DMERC Medicare News

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The enclosed information was current at the time of publication. Please visit our Web site for recent updates.

Articles are identified by area of interest as follows: **DRU** = Drugs, **GEN** = General, **MOB** = Mobility/Support Surfaces, **O&P** = Orthotics & Prosthetics, **OXY** =Oxygen, **PEN** = Parenteral/Enteral Nutrition, **SPE** = Specialty Items, **VIS** = Vision

This bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no cost from our Web site at *www.umd.nycpic.com*.

CMS CENTERS for MEDICARE & MEDICAID SERVICES

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***NOTE**: In order to meet the timely filing requirements for submission, claims with dates of service between October 1, 2002, and September 30, 2003, must be accepted into our processing system by 5:00 p.m. on Thursday, December 30, 2004. Please remember, Medicare no longer accepts Statements of Intent (SOIs) to extend the timely filing limit for filing initial claims (see MM3310).*

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

Medlearn Matters Number: MM3422
Related Change Request (CR) #: 3422
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 283
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects physicians, providers, and suppliers.

Provider Action Needed

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

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

Background

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

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

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

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier and fiscal intermediary regarding this change. That instruction may be viewed by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** From that Web page, look for CR3422 in the CR NUM column on the right, and click on the file for that CR.

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

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

Medlearn Matters Number: MM3377
Related Change Request (CR) #: 3377
Related CR Release Date: August 10, 2004
Related CR Transmittal #: 272
Effective Date: January 1, 2004 for revised 2004 fee schedule amounts
Implementation Date: October 4, 2004

The following information affects 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 (Social 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 (CMS) 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: ***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: ***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: ***www.cms.hhs.gov/medlearn/tollnums.asp***

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

Medlearn Matters Number: MM3350
Related Change Request (CR) #: 3350
Related CR Release Date: July 9, 2004
Related CR Transmittal #: 226
Effective Date: October 1, 2004
Implementation Date: October 4, 2004

The following information affects 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 an 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 supply and therapy codes that must be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes 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:

Code	Description of Code
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: ***www.cms.hhs.gov/providers/hhapps/#billing***

The official instruction issued to your carrier regarding this change may be found by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** From that Web page, look for CR3350 in the CR NUM column on the right, and click on the file for that CR.

Reasonable Charge Update for 2005 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, Therapeutic Shoes, and Certain Intraocular Lenses

Medlearn Matters Number: MM3430
Related Change Request (CR) #: 3430
Related CR Release Date: September 10, 2004
Related CR Transmittal #: 297
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects physicians, providers, and suppliers.

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

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

This instruction provides details regarding the calculation of reasonable charges for payment of

claims for **splints, casts**, dialysis supplies, dialysis equipment, **and intraocular lenses** furnished in calendar year 2005.

- For **therapeutic shoe Healthcare Common Procedure Coding System (HCPCS) codes A5500, A5501, A5503-A5507, K0628, and K0629** the Medicare Modernization Act of 2003 (MMA, Section 627) changes the payment methodology from reasonable charge to the prosthetic and orthotic fee schedule. Further information on the pricing update for therapeutic shoes will be provided in a separate article for the 2005 update of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule.

For splints and casts the following applies:

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

Implementation

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

Additional Information

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

From that Web page, look for change request (CR) 3430 in the CR NUM column on the right, and click on the file for that CR. That CR has a detailed list of HCPCS codes for splints and casts with associated gap-filled payment amounts that your carrier will use in making payment in 2005 based on the lower of the actual charge or the gap-filled payment amount. If you have any questions, please contact your carrier or DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Clarification of Epoetin Alfa (EPO) Billing Procedures and Codes in ESRD

Medlearn Matters Number: SE0406
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The following information affects physicians, suppliers, and renal dialysis facilities (RDFs) caring for patients with End Stage Renal Disease (ESRD).

Provider Action Needed

Physicians, suppliers, and RDFs should note that this Special Edition provides an overview of the differences between Medicare's billing procedures and codes for End Stage Renal Disease Renal Disease (ESRD) usage of EPO/DPA.

Background

Epoetin Alfa (EPO) Billing Procedures and Codes

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

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

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

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

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

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

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

Summarizing for EPO

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

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

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

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

Total: 31,060 units
For value code 68, enter 31,060.
Your intermediary uses 31,100 to determine the rate payable. This is 31,060 rounded to the nearest 100 units. The rate payable is $311.00 (31.1 × $10).
Hgb=10.2
Revenue Code: 634 – 12
Value Code: 68 – 31,060
HCPCS: Q4055
VC 48: 10.2

Example 2: The following number of EPO units was administered during the billing period 5/1/04 – 5/30/04:

Date	EPO Units	Date	EPO Units
5/10	20,000	5/24	9,500
5/12	9,000	5/26	10,000
5/14	11,000	5/28	10,000
5/19	8,000	5/30	10,000
5/22	15,000		

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

If an electronic submitter has additional documentation, which Medicare may require, they can indicate "DOCUMENTATION AVAILABLE UPON REQUEST" in the narrative (NTE02) segment. If the additional documentation you have is needed for Medicare to make its payment determination, a development letter will be sent requesting the information.

If the NTE02 segment does not indicate the availability of the additional documentation or the information is not returned in a timely manner, the claim will be returned as unprocessable.

Related Instructions

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

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

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

Additional Information

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

Also, you can find the Medicare Benefit Policy Manual, Chapter 11, regarding billing and payment details for EPO and DPA at the following CMS Web site: ***www.cms.hhs.gov/manuals/102_policy/bp102c11.pdf*** Lastly, see the Medicare Claims Processing Manual, Pub. 100-04, Chapter 8, Section 60.4 at the following CMS Web site: ***www.cms.hhs.gov/manuals/104_claims/clm104c08.pdf***

Skilled Nursing Facility Consolidated Billing

Medlearn Matters Number: SE0431
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

The following information affects all Medicare providers, suppliers, physicians, skilled nursing facilities (SNFs), and rural swing bed hospitals.

Provider Action Needed

This article is informational only and is intended to remind affected providers that SNFs must submit all Medicare claims for the services its residents receive, except for a short list of specifically excluded services as mentioned in the "Excluded Services" 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), an SNF could elect to furnish services to a resident in a covered Part A stay, either:

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

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

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

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

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

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

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

Effective Dates

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

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

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

Excluded Services

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

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

Physician "Incident To" Services

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

Outpatient Hospital Services

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

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

Effective with services furnished on or after April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA, P.L. 106-113, Appendix F) has identified certain additional exclusions from CB. The additional exclusions enacted in the BBRA apply only to certain specified, individual services ***within*** a number of broader service categories that otherwise remain subject to CB. Within the affected service categories the

exclusion applies only to those individual services that are specifically identified by HCPCS code in the legislation itself, while all other services within those categories remain subject to CB. These service categories are:

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

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

Finally, effective January 1, 2004, as provided in the August 4, 2003, final rule (68 Federal Register 46060), two radiopharmaceuticals, Zevalin and Bexxar, were added to the list of chemotherapy drugs that are excluded from CB (and, thus, are separately billable to Part B when furnished to an 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 (***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0432.pdf***)
- Skilled Nursing Facility Consolidated Billing as It Relates to Ambulance Service (***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0433.pdf***)
- Skilled Nursing Facility Consolidated Billing and Erythropoietin (EPO, Epoetin Alfa) and Darbepoetin Alfa (Aranesp) (***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0434.pdf***)
- Skilled Nursing Facility Consolidated Billing as It Relates to Dialysis Coverage (***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0435.pdf***)
- Skilled Nursing Facility Consolidated Billing and Preventive/Screening Services (***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0436.pdf***)
- Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetics and Orthotics (***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 (***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0438.pdf***)
- Skilled Nursing Facility Consolidated Billing as It Relates to Clinical Social Workers (***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0439.pdf***)
- Skilled Nursing Facility Consolidated Billing as It Relates to Certain Diagnostic Tests (***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 Web site can be found at: ***www.cms.hhs.gov/medlearn/snfcode.asp*** It includes the following relevant information:

- General SNF consolidated billing information;

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

The SNF PPS Consolidated Billing Web site can be found at: ***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 Number: SE0434
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

The following information affects 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: ***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

illness other than ESRD. In this case, the SNF is responsible for reimbursing the supplier. The SNF should include the charges on the Part A bill filed 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:
www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

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

You can find the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 11, End Stage Renal Disease (ESRD), at the following CMS Web site:
www.cms.hhs.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 Web site:
www.cms.hhs.gov/manuals/104_claims/clm104index.asp

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

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

The SNF PPS Consolidated Billing Web site can be found at: ***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 Number: SE0437
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

The following information affects 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:
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: ***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: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf***

The Centers for Medicare & Medicaid Services (CMS) Medlearn Consolidated Billing Web site can be found at: ***www.cms.hhs.gov/medlearn/snfcode.asp*** It includes the following relevant information:

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

The SNF PPS Consolidated Billing Web site can be

found at: ***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).

Processing Part B Claims for the Indian Health Services (IHS)

Medlearn Matters Number: MM3288
Related Change Request (CR) #: 3288
Related CR Release Date: July 23, 2004
Related CR Transmittal #: 241
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects Indian Health Services, tribe, and tribal organizations (non-hospital or non-hospital based) facilities.

Provider Action Needed

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

Background

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

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

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

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

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

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

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

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

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

- Enroll with the NSC as a "DME supplier"
- Comply with the supplier standards specified in 42 CFR, Section 424.57
- Submit all DMEPOS claims to the CIGNA DMERC, or

(at the facility's option) submit DME claims to the appropriate DMERC based on current DME jurisdiction rules
- DMEPOS claims submitted to the DMERC must be billed with a place of service "12" (home)
- Claims submitted to the DMERC must have a specialty code from the NSC of "A9". The "A9" must not be transmitted as the "primary specialty" on DMEPOS claims.

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

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

Additional Information
For complete details, including the revised sections of the Medicare Claims Processing Manual, please see the official instruction issued to your Medicare contractor regarding this change. That instruction may be viewed at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** From that Web page, look for CR3288 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

DMERC A Update: Due to the suppression of IHS claims from the Medicare Summary Notice (MSN), the assignment will be flipped for all non-assigned IHS claims to assigned.

Invalid Diagnosis Code Editing – Second Phase

Medlearn Matters Number: MM3260
Related Change Request (CR) #: 3260
Related CR Release Date: October 22, 2004
Related CR Transmittal #: 326
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

The following information affects all physicians, providers, and suppliers who bill Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs).

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

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

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

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

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

Additional Information
Additional information regarding this topic can be found in Transmittal 86 (CR 3050). The official instruction issued to your carrier regarding this change

may be found by going to:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp
From that Web page, look for CR3260 in the CR NUM column on the right, and click on the file for that CR.

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Medlearn Matters Number: MM3466
Related Change Request (CR) #: 3466
Related CR Release Date: October 15, 2004
Related CR Transmittal #: 313
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects all providers.

Provider Action Needed

Impact to You

The June 2004 updates have been posted for the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes.

What You Need to Know

The most current and complete list will be found online at: ***www.wpc-edi.com/codes/Codes.asp***

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

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

What You Need to Do

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

Background

The Remittance Advice Remark Code list is one of the code lists mentioned in the ASC X12 transaction 835 (Health Care Claim Payment/Advice) version 4010A1 Implementation Guide (IG). This list is maintained by The Centers for Medicare & Medicaid Services (CMS) and is updated three times a year. The complete list of current codes is available online at the WPC Web site: ***www.wpc-edi.com/codes/Codes.asp***

The Health Care Claim Adjustment Codes are maintained by the Claim Adjustment Reason Code and Status Code Maintenance Committee. The Committee meets at the beginning of each X12 trimester meeting (February, June, and October) and decides on any additions, modifications, or retirement of reason codes. The updated list is posted three times a year and the complete list of current codes is available online at the WPC Web site: ***www.wpc-edi.com/codes/Codes.asp***

Additional Information

The most recent changes approved for the Remittance Advice Remark Codes and the Claim Adjustment Reason Codes can be found in the official instruction issued to your carrier or fiscal intermediary, including Durable Medical Equipment Regional Carriers (DMERCs). That official instruction is found in CR 3466, which is available at:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

Once at that page, scroll down the CR NUM column on the right to find the link for CR3466. Click on the link to open and view the file for the CR. The CR attachments also include information on the process of decision making that results in updates to the X12N 835 Health Care Remittance Advice Remark Codes and the X12 N 835 Health Care Claim Adjustment Reason Codes. It also includes a table of changes; however, please note that the most current and complete list is online at the WPC Web site. This CR includes changes made only from March through June of 2004.

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

Guidance Regarding Elimination of Standard Paper Remittance (SPR) Advice Notices in the Old Format

Medlearn Matters Number: SE0451
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: January 1, 2005

The following information affects all Medicare physicians, providers, and suppliers.

Provider Action Needed

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

Background

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

CMS has issued a memorandum to all Medicare carriers and fiscal intermediaries, including durable medical equipment carriers and regional home health intermediaries, stating that, effective January 1, 2005, only the 835 version 4010A1 flat file is to be used to produce the SPRs; no other format for SPRs will be used.

Additional Information

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

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

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

Billing J7507

The Region A Durable Medical Equipment Regional Carrier (DMERC A) has been observing a large number of claim submission errors for J7508 (tacrolimus, oral, per 5 mg). The procedure code, J7508, has been deleted as of March 30, 2004, and is no longer a valid procedure code for claims submission.

When the doctor prescribes the 5mg tablet of tacrolimus, the claim must be billed as 5 units of J7507 (TACROLIMUS, ORAL, PER 1 MG). If the patient is receiving both the 1mg and the 5mg tablets, the total amount of milligrams for both tablets should be billed under J7507. For example:

> Patient is receiving five (5) tablets of 1mg and five (5) tablets of 5mg. The claim should be billed using J7507 and 30 units.

The above instructions apply to paper, National Standard Format (NSF), and American National Standards Institute (ANSI) version 4010A1 claims only. If billing National Council for Prescription Drug Programs (NCPDP) claims, submit with appropriate National Drug Code (NDC) accordingly.

Fee Schedule Updates

The 2004 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site, ***www.umd.nycpic.com/dmfees.html***. The following notices can be accessed via the "2004 Fee Schedule Article/Information" link. **Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.**

Revised 2004 Fee Schedule Amounts for Wheelchair Seat and Back Cushions

Effective November 12, 2004, the fee schedule amounts found at ***www.umd.nycpic.com/dmfees-articles.html#RevWheelchair-CushionAmounts*** will be effective on all claims for codes K0650-K0658, K0660-K0666, and K0668 that are processed on or after November 12, 2004. For additional information, refer to the Region A DMERC Program Safeguard Contractor (PSC) November 2004 Bulletin article "Wheelchair Seating - Coding and Pricing Changes."

October 2004 Quarterly Fee Updates

Listed below are the revised fees for the Lumbar-Sacral-Orthosis (LSO) Healthcare Common Procedure Coding System (HCPCS) codes K0630 through K0646. HCPCS codes K0630 through K0649 became effective on April 1, 2004, and fees were implemented for these codes on July 1, 2004. **Please note that fees for some codes will be increasing, while other fees will be decreasing.** The fees for any codes that are increasing will be effective for claims processed on or after August 16, 2004, for dates of service on or after April 1, 2004. Fees for any codes that are decreasing, as well as codes which had a fee and will now be based on individual consideration (IC), will be effective for claims processed on or after October 1, 2004, for dates of service on or after April 1, 2004.

- Fees are **increasing** for the following spinal orthotic codes: K0630, K0637, K0640, K0642, and K0646.
- Fees are **decreasing** for the following spinal orthotic codes: K0634, K0635, K0636, and K0639.
- Codes which were based on individual consideration (IC) and now have an established fee schedule allowance are: K0631, K0644, and K0645.
- Code which originally had a fee for 2004 and will now be based on individual consideration (IC) is: K0632.
- Codes which will continue to be based on individual consideration (IC) are: K0633, K0638, K0641, and K0643.
- Codes whose fees will remain unchanged are: K0647, K0648, and K0649.

HCPCS	K0630	K0631	K0632	K0634
CT	81.32	259.29	IC	43.27
DE	69.41	227.36	IC	43.27
MA	81.32	259.29	IC	43.27
ME	81.32	259.29	IC	43.27
NH	81.32	259.29	IC	43.27
NJ	72.82	194.47	IC	43.27
NY	72.82	194.47	IC	43.27
PA	69.41	227.36	IC	43.27
RI	81.32	259.29	IC	43.27
VT	81.32	259.29	IC	43.27

HCPCS	K0635	K0636	K0637	K0639
CT	61.25	322.98	65.92	127.26
DE	61.25	322.98	65.92	127.26
MA	61.25	322.98	65.92	127.26
ME	61.25	322.98	65.92	127.26
NH	61.25	322.98	65.92	127.26
NJ	61.25	322.98	65.92	127.26
NY	61.25	322.98	65.92	127.26
PA	61.25	322.98	65.92	127.26
RI	61.25	322.98	65.92	127.26
VT	61.25	322.98	65.92	127.26

HCPCS	K0640	K0642	K0644	K0645
CT	806.64	225.31	736.28	1,185.93
DE	806.64	225.31	720.54	1,066.65
MA	806.64	225.31	736.28	1,185.93
ME	806.64	225.31	736.28	1,185.93
NH	806.64	225.31	736.28	1,185.93
NJ	806.64	225.31	765.98	1,136.01
NY	806.64	225.31	765.98	1,136.01
PA	806.64	225.31	720.54	1,066.65
RI	806.64	225.31	736.28	1,185.93
VT	806.64	225.31	736.28	1,185.93

HCPCS	K0646		
CT	820.28	NJ	820.28
DE	820.28	NY	820.28
MA	820.28	PA	820.28
ME	820.28	RI	820.28
NH	820.28	VT	820.28

EDI/HIPAA-Compliant Claims Transactions

Please see the note under the Billing/Finanace section regarding initial claims submission and timely filing limits.

Inappropriate Access to or Use of Electronic Data Interchange (EDI) Transaction Data by Third-Party Entities

Medlearn Matters Number: SE0461
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The following information affects all physicians, suppliers, and providers.

Provider Action Needed

Impact to You

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

What You Need to Know

This article clarifies and reminds affected physicians, providers, and suppliers of existing Medicare requirements and prohibitions concerning use of EDI numbers and passwords.

What You Need to Do

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

Background

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

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

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

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

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

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

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

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

This instruction is being issued to clarify and remind affected parties of existing Centers for Medicare & Medicaid Services (CMS) requirements and prohibitions concerning access to and use of EDI numbers and passwords.

Issues

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

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

CMS Policy

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

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

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

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

As stated in the CSRs in BPSSM Section 2.9.10, passwords (1) are "unique for specific individuals," and

(2) must be "controlled by the assigned user and [are] not subject to disclosure."

Contractor Actions if Improper Access is Identified

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

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

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

- Loss of EDI privileges could result in termination of Medicare payment since the ASCA prohibits payment of claims submitted on paper that should have been submitted to Medicare electronically; and
- In those cases when ASCA permits claims to be submitted on paper, payment is delayed as result of the lengthier payment floor that applies to paper claims.

Additional Information

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

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

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

EDI Low-Cost Software Installation Online Tutorial

The Region A Durable Medical Equipment (DMERC A) Electronic Data Interchange (EDI) Department has produced an online tutorial covering the installation of ExpressPlus, our low-cost billing software. This tutorial can be found at: ***www.umd.nycpic.com/dme-eduonline.html***. All new users of ExpressPlus as well as those needing to reinstall the software for any reason will benefit from this presentation. If you do not have Internet access, please note that this same material can be found in the ExpressPlus manual on your installation CD.

For Your Information

OIG Alert About Charging Extra for Covered Services

Medlearn Matters Number: SE0421
Related Change Request (CR) #: N/A
Release Date: N/A

The following information affects 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 Web site is extensive and includes information about Medicare Participation, Participating Physician Directory, Policies and Regulations, including the Centers for Medicare & Medicaid Services (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 Web site can be found at:
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 Web site:
oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf

Update to Medicare Deductible, Coinsurance, and Premium Rates for Calendar Year (CY) 2005

Medlearn Matters Number: MM3463
Related Change Request (CR) #: 3463
Related CR Release Date: September 10, 2004
Related CR Transmittal #: 10
Effective Date: January 1, 2005
Implementation Date: January 3, 2005

The following information affects physicians, providers, and suppliers.

Provider Action Needed

This instruction updates Medicare deductibles, coinsurance, and premium rates for CY 2005.

Background

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) or Part A benefits without a premium payment. The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but they are subject to the payment of a monthly premium. Since 1994, voluntary enrollees may qualify for a reduced premium if they have 30-39 quarters of covered employment. **When voluntary enrollment takes place more than 12 months after a person's initial enrollment period for HI benefits, the monthly premium is increased by 10 percent.**

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

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

Inpatient Hospital Services

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

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

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

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

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

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

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

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

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

Implementation

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

Related Instructions

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

Additional Information

The Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-01), Chapter 3 (Deductibles, Coinsurance Amounts, and Payment Limitations) has been revised and the updated manual instructions are attached to the official instruction released to your carrier/intermediary. You may view that instruction by going to:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp
From that Web page, look for CR3463 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Application of the Medicare Secondary Payer for the Working Aged Provision to Former Spouses and the Medicare Secondary Payer for the Disabled Provision to Former Spouses and Certain Family Members with Coverage Under the Federal Employees Health Benefits (FEHB) Program

Medlearn Matters Number: MM3120
Related Change Request (CR) #: 3120
Related CR Release Date: August 27, 2004
Related CR Transmittal #: 18
Effective Date: November 29, 2004
Implementation Date: November 29, 2004

The following information affects all Medicare providers.

Provider Action Needed

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

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

Background

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

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

Under the Spouse Equity Act, the individual is no longer on the former spouse's policy. The coverage is considered to be a separate, self-only policy, i.e., not dependent coverage but a policy separate from the former spouse. The employer makes no contributions to the coverage. Since the language in the Spouse Equity Act gives the former spouse the right to enroll in FEHB whether or not the spouse himself or herself is enrolled, the FEHB former spouse coverage is not considered employment based. Consequently, Medicare

is the primary payer for the former spouse, once they are entitled to Medicare under the working aged provision. Under the Medicare secondary for the disabled provision, Medicare would be primary for the former spouse as well as any covered family members since the coverage is not considered employment based.

Additional Information

The official instruction issued to your carrier regarding this change may be found by going to:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp
From that Web page, look for CR3120 in the CR NUM column on the right, and click on the file for that CR.

Clarification of Medicare Secondary Payer (MSP) Rules in Relation to a Temporary Leave of Absence

Medlearn Matters Number: MM3447
Related Change Request (CR) #: 3447
Related CR Release Date: September 24, 2004
Related CR Transmittal #: 19
Effective Date: October 25, 2004
Implementation Date: October 25, 2004

The following information affects all providers.

Provider Action Needed

Impact to You

Medicare secondary payer (MSP) rules state that if an employee retains their employment status, Medicare remains the secondary payer.

What You Need to Know

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

What You Need to Do

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

Background

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

Additional Information

You may also refer to the revised Publication 100-05, Chapter 1, Section 50B, which is part of the official instruction issued to your carrier/intermediary regarding this change. That instruction may be found at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 3447. Click on the link to open and view the file for the CR. If you have questions regarding this issue, you may also contact your carrier or fiscal intermediary at their toll-free number, which may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

Information and Education Resources for Medicare Providers, Suppliers, and Physicians

Medlearn Matters Number: SE0454
Related Change Request (CR) #: N/A
Effective Date: N/A
Implementation Date: N/A

The following information affects all Medicare physicians, providers, and suppliers.

Provider Action Needed

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

Background

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

Three-Pronged Provider Information and Outreach Approach

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

1) Medicare Contractors

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

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

2) CMS Regional Offices

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

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

3) CMS Central Office in Baltimore, Maryland

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

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

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

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

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

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

- **Other Popular Provider Web Pages** ~ In addition to the pages mentioned above, other frequently visited pages include the CMS Online Manual System at ***www.cms.hhs.gov/manuals***; the CMS Quarterly Provider Update at ***www.cms.hhs.gov/providerupdate***, which gives a listing of regulations and major policies currently under development during the quarter, regulations and major policies completed or cancelled, and new or revised manual instructions; the Medicare Coverage Home page at ***www.cms.hhs.gov/coverage***, which contains complete coverage information including links to CMS coverage databases, frequently asked questions, and "What's New" lists.
- **ListServe Messages** ~ CMS has a number of ListServes that transmit important Medicare notices and reminders to subscribers. For example, ListServes have been established for most provider-specific Web pages as well as for updates on the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the Medicare Learning Network, and the Quarterly Provider Update. To view and subscribe to one or more ListServe, please visit ***www.cms.hhs.gov/mailinglists***.
- **Open Door Forums** ~ CMS is very interested in hearing from and interacting with the physicians and other providers who deliver quality health care to our nation's beneficiaries. We continue to emphasize our responsiveness through an ongoing series of Open Door Forums that provide an environment for interactive dialogue. Forums are chaired by senior-level Agency officials and co-chaired by CMS Regional Office officials. For more information, please visit ***www.cms.hhs.gov/opendoor***.
- **Exhibit Program** ~ CMS hosts exhibit booths at provider, supplier, and physician association meetings. The CMS Exhibit Program provides an excellent opportunity for CMS Central and Regional Office staff to have direct contact with the Medicare provider, supplier, and physician community to listen to issues, concerns, and challenges and to share timely and relevant information. If you are interested in having a CMS exhibit at your national conference, please contact David Clark at **dclark@cms.hhs.gov**.

Physician and Other Provider Feedback

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

www.cms.hhs.gov/medlearn/suggestform.asp. We look forward to hearing from you.

Medicare-Approved Drug Discount Cards and Transitional Assistance Programs

Current information is available for physicians and other health care professionals via the Centers for Medicare & Medicaid Services (CMS) Web site at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0422.pdf*** and ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0457.pdf***, and for pharmacists and other pharmacy professionals at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0423.pdf*** and ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0458.pdf***.

For more information, visit:

- ***www.medicare.gov***, download a patient-education brochure
- ***www.cms.hhs.gov/medlearn/drugcard.asp***, read materials on the Medicare-Approved Drug Discount Cards and Transitional Assistance Programs
- ***www.cms.hhs.gov/opendoor***, regarding details on CMS Open Door Forums
- ***www.cms.hhs.gov/medicarereform***, obtain the latest information on the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)

Attention Pharmacists

Please read the following important message from the Centers for Medicare & Medicaid Services (CMS) regarding Medicare-approved discount drug card automatic enrollment.

Dear Pharmacist –
As a pharmacy that participates in the Medicare-approved drug card program, you are aware of the savings that are available to people who enroll in Medicare. In October, more than a million people with Medicare will be getting the attached "Important Message from Medicare" [available via the CMS Web site at: ***www.cms.hhs.gov/partnerships/news/autoenroll/lettertobenes.pdf***] and a Medicare-approved drug discount card in the mail. People receiving this important message are likely to qualify for up to $1,200 in credits from Medicare to help pay for their prescription drug costs.

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

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

We have also enclosed a flyer [available via the CMS Web site at: ***www.cms.hhs.gov/partnerships/news/autoenroll/flier.pdf***] appropriate for public display in your pharmacy. The purpose of this flyer is to encourage people who may qualify for the $1,200 credit to call and find out if they are eligible to receive this important benefit. If you need any additional information or resources, please visit ***www.cms.hhs.gov/partnerships***; click on the box on the far right with the "Medicare RX" symbol.

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

Medicare Replacement Drug Demonstration

The Centers for Medicare & Medicaid Services (CMS) needs your help to reach beneficiaries who could benefit from this demonstration. These beneficiaries include people who have been diagnosed with rheumatoid arthritis, multiple sclerosis,

osteoporosis, pulmonary hypertension, secondary hyperparathyroidism, Paget's Disease, Hepatitis C, CMV retinitis, or certain kinds of cancer. If you have any patients you think might be interested and eligible to apply, **let them know**. Be aware that both Fee-for-Service and Medicare Advantage beneficiaries are eligible to apply for the demonstration. If they would like to request an application or have any questions related to the demonstration, or need assistance completing the application, they can call a toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387). There is also helpful information on CMS' Web site (***www.medicare.gov***), including an application package that can be downloaded.

For more information on this demonstration, please visit **www.medicare.gov** or call the toll-free number: 1-866-563-5386 (TTY number: 1-866-563-5387) between 8 am and 7:30 pm Eastern time, Monday - Friday. You can also use the toll-free number if you have questions about the demonstration or the application. CMS also has a beneficiary brochure available that describes the demonstration and its benefits. Copies of the brochure can be requested at: **outreach.mrdd@trailblazerhealth.com**

To view further information regarding this demonstration, see the Medlearn Matters Special Edition article SE0443, which may be found at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0443.pdf***

Use of Group Health Plan Payment System to Pay Capitated Payments to Chronic Care Improvement Organizations Serving Medicare FFS Beneficiaries Under § 721 of the MMA

Beginning January 3, 2005, the Centers for Medicare & Medicaid Services (CMS) will be conducting large-scale programs under the Voluntary Chronic Care Improvement Program (Section 721 of the Medicare Modernization Act [MMA]) in which private organizations will contract with CMS to provide chronic care services to beneficiaries enrolled in the traditional Fee-For-Services (FFS) Medicare program.

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

For more information on this initiative, see the Medlearn Matters article MM3410, which may be found at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3410.pdf***

DMERC A's Gift Policy

During the holiday season, people often like to show their appreciation with gifts. Occasionally, we at the Region A Durable Medical Equipment Regional Carrier (DMERC A) receive gifts such as candy, fruit baskets, and flowers from beneficiaries, providers, and their billing staffs, in appreciation and thanks for our customer service. While we greatly appreciate the generosity of such gifts, we are unable to accept them. As part of our Code of Conduct, DMERC A has a zero tolerance policy regarding gifts - we cannot accept any.

If you would like to express your thanks for service you have received from DMERC A's representatives, we welcome notes/letters of appreciation in place of gifts.

DMERC A 2005 Holiday Schedule

The Region A Durable Medical Equipment Regional Carrier (DMERC A) will be observing the following holidays:

New Year's Day Holiday	Friday, December 31, 2004
Martin Luther King, Jr. Day	Monday, January 17, 2005
Memorial Day	Monday, May 30, 2005
Independence Day	Monday, July 4, 2005
Labor Day	Monday, September 5, 2005
Thanksgiving Day	Thursday, November 24, 2005
Day after Thanksgiving	Friday, November 25, 2005
Day before Christmas Holiday	Friday, December 23, 2005

Christmas Holiday Monday, December 26, 2005

(The Christmas Holiday dates for 2004 are December 23 and 24. The Bulletin Board System and Interactive Voice Response will be available.)

Program Inquiries

Implementation of New Medicare Redetermination Notice

Medlearn Matters Number: MM2620
Related Change Request (CR) #: 2620
Related CR Release Date: February 6, 2004 **Revised**
Related CR Transmittal #: R97CP
Effective Date: October 1, 2004
Implementation Date: July 6, 2004
Note: This article was revised on September 30, 2004, to show that providers and patients will receive the Medicare Redetermination Notice for any partially favorable or unfavorable decision made on a redetermination request made on or after October 1, 2004.

The following information affects all Medicare physicians, providers, and suppliers.

Provider Action Needed

Impact to You

Redeterminations are the new first level of appeal for fee-for-service appeals. You and your patients will receive a formal notification letter, the Medicare Redetermination Notice (MRN), for any partially favorable or unfavorable 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 MRN. This document describes the redetermination process, explains the results of the Medicare appeal, and provides information about how to file an appeal regarding Medicare's decision.

What You Need to Do

The newly initiated Redetermination Appeals Process provides for timely notification of beneficiaries and providers via the MRN. Ensure that you 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.

The Centers for Medicare & Medicaid Services (CMS) has provided a model cover letter and an MRN 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 percent of redeterminations 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 with 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 explaining what policy was used to make the decision and to identify documentation required to appeal at the Independent Appeal Level.
- An *Additional Relevant Information* section to present any additional relevant information, not including any

sensitive medical information.

- A section on *Important Information About Your Appeal Rights*, including contact information and an explanation of the next level of the appeal process.

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

Requests for Reopening of Fair Hearing Determinations

The Region A Durable Medical Equipment Regional Carrier (DMERC A) has experienced an increase in requests for fair hearing reopenings. Please note a reopening request is **not** an appeal right.

The Centers for Medicare & Medicaid Services (CMS) policy is to reopen only after appeal rights have been exhausted, or the time limit for requesting an appeal has expired. Reopenings are not appeals. They are discretionary actions initiated by DMERC A at our own volition or in response to a request by a beneficiary, provider, physician, or other supplier **only** after the appeal rights provided by law are exhausted.

The contractor or hearing officers will **not** grant a reopening in the absence of new additional and relevant information or a clear error. A reopening is never conducted in response to an appeal request if appeal rights are available. The contractor or hearing officer decision not to reopen is not subject to appeal.

To ensure the timely request of your appeal, you are required to submit a request for fair hearing no more than six (6) months from the initial date of a review determination and a request for Administrative Law Judge not more than 60 days from the initial fair hearing determination. A hearing officer decision of dismissal may not be appealed, however for good cause shown, a hearing officer may vacate his/her order of dismissal within six (6) months of the date of the dismissal.

Further information regarding reopenings may be accessed through the CMS Internet-Only Manuals, specifically, Chapter 29, Appeals of Claims Decisions, of Pub. 100-4, Medicare Claims Processing Manual.

Program Education & Training

Claim Submission Errors for the Fourth Quarter of Fiscal Year 2004

Claim submission errors (CSEs) are errors made on a claim that would cause the claim to reject upon submission to the Region A Durable Medical Equipment Regional Carrier (DMERC A). The top ten American National Standards Institute (ANSI) CSEs, for July 1, 2004 through September 30, 2004, are provided in the following chart. The total number of ANSI errors for this period was **186,023**.

ANSI Error Number - Narrative (Total Errors)	**Reason for Error**
1) 40068 - Invalid/Unnecessary Certificate of Medical Necessity (CMN) Question (32,844 errors)	The question number entered is not valid for the DMERC CMN you are sending.
2) 40022 - Procedure Code/ Modifier Invalid (28,904 errors)	The procedure code and/or modifier used on this line is invalid.
3) 40073 - Dates of Service Invalid with Procedure (14,059 errors)	The procedure code used is not valid for the dates of service used.
4) 20143 - Ordering Provider Secondary ID Invalid (6,332 errors)	If indicating that you are sending in a Medicare provider number, you must send in a valid provider number. When indicating you are sending a provider Unique Physician Indentification Number (UPIN), you must send in a valid UPIN.
5) 20025 - Subscriber ID Code Invalid (5,512 errors)	Subscriber ID code entered is not in a valid format.
6) 40037 - Service Date Greater Than Receipt Date (5,368 errors)	Service date is greater than date claim was received.

ANSI Error Number - Narrative (Total Errors)	Reason for Error
7) 40067 - Invalid/Unnecessary CMN Version Submitted (4,668 errors)	The DMERC CMN version number entered is not valid for the Healthcare Common Procedure Coding System (HCPCS) code submitted.
8) 40066 - Invalid/Unnecessary CMN Submitted (4,639 errors)	The DMERC CMN form number entered is not valid for the HCPCS code submitted.
9) 40014 - Ordering Provider Information Missing (4,630 errors)	The ordering provider information should be included with every service line.
10) 40036 - Service Date Does Not Equal "To" Date (4,164 errors)	The procedure code submitted does not allow for spanned dates of service.

In an effort to reduce other initial claim denials, the below information represents the top ten return/reject denials for the fourth quarter of fiscal year 2004. Claims denied in this manner are considered to be unprocessable and **have no appeal rights**.

An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally. Please refer to Chapter 1, Section 80.3.1, of Pub. 100-4, Medicare Claims Processing Manual.

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form Entry Requirement
1) CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid procedure codes(s) and/or rates. (18,165 claims)	**Item 24D** - Enter the procedures, services, or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.
2) M81 Patient's diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect or missing; you are required to code to the highest level of specificity. (15,509 claims)	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity. You may enter up to four codes in priority order (i.e., primary, secondary condition).
3) CO 16 M78 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid HCPCS modifier. (6,821 claims)	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable, show HCPCS modifiers with the HCPCS code.
4) CO 16 MA 83 Claim/service lacks information which is needed for adjudication. Did not indicate whether we are the primary or secondary payer. (6,438 claims)	**Item 11** - Enter the name of the enrollee in a Medigap policy if different from Item 2. Otherwise, write "SAME." If no Medigap benefits are assigned, leave blank. Item 11 **must** be completed. If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE."
5) CO 16 M77 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid place of service. (4,618 claims)	**Item 24B** - Enter the appropriate place of service code(s). Identify the location, using a place of service code, for each item used or service performed.
6) CO 16 MA82 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number. (3,944 claims)	**Item 33** - Enter the provider of service/supplier's billing name, address, zip code, and telephone number. Enter the Physician Identification Number (PIN) for the performing provider of service/supplier who is not a member of a group

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form Entry Requirement
	practice. Enter the group PIN for the performing provider of service/supplier who is a member of a group practice.
7) CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different. (3,586 claims)	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.
8) CO 16 M79 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid charge. (487 claims)	**Item 24F** - Enter the charge for each listed service.
9) CO 16 M53 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid days or units of service. (354 claims)	**Item 24G** - Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral "1" must be entered.
10) CO 4 The procedure code is inconsistent with the modifier used, or a required modifier is missing. (174 claims)	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable, show HCPCS modifiers with the HCPCS code.

Make it a goal to reduce the number of CSEs by taking the extra time to review your claims before submission to ensure that **all** the required information is on each claim. DMERC A will continue to provide information to assist you in reducing these errors and increasing claims processing efficiency. Please take advantage of the information in the above charts, and share it with your colleagues!

Provider Communications (PCOM) Advisory Group

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department encourages interested representatives to become a member of the PCOM Advisory Group. It is important to ensure our targeted educational efforts are both meaningful and helpful to the provider community as a whole, and members of this group play a vital role in accomplishing this task.

The fourth quarterly meeting for fiscal year 2004 was held at the Hyatt Harborside at Logan Airport in Boston, MA on August 11, 2004. Participants included representatives from the Centers for Medicare & Medicaid Services (CMS); TriCenturion, the Program Safeguard Contractor (PSC) for Region A; billing services; state provider associations; and individual provider organizations. Besides topic discussions (see minutes for details), this meeting included presentations by two guest speakers. Bill Mackenzie, CMS Boston Regional Office, spoke about the Health Insurance Portability and Accountability Act (HIPAA) and the Medicare Modernization Act of 2003 (MMA). Ellen Pothier, MassPro Quality Improvement Organization (QIO), spoke about MassPro's beneficiary quality care initiatives.

Minutes from the quarterly meetings are available via the "PCOM Advisory Group" section of the DMERC A Web site at ***www.umd.nycpic.com/dmerc_PCOM.html***. In addition to meeting minutes, this site contains supplementary information on the PCOM Advisory Group, a list of member organizations, and instructions on becoming a member. There are currently membership openings, and **membership is FREE**!

If you would like more information regarding the PCOM Advisory Group, or if you wish to become a member, please visit our Web page or contact the PET Department at 570-735-9666, and select **option 1**.

Live, Web-based Seminars and Workshops

Now that winter is here, you can take advantage of live, interactive seminars from the convenience and comfort of your own office, meeting room, or home. These sessions will allow you to attend individually, or as a group, giving you the opportunity to interact via the

computer with the Program Education & Training Department. The following topics are currently scheduled through January 27, 2005:

- DMERC 101
- DMERC Updates
- Documentation
- Pharmacy Billing
- Vision Billing

For more information regarding the live sessions, and to find out how you can participate, please visit the "Events" section of our Web site at:
www.umd.nycpic.com/dmprovcaln.html

Web Site Resources

Area of Interest Article Identifiers

In December 2003, a new method for categorizing and organizing the content within the *DMERC Medicare News* was implemented. This method includes the use of identifiers to define an article's area of interest. (Areas of interest include drugs, mobility/support surfaces, oxygen etc. Articles that may be of interest to a variety of audiences are identified as general articles.)

Due to the success of this user-friendly feature, the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site has adopted the use of article identifiers. To help you determine whether an article pertains to your area of interest, reference the orange-colored identifier posted next to the article title. Identifiers will be included with newly-posted articles.

To view the definition of an identifier, click on the identifier. When you click on the identifier, a small window will open in the middle of your screen. Within this window, you will find the definition for identifiers used on the DMERC A Web site, as well as a brief description of area of interest identifiers.

We hope this new feature enhances your Web site experience, and allows you to easily and quickly find the information you're interest in.

DMERC A ListServes

The Region A Durable Medical Equipment Regional Carrier (DMERC A) ListServes are used to notify subscribers **via email** of important and time-sensitive Medicare program information, and other important announcements or messages. All you need is Internet access and an email address.

What are the benefits of joining the DMERC A ListServes? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly bulletins, the *DMERC Medicare News*, become available.

DMERC A offers the following ListServes:

- **DMERC A ListServe** - For general Medicare program information and DMERC A Web site updates, and information regarding the availability of our bulletins. We encourage all suppliers/providers to join the DMERC A ListServe.
- **Supplier Manual ListServe** - For notification of *DMERC A Supplier Manual* revisions. We encourage all suppliers/providers to join the Supplier Manual ListServe.
- **EDI ListServe** - DMERC A encourages all software vendors, billing services, and clearinghouses to join our Electronic Data Interchange (EDI) ListServe. Subscribing enables the EDI Department to notify you of important and time-sensitive electronic data interchange information as it pertains to the way you and your clients do business with DMERC A.

Effective September 30, 2004, specialty ListServes include:

- **Drug Coverage** - For notification of the availability of drug coverage-related information (e.g., fee changes, Medicare demonstrations/discount card program, etc.).
- **Mobility/Support Surfaces** - For notification of the availability of mobility/support surfaces-related information (e.g., wheelchairs, hospital beds, etc.).
- **Oxygen** - For notification of the availability of oxygen-related information (e.g., respiratory assist devices, ventilators, etc.).
- **Parenteral/Enteral Nutrition (PEN)** - For notification of the availability of PEN-related information (e.g., nutrients, supplies, etc.).
- **Prosthetics & Orthotics** - For notification of the availability of prosthetics/orthotics-related information (e.g., lower limb prosthesis, spinal orthotics, etc.).

- **Specialty Items** - For notification of the availability of specialty items-related information (e.g., ostomy and urological supplies, surgical dressings, etc.).
- **Vision** - For notification of the availability of vision-related information (e.g., refractive lenses, frames, etc.).
- **Frequently Asked Questions (FAQs)** - For notification of the availability of FAQs on our Web site.

The specialty/area of interest ListServes enable DMERC A to send targeted information to specific supplier/provider audiences, when the information is posted on our Web site. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

Signing up for the DMERC A ListServes gives you immediate notification of important information on Medicare changes impacting your business. Subscribe today by visiting the "ListServes" section of our Web site at ***www.umd.nycpic.com/dmlistserve.html***. (***Note*:** DMERC A strives to limit notification to one email message per day for each ListServe, as applicable.) In addition, subscribe to the Region A Program Safeguard Contractor (PSC) ListServe by visiting: ***www2.palmettogba.com/cgi-bin/mojo/mojo.cgi***

Supplier Manual News

The 2003 edition of the Region A Durable Medical Equipment Regional Carrier (DMERC A) supplier manual is available via the "Publications" section of our Web site at ***www.umd.nycpic.com/dmprovpublcopy.html***. After accepting the CPT License Agreement, suppliers can access the entire *DMERC A Supplier Manual*, including revised chapters and archived revisions. The 2003 edition is available to current suppliers via the DMERC A Web site only, and newly-enrolled suppliers will continue to receive initial hard copy manuals, as mandated by the Centers for Medicare & Medicaid Services (CMS). The option to request additional copies for a fee is not available to anyone at this time.

Corrections/updates have been made to the manual as indicated below:

Revision 2003-06 (September 2004)

- Chapter 1 (Contact Information) - beneficiary toll-free line updated to reflect the national 1-800-MEDICARE number; other contacts information corrected/updated as appropriate

Revision 2003-07 (October 2004)

- Chapter 1 (Contact Information) - updated to include TTY numbers for suppliers and beneficiaries
- Chapter 5 (Medicare Secondary Payer) - updated to reflect current information, as in the CMS Online Manual System
- Chapter 6 (Pricing) - updated to reflect current information, as in the CMS Online Manual System, including recent average wholesale pricing (AWP) factor change
- Chapter 8 (Appeals) - updated to reflect current information, as in the CMS Online Manual System, including recent implementation of "redetermination" as first level of appeal
  (***Note***: The table of contents was updated under revision 2003-07.)

Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. Please follow the download instructions to print the revised pages. Instructions for downloading and viewing a Portable Document Format (PDF) file can be found at ***www.umd.nycpic.com/dmepdfdownload.html***.

Region A Provider Information

Both the Region A Durable Medical Equipment Regional Carrier (DMERC A) and Program Safeguard Contractor (PSC) maintain separate Web sites. Providers should visit the DMERC A Web site (***www.umd.nycpic.com***) for information regarding billing, educational updates and events, electronic data interchange (EDI), fee schedules, ListServes, what's new, etc. Online versions of the *DMERC Medicare News* are also available via this Web site.

Providers can gain access to the PSC Web site via the "TriCenturion" link on the DMERC A Web site (***www.umd.nycpic.com/dmprovlink.html***) or directly at: ***www.tricenturion.com***. Providers should access the PSC Web site for information on Fraud and Abuse, Healthcare Common Procedure Coding System (HCPCS), and Local Coverage Determinations (LCDs). Recent updates involving medical policy development, medical review, or benefit integrity can be accessed by visiting the PSC "What's New" section at: ***www.tricenturion.com/content/whatsnew_dyn.cfm***

Providers can obtain additional information by visiting the following Centers for Medicare & Medicaid Services (CMS) Web sites:

- ***www.cms.hhs.gov***
  (CMS Home page)
- ***www.cms.hhs.gov/coverage***
  (Medicare Coverage Home page)
- ***www.cms.hhs.gov/medicare***
  (Medicare Information Resource)
- ***www.cms.hhs.gov/providers***
  (Medicare Providers Web page)
- ***www.cms.hhs.gov/suppliers/dmepos***
  (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Information Resource for Medicare)
- ***www.cms.hhs.gov/manuals***
  (Medicare and Medicaid Program Instructions)

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 Quarterly Provider Update, which can be accessed at: ***www.cms.hhs.gov/providerupdate***. We encourage you to bookmark this Web site and visit it often for this valuable information. To receive notification when regulations and program instructions are added throughout the quarter, sign up for the Quarterly Provider Update ListServe at: ***list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1***

The Pulse of CMS

The Centers for Medicare & Medicaid Services (CMS) provided the Region A Durable Medical Equipment Regional Carrier (DMERC A) with a copy of the Fall 2004 edition of "The Pulse of CMS." This quarterly regional publication, for health care professionals, is available via the "Education - Articles and Publication Highlights" section of the DMERC A Web site at ***www.umd.nycpic.com/dmeduc.html***. (***Note***: This is a Portable Document Format (PDF) file, therefore, please follow the PDF download instructions.)

Printed Copies of the Bulletin

The Region A Durable Medical Equipment Regional Carrier (DMERC A) will continue to offer our provider bulletin, the *DMERC Medicare News*, in electronic format via our Web site in fiscal year 2005, where copies can be printed free of charge. To access the bulletin, go to the "Publications" section at ***www.umd.nycpic.com/dmprovpublcopy.html***. After accepting the CPT License Agreement, you can access the entire collection of bulletins.

If you do not have Internet access and require the bulletin via hard copy or CD-ROM, you may subscribe to it for a fee. The annual subscription fee is **$30.00** for hard copies and **$25.00** for CDs. The subscription includes four quarterly bulletins published during the fiscal year – December 2004, March 2005, June 2005, and September 2005. Please complete the following form and submit with payment, via check only, to the address listed below.

Name: _____

Provider Number: _____

Address: _____

_____

Telephone Number: (____) _____

1. I am a:

- ❑ Provider/Supplier
- ❑ Association/Medical Society
- ❑ Vendor/Billing Agency
- ❑ Other _____

2. Indicate the reason you are requesting hard copies/CDs:

- ❑ No Internet access
- ❑ Other (please explain) _____

_____

_____

3. I would like to receive the *DMERC Medicare News* via:
*(**Note**: Both options include the December 2004, March 2005, June 2005, and September 2005 bulletins.)*

- ❑ Hard Copy - $30.00 per year
- ❑ CD - $25.00 per year

Enclose your check, in the amount of $30.00 for hard copies or $25.00 for CDs, **payable to: HealthNow New York Inc.**

Mail your completed form with payment to: Publications Specialist, DMERC A, P.O. Box 5206, Binghamton, NY 13902-5206

Telephone Numbers

Caller Information Network	
Supplier Toll-Free Line	866-419-9458
[*TTY Hearing Impaired*	866-374-6848]
Beneficiary Toll-Free Line	1-800-MEDICARE (1-800-633-4227)
[*TTY Hearing Impaired*	1-877-486-2048]
EDI Services Help Desk	866-861-7348
Program Education & Training	570-735-9666
Program Inquiries	
Telephone Redeterminations Line	866-420-6906
FAX Numbers	
Check Control/MSP	570-735-9594
Electronic Data Interchange	570-735-9510
Extra Documentation/ADMC	570-735-9402
Program Education & Training	570-735-9442
Program Inquiries (Hearings & Redeterminations)	570-735-9599
National Supplier Clearinghouse	866-238-9652
SADMERC	877-735-1326

Web Sites
www.umd.nycpic.com
www.cms.hhs.gov

Addresses

Accounting
P.O. Box 6900
Wilkes-Barre, PA 18773-6900
[*for Check Control/Refunds*]

Administrative Law Judge (ALJ)
Hearings and Fair Hearings
P.O. Box 450
Wilkes-Barre, PA 18703-0450

Drugs Claims
P.O. Box 587
Wilkes-Barre, PA 18703-0587

General Correspondence
P.O. Box 1363
Wilkes-Barre, PA 18703-1363
[*for Written Inquiries, Freedom of Information Act (FOIA), Medicare Secondary Payer (MSP)*]

Mobility/Support Surfaces Claims
P.O. Box 599
Wilkes-Barre, PA 18703-0599

Oxygen Claims
P.O. Box 508
Wilkes-Barre, PA 18703-0508

PEN Claims
P.O. Box 877
Wilkes-Barre, PA 18703-0877

Program Inquiries/Reviews
P.O. Box 6300
Wilkes-Barre, PA 18773-6300

Reviews
P.O. Box 1068
Wilkes-Barre, PA 18703-1068
[*for Written Redeterminations*]

Specialty Claims
P.O. Box 1246
Wilkes-Barre, PA 18703-1246
[*for all other claim types not listed above*]

Suppliers: This bulletin should be directed to your billing manager.

MEDICARE

DMERC A
P.O. Box 6800
Wilkes-Barre, PA 18773-6800

A CMS Contracted Carrier