashion. It is, however, important to respond in a timely fashion to CERT requests and to provide the CERT contractor with

all applicable medical records used to support a sampled claim.

If providers do not respond to initial CERT requests for medial records, they will receive up to four letters and three phone calls from the CERT contractor. Providers who fail to submit medical documentation to the CERT contractor should expect to receive overpayment demand letters from their AC, as services for which there is no documentation are interpreted as services not rendered.

Additional Information - The fax numbers for the CERT contractor are: 804-864-3268; 804-864-9940; and 804-864-9979. You can also mail documentation to: AdvanceMed, CERT Operations Center, 1530 E. Parham Road, Richmond, VA 23228. If you have questions regarding this process, please contact your carrier or intermediary at their toll-free number, which may be found at: http://www.cms.hhs.gov/medlearn/tollnums.asp

To learn more about the CERT program, you can view the manual instructions issued to your carrier/intermediary under CR 2976 by visiting: http://www.cms.hhs.gov/manuals/pm_trans/R67PI.pdf

Recently, CMS issued additional clarifications (CR3229) to your carrier/intermediary. To view these clarifications, visit: http://www.cms.hhs.gov/manuals/pm_trans/R77PI.pdf

To find future CERT manual instructions issued to your carrier/intermediary, visit: http://www.cms.hhs.gov/manuals/108_pim/pim83c12.pdf

Use Of Group Health Plan Payment System For Demonstrations Serving Medicare Fee-For-Service Beneficiaries

Medlearn Matters Article Number: MM3283

Provider Types Affected - All Medicare providers.

Provider Action Needed - No action needed.

Background - The Centers for Medicare & Medicaid Services (CMS) is conducting several large coordinated care and disease management demonstrations under which private organizations will contract with CMS to provide disease management services to beneficiaries enrolled in the traditional Medicare Fee-For-Service program. In a previous Medlearn Matters article published on 5/13/2004 (SE0425), a summary of the Medicare Disease Management Demonstration was provided with an instruction to treat participants in the demonstration as traditional fee-for-service beneficiaries.

The Medicare beneficiaries participating in these demonstrations are NOT enrolled in an HMO. The Disease Management Organizations are being paid using the CMS Group Health Plan System as an "Option 1" cost plan. All fee-for-service claims will continue to be able to be processed under traditional Medicare payment rules and beneficiaries enrolled in these demonstrations will be considered covered under the traditional Medicare Fee-For-Service program.

Beneficiaries will only receive coordinated care/disease management services from these special demonstration plans. They are not restricted in any way as to how they receive their other Medicare services.

In order to avoid confusion about a beneficiary's access to services when providers or others check beneficiary eligibility on certain standard system screens, the related CR 3283 directs CWF to suppress any reference to HMO information on certain screens for beneficiaries enrolled in these demonstrations.

Welcome New DMEPOS Suppliers!

If you have received a Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier authorization number from the National Supplier Clearinghouse (NSC), you are on our list to receive important information that will assist you in preparing and submitting DMEPOS claims, and in understanding the Medicare payment and appeals processes and many other Medicare rules and regulations.

Within 3-4 weeks after a supplier number is issued, we will mail the most current Region D DMERC publications CD-ROM to the mailing address for each new supplier number. The CD-ROM includes the following information:

- DMERC Region D Supplier Manual
- *DMERC Dialogue* Newsletter & previous issues
- Fee Schedules
- Forms
- Supplier Resources for Claim Submission - Questions and Answers
- Electronic Data Interchange information
- Health Insurance Portability & Accountability (HIPAA) information

DMERC Region D publications and all other information included on the publications CD-ROM may be downloaded from http://www.cignamedicare.com/dmerc/.

If you are unable to utilize the CD-ROM or you prefer paper, you may receive one hardcopy *DMERC Region D Supplier Manual* at no cost by submitting a written request to:

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

After you have received your new supplier CD-ROM, you may decide to choose an alternative publication distribution method. Region D publications are issued quarterly, at no cost, to all suppliers with valid supplier numbers who have submitted claims in the previous twelve months.

Publications are issued on CD-ROM unless the supplier chooses to opt out. Only the hardcopy *DMERC Dialogue* newsletter is mailed to suppliers that opt out.

Suppliers with multiple sites and multiple supplier numbers may eliminate publication distribution to some or all of their sites by opting to have one CD-ROM mailed to their corporate address.

Suppliers may opt out of the CD-ROM distribution or eliminate multiple supplier numbers by completing the "DMERC Region D Publications Designation Form," or by submitting a written request that includes the information on the form. Requests may be faxed or mailed as indicated on the form.

Suppliers must notify the NSC of any changes to their application, including address changes to ensure they continue receiving Region D publications. Additional copies of publications may be obtained at a cost by completing the "DMERC Region D Publication Form." The form and payment must be submitted to the address indicated on the form.

For the latest DMERC news, visit http://www.cignamedicare.com/dmerc/whatsnew.html. To receive automatic notification via e-mail when news is posted, subscribe to the CIGNA Medicare electronic mailing list at http://www.cignamedicare.com/medicare_dynamic/mailer/reminder.asp.

Region D Publications Distribution Options

CIGNA Medicare 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. This request will include all supplier numbers issued thereafter that have the same "Mail To" address. Secondly, multiple-site suppliers may choose to eliminate the CD-ROM mailing only for the supplier numbers listed. This request would not include any newly issued supplier numbers unless a new request for CD-ROM elimination is submitted.

DMERC Region D quarterly publications are distributed via Internet (www.cignamedicare.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 (see Appendix A-3) 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 Medicare
Region D DMERC
Attn: Communications Department
Two Vantage Way
Nashville, TN 37228

Or by fax: 615.782.4445

Frequently Asked Questions

1. Why are payments for capped rental items different after the third month of rental?

   ANSWER: The first three months of rental are reimbursed at the full fee schedule allowance. For each of the remaining months of rental, the fee schedule allowance will be reduced by 25%. For example: if the normal fee schedule allowance for an item is $100, Medicare would allow $100 for rental months 1-3, and then $75 a month thereafter.

   (CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 20, Section 30.5.1)

2. What does the supplier do if a claim was billed incorrectly?

   ANSWER: When a claim is billed incorrectly the supplier may resubmit a new claim, request a claim adjustment, or request a review (redetermination) when the claim has completed processing.

   If no payment was made for the item billed incorrectly, it may be resubmitted as a new claim. If the claim was denied due to medical necessity the supplier must request a review (redetermination).

   If the claim was paid or partially paid the supplier may request a claim adjustment. Adjustments are generally simple billing corrections such as a change in unit, HCPCS code, or submitted charge. (Refer to the article entitled "Correcting Minor Errors through the Adjustment Process" in this issue.)

   (Region D DMERC Dialogue, Spring 1999, page 9)

3. How do I avoid "same or similar" equipment denials?

   ANSWER: Suppliers should obtain, from the beneficiary (or legal guardian), all the information possible to determine whether same or similar equipment has previously been provided to that beneficiary. Suppliers should ask specific questions when providing items to Medicare patients. Suppliers should determine such information as:

   - The beneficiary's correct Health Insurance Claim Number (HICN);
   - If the beneficiary has employer insurance or is enrolled in a Health Maintenance Organization (HMO);
   - If the beneficiary currently has or had an identical or similar item in the past;
   - When the beneficiary received the item(s) and if the item(s) has been returned;
   - Where the item will be used; and
   - Certificate of Medical Necessity (CMN) information.

   Suppliers should make certain the beneficiary understands that items such as wheelchairs and power operated vehicles are considered "similar equipment," and that Medicare will not cover both items when they are used simultaneously or as a backup. Also, suppliers should encourage the beneficiary to inform them if the medical need for the item changes and the beneficiary requires a different piece of equipment that serves a similar purpose. The Medicare program will only allow items that meet the beneficiary's current needs.

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

Frequently Asked Questions (cont'd)

4. Do fields 17 and 17A of the CMS-1500 form have to be completed for each claim? If so, what should be entered into these two fields?

   ANSWER: These two fields must be completed for every claim submitted. Enter the name of the referring or ordering physician in item 17 if the service or item was ordered or referred by a physician. Enter the CMS assigned Unique Physicians Identification Number (UPIN) in item 17a of the referring/ ordering physician listed in item 17. Refer to the *DMERC Region D Supplier Manual,* Chapter 6, for detailed claim completion instructions.

   (CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 26)

5. Can the Customer Service Representative (CSR) give the fee schedule amounts on specific codes?

   ANSWER: A much faster method of accessing fee schedule information is to access the Interactive Voice Response (IVR) system at 877.320.0390. You can also access this information on CIGNA Medicare's Web site at *www.cignamedicare.com*.

6. How do I obtain a Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) supplier number?

   ANSWER: All suppliers who plan to file claims to a DMERC must apply for and obtain a national supplier number from the National Supplier Clearinghouse (NSC). Prospective DMEPOS suppliers may request an enrollment application by writing or call the NSC at the following address: National Supplier Clearinghouse, P.O. Box 100142, Columbia, SC 29202-3142; toll free number 1.866.238.9652. Additional information can be obtained on the Internet at www.palmettogba.com (Other Partners, National Supplier Clearinghouse).

   (DMERC Region D Supplier Manual, Chapter 2)

7. How do I complete field 11 on the CMS – 1500 claim form?

   ANSWER: Field 11 is a required field. By completing this field, the supplier acknowledges having made a good faith effort to determine whether Medicare is the primary or secondary payer. If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to fields 11a – 11c. Fields 4, 6, and 7 must also be completed.

   Enter the appropriate information in field 11c if insurance primary to Medicare is indicated in field 11. If there is no insurance primary to Medicare, enter the word **"NONE"** and proceed to field 12.

   If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word **"NONE"** and proceed to field 11b.

   Circumstances under which Medicare payment may be secondary to other insurance include: Group Health Plan Coverage; Working Aged, Disability (Large Group Health Plan), and End Stage Renal Disease; No Fault and/or Other Liability; and Work Related Illness/Injury; Worker's Compensation, Black Lung, and Veterans Benefits.

   (DMERC Region D Supplier Manual, Chapter 6, pp. 37-38)

Frequently Asked Questions (cont'd)

8. What is the time limit for requesting a review (redetermination)? Where do I send my request?

   ANSWER: The supplier has 120 days from the date of initial determination of the claim for the date of service in question to submit a request for review (redetermination). The review request should be sent to CIGNA Medicare, Attn: Review Department, P.O. Box 22995, Nashville, TN., 37202. The request should include a copy of the claim and any additional documentation supporting the need for the item/ service.

   (DMERC Region D Supplier Manual, Chapter 13, page 3)

9. Do I send a refund to CIGNA Medicare's address in Nashville, TN?

   ANSWER: No, all refunds should be sent to: CIGNA Federal Insurance Benefits, DMERC P.O. Box 10927, Newark, New Jersey, 07193-0927

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

10. Can a supplier request a duplicate remittance notice from a Customer Service Representative (CSR)?

    ANSWER: Yes, but a much faster method is to submit a request through the Interactive Voice Response (IVR) system at 877.320.0390.

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MEDICARE WRITTEN ADJUSTMENT REQUEST FORM

Mail To: CIGNA Medicare
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 # ( )

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MEDICARE REDETERMINATION REQUEST FORM

Mail To: CIGNA Medicare
DMERC Region D
P. O. Box 22995
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 _____

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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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 Medicare, 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

07/01/2004

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 Medicare. Personally identifying information that is collected will be used only in connection with the specified request. CIGNA Medicare 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.cignamedicare.com/dmerc/dmsm/index.html. (Also, hardcopies are not available for the Summer and Fall 2002 updates, please download from the Web.)

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

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

Total Amount Due **$_____**

Payment/Order Information

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

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

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

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

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

(Rev. 10/2004)

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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.

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/.

Suggested Intake Form

Order taken by:		Date:
Telephone:	Referral Person Calling in Order:	

BENEFICIARY INFORMATION

Name:		Date of Birth:
Street Address:		Gender: ☐ Male ☐ Female
City, State, Zip:		Weight: / Height:
Telephone:		Medicare Number:

Name of Legally Responsible Representative:

Relationship to beneficiary:	
Street Address:	
City, State, Zip:	Telephone:

ORDERING PHYSICIAN INFORMATION

Name:	UPIN #:
Street Address:	
City, State, Zip:	Telephone:
Specialty:	

QUESTIONS FOR THE BENEFICIARY

Has the beneficiary ever received the same or similar supplies/equipment? ☐ Yes ☐ No			
If yes, list equipment/supplies:			
Who was it purchased or rented from?			
Date purchased or if rented, how many months?	Date of past setup:	Date equipment was returned:	
Was item returned to original supplier? ☐ Yes ☐ No			
Why was the item returned?			
Is the item being replaced? ☐ Yes ☐ No			
Is there a new medical necessity? ☐ Yes ☐ No			
Describe condition for previous need:			
Describe new/changed condition:			
Is the beneficiary enrolled in a Medicare HMO/managed care program? ☐ Yes ☐ No			
Has the beneficiary been enrolled in a Medicare HMO/managed care program and is returning to Fee-For-Service (FFS)? ☐ Yes ☐ No			

QUESTIONS FOR THE SUPPLIER

If providing repairs on equipment obtain the following information for the item being repaired:

Manufacturer:	Model Name or Number:	Serial Number:	Purchase Date:
Reason or nature of repairs:			
Do you have medical necessity to file for repairs?			
Does beneficiary meet criteria for item being repaired? ☐ Yes ☐ No		Where will the item be used?	
Did I photocopy the Medicare card and/or other insurance cards? ☐ Yes ☐ No			
Do I have a dispensing order and/or a detailed written order? ☐ Yes ☐ No			
Will I need a Certificate of Medical Necessity (CMN)? ☐ Yes ☐ No			
Do I have supporting documentation on file to meet medical necessity? ☐ Yes ☐ No			
Should I obtain an Advanced Beneficiary Notice (ABN)? ☐ Yes ☐ No			
What is the primary diagnosis?	List any other diagnoses if applicable:		
Is Medicare the beneficiary's ☐ primary or ☐ secondary insurer?			
Is the beneficiary or beneficiary's spouse employed? ☐ Yes ☐ No			
Is the current condition related to employment, auto or other accident? ☐ Yes ☐ No			
Is the beneficiary nearing Medicare eligibility? ☐ Yes ☐ No If yes, give eligibility date:			
Do I need to obtain a one-time authorization form? ☐ Yes ☐ No			
Did the beneficiary sign and date this intake form? ☐ Yes ☐ No			
Beneficiary Signature:	Date Signed:		

This is just a **suggested** intake form and suppliers can model one to fit their particular type of business. For example if you are providing oxygen there may be certain questions you need to ask regarding oxygen patients or if you are providing wheelchairs there may be certain questions pertinent to wheelchairs. These are the basic questions to aid you in compiling information at the time of intake. This form does not in anyway replace obtaining an Advanced Beneficiary Notice (ABN) if there is reason to believe the item(s) may be denied due to medical necessity reasons. Please refer to the *DMERC Region D Supplier Manual*, Chapter 3, for information about same or similar equipment and ABNs and the Limitation of Liability section in Chapter 6 for more information.

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Notes

Notes

Customer Service Available

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CIGNA HealthCare
Medicare Administration

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

DMERC Dialogue *...a service of*

CIGNA Medicare
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.

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