DMERC A 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

DMERC A
A Division of HealthNow New York Inc.
A CMS Contracted Carrier

HealthNow HealthNow New York Inc.

Cover Story

HealthNow New York Inc. DMERC A Relocated

Effective Monday, October 24, 2005, the Region A Durable Medical Equipment Regional Carrier (DMERC A) physical street address for the Nanticoke, PA location has changed.

New address:
HealthNow New York Inc. DMERC A
1190 Memorial Highway
Dallas, PA 18612

Previous address:
HealthNow New York Inc. DMERC A
60 E. Main Street
Nanticoke, PA 18634

Along with the street address, the telephone numbers also changed; the 570-**735**-#### exchange has been updated to the new exchange, 570-**255**-####, including the numbers for the fax machines (**Note**: please refer to the back cover of this publication for the new numbers).

The toll-free telephone numbers and post office (P.O.) box addresses have not been affected by this move.

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Billing/Finance

News from CMS…

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

Medlearn Matters Number: MM4026
Related Change Request (CR) #: 4026
Related CR Release Date: September 2, 2005
Related CR Transmittal #: 665
Effective Date: January 1, 2005, for implementation of revised fee schedule amounts for codes in effect on January 1, 2005; October 1, 2005, for all other changes
Implementation Date: October 3, 2005

The following information affects physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services paid under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

Provider Action Needed

This article is based on Change Request (CR) 4026 and provides specific information regarding the October quarterly update of the 2005 DMEPOS fee schedule.

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to:

- Implement fee schedule amounts for new codes; and
- Revise any fee schedule amounts for existing codes that were calculated in error.

Payment on a fee schedule basis is required for:

- Durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Sections 1834(a)(h)(i)); and
- Parenteral and enteral nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

Note: There are no changes to the PEN fee schedule file for October 2005.

The following codes are being added to the Healthcare Common Procedure Coding System (HCPCS) on October 1, 2005, and are effective for claims with dates of service on or after October 1, 2005:

Code	Description of Code
Q0480	Driver for use with pneumatic ventricular assist device, replacement only
Q0481	Microprocessor control unit for use with electric ventricular assist device, replacement only
Q0482	Microprocessor control unit for use with electric/pneumatic combination ventricular assist device, replacement only
Q0483	Monitor/display module for use with electric ventricular assist device, replacement only
Q0484	Monitor/display module for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0485	Monitor control cable for use with electric ventricular assist device, replacement only
Q0486	Monitor control cable for use with electric/pneumatic ventricular assist device, replacement only
Q0487	Leads (pneumatic/electrical) for use with any type electric/pneumatic ventricular assist device, replacement only
Q0488	Power pack base for use with electric ventricular assist device, replacement only
Q0489	Power pack base for use with electric/pneumatic ventricular assist device, replacement only
Q0490	Emergency power source for use with electric ventricular assist device, replacement only
Q0491	Emergency power source for use with electric/pneumatic ventricular assist device, replacement only
Q0492	Emergency power supply cable for use with electric ventricular assist device, replacement only
Q0493	Emergency power supply cable for use with electric/pneumatic ventricular assist device, replacement only
Q0494	Emergency hand pump for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0495	Battery/power pack charger for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0496	Battery for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0497	Battery clips for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0498	Holster for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0499	Belt/vest for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0500*	Filters for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0501	Shower covers for use with electric or electric/pneumatic ventricular assist device, replacement only
Q0502	Mobility cart for pneumatic ventricular assist device, replacement only
Q0503	Battery for pneumatic ventricular assist device, replacement only, each
Q0504	Power adapter for pneumatic ventricular assist device, replacement only, vehicle type
Q0505	Miscellaneous supply or accessory for use with ventricular assist device

*** Replacement filters** described by code Q0500 are furnished in boxes of varying quantities by different manufacturers. Therefore, the base unit for code Q0500 for billing purposes is per each filter.

Note: Instructions regarding the implementation of the above codes were furnished in CR 3931.

The following table describes upcoming changes in certain HCPCS codes for wheelchairs beginning October 1, 2005.

HCPCS CODE	New Information
E0971 (anti-tipping device for wheelchairs)	The fee schedule amount for code E0971 is being revised to reflect a base **billing unit of "EACH."** Up to this point, E0971 represented "each" or a "pair" of devices. In October, the fee schedule will be standardized to represent fees per each unit.
E1038 & E1039 (transport chairs)	The fee schedule amounts for E1038 are being revised to correct errors in the fee calculations and reflect changes in billing for items under these codes. The fees **erroneously included elevating leg rests and those should be billed separately using code K0195**. The updated schedule will no longer include prices for the leg rests.
K0195 (elevating leg rests)	Suppliers should be billing these leg rests under this code.
E1039 (transport chairs with patient weight capacity **over 300 pounds**)	Claims dated on/after October 1, 2005, should contain E1039 for chairs with weight capacity OVER 300 pounds.
E1038 (transport chairs with patient weight capacity **under 300 pounds**)	Claims dated on/after October 1, 2005, should contain E1038 for chairs with weight capacity of 300 pounds or less.
E1238 (Pediatric size, folding, adjustable wheelchair without seating system)	The fee schedule is being revised for E1238 to correct fee schedule calculation errors.

HCPCS codes L3000 through L3649 were added to the fee schedule file effective July 1, 2005, for use in paying claims for shoes that are an integral part of an orthoses.

L5685 was added to the HCPCS effective January 1, 2005. The fee schedules are being established as part of this report.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the Centers for Medicare & Medicaid (CMS) Web site. From that Web page, look for CR 4026 in the CR NUM column on the right, and click on the file for that CR.

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

Also, the quarterly updates process for the DMEPOS fee schedule is located in the Medicare Claims Processing Manual (Pub 100-04, Chapter 23, Section 60). This manual can be accessed at ***www.cms.hhs.gov/manuals/104_claims/clm104index.asp*** on the CMS Web site.

October 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective October 1, 2005, and Revisions to April 2005 and July 2005 Quarterly ASP Medicare Part B Drug Pricing Files

Medlearn Matters Number: MM3992
Related Change Request (CR) #: 3992
Related CR Release Date: August 19, 2005 **Revised**
Related CR Transmittal #: 653
Effective Date: April 1, 2005, July 1, 2005, and October 1, 2005, respectively
Implementation Date: October 3, 2005
Note: This article was revised on September 19, 2005, to reflect that three quarters of updated files were made available for the quarters specified for the effective dates shown above.

The following information affects all Medicare providers who bill Medicare contractors: carriers, including durable medical equipment regional carriers (DMERCs), fiscal intermediaries (FIs), and regional home health intermediaries (RHHIs).

Provider Action Needed

Impact to You

Change Request (CR) 3992 provides the payment allowance limits in the April 2005, July 2005, and October 2005 drug pricing files. The revised payment limits for the codes listed in this article supersede the payment limits for these codes in any publication published prior to this document.

What You Need to Know

Be aware that certain Medicare Part B drug payment limits were revised for dates of service on or after April 1, 2005, on or before June 30, 2005, on or after July 1, 2005, and on or before September 30, 2005.

What You Need to Do

Make certain your billing staff is aware of these changes. The downloads for the April 2005, July 2005, and October 2005 average sales price (ASP) drug pricing files are available after September 19, 2005. See the "Additional Information" section in this article for the Web site address.

Background

According to Section 303 (c) of the Medicare Modernization Act (MMA), the Centers for Medicare & Medicaid Services (CMS) will update the payment allowances for Medicare Part B drugs on a quarterly basis. Beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the ASP. The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis. Each quarter, CMS will update your carrier/FI payment allowance limits with the ASP files.

Exceptions

There are, however, exceptions to the general rule and they were summarized in MM3846 effective April 1, 2005. This article may be found at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3846.pdf*** on the CMS Web site.

The **one new exception** listed in this CR states that the payment allowance limits for radiopharmaceuticals are not subject to ASP. Medicare contractors (carriers, DMERCs, FIs, and RHHIs) will determine payment limits for radiopharmaceuticals based on invoice pricing or the methodology in place in November 2003.

Implementation
The implementation date for the instruction is October 3, 2005.

Additional Information
The official instruction issued to your Medicare contractor regarding this change may be found at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 3992 in the CR NUM column on the right and click on the file for that CR. CMS will also update the Microsoft Excel files on the CMS Web site to reflect these revised payment limits. Those files are at ***www.cms.hhs.gov/providers/drugs/asp.asp*** on the CMS Web site.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Revised October 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective October 1, 2005

Medlearn Matters Number: MM4160
Related Change Request (CR) #: 4160
Related CR Release Date: October 28, 2005
Related CR Transmittal #: 729
Effective Date: October 1, 2005
Implementation Date: November 28, 2005

The following information affects all Medicare providers who bill Medicare for Part B drugs.

Provider Action Needed
Impact to You
Change Request (CR) 4160 revises the payment allowance limits in the October 2005 Medicare Part B drug pricing files.

What You Need to Know
The revised October 2005 payment allowance limits apply to dates of service October 1, 2005, through December 31, 2005.

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

Background
The Medicare Modernization Act of 2003 (MMA), Section 303(c), revises the methodology for paying for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs are paid based on the new average sales price (ASP) drug payment methodology. The ASP file, used in the ASP methodology, is based on data the Centers for Medicare & Medicaid Services (CMS) receives quarterly from manufacturers. Each quarter, CMS will update your carrier and fiscal intermediary (FI) payment allowance limits with the ASP drug pricing files based on these manufacturers' data.

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

Exceptions to General Rule
However, there are exceptions to this general rule as summarized below:

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

  Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
- For **infusion drugs** furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the DME is implanted. **The payment allowance limits will not be updated in 2005.**

  The payment allowance limits for infusion drugs furnished through a covered item of DME that were not listed in the published compendia as of October 1, 2003 (i.e., new drugs), are 95 percent of the first published AWP.
- For **influenza, pneumococcal, and hepatitis B vaccines**, payment allowance limits are 95 percent of the AWP as reflected in the published compendia.

- For **drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File**, payment allowance limits are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, carriers/FIs will follow the methodology specified in Chapter 17 of the Medicare Claims Processing Manual for calculating the AWP, but substitute WAC for AWP. Chapter 17 (Drugs and Biologicals) is available at ***www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf*** on the CMS Web site: The payment limit is 100 percent of the WAC for the lesser of the lowest brand or median generic. Your carrier or FI may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting carrier/FI or by posting an MS Excel file on the CMS Web site. If the payment limit is available from CMS, carriers/FIs will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File**, payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after January 1, 2005.
- The payment allowance limits for **radiopharmaceuticals** are not subject to ASP. Payment limits for radiopharmaceuticals are based on the methodology in place as of November 2003.

Your carrier/FI will not search and adjust claims that are processed prior to implementation of this change unless you bring such claims to their attention. The payment limits included in the revised ASP and NOC payment files supersede the payment limits for these codes in any publication published prior to this document.

Note that the absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit does not indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that specific category. The local Medicare contractor processing the claim will make these determinations.

Implementation

The implementation date for the instruction is November 28 2005.

Additional Information

The official instructions issued to the intermediary regarding this change can be found at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. On the above page, scroll down while referring to the CR NUM column on the right to find the link for CR 4160. Click on the link to open and view the CR.

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

National Modifier and Condition Code To Be Used To Identify Disaster-Related Claims

Medlearn Matters Number: MM4106
Related Change Request (CR) #: 4106
Related CR Release Date: October 14, 2005 **Revised**
Related CR Transmittal #: 184
Effective Date: August 21, 2005
Implementation Date: October 3, 2005, but no later than October 31, 2005
Note: This article was revised on October 14, 2005, to clarify that Change Request (CR) 4106 related to Medicare beneficiaries and it also relates to Hurricane Rita. In addition, the CR release date and transmittal number (see above) were modified.

The following information affects physicians, suppliers, and providers billing Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)) for services rendered to beneficiaries affected by Hurricane Katrina.

Provider Action Needed

Impact to You

This article is based on CR 4106, which establishes a new condition code and modifier for providers to use to indicate claims for victims of Hurricanes Katrina and Rita and other disasters.

What You Need to Know

To accommodate the emergency health care needs of Medicare beneficiaries and providers affected by Hurricanes Katrina and Rita and any future disasters, the Centers for Medicare & Medicaid Services (CMS) has created the following new condition code and

modifier, effective for dates of service on and after August 21, 2005. The new condition code is "**DR (Disaster Related)**" and the new modifier is "**CR (Catastrophe/Disaster Related)**."

What You Need to Do
See the "Background" section of this article for further details regarding these changes.

Background

CMS has acted to ensure that the Medicare program will be flexible enough to accommodate the emergency health care needs of beneficiaries and medical providers in the states devastated by Hurricanes Katrina and Rita. Many of the programs' normal operating procedures have been relaxed to speed the provision of health care services to the elderly and persons with disabilities who depend on Medicare services.

Because of hurricane damage to local health care facilities, many Medicare beneficiaries have been evacuated to neighboring states where receiving hospitals and nursing homes have no access to patients':

- Health care records;
- Current health status; or
- Verification of status as Medicare beneficiaries.

Note: CMS is assuring facilities and medical providers receiving Medicare beneficiaries affected by Hurricanes Katrina and Rita that **the normal requirements for documentation will be waived and the presumption of eligibility should be made**.

Health care providers that furnish medical services in good faith, but who cannot comply with normal program requirements because of Hurricanes Katrina and Rita, will be:

- Paid for services provided; and
- Exempt from sanctions for noncompliance (unless it is discovered that fraud or abuse occurred).

New Condition Code and Modifier

To facilitate Medicare claims processing and track services and items provided to victims of Hurricanes Katrina and Rita and any future disasters, CMS has established a new condition code and modifier for providers to use on disaster-related claims. The new condition code and modifier are for use by providers submitting claims for Medicare beneficiaries who are Katrina disaster patients in any part of the country and are effective for dates of service on and after August 21, 2005. The new codes are the following:

- The new condition code is **DR - Disaster Related**
- The new modifier is **CR - Catastrophe/Disaster Related**

For physicians or suppliers billing their local carrier or DMERC, only the modifier (CR) should be reported and not the condition code. A condition code is used in FI billing. For institutional billing, either the condition code or modifier may be reported. The condition code would identify claims that are impacted or may be impacted by specific payor policies related to a national or regional disaster. The modifier would indicate a specific Part B service that may be impacted by policy related to the disaster.

CR 4106 instructs Medicare contractors to recognize the new condition code and modifier on October 3, 2005, if possible, but no later than October 31, 2005.

In addition to this Medlearn Matters article, CMS regional offices will help facilitate contractor outreach regarding provider education on the use of the new modifier and condition code.

Implementation

The targeted implementation date is October 3, 2005, but no later than October 31, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/FI regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 4106 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/FI at their toll-free number, which may be found at ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Evidence of Medical Necessity: Power Wheelchair and Power Operated Vehicle (POV)/Power Mobility Device (PMD) Claims

Medlearn Matters Number: MM3952
Related Change Request (CR) #: 3952
Related CR Release Date: October 28, 2005 **Revised**
Related CR Transmittal #: 128
Effective Date: May 5, 2005
Implementation Date: The implementation date for the Medicare system changes contained in Change Request (CR) 3952 is April 3, 2006; otherwise, implementation will occur on October 25, 2005.
Note: This article was revised on November 3, 2005, to reflect that CR 3952 was revised and reissued on October 28, 2005. The CR release date and transmittal number (see above) were changed, but all other information remains the same.

The following information affects providers prescribing power mobility devices (PMDs) and suppliers billing Medicare durable medical equipment regional carriers (DMERCs) for PMDs.

Provider Action Needed

Impact to You

Effective for dates of service on or after May 5, 2005, the procedure for documenting and submitting a claim for a wheelchair or PMD has changed.

What You Need to Know

Make certain to meet criteria regarding who can prescribe PMDs, retain appropriate prescribing documentation, and understand the boundaries for prescribing and billing for PMDs.

What You Need to Do

Please be aware of the criteria addressed in the related instruction (CR 3952) and ensure that billing staffs submit claims accordingly.

Background

This article includes information from CR 3952 that outlines the changes regarding Medicare adjudication of claims for PMDs as set forth in Section 302 (a) (2) (E) (iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Also outlined are criteria determining who can prescribe PMDs and a definition of the devices. The following rules are in place for claims with dates of service on or after May 5, 2005:

Rules for Adjudicating Claims for PMDs

Physicians should be aware of the critical role they play in prescribing power wheelchairs. Specifically, physicians evaluate a patient's medical conditions and need for mobility and, as such, are the primary gatekeepers of the information CMS uses to base decisions for payment To this end, physicians should be conscientious when documenting patient encounters and pay particular attention to describing the patient's clinical condition (e.g., medical history, disease progression, changes in health status), as well as their need for mobility, their living situation (e.g., family support and caregivers), and other treatments that have been tried and considered. All of this information is used by our contractors (Medicare's DMERCs) when evaluating a claim for payment.

Face-to-Face Examination and Prescription

A condition for payment for motorized or power wheelchairs is that the PMD must be prescribed by a physician or treating practitioner (a physician assistant, nurse practitioner, or a clinical nurse specialist) who has conducted a face-to-face examination of the beneficiary and has written a prescription for the PMD. The face-to-face examination requirement does not apply when only accessories for PMDs are being ordered.

The written prescription (order) must include the following:

- Beneficiary's name;
- Date of the face-to-face examination;
- Diagnoses and conditions that the PMD is expected to modify;
- Description of the item;
- How long it is needed;
- The physician or treating practitioner's signature; and
- The date the prescription is written.

The written prescription (order) must be:

- In writing;
- Signed and dated by the physician or treating practitioner (a physician assistant, nurse practitioner or clinical nurse specialist) who performed the face-to-face examination; and
- Be received by the supplier within 30 days after the face-to-face examination.

The physician or treating practitioner must submit a written prescription (order) for the PMD to the supplier. This prescription must be received by the supplier

within 30 days of the face-to-face evaluation, or, in the case of a recently hospitalized beneficiary, within 30 days after the date of discharge from the hospital.

Additional Documentation

The physician or treating practitioner must also provide the supplier with additional documentation describing how the patient meets the clinical criteria for coverage as described in the National Coverage Determination (NCD), as documented in CR 3791. (Instructions for accessing CR 3791 are in the "Related Instructions" section of this article.) The actual documentation needed to describe how the coverage is met varies, but may include the history, physical examination, diagnostic tests, summary of findings, diagnoses, and treatment plans, along with any other information explaining the patient's need for the equipment.

Durable medical equipment (DME) suppliers should retain on file the prescription (written order), signed and dated by the treating physician or treating practitioner, along with the supporting documentation that supports the PMD as reasonable and necessary.

Other Rules

- It is no longer necessary to require a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology to provide a written order for power operated vehicles (POVs).
- The use of the certificates of medical necessity (CMNs) for motorized wheelchairs, manual wheelchairs, and POVs will be phased out for claims with dates of service (DOS) on or after May 5, 2005.
- Until Medicare systems changes are fully implemented in April 2006, for claims with DOS on or after May 5, 2005, suppliers must submit a partially completed and unsigned CMN.
- For claims with DOS before May 5, 2005, claims must be submitted and processed using the appropriate fully completed and signed CMN.

[**Note**: The information from a CMN (either a partially completed and unsigned CMN for services after May 5, 2005, or from a fully completed and signed CMN for services before May 5, 2005) needs to be submitted in the electronic claim. For ExpressPlus users, more information can be found in the article titled, "Data Entry Guidelines for ExpressPlus Users - Entering CMN Data for Wheelchairs," which is found on page 32 of this publication. Due to current system limitations, DMERCs will be editing claims based on the Initial Date of the CMN, not the DOS on the claims.]

Implementation

The implementation date for the system changes contained in CR 3952 is April 3, 2006; otherwise, implementation will occur on October 25, 2005.

Related Instructions

MM3791 provides additional information that describes the steps the healthcare provider must take to justify the POV. MM3791 lists the *Clinical Criteria for MAE Coverage*, along with the *MAE Coverage Flow Chart*. Go to ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3791.pdf*** on the CMS Web site to view that information.

For complete details, please see the official instruction regarding this change. The instruction includes the complete Section 280.3; it may be viewed by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 3791 in the CR NUM column on the right, and click on the file for that CR. You will note two files for CR 3791. The file reflecting transmittal number 37 contains the revisions to the *Medicare National Coverage Determinations Manual*, and the file with transmittal number 574 contains the Medicare claims processing business requirements/instructions.

Additional Information

For more information regarding wheelchair coverage, visit ***www.cms.hhs.gov/coverage/wheelchairs.asp*** on the CMS Web site. For complete details regarding CR 3952, please see the official instruction issued to your DMERC regarding this change. The instruction may be viewed at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 3952 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your DMERC at their toll-free number, which may be found at ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

DMERC A Billers: Additional specific guidance for Region A, including instructions for paper claims and the draft PMD policy, is available via the "What's New" section of the Region A Program Safeguard Contractor (PSC) Web site at: ***www.tricenturion.com/content/whatsnew_dyn.cfm***

Full Replacement of CR3607, Payment Edits in Applicable States for DMEPOS Suppliers of Prosthetics and Certain Custom-Fabricated Orthotics; CR 3607 is Rescinded

Medlearn Matters Number: MM3959
Related Change Request (CR) #: 3959
Related CR Release Date: August 19, 2005
Related CR Transmittal #: 656
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

The following information affects physicians, pedorthists, physical therapists, occupational therapists, orthotics personnel, and prosthetics personnel in Alabama, Florida, Illinois, New Jersey, Ohio, Oklahoma, Rhode Island, Texas, or Washington who provide or supply prosthetics and orthotics (P&O) and bill Medicare durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Impact to You

If you are an affected supplier in **Alabama, Florida, Illinois, New Jersey, Ohio, Oklahoma, Rhode Island, Texas, or Washington**, your state requires the use of a licensed/certified orthotist or prosthetist for furnishing orthotics or prosthetics. Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers in any one of these nine states planning to submit claims for Medicare payment for prosthetics and orthotics may enroll with the National Suppler Clearinghouse (NSC) and provide all required licenses and/or certifications to comply with Medicare requirements.

What You Need to Know

Change Request (CR) 3959 puts new edits in the DMERC claims processing system that will look for specialty codes 51, 52, 53, 55, 56, 57, 65, 67, and all physician specialty codes listed in the *Medicare Claims Processing Manual, Chapter 26, Section 10.8.2*, in order to ensure that only those who specify P&O on their enrollment application forms (Form CMS-855S) are reimbursed for P&O supplies. (**Note**: A copy of the state license for these specialty codes should also be on file at the NSC.)

What You Need to Do

Make certain that your billing staffs provide your specialty codes, required licenses, and/or certifications to the NSC.

Background

At this time, DMERCs process claims from enrolled and approved DMEPOS suppliers without noting the specialty identified and services to be provided on the enrollment application form (Form CMS-855S). Because there is no national Medicare policy regarding who may bill and be paid for prosthetics and certain custom-fabricated orthotics, the **NSC follows state requirements** that are in place in the (currently) nine states that require the use of an orthotist or prosthetist for furnishing of orthotics or prosthetics.

New Specialty Code Edits

The claims system used by the DMERCs will have new edits - effective for services supplied on or after the implementation date for this CR - that look for specialty codes to ensure that suppliers billing for prosthetics and/or orthotics are permitted to bill in accordance with the law **in the applicable states**. CMS regulations (see 42 CFR 424.57(c)) require that all DMEPOS suppliers wishing to bill Medicare meet all supplier standards. The standard in Section 424.57(c)(1) requires suppliers to operate their business and furnish Medicare-covered items in compliance with all applicable federal and state licensure and regulatory requirements.

The following specialties may be licensed or certified by the state when applicable, and they can bill for Medicare services when state law permits them to furnish prosthetic or orthotic items:

Specialty	Specialty Code
Medical Supply Company with Orthotics Personnel	51
Medical Supply Company with Prosthetics Personnel	52
Medical Supply Company with Orthotics and Prosthetics Personnel	53
Orthotics Personnel	55
Prosthetics Personnel	56
Orthotics Personnel, Prosthetics Personnel, and Pedorthists	57
Physical Therapist	65
Occupational Therapist	67
All physician specialty codes listed in the *Medicare Claims Processing Manual, Pub. 100-04, Chapter 26, § 10.8.2*.	

If you are located in one of the nine states listed in this article, check with the NSC to make certain that the correct specialty code is on file. The NSC is responsible for maintaining a central data repository for information regarding suppliers.

To ensure that your correct specialty code is on file and/or you need to update your file with the correct code, **you** must submit to the NSC a "Change of Information" on the CMS-855S form. The NSC will transmit this information to your DMERC.

Implementation

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

Additional Information

You can find more information about payment to suppliers qualified to bill Medicare for prosthetics and certain custom-fabricated orthotics, including the complete list of Healthcare Common Procedure Coding System (HCPCS) codes for customized orthotics and prosthetics affected by the edit by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the Centers for Medicare & Medicaid Services (CMS) Web site. From that Web page look for CR 3959 in the CR NUM column on the right, and click on the file for that CR. A list of the prosthetic and orthotic codes affected by this edit is attached to CR 3959.

The following is contact information for the NSC:

Toll-Free Number: 866-238-9652

Web site: ***www.PalmettoGBA.com***. Click on "Other Partners," or click on "Providers," then National Supplier Clearinghouse.

Email: medicare.nsc@palmettogba.com

Mailing address:
National Supplier Clearinghouse
P.O. Box 100142
Columbia, S.C. 29202-3142

Overnight Mailing Address:
National Supplier Clearinghouse
2300 Springdale Drive
Bldg 1, AG-495
Camden, S.C. 29020

New Diagnosis Code Requirements for Method II Home Dialysis Claims

Medlearn Matters Number: MM4095
Related Change Request (CR) #: 4095
Related CR Release Date: October 7, 2005
Effective Date: October 1, 2005
Related CR Transmittal #: 701
Implementation Date: November 7, 2005

The following information affects all providers/suppliers who submit Method II home dialysis claims to Medicare durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Impact to You

This article revises the diagnosis code requirements for Method II home dialysis claims.

What You Need to Know

Be aware that, on October 1, 2005, **diagnosis code 585.0 will no longer be accepted** by Medicare. Instead, **use diagnosis code 585.6** (End Stage Renal Disease) on Method II home dialysis claims.

What You Need to Do

Make certain that your billing staff knows that, on your DMERC claims, they **must use diagnosis code 585.6** instead of 585.0.

Background

On June 24, 2005, the Centers for Medicare & Medicaid Services (CMS) published the annual update to the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes. Based on that update, effective October 1, 2005, diagnosis code 585.0 will no longer be acceptable, and suppliers must use diagnosis code 585.6 (End Stage Renal Disease) on Method II home dialysis claims. Previously, instructions published in the *Medicare Claims Processing Manual*, Chapter 8, Section 90.2.1, required suppliers to use diagnosis code 585.0.

Implementation

The implementation date for the instruction is November 7, 2005.

Additional Information

The official instructions issued to DMERCs regarding this change can be found at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. On the above page, scroll down while referring to the CR NUM column on the right to find the link for Change Request (CR) 4095. Click on the link to open and view the CR.

Medlearn Matters article MM3888 describes the ICD-9-CM annual update. You may view the article at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3888.pdf*** on the CMS Web site.

If you have any questions, please contact your DMERC at their toll-free number, which may be found at ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Update to the Healthcare Provider Taxonomy Codes (HPTC) Version 5.1

Medlearn Matters Number: MM4072
Related Change Request (CR) #: 4072
Related CR Release Date: September 30, 2005
Related CR Transmittal #: 694
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

The following information affects physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4072, which includes details regarding the version 5.1 healthcare provider taxonomy codes (HPTC) update.

What You Need to Know

CR 4072 advises your carrier and/or DMERC to obtain the HPTC list version 5.1 and use it to update their internal HPTC tables to process your claim(s) correctly.

What You Need to Do

Please see the "Background" section of this article for further details regarding this update.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that submitted data, which is part of a named code set, be valid data from that code set. Claims with invalid data are non-compliant. Because healthcare provider taxonomy is a named code set in the American National Standards Institute (ANSI) X12N 837 Professional Implementation Guide, Medicare carriers, including DMERCs, must validate the inbound taxonomy codes against their internal HPTC tables.

The HPTC is an external non-medical data code set designed for use in classifying healthcare providers in an electronic environment according to provider type, or practitioner specialty. HPTCs are scheduled to be updated twice per year (April and October). The updated code list is available from the Washington Publishing Company (WPC) at ***www.wpc-edi.com/codes/taxonomy*** in two forms:

- Free Adobe Portable Document Format (PDF) download; and
- Available for purchase, an electronic representation of the list, which will facilitate the automatic loading of the code set.

CR 4072 advises your carrier and/or DMERC to use the most cost-effective means to obtain the version 5.1 HPTC list and update their HPTC tables as necessary.

Implementation

The implementation date for the instruction is October 3, 2005.

Additional Information

To summarize the changes in version 5.1, the following taxonomy codes are added:

- 170300000X
- 171000000X
- 1710I1002X
- 1710I1003X

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the Center for Medicare & Medicaid Services (CMS) Web site. From that Web page, look for CR 4072 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*** on the CMS Web site.

Claim Status Code/Claim Status Category Code Update

Medlearn Matters Number: MM3960
Related Change Request (CR) #: 3960
Related CR Release Date: July 29, 2005
Related CR Transmittal #: 631
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

The following information affects all providers submitting Health Care Claim Status Transactions to Medicare carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs).

Provider Action Needed

This is a reminder item regarding the periodic update of certain code sets used as a result of the Health Insurance Portability and Accountability Act (HIPAA). Effective January 1, 2006, the Medicare claims processing system will update its lists of Health Care Claims Status Codes and Health Care Claims Status Category Codes with all applicable code changes posted online with the "new as of 10/05" and prior date designations.

Background

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

Claim Status Category Codes and Claim Status Codes are used in the Health Care Claim Status Inquiry and Response (276/277) transactions:

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

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

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/FI/RHHI 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 Change Request (CR) 3960 in the CR NUM column on the right, and click on the file for that CR.

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

Financial Liability for Services Subject to Home Health Consolidated Billing

Medlearn Matters Number: MM3948
Related Change Request (CR) #: 3948
Related CR Release Date: August 5, 2005
Related CR Transmittal #: 635
Effective Date: October 1, 2000
Implementation Date: November 3, 2005

The following information affects home health agencies (HHAs) and providers and suppliers of services to Medicare patients in a home health episode of care.

Provider Action Needed

This instruction is intended mostly as an informational refresher. However, the article and Change Request (CR) 3948 clarify guidance regarding home health services (HHS) consolidated billing, particularly the guidance that addresses potential provider and beneficiary liability for payment. **Providers/suppliers treating Medicare patients in an episode of home health care are encouraged to review the entire CR 3948.** Instructions for accessing CR 3948 are provided at the end of this article. The Centers for Medicare & Medicaid Services (CMS) is providing this information because questions about payment liability have persisted since the Home Health Prospective Payment System (HH PPS) was implemented in October 2000. CMS believes that providing clear answers in the *Medicare Claims Processing Manual* will help you better understand HH PPS.

Background

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing for all home health services that are included under a physician-authorized home health care plan. Earlier guidance and information about HH PPS consolidated billing was primarily published in articles attached to Program Memoranda. CR 3948 (from which this article is taken) improves the organization of and clarifies instructions about HH PPS. In particular, it identifies circumstances in which providers or beneficiaries may be liable for payment for services subject to HH PPS consolidated billing.

A Short Summary of the Guidance

Under HHS consolidated billing, only the primary HHA can bill for services included in a beneficiary's home health benefit during the beneficiary's HHA episode of care. With the exception of durable medical equipment (DME) and physician-provided therapy services (discussed below), Medicare will not separately pay other providers or suppliers for any home health services that they render. Therefore, providers and suppliers of home health services should be aware that, under certain circumstances, they, or the beneficiary, could potentially bear the cost of these services.

The Guidance in More Detail

HH PPS consolidated billing provides that the Medicare payment for all of a beneficiary's home health items and services is to be made to a single (known as "primary") HHA that oversees that beneficiary's physician-authorized home health plan. This primary HHA is the **only** agency that may bill Medicare for home care for a given homebound beneficiary at a specific time. Further, the payment Medicare makes is to the primary HHA, regardless of who actually furnishes the service (including services furnished by others under arrangement to the primary HHA, by any other contracting or consulting arrangements existing with the primary HHA, or by any other mechanism). However, while the primary HHA is responsible for providing all of a patient's home health services, they would not be responsible for payment to another provider if they were unaware of the physician's orders for that service. Therefore, if an independent provider/supplier were to provide the beneficiary a home health service that was already consolidated into the HHA's payment, his/her claim would be denied by Medicare and he/she would not receive payment.

Types of Services Subject to Home Health Billing

The following types of services are subject to this home health consolidated billing provision, and are included in the primary HHA's payment:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and non-routine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of an HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

Two types of services, however, are an exception to this guidance, and are therefore not subject to the home health consolidated billing methodology. These services are:

- Physician-performed therapy services (which means that although the procedure code would be subject to HH consolidated billing, the specialty code which indicates that it was provided by a physician removes it); and
- Durable medical equipment (DME).

Billing of Durable Medical Equipment

DME warrants some further discussion. DME may be billed by a supplier to a durable medical equipment regional carrier (DMERC) or billed by an HHA (including HHAs other than the primary HHA) to a regional home health intermediary (RHHI). To prevent duplicate RHHI and DMERC billing (the same dates of service for the same beneficiary), Medicare system edits ensure that all DME items billed by HHAs have a line-item date of service and Healthcare Common Procedure Coding System (HCPCS) code, even though, by law, HH consolidated billing does not apply to DME. If the RHHI and the DMERC receive duplicate bills (for either purchase or rental), the first claim received will be processed and paid, and the subsequent duplicate claims will be denied.

How Do You Protect Yourself and the Beneficiaries?

In general, all providers and suppliers serving a home health patient should attempt to protect the beneficiary from unexpected liability by notifying them of the possibility that they can be responsible for payment.

Primary HHAs

Let's first discuss your responsibilities if you are the primary HHA. When a homebound beneficiary seeks care from you, you need to determine if he/she is already being served by a primary HHA. You can ask the beneficiary or his/her representative, if he/she is already being served by an HHA. Or, you can send an inquiry to your RHHI. If the response indicates that the beneficiary is not already under the care of another HHA, you may admit him/her and you will become primary. The HHA that submits a successfully processed request for anticipated payment (RAP) or No-RAP Low Utilization Payment Adjustment (LUPA) will be recorded as the primary HHA for a given episode in the Common Working File (CWF). You may also admit him/her, even if an episode is already open at another HHA, if the patient has chosen to transfer. If a beneficiary transfers during a 60-day episode, then the transfer HHA that establishes the new plan of care assumes responsibility for that patient's consolidating billing.

At the time of his/her initial home health care admission, you, as the primary HHA, must advise the patient that you will be providing all of his/her home health services, including therapies and supplies. You must also explain the disciplines (e.g., skilled nursing, physical therapy, home health aide, etc.) that will be furnishing his/her care, and the proposed visit frequency. In addition, you must advise the patient, in advance (both orally and in writing), about possible payment sources, including what Medicare is expected to cover, as well as other payment sources, including payment from the patient. This discussion should help alert the beneficiary to the possibility of payment liability if he/she was to obtain services from anyone other than his/her primary HHA.

Independent Providers/Suppliers

Since Medicare payment for services that fall under home health consolidated billing is made to the primary HHA, independent providers or suppliers of these services need to understand that Medicare will not pay you separately. Therefore, before you provide a homebound beneficiary any services, you need to first determine if he/she is being served by a primary HHA. To get this information you can, first, ask the beneficiary (or his/her authorized representative) if he/she is currently receiving home health services under a home health plan of care. In fact, beneficiaries and their representatives should have the most complete information as to whether or not they are receiving home health care. But, beneficiary-derived HH information, in and of itself, does not shift liability to either the beneficiary or to Medicare. Additionally, you can ask your intermediary or carrier.

Institutional providers who bill fiscal intermediaries (FIs) can access this information electronically through the home health CWF inquiry process (See Chapter 10, Section 30.1, Health Insurance Eligibility Query to Determine Episode Status attached to CR 3948.) Independent therapists who bill carriers or suppliers who bill DMERCs can call the provider toll-free line to request home health eligibility information available on the CWF. (Those toll-free numbers are available at ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.) But remember that the carrier's or DMERC's information is based only on claims Medicare has received from HHAs by the day of the contact.

If you are concerned about the reliability of any of this information, you should advise the HH beneficiary that if he/she decides to accept your services rather than those provided by the primary HHA, he/she could be liable for the payment.

Finally, if you learn of a home health episode and contact the primary HHA, you might inquire about the possibility of making a payment arrangement with them for the service. Such contacts may foster relationships between therapy providers, suppliers, and HHAs that are beneficial both to the providers involved and to Medicare beneficiaries.

Hospitals

Hospitals are responsible for making Medicare beneficiaries and caregivers aware of Medicare home health coverage policies in order to:

- Help ensure that those services are provided appropriately; and
- Alert the beneficiary to his/her potential liability under home health consolidated billing.

Under the Medicare Conditions of Participation (COP) for Hospitals: Discharge planning, (42 CFR, §482.43 (b) (3) and (6)), your discharge planning process must include an evaluation of the likelihood that a patient will require post-hospital services and an evaluation of

their availability. Hospitals need to counsel those beneficiaries who are to receive HH services after discharge that their primary HHA will provide all of their home health services. You should also provide them with a list of HHAs from which to choose, and notify the agency that you are referring the patient to and provide the agency with any counseling notes. This should serve as a reminder to the HHA to notify the beneficiary that they will be providing all of his/her HH services.

Other Important Information

Institutionalizing an HH Patient

Under HH PPS, claims for inpatient hospital and skilled nursing facility (SNF) services have priority over claims for home health services. Because institutionalized beneficiaries cannot receive home care, if Medicare detects dates of service on an HH PPS claim that fall within the dates of an inpatient or SNF claim (not including the dates of admission and discharge), the RHHI will reject the HH claim. This will be the outcome even if the HH PPS claim were received first and the SNF or inpatient hospital claims came in later.

Edits and Denials

Claims subject to consolidated billing may be identified either pre-payment or post-payment. HH consolidated billing editing is applied when Medicare has received and processed the episode claim. Any line-item services within the episode start and end, or last billable service dates, will be edited. Medicare sends information to the FIs and carriers that enable them to reject or deny line items on claims subject to consolidated billing. This rejection or denial may take place either prior to, or after, payment. If it occurs after payment, Medicare notifies the FI or carrier to make a post-payment rejection or denial. FI post-payment recoveries will be made automatically in the claims process, and carriers follow their routine overpayment identification and recovery procedures.

Important editing issues include the following:

- If Medicare receives only a Request for Anticipated Payment (RAP) from an HHA for an episode and an incoming claim from another provider contains dates of service within the 60-day home health episode period, Medicare alerts the FI or carrier that the incoming claim may be subject to consolidated billing.

  The FI or carrier will process the claim for payment, but also alerts the provider on the remittance advice with remark code **N88**: "This payment is being made conditionally. An HHA episode of care notice has been filed for this patient...This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."
- If an independent provider/supplier submits a claim for services (subject to home health consolidated billing) for a beneficiary under a home health care plan (place of service on the claim is "12 home"), but Medicare does not yet have a record of either a RAP or a home health claim for the episode of care, your carrier will alert you on the remittance advice with remark code **N116**: "This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care…This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care."
- In HH PPS consolidated billing, non-routine medical supplies are identified as a list of discrete items by HCPCS code. Medicare periodically publishes Routine Update Notifications that contain updated lists of non-routine supply codes and therapy codes that must be included in home health consolidated billing. The lists are updated annually, effective January 1, as a result of the annual changes in HCPCS codes, and also as frequently as quarterly if required by the creation of new, mid-year HCPCS codes. (Medlearn Matters articles are prepared to inform providers of these periodic updates.)
  - Any claim submitted to a DMERC, with dates of service that overlap the dates of an open HH PPS episode and containing a non-routine supply HCPCS code, will be denied.
  - Non-routine supply HCPCS codes, which may be claimed as part of providing certain emergency, surgical, diagnostic, and end stage renal disease (ESRD) services, are either bundled into the rate paid for the primary service, or are otherwise incident to the primary service(s) being rendered. They do not fall within the bundling provisions of HH PPS and are not subject to CWF consolidated billing edits.
- Medicare enforces consolidated billing for outpatient therapies on claims submitted to FIs, recognizing as therapies all services billed under revenue codes 042X, 043X, and 044X. These revenue codes have been cross-referenced to a list of HCPCS codes that represent the same services for use in editing against carrier claims. This list will also be updated periodically by Routine Update Notification.
- Remember, however, as mentioned earlier, physician-performed therapy services are not subject to home health consolidated billing.

- **Osteoporosis drugs** are subject to home health consolidated billing, even though they continue to be paid on a cost basis. Only a primary HHA can bill for their use by Medicare patients in an episode of care. For more detailed information, refer to Section 90.1 of Chapter 10 of the *Medicare Claims Processing Manual*, which is available at ***www.cms.hhs.gov/manuals/104_claims/clm104index.asp*** on the CMS Web site.

Additional Information

This article summarizes the information made available in CR 3948. Providers treating Medicare patients in a home health episode of care are encouraged to be familiar with all the details of CR 3948. You can find CR 3948 at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 3948 in the CR NUM column on the right, and click on the file for that CR. CR 3948 includes revised portions of the *Medicare Claims Processing Manual* related to the HH PPS.

Finally, if you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Nature and Effect of Assignment on Carrier Claims

Medlearn Matters Number: MM3897
Related Change Request (CR) #: 3897
Related CR Release Date: August 12, 2005
Related CR Transmittal #: 643
Effective Date: January 1, 2005
Implementation Date: November 14, 2005

The following information affects physicians and suppliers who are Medicare participating physicians/suppliers and non-participating physicians/suppliers who are required by law to accept assignment (direct payment) from Medicare carriers, including durable medical equipment regional carriers (DMERCs), for covered Part B services, equipment, and supplies.

Provider Action Needed

Providers need to be aware that on January 1, 2005, Medicare regulations at 42 C.F.R. 424.55 were amended to eliminate the requirement that beneficiaries formally assign claims to suppliers when suppliers are **required by law** to accept assignment. In other words, the beneficiary is not required to assign the claim to the physician or supplier in order for an assignment to be effective in "mandatory assignment" situations.

Background

This action affirms the pattern that has emerged over time as the Social Security Act was amended in various sections to require suppliers to accept assignment for Medicare-covered services whether or not the beneficiary actually assigned the claim to the supplier. The following is a synopsis of the Change Request (CR) 3897 and the revised Medicare Claims Processing instructions (Chapter 1, Section 30.3.2) that are attached to CR 3897:

- Physicians and suppliers who accept assignment from Medicare, by choice or by law, may **not** attempt to collect more than the appropriate Medicare deductible and coinsurance amounts from the beneficiary, his/her other insurance, or anyone else.
- If the physician/supplier is not satisfied with the amount allowed by Medicare, procedures are in place for appeal of the contractor initial determination.
- If an enrollee has private insurance in addition to Medicare, the physician/supplier is in violation of his/her assignment if he/she collects from the enrollee or the private insurance an amount that when added to the Medicare benefit exceeds the Medicare allowed amount.
- The beneficiary must continue to authorize the release of medical or other information necessary to process the claim.
- A non-participating physician/supplier who accepts assignment for some Medicare-covered services is not prohibited from billing the patient for services for which he/she does not accept assignment. Also, the non-participating physician/supplier is not precluded from billing a patient for services that are not covered by Medicare.
- Physicians/suppliers should remember they may **not** attempt to "fragment" their bills. Fragmenting is defined as accepting assignment for some services and then billing the enrollee for other services performed at the same place and on the same occasion. When Medicare carriers become aware that services are being "fragmented," they will inform the physician/supplier that the practice is unacceptable and that he/she must either accept assignment or bill the enrollee for all services performed at the same place on the same occasion. There is an **EXCEPTION**. In situations where assignment is mandatory, i.e., where a physician/supplier must accept assignment for certain services as a condition for any payment or for full payment to be made (e.g., clinical diagnostic laboratory tests, physician

assistants), he/she may accept assignment for those conditional services without accepting assignment for other services furnished by him/her for the same enrollee at the same place and on the same occasion.

Implementation

The implementation date for CR 3897 is November 14, 2005.

Related Instructions

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the Centers for Medicare & Medicaid Services (CMS) Web site. From that Web page, look for CR 3897 in the CR NUM column on the right, and click on the file for the desired CR.

For additional information relating to this issue, please refer to your carrier/DMERC. To find their toll-free telephone numbers go to ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Requirements for Voided, Canceled, and Deleted Claims

Medlearn Matters Number: MM3627
Related Change Request (CR) #: 3627
Related CR Release Date: June 17, 2005 **Revised**
Related CR Transmittal #: 159
Effective Date: October 1, 2005
Implementation Date: October 3, 2005
Note: This article was revised on October 4, 2005, to correct errors in the "Acceptable Claims Deletions" subsection, of the "Background" section. Specifically, references to form HCFA-1500 were corrected to state form CMS-1500.

The following information affects all Medicare physicians, providers, and suppliers billing Medicare carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs).

Provider Action Needed

This Medlearn Matters article is based on information contained in Change Request (CR) 3627, which describes new Centers for Medicare & Medicaid Services (CMS) procedures and specific instructions to Medicare contractors (Medicare carriers, intermediaries, and DMERCs) for voiding, canceling, and deleting claims. As a result of these changes, providers should note that some claims they were able to delete in the past will no longer be deleted from Medicare's systems, but will instead become denied claims.

Background

The Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) has verified instances in which Medicare claims have been voided, cancelled, or deleted by Medicare carriers, DMERCs, and FIs. Further, the Medicare contractors have not traditionally maintained an audit trail for the voided, cancelled, or deleted claims. The OIG has indicated that Medicare must maintain an audit trail for voided, cancelled, and deleted claims. CMS is therefore implementing requirements for Medicare contractors (carriers/FIs, including DMERCs and regional home health intermediaries (RHHIs)) to:

- Deny or reject claims that do not meet CMS requirements for payment for unacceptable reasons;
- Cancel, void, or delete claims that are unprocessable for acceptable reasons;
- Return as unprocessable claims that meet conditions mentioned below for the return of unprocessable claims; and
- Maintain an audit trail for all cancelled, voided, or deleted claims that Medicare systems have processed far enough to have assigned a Claim Control Number (CCN) or Document Control Number (DCN).

Note: CR 3627 requires that Medicare carriers, intermediaries, and DMERCs keep an audit trail on these claims once a CCN or DCN has been assigned to the claim.

Acceptable Claims Deletions

Below is a list of acceptable reasons a Medicare contractor may cancel, delete, or void a claim:

1. The current CMS-1500 form or the current CMS-1450 form is not used.
2. The front and back of the CMS-1500 (12/90) claim form are required on the same sheet and are not submitted that way (claims submitted to carriers only).
3. A breakdown of charges is not provided, i.e., an itemized receipt is missing.
4. Only six line items have been submitted on each CMS-1500 claim form (Part B only).
5. The patient's address is missing.
6. An internal clerical error was made.
7. The certificate of medical necessity (CMN) was not with the claim (Part B only).
8. The CMN form is incomplete or invalid (Part B only).

9. The name of the store is not on the receipt that includes the price of the item (Part B only).

Note: The Medicare contractor must keep an audit trail for all claims in the above "Acceptable Claims Deletions" category if a CCN or a DCN was assigned to the claim.

Unacceptable Claims Deletions

The following are unacceptable reasons for Medicare contractors to void, cancel, or delete claims:

1. A provider notifies the Medicare contractor that claim(s) were billed in error and requests the claim be deleted (carrier claims only).
2. The provider goes into the claims processing system and deletes a claim via any mechanism other than submission of a cancel claim (type of bill xx8). Providers may only cancel claims that are not suspended for medical review or have not been subject to previous medical review. (FI claims only)
3. The patient's name does not match any Health Insurance Claim Number (HICN).
4. A claim meets the criteria to be returned as unprocessable under the incomplete or invalid claims instructions in the *Medicare Claims Processing Manual*, Chapter 1, Section 80.3.2.ff, which is available at ***www.cms.hhs.gov/manuals/104_claims/clm104index.asp*** on the CMS Web site.

Medicare contractors must deny or reject claims in the above "Unacceptable Claims Deletions" category.

Return as Unprocessable Claims

Medicare contractors may return a claim as unprocessable for the following reasons:

1. Valid procedure codes were not used and/or services are not described (e.g., Item 24D of the CMS-1500) (Part B only).
2. The patient's HICN is missing, incomplete, or invalid (e.g., Item 1A of the CMS-1500).
3. The provider number is missing or incomplete.
4. No services are identified on the claim.
5. Item 11 (insured policy group or FECA Number) of the CMS-1500 is not completed to indicate whether an insurer primary to Medicare exists (Part B only).
6. The beneficiary's signature information is missing (Part B only).
7. The ordering physician's name and/or Unique Physician Identification Number (UPIN) are missing/invalid (Items 17 and 17A of the CMS-1500).
8. The place of service code is missing or invalid (Item 24B of the CMS-1500 - Part B only).
9. A charge for each listed service is missing (e.g., Item 24F of the CMS-1500).
10. The days or units are missing (e.g., Item 24G of the CMS-1500).
11. The signature is missing from Item 31 of the CMS-1500 (Part B only).
12. Dates of service are missing or incomplete (Item 24A of the CMS-1500).
13. A valid HICN is on the claim, but the patient's name does not match the name of the person assigned that HICN.

Summary

In summary, CMS believes the following:

- The problems listed under the "Acceptable Claims Deletions" heading are valid reasons to void/delete/cancel a claim if the Medicare contractor maintains an audit trail; and
- Claims with problems listed under the "Unacceptable Claims Deletions" heading should be denied or rejected by Medicare, and the decision to deny/reject the claim should be recorded in the Medicare contractor's claims processing system history file.

If a Medicare contractor determines that a claim is unprocessable before the claim enters that contractor's claims processing system (i.e., the claim processing system **did not assign a CCN or DCN** to the claim):

- The claim may be denied; and
- The contractor does not have to keep a record of the claim or the deletion.

If a Medicare contractor determines that a claim is unprocessable after the claim enters their claims processing system (i.e., the claim processing system **did assign a CCN or DCN** to the claim):

- The denied or rejected claim will not be totally deleted from Medicare's claims processing system. The Medicare contractor must maintain an audit trail for all deleted claims that have entered the claims processing system (i.e., the system assigned a CCN or DCN to the claim).

Implementation

The implementation date for the instruction is October 3, 2005.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.a***

sp on the CMS Web site. From that Web page, look for CR 3627 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*** on the CMS Web site.

The Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contract (RAC) Initiative

Medlearn Matters Number: SE0565
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The following information affects physicians, providers, and suppliers, especially in California, Florida, and New York.

Provider Action Needed

Physicians, providers, and suppliers should note that this initiative is designed to determine whether the use of Recovery Audit Contracts (RACs) will be a cost-effective means of ensuring that you receive correct payments and to ensure that taxpayer funds are used for their intended purpose. As the states with the largest Medicare expenditure amounts, California, Florida, and New York were selected for pilot RACs that began earlier this year and that will last for three years. Contractors selected for this pilot program will identify and collect Medicare claims overpayments that were not previously identified by the Medicare Affiliated Contractors (MACs), which include carriers, fiscal intermediaries (FIs), and durable medical equipment regional carriers (DMERCs).

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 306) directs the Secretary of the U.S. Department of Health and Human Services (HHS) to demonstrate the use of RACs under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the Medicare program (for services for which payment is made under Part A or Part B of Title XVIII of the Social Security Act).

Update

On January 11, 2005, the Centers for Medicare & Medicaid Services (CMS) announced the recovery audit contractor demonstration project. (See Medlearn Matters article SE0469, which is available at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0469.pdf*** on the CMS Web site.) The demonstration, mandated by the MMA, will evaluate the use of recovery audit contractors in identifying Medicare underpayments and overpayments and recouping overpayments.

On March 28, 2005, CMS awarded five RACs and officially announced the beginning of the recovery audit contractor demonstration. Three of the five recovery audit contractors will perform post-payment medical review in the states of California, Florida, and New York. Those firms and the state they are responsible for are as follows:

- Connolly Consulting will perform claim reviews for providers who are serviced by a FI or carrier in New York. Connolly Consulting will also perform reviews for durable medical equipment claims for Medicare beneficiaries who reside in New York.
- PRG Schultz and its subcontractor, Concentra Preferred Systems, will perform claim reviews for providers who are serviced by a FI or carrier in California. PRG Schultz will also perform reviews for durable medical equipment claims for beneficiaries who reside in California.
- HealthData Insights will perform claim reviews for providers who are serviced by a FI or carrier in Florida. Connolly Consulting will also perform reviews for durable medical equipment claims for beneficiaries who reside in Florida.

CMS is committed to alerting the provider community regarding the focus of the recovery audit contractor demonstration. The recovery auditors have at least three years of claims they may review.

Three-Tiered Review Process

The recovery audit contractors have a three-tiered process that is explained below:

- The first level involves Part A Diagnosis Related Group (DRG) reviews. These reviews normally involve making a request for medical records. Providers located in Florida began seeing medical record requests in August.

Providers located in New York began seeing medical record requests in September. California providers will see medical record requests some time after October.

- The second level involves overpayments determined by the recovery audit contractor's proprietary data mining systems. These are overpayments that clearly do not meet the requirements of Medicare policies. These overpayments do not require a medical record request because it is very clear that an overpayment has occurred. However, CMS is approving a sample of these overpayments before the demand letters are released. In October 2005, physicians in Florida may receive overpayment demand letters resulting from these automated reviews. Beginning in October, physicians in California and New York may also see overpayment demand letters resulting from these reviews.
- The last level involves the actual request of medical records for Part B services. All of the recovery companies have indicated that physicians may see medical record requests for Part B services in October or November of 2005. In a future Medlearn Matters article, CMS will update the provider community when medical record requests could be made.

Note: Questions concerning the recovery audit contractor demonstration may be directed to an email address CMS has established for the demonstration. That email address is **cmsrecoveryauditdemo@cms.hhs.gov**.

Additional Information

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*** on the CMS Web site.

Find out more about the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) at ***www.cms.hhs.gov/medicarereform/*** on the CMS Web site.

Medical Review Additional Documentation Requests (ADRs)

Medlearn Matters Number: MM4022
Related Change Request (CR) #: 4022
Related CR Release Date: September 30, 2005
Related CR Transmittal #: 125
Effective Date: December 30, 2005
Implementation Date: December 30, 2005

The following information affects all Medicare providers and suppliers.

Provider Action Needed

Impact to You

Through the use of the additional documentation request (ADR), your carrier, including durable medical equipment regional carriers (DMERCs), or intermediary may ask you for additional documentation regarding a particular Medicare claim.

What You Need to Know

To get a more complete picture of a patient's clinical condition, Change Request (CR) 4022 allows carriers, DMERCs, and intermediaries to request additional documentation about the patient's condition before and after a specific service to gain a more complete picture of the patient's clinical condition.

What You Need to Do

Your staffs should be aware of ADRs and should be prepared to respond to them within 30 days.

Background

When a carrier, DMERC, or intermediary (also referred to as Medicare contractor(s)), cannot make a coverage or coding determination from the information that has been provided on a claim and its attachments, they may ask for additional documentation by issuing an ADR. The Medicare contractor must request records related to the claim(s) being reviewed. The Medicare contractor may collect documentation related to the patient's condition before and after a service in order to get a more complete picture of the patient's clinical condition. Your Medicare contractor will not deny other claims related to the documentation of the patient's condition before and after the claim in question unless they review and give appropriate consideration to the actual additional claims and associated documentation.

Additional Information

For more information about ADRs during prepayment or post-payment medical review, go to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the Centers for Medicare & Medicaid Services (CMS) Web site. From that Web page, look for CR 4022 in the CR NUM column on the right and click on the file for that CR. Also useful is the *Medicare Program*

Integrity Manual, Chapter 3 (Verifying Potential Errors and Taking Corrective Actions), Section 3.4.1.2 (Additional Documentation Requests (ADR) During Prepayment or Postpayment MR), which is an attachment to CR 4022.

Finally, if you have any questions, please contact your carrier/DMERC/intermediary at their toll-free number, which may be found at ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Full Replacement of and Rescinding Change Request (CR) 3504 - Modification to Online Medicare Secondary Payer Questionnaire

Change Request (CR) 3504 was to have made several changes to the "Medicare Secondary Payer Questionnaire." However, only one of the changes was specifically mentioned in CR 3504. In addition, none of the changes were incorporated in the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOM).

We [CMS] have received concerns that CR 3504 did not specify all the changes we made to the "Medicare Secondary Payer Questionnaire." This CR (4098, transmittal 41, dated October 21, 2005) will alert providers to the changes that were made, will incorporate these changes in the IOM, and will make additional changes to the model questionnaire to assist providers in identifying other payers that may be primary to Medicare.

For complete details, please see the official instruction regarding this change. That instruction (CR 4098) may be viewed at ***www.cms.hhs.gov/manuals/pm_trans/R41MSP.pdf*** on the CMS Web site. The following is the revised IOM questionnaire (changes in italics):

Medicare Secondary Payer (MSP) Manual

Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements

20.2.1 - Admission Questions to Ask Medicare Beneficiaries

(Rev. 41, Issued: 10-21-05; Effective/Implementation Dates: 01-21-06)

The following *questionnaire contains* questions *that can be used* to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers *may use this* as a guide to help identify other payers that may be primary to Medicare. *This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.*

Part I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: *MM/DD/CCYY*

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

___ No.

2. Are the services to be paid by a government program such as a research grant?

___ Yes; Government Program will pay primary benefits for these services

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

___ Yes.

DVA IS PRIMARY FOR THESE SERVICES.

___ No.

4. Was the illness/injury due to a work related accident/condition?

___ Yes; Date of injury/illness: *MM/DD/CCYY*

Name and address of WC plan: _____

Policy or identification number: _____

Name and address of your employer: _____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS, GO TO PART III.

___ No. **GO TO PART II.**

Part II

1. Was illness/injury due to a non-work related accident?

___ Yes; Date of accident: *MM/DD/CCYY*

___ No. **GO TO PART III.**

2. What type of accident caused the illness/injury?

___ Automobile.

___ Non-automobile.

Name and address of no-fault or liability insurer: _____

Insurance claim number: _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ Other

3. Was another party responsible for this accident?

___ Yes;

Name and address of any liability insurer: _____

Insurance claim number: _____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ No. **GO TO PART III.**

Part III

1. Are you entitled to Medicare based on:

___ Age. **Go to Part IV.**

___ Disability. **Go to Part V.**

___ ESRD. **Go to Part VI.**

Part IV - Age

1. Are you currently employed?

___ Yes.

Name and address of your employer: _____

___ No. Date of retirement: *MM/DD/CCYY*

___*No. Never Employed.*

2. Is your spouse currently employed?

___ Yes.

Name and address of spouse's employer: _____

___ No. Date of retirement: *MM/DD/CCYY*

___*No. Never Employed.*

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?

___ Yes.

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. Does the employer that sponsors your GHP employ 20 or more employees?

___ Yes. **STOP. *GHP* IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP: _____

Policy identification number (*this number is sometimes referred to as the health insurance benefit package number*): _____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/*named insured*: _____

Relationship to patient: _____

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

Part V - Disability

1. Are you currently employed?

___ Yes.

Name and address of your employer: _____

___ No. Date of retirement: *MM/DD/CCYY*

___*No. Never Employed.*

2. *If married, is your spouse* currently employed?

___ Yes.

Name and address of your *spouse's* employer: _____

___ *No. Date of retirement: MM/DD/CCYY*

___*No. Never Employed.*

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?

___ Yes.

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO THE QUESTIONS IN PART I OR II.**

4. Are you covered under the group health plan of a family member other than your spouse?

_____*Yes.*

Name and address of your family member's employer: _____

_____*No.*

5. Does the employer that sponsors *the* GHP employ 100 or more employees?

___ Yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP: _____

Policy identification number (*this number is sometimes referred to as the health insurance benefit package number*): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/*named insured*: _____

Relationship to patient: _____

___ No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.**

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

*If yes, n*ame and address of GHP: _____

Policy identification number (*this number is sometimes referred to as the health insurance benefit package number*):_____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/*named insured*: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

___ No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

___ Yes. Date of transplant: *MM/DD/CCYY*

___ No.

3. Have you received maintenance dialysis treatments?

___ Yes. Date dialysis began: *MM/DD/CCYY*

If you participated in a self-dialysis training program, provide date training started: CCYY/MM/DD

___ No

4. Are you within the 30-month coordination period *that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)*

___ Yes

___ No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ Yes.

___ No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

___ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primarily based on age or disability entitlement?

___ Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

___ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in *the Common Working File (*CWF*)* for the beneficiary, the provider still asks the *types of* questions above and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition Medlearn Matters Articles on NPI-Related Activities

Medlearn Matters Number: SE0555
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Revised: This article was revised on October 3, 2005, to modify the language (in italicized print) in the first sentence under Part 2. All other information remains the same.

Table of Contents

The following information affects providers and suppliers who conduct Health Insurance Portability and Accountability Act (HIPAA) standard transactions, such as claims and eligibility inquiries. In addition, organizations or associations that represent providers and plan to obtain National Provider Identifiers (NPIs) for those providers should take note of this article.

Part 1: Information That Applies to All Providers

Background

All healthcare providers are eligible to receive NPIs. All HIPAA-covered healthcare providers, whether they are **individuals** (such as physicians, nurses, dentists, chiropractors, physical therapists, or pharmacists) or **organizations** (such as hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, health maintenance organizations, suppliers of durable medical equipment, pharmacies, etc.) must obtain an NPI for use to identify themselves in HIPAA standard transactions. Once enumerated, a provider's NPI will not change. The NPI remains with the provider regardless of job or location changes.

Note: HIPAA-covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use **only** the NPI to identify covered healthcare providers in standard transactions by **May 23, 2007**. Small health plans must use **only** the NPI by **May 23, 2008**.

Obtaining and Sharing Your NPI

Providers and suppliers may now apply for their NPI on the National Plan and Provider Enumeration System (NPPES) Web site, ***https://nppes.cms.hhs.gov***. The NPPES is the only source for NPI assignment.

The NPI will replace healthcare provider identifiers in use today in standard healthcare transactions by the above dates. The application and request for an NPI does not replace the enrollment process for health plans. Enrolling in health plans authorizes you to bill and be paid for services.

Healthcare providers should apply for their NPIs as soon as it is practicable for them to do so. This will facilitate the testing and transition processes and will also decrease the possibility of any interruption in claims payment. Providers may apply for an NPI in one of three ways:

- An easy Web-based application process is available at ***https://nppes.cms.hhs.gov***.
- A paper application may be submitted to an entity that assigns the NPI (the Enumerator). A copy of the application, including the Enumerator's mailing address, is available at ***https://nppes.cms.hhs.gov***. A copy of the paper application may also be obtained by calling the Enumerator at 800-465-3203 or TTY 800-692-2326.
- With provider permission, an organization may submit a request for an NPI on behalf of a provider via an electronic file.

Knowing the NPI Schedule of Your Health Plans and Practice Management System Companies

Providers should be aware of the NPI readiness schedule for each of the health plans with which they do business, as well as any practice management system companies or billing companies (if used). They should

determine when each health plan intends to implement the NPI in standard transactions and keep in mind that each health plan will have its own schedule for this implementation. Your other health plans may provide guidance to you regarding the need to submit both legacy numbers and NPIs.

Providers should submit their NPI(s) on standard transactions only when the health plan has indicated that they are ready to accept the NPI. Providers should also ensure that any vendors they use will be able to implement the NPI in time to meet the compliance date.

Sharing Your NPI

Once providers have their NPI(s), they should protect them. Covered providers must share their NPI with any entity that would need it to identify the provider in a standard transaction. For example, a referring physician must share their NPI with the provider that is billing for the service. Other entities the provider should consider sharing their NPI with are:

- Any provider with which they do business (e.g., pharmacies);
- Health plans with which they conduct business; and
- Organizations where they have staff privileges.

Note: We understand that providers have many questions related to electronic file interchange (EFI) or bulk enumeration, NPPES Data Dissemination, and the Medicare subparts policy. We have included information currently available on these key topics in this article and will continue to provide updates, as more information becomes available.

Electronic File Interchange (EFI) - Formerly Known as Bulk Enumeration

The Centers for Medicare & Medicaid Services (CMS) is in the process of putting into place a mechanism that will allow for bulk processing of NPI applications. EFI allows an organization to send NPI applications for many healthcare providers, with provider approval, to the NPPES within a single electronic file. For example, a large group practice may want to have its staff handle the NPI applications for all its members. If an organization/provider employs all or a majority of its physicians and is willing to be considered an EFI submitter, EFI enumeration may be a good solution for that group of providers.

The EFI Steps

Once EFI is available, concerned entities will follow these steps:

- An organization that is interested in being an EFI organization will log on to an EFI home page (currently under construction) on the NPPES Web site (***https://nppes.cms.hhs.gov***) and download a certification form.
- The organization will send the completed certification form to the Enumerator to be considered for approval as an EFI organization (EFIO).
- Once notified of approval as an EFIO, the entity will send files in a specified format, containing NPI application data, to the NPPES.
- Providers who wish to apply for their NPI(s) through EFI must give the EFIO permission to submit their data for purposes of applying for an NPI.
- Files containing NPI application data, sent to NPPES by the EFIO, will be processed. NPI(s) will be assigned and the newly assigned NPI(s) will be added to the files submitted by the EFIO.
- The EFIO will then download the files containing the NPI(s) and will notify the providers of their NPI(s). An EFIO may also be used for updates and deactivations, if the providers agree to do so.

National Plan and Provider Enrollment System (NPPES) Data Dissemination Policy

CMS expects to publish a notice regarding its approach to NPI data dissemination in the coming months. The notice will propose the data dissemination strategy and processes. The approach will describe the data that CMS expects to be available from the NPPES, in compliance with the provisions of the Privacy Act, the Freedom of Information Act (FOIA), the Electronic FOIA Amendments of 1996, the NPPES System of Records Notice, and other applicable regulations and authorities.

Crosswalks

Each health plan may create its own crosswalk, to cross check NPI and legacy identifiers. To that end, CMS stresses the importance of healthcare providers entering all of their current identification numbers onto their NPI application to facilitate the building of the crosswalks.

Subparts of a Covered Organization

Covered-organization healthcare providers (e.g., hospitals, suppliers of durable medical equipment,

pharmacies, etc.) may be made up of components (e.g., an acute care hospital with an end stage renal disease (ESRD) program) or have separate physical locations (e.g., chain pharmacies) that furnish health care, but are not themselves legal entities. The Final NPI Rule calls these entities "subparts" to avoid confusion with the term healthcare "components" used in HIPAA privacy and security rules. Subparts cannot be individuals such as physicians, e.g., group practices may have more than one NPI, but individual members of that group practice by definition are not and cannot be "subparts."

The NPI was mandated to identify each healthcare provider, not each service address at which health care is furnished. Covered-organization providers must designate as subparts (according to the guidance given in the NPI Final Rule) any component(s) of themselves or separate physical locations that are not legal entities and that conduct their own standard transactions. Covered organizations/providers must obtain NPI(s) for their subparts, or instruct the subparts to obtain their own NPIs. The subparts would use their NPIs to identify themselves in the standard transactions they conduct. The NPI Final Rule also gives covered organizations/providers the ability to designate subparts should there be other reasons for doing so. Federal regulations or statutes may require healthcare providers to have unique billing numbers in order to be identified in claims sent to federal health programs, such as Medicare.

In some cases, healthcare providers who need billing numbers for federal health programs are actually components of covered healthcare providers. They may be located at the same address as the covered-organization provider or they may have a different address.

In situations where such federal regulations or statutes are applicable, the covered-organization providers would designate the components as subparts and ensure that they obtain NPI(s) in order to use them in standard transactions. The NPI will eventually replace the billing numbers in use today.

What Providers Can Do to Prepare for NPI Implementation

- Watch for information from the health plans with which you do business on the implementation/testing of NPIs in claims, and, eventually, in other standard transactions.
- Check with your billing services, vendors, and clearinghouses about NPI compliance and what you need to do to facilitate the process.
- Review laws in your state to determine any conflicts or supplements to the NPI. For example, some states require the NPI to be used on paper claims.
- Check in your area for collaborative organizations working to address NPI implementation issues on a regional basis among the physicians, hospitals, laboratories, pharmacies, health plans, and other impacted parties.

Part 2: Information that Applies to Medicare Fee-For-Service (FFS) Providers Only

All Medicare providers are reminded that they will be required to use the NPI **in Medicare claims transactions**.

NPI Transition Plans for Medicare FFS Providers

Medicare's implementation involving acceptance and processing of transactions with the NPI will occur in separate stages, as shown in the table below:

Stage	Medicare Implementation
May 23, 2005 - January 2, 2006:	Providers should submit Medicare claims using only their existing **Medicare** numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.
January 3, 2006 - October 1, 2006:	Medicare systems will accept claims with an NPI, but an existing legacy Medicare number **must also be on the claim**. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes **only** an NPI. Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.
October 2, 2006 - May 22, 2007:	CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and noMedicare legacy identifier is submitted, the provider may not be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.* Medicare will be capable of sending the NPI as primary provider identifier **and** legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.

Stage	Medicare Implementation
May 23, 2007 - Forward:	CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

Crosswalk

The Medicare health plan is preparing a crosswalk to link NPI and Medicare legacy identifiers exclusively for Medicare business, which should enable Medicare to continue claims processing activities without interruption. NPI(s) will be verified to make sure that they were actually issued to the providers for which reported. Medicare will use the check-digit to ensure the NPI(s) are valid.

Subparts Policy

CMS is currently developing policy on how Medicare providers should identify Medicare subparts. Further details will be provided when this policy is finalized.

Resources for Additional Information

Coming Soon - CMS is developing a Medlearn Web page on NPI for Medicare FFS providers, which will house all Medicare fee-for-service educational resources on NPI, including links to all Medlearn Matters articles, frequently-asked-questions (FAQs), and other information. CMS will widely publicize the launch of this Web page in the coming weeks.

You may wish to visit ***www.cms.hhs.gov/hipaa/hipaa2/*** regularly for the latest information about the NPI, including FAQs, announcements of Roundtables, conferences, and guidance documents regarding the NPI.

Go to ***www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/CoveredEntityFlowcharts.pdf*** to access a tool to help establish whether one is a covered entity under the administrative simplifications of HIPAA.

A helpful tool that provides an overview of the NPI and the application process for obtaining an NPI is available at ***www.cms.hhs.gov/medlearn/npi/npiviewlet.asp***.

The Federal Register notice containing the NPI Final Rule is available at ***a257.g.akamaitech.net/7/257/2422/14mar20010800/edocket.access.gpo.gov/2004/pdf/04-1149.pdf***.

There are some non-CMS Web sites that have information on NPI-related issues. While CMS does not necessarily endorse those materials, there may be information and tools available that might be of value to you.

You may also find some industry implementation recommendations and white papers on the NPI at ***www.wedi.org***, which is the site of the Workgroup for Electronic Data Interchange (WEDI).

News from DMERC A…

Fee Schedule Updates

The 2005 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 have been posted:

- 4th Quarter 2005 Update: Oral Anti-cancer Drug Fees
- Revised 3rd Quarter 2005 Update: Oral Anti-cancer Drug Fees
- Revised 2nd Quarter 2005 Update: Oral Anti-cancer Drug Fees

In addition, the following notices can be accessed via the "2005 Fee Schedule Article/Information" link:

- October 2005 Drug Fees In Average Sales Price (ASP) File
- July 2005 Revised Fees In Average Sales Price (ASP) File
- April 2005 Revised Fees In Average Sales Price (ASP) File
- October 2005 DMEPOS Revised Fees

Note: The January 1 fees for the current calendar year are posted as the "Region A DMERC Fee Schedule" for that particular year, and these files are **not** changed throughout the year. Rather, separate notices are posted as fee revisions/updates become available. Please be sure you are viewing the appropriate file/notice for the item and date of service.

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

CERT

News from CMS…

The Comprehensive Error Rate Testing (CERT) Process for Handling a Provider's Allegation of Medical Record Destruction

Medlearn Matters Number: SE0547
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The following information affects all Medicare providers.

Provider Action Needed

Impact to You

SE0547 outlines the process Medicare providers should follow when medical records requested by Medicare's Comprehensive Error Rate Testing (CERT) Documentation Contractor (CDC) and/or Medicare's CERT Review Contractor (CRC) are destroyed by disaster.

What You Need to Know

For CERT purposes, a "disaster" is defined as any natural or man-made catastrophe, which causes damages of sufficient severity and magnitude to partially or completely destroy or delay access to medical records and associated documentation.

- Natural disasters would include hurricanes, tornadoes, earthquakes, volcanic eruptions, fires, mudslides, snowstorms, and tsunamis.
- Man-made disasters would include terrorist attacks, bombings, floods caused by man-made actions, civil disorders, and explosions. A disaster may be widespread or impact multiple structures or be isolated and impact a single site only.

What You Need to Do

If you cannot submit the requested medical records because they were destroyed by a disaster, the CDC/CRC will ask you to attest, under penalty of perjury, to the destruction of the medical records. The **Attestation Form** is available to providers at ***www.certprovider.org***. Providers who need to use this form can print and fax the form to the CDC, who will either retain the form or send it to the CRC depending on which contractor sent the initial request letter for medical record documentation to the provider.

Background

The Centers for Medicare & Medicaid Services (CMS) recognizes that there are circumstances in which destruction of medical record documentation because of unforeseen events should not count as a "no documentation error." Therefore, CMS has established the following process and procedures to corroborate allegations that CERT-requested medical records were destroyed by a disaster. The **corroboration process is comprised of two steps: 1) qualification and 2) accuracy**. In the first step, the CDC/CRC will review the attestation statement to determine if the event qualifies as a disaster. Provider-induced disasters and disasters caused by negligence on the part of providers will be counted as "no documentation errors."

The following are examples of provider-induced disasters and **disasters caused by negligence** on the part of providers that **would NOT qualify** as a natural or man-made disaster:

- My dog ate the medical record
- My computer lost or destroyed the medical record

If the event does not qualify as a natural or man-made disaster defined in the "Provider Action Needed" section of this article, the claim associated with that medical record is documented as a "no documentation error."

The following are examples of events that **WOULD qualify** as a natural or man-made disaster:

- The medical record was destroyed by a flood
- Office fire consumed the medical record

If the event does qualify as a natural or man-made disaster, the CDC/CRC will move to the **second step in the corroboration** process: confirming the accuracy of the attestation. The CDC will confirm the attestation statement through any or all of the following means:

The CDC **checks the following database records for evidence** of natural, man-made, and/or provider-induced disasters: Pacer (Civil and Criminal Searches), Crimetime.com, News Searches, Internet Search, Health & Human Services (HHS) Office of Inspector

General (OIG) Sanctioned Providers, Merlin, State Record Searches (Courthouse Records, Insurance Carriers or ***www.insurancefraud.org/*** Choicepoint/ Autotrak, Argyli, Tracer, and the National Crime Insurance Bureau).

The **CDC interviews the provider** who reported the destruction of medical records. The CDC determines the events leading up to the destruction of medical records, such as: what caused the destruction (weather, fire, etc.), were back-up records maintained (electronic or otherwise), what else might have been destroyed, were fire, police, insurance adjusters called to review the damage? The CDC will identify the magnitude of the destruction to medical records, determine if the Medicare carrier/durable medical equipment regional carrier (DMERC)/fiscal intermediary (FI) has copies, interview other third parties as necessary, and determine if medical records were retained elsewhere and how were they maintained.

The **CDC validates additional supporting evidence** for the event, which may include but not be limited to the following sources:

- Weather-related events, such as, rain, floods, hurricanes, tornadoes, etc., that can be confirmed by the National Oceanographic & Atmospheric Administration (NOAA) on a state and county geographical basis.
- Fire that can be confirmed by checking with the local Fire Marshall.
- Explosions, such as, natural gas that can be confirmed by the local Fire Marshall or local gas company.
- Explosions, such as, chemical explosions that can be confirmed by the local Fire Marshall and the Bureau of Alcohol, Tobacco, and Firearms.
- Local, state, and federal investigative officials can confirm explosions.
- State insurance officials can confirm whether doctors, hospitals, and durable medical equipment (DME) suppliers applied for insurance coverage under their insurance policies.
- The Federal Emergency Management Agency (FEMA) can confirm if doctors, hospitals, and DME suppliers applied for disaster recovery loans.
- Local and state investigative agencies may be able to confirm events leading to the destruction of medical records.
- Employees or non-employees of doctors, hospitals, and DME suppliers may have contributed to the destruction of medical records and there should be records disclosing charges against that individual(s).

Where the CDC is unable to verify the accuracy of the explanation provided in the attestation statement, the claim will be counted as a "no documentation error." Please note that this could eventually lead to a determination that an overpayment has occurred and overpayment recovery action could result.

Additional Information

Medlearn Matters article MM2976 describes the CERT program and MM3812 provides additional information on CERT. Those articles can be viewed at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM2976.pdf*** and ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3812.pdf***, respectively, on the CMS Web site.

To review copies of the letters CERT contractors use to request medical record documentation from Medicare physicians/providers go to ***www.cms.hhs.gov/CERT/letters.asp*** on the CMS Web site. Also on this site are CERT Newsletters that provide information about the entire CERT process.

If you have questions, please contact your carrier or intermediary at their toll-free number, which is available at ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

News from DMERC A...

New Section on DMERC A Web Site

Due to the importance of the Centers for Medicare & Medicaid Services (CMS) Comprehensive Error Rate Testing (CERT) initiative and to make CERT information easier to access, the Region A Durable Medical Equipment Regional Carrier (DMERC A) added a "CERT" section to our Web site. This section can be accessed at ***www.umd.nycpic.com/dmerc_cert.html***. From this page, visitors can link to the CMS CERT Web site, the CERT Provider Web site, and the Region A Program Safeguard Contractor (PSC) Web site for further information. In addition, there is a "Publications" page that contains the Portable Document Format (PDF) CERT newsletters and links to the CERT Fact Sheet and CMS Medlearn Matters

articles regarding CERT. This page can be accessed at ***www.umd.nycpic.com/dmerc_cert_pub.html***.

Providers/suppliers are encouraged to visit this new section on the DMERC A Web site, since the purpose of the CERT program is to measure and improve the quality and accuracy of Medicare claims submission, as well as processing and payment.

CERT News

The goal of the Centers for Medicare & Medicaid Services (CMS) Comprehensive Error Rate Testing (CERT) initiative is to ensure that Medicare claims are paid correctly and accurately by consistently reducing the number of errors made in claims adjudication. In support of this CMS initiative, the Region A Durable Medical Equipment Regional Carrier (DMERC A) is making CERT newsletters accessible to our supplier community via our Web site in order to provide a better understanding of the CERT process and its activities. To view the most recent editions, visit ***www.umd.nycpic.com/dmerc_cert_pub.html*** and follow the download instructions.

EDI Services

Medicare Remit Easy Print Software and Electronic Remittance Advice

Medicare Remit Easy Print (MREP) Software Available From the Centers for Medicare & Medicaid Services (CMS) as of October 11, 2005

Are you still using the Standard Paper Remittance (SPR)? Save TIME and MONEY by taking advantage of FREE Medicare Remit Easy Print (MREP) software now available for viewing and printing the Health Insurance Portability and Accountability Act (HIPAA)-compliant Electronic Remittance Advice (ERA)! The MREP software gives providers and suppliers the following abilities:

- Easy navigation and viewing of the ERA using your personal computer;
- Print the ERA in the SPR format;
- Search capability that allows providers and suppliers the ability to find claims information easily;
- Print and export reports about ERAs including denied, adjusted, and deductible applied claims;
- Easy-to-use method to archive, restore, and delete imported ERAs.

Providers and suppliers can view and print as many or as few claims as needed. This will be especially helpful when you need to print only one claim from the remittance advice when forwarding the claim to a secondary payer. This FREE software can save you time resolving Medicare claim issues. Take advantage of the MREP features unavailable with the SPR.

In order to utilize the MREP software, you need to receive an HIPAA-compliant ERA. Contact the Region A Durable Medical Equipment Regional Carrier (DMERC A) Electronic Data Interchange (EDI) Department at 866-861-7348 to find out more about MREP and/or for information on how to receive an HIPAA-compliant ERA. Take full advantage of this new software. Begin using MREP today!

Realizing the Benefits of the Electronic Remittance Advice

As a leader in implementation of HIPAA mandates, CMS is clearly moving toward the exclusive use of electronic Medicare transactions whenever and as soon as possible. This includes discontinuing use of the SPRs in favor of HIPAA-compliant ERAs.

Beyond compliance with CMS requirements, there are many factors that make it good business practice for Medicare providers to take full advantage of the ERA:

- Utilizing current technology to increase productivity and reduce potential for error
- Faster communication of claims payment information
- Paperwork reduction
- Efficient and accurate account reconciliation through electronic posting
- Opportunities for additional improvements in accounts receivable (AR) management

Any provider or supplier who submits claims electronically to DMERC A, either directly or through a third party (e.g., billing service, clearinghouse), is eligible to receive ERAs. ERA implementation plans need to be considered by providers and suppliers who:

- Currently receive only an SPR

- Currently receive both SPRs and ERAs
- Currently receive an SPR and have a third party receive the ERA

CMS recently published "Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers." This helpful and comprehensive source of information can be found on the CMS Web site at ***www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf***. A link to this document can also be found on the new "Electronic Remittance Advice and Easy Print Software" section of the DMERC A Web site.

New EDI Section and ListServe on the DMERC A Web Site

A new section, "Electronic Remittance Advice and Easy Print Software," can be accessed from the main EDI page of the DMERC A Web site. This section was established to provide:

- Information about HIPAA-compliant ERAs and the MREP free software
- A link to the CMS Web site for downloading MREP and a User Guide
- Enrollment for a new MREP ListServe to receive important updates on ERAs and the MREP software. Subscription to the ListServe is strongly recommended for both active and potential users of ERAs and MREP.

You can directly access this new section and ListServe at ***www.umd.nycpic.com/dmedi_mrep.html***.

MREP Brochure

CMS developed a brochure for professional providers that includes an overview of the software, availability, benefits, and minimum system requirements. Please refer to this brochure for additional information. To access the brochure, visit the "Electronic Remittance Advice and Easy Print Software" section of the DMERC A Web site and click on the appropriate link, or directly via the CMS Web site at ***www.cms.hhs.gov/medlearn/remit_easy_print.pdf***.

Two DMERC A ListServes for Electronic Transaction Users

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Electronic Data Interchange (EDI) Department maintains two ListServes that provide information that is specific for users and potential users of electronic Medicare claims transactions. Subscribe to the original EDI ListServe at ***www.umd.nycpic.com/edilistserve.html*** to receive automatic email messages with important information related to EDI topics. These messages often provide timely updates and/or notification of:

- Bulletin Board (BBS) operations, including known systems issues that are being or have been corrected
- The latest guidelines and requirements related to the implementation of the Health Insurance Portability and Accountability Act (HIPAA)-mandated electronic transactions
- Updates to the DMERC A low-cost Medicare billing software, ExpressPlus

Subscribe to the new EDI ListServe at ***www.umd.nycpic.com/edimreplistserve.html*** for important information and announcements regarding the Medicare Remit Easy Print (MREP) software and use of electronic remittance advices (ERAs).

EDI Online Tutorials

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Electronic Data Interchange (EDI) Department has produced three online tutorials that can be accessed via our Web site. There is no charge to participate in these tutorials and no limit to the number of times they can be accessed. Currently, available tutorials include:

- **Understanding the VIPS Medicare System (VMS) Report** - A detailed explanation of the information contained in the "VMS Error Report" that is produced for every electronic claims file that is successfully sent to the DMERC A Bulletin Board System (BBS). The report provides status and error information for claims that are both accepted for processing and those that are rejected during front-end editing. All electronic submitters who need help reading or understanding the VMS report will benefit from this presentation.
- **Installation of ExpressPlus Software** - Step-by-step instructions for installing the ExpressPlus low-cost Medicare claims software on your computer. New users of the ExpressPlus software will benefit from this presentation.
- **ExpressPlus File Submission - A Guide to Submitting Claims Inputted in ExpressPlus** - Step-by-step instructions for submitting claims after data has

been entered into the ExpressPlus low-cost Medicare claims software. New and existing users of the ExpressPlus software will benefit from this presentation.

Information and links to all EDI-specific tutorials can be found via the "Education - Tutorials" section of the DMERC A Web site at ***www.umd.nycpic.com/dme-eduonline.html***.

Data Entry Guidelines for ExpressPlus Users - Entering CMN Data for Wheelchairs

Based on the billing instructions provided by the Region A Durable Medical Equipment Regional Carrier (DMERC) Program Safeguard Contractor (PSC) in the article, "Wheelchair CMNs - Transition Instructions," which is available via the "What's New" section of the PSC Web site at ***www.tricenturion.com/content/whatsnew_dyn.cfm***, the following data entry guidelines are provided for users of the DMERC A low-cost software - ExpressPlus.

DME Certification Screen:

1. Enter the **Date of Service** (i.e., the delivery date) in the "Initial Certification Date" field.
2. Enter **Y** in the "Certification on File" field.
3. Enter **N** in the "Replacement Item" field.
4. Enter **99** in the "Length of Need" field.
5. Enter **5/5/2005** in the "Date Certification Signed" field.

Certification Record Screen:

Enter **D** as the answer to all questions except for Question 5, where **24** must be answered for manual wheelchairs and power wheelchairs.

New Specifications for ANSI 835 ERA Files

In order to fully comply with the Centers for Medicare & Medicaid Services (CMS) mandates for Health Insurance Portability and Accountability Act (HIPAA)-Electronic Data Interchange (EDI) implementation, the Region A Durable Medical Equipment Regional Carrier (DMERC A) was required to modify the American National Standards Institute (ANSI) 835, version 4010A1, electronic remittance advice (ERA) files that are returned to electronic billers and their agents. ERA files are no longer created with a Carriage Return and Line Feed after every 80 positions. This file format change was effective for all ERA files posted to the DMERC A Bulletin Board System (BBS) for retrieval on or after October 3, 2005.

End of CMS Contingency Plan for HIPAA-Compliant Electronic Claims and Enforcement of the Administrative Simplification Compliance Act (ASCA)

As of July 2005, Medicare contractors, including the Region A Durable Medical Equipment Regional Carrier (DMERC A), have started to review providers who submit claims to Medicare on paper. These reviews are required by Section 3 of the Administrative Simplification Compliance Act (ASCA), PL107-105, and the implementing regulation at 42 CFR 424.32. The act stipulates that **all** Medicare claims for reimbursement must be submitted electronically, with limited exception, in a Health Insurance Portability and Accountability Act (HIPAA)-compliant transaction. Refer to the Centers for Medicare & Medicaid Services (CMS) Medlearn Matters article MM3440, "Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims" (***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3440.pdf***), for additional information regarding electronic billing requirements, exceptions, and the enforcement process.

The enforcement activities require Medicare contractors to identify providers who have submitted claims on paper and to select those providers who **must** provide specific documentation of their eligibility to do so for some or all of their Medicare claims. If you are selected for review, you will be asked to provide documentation to prove you are eligible to submit claims on paper. If your eligibility cannot be proven, all subsequent claims submitted on paper will be denied. Any selected provider who does not submit written documentation that substantiates his/her exception will be deemed ineligible to submit paper claims to DMERC A. You

will be notified by mail of your ineligibility; this Medicare decision is **not subject to appeal**. After a provider is deemed ineligible to submit paper claims, any paper claims subsequently submitted will be denied with group code **CO**, reason code **96**, and remark code **M117**. The denial message is: **Not covered unless submitted via electronic claim.**

If you are not eligible to submit paper claims and are seeking options for electronic claims submission, you have several alternatives. One option is to acquire the low-cost software for HIPAA-compliant billing that is available from DMERC A - ExpressPlus. There is no charge for the software and support; there is a $25.00 fee to cover the cost of materials and processing. There are also commercial billing software programs, billing agents, and clearinghouse services available on the open market that often include services other than Medicare billing, and these may better meet your business needs. Please visit the Centers for Medicare & Medicaid Services (CMS) Web site at ***www.cms.hhs.gov/providers/edi/hipaavendors.asp*** to see a list of HIPAA vendor services in your state, or go the "Electronic Data Interchange (EDI)" section of the DMERC A Web site at ***www.umd.nycpic.com/dmedi.html*** for additional information on billing options and requirements specific to Region A.

In order to transmit Medicare claims electronically, using ExpressPlus or by any other means, providers must first enroll as a Region A Medicare submitter. Complete information about ordering ExpressPlus or enrolling as an electronic claims submitter with DMERC A can be found on our Web site at ***www.umd.nycpic.com/dmedi.html***.

HIPAA Information

Clarification on Termination of the Incoming Claim Health Insurance Portability and Accountability Act (HIPAA) Contingency Plan

The Centers for Medicare & Medicaid Services (CMS) has received a number of inquiries about the impact of termination of the contingency plan for incoming claims on October 1, 2005, on submission of Medicare Secondary Payer (MSP) claims. The following information is being furnished to clarify the Medicare requirements for submission of compliant MSP claims as required by the Health Insurance Portability and Accountability Act (HIPAA).

On August 4, 2005, CMS announced that the HIPAA contingency period for claims sent to Medicare would end on October 1, 2005. This termination does **not** apply to claims that Medicare sends outbound to other payers that have signed a coordination of benefits (COB) trading partner agreement for the transfer of claims by Medicare. It does apply to claims sent to Medicare for secondary payment following processing by a primary payer, however. Therefore, effective October 1, 2005, electronic MSP claims **must** comply with all X12 837 version 4010A1 implementation guide requirements, and include standard claim adjustment reason (CAS) codes to describe adjustments that a primary payer made during adjudication, or they will be rejected.

CMS is aware of provider concerns that primary payers frequently send paper explanations of benefits or 835 transactions that contain local messages or codes rather than standard CAS codes. HIPAA does not require that standard CAS codes be reported in paper explanations of benefits, and payers that still have an X12 835 HIPAA contingency plan in effect may not yet be able to report standard CAS codes. HIPAA does require health care benefit payers to send providers X12 835 version 4010A1 transactions if requested by providers, and those 835 transactions must contain standard CAS codes by the end of each payer's 835 contingency period.

CMS is working with the HIPAA standards committee that maintains the CAS codes to develop a simplified means to translate non-standard messages and codes into standard CAS codes. We expect this process to be approved and implemented quickly. However, until an alternate solution is approved for use, electronic MSP claims sent to Medicare are required to contain standard CAS codes, along with other loops, segments, and data elements that apply. It is the **provider's responsibility** to convert local adjustment reason

codes or messages into the appropriate standard CAS codes prior to transmission of an 837 version 4010A1 claim to Medicare for secondary payment.

General Information

News from CMS…

Medicare Care Management for High Cost Beneficiaries (CMHCB) Demonstration

Medlearn Matters Number: MM4100
Related Change Request (CR) #: 4100
Related CR Release Date: September 23, 2005
Related CR Transmittal #: 28
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

Provider types affected by Change Request (CR) 4100 include physicians and providers who bill any Medicare contractor (carrier, durable medical equipment regional carrier (DMERC), fiscal intermediary (FI), or regional home health intermediary (RHHI)) for services provided to Medicare Fee-for-Service (FFS) beneficiaries (i.e., those in the traditional FFS Medicare program) who reside in any one of the geographic areas described below and who have enrolled in a Care Management for High Cost Beneficiaries (CMHCB) program.

The CMHCB programs in these geographic areas are operated by one of six organizations, known as Care Management Organizations (CMOs), that will deliver provider-based intensive care management services to certain FFS Medicare beneficiaries with one or more chronic conditions. Beneficiaries eligible for participation in the demonstration will be designated by the Centers for Medicare & Medicaid Services (CMS). If you submit claims to the Medicare contractors listed in the following charts, for Medicare patients who reside in the geographic areas shown in the charts, this article is of special interest to you:

Carrier, FI, DMERC, RHHI	Geographic Areas to be Served
Anthem Health Plans of Maine, Inc.	Massachusetts
Blue Cross and Blue Shield of South Carolina, also known as Palmetto GBA	Florida, Texas
Connecticut General Life Insurance Company	California, Nevada, Oregon, Washington
Empire HealthChoice Assurance, Inc.	New York
First Coast Service Options, Inc.	Florida
Group Health Incorporated	New York
HealthNow New York Inc.	Massachusetts, New York
National Heritage Insurance Company	California, Massachusetts
Noridian Mutual Insurance Company	Nevada, Oregon, Washington
Regence BlueCross BlueShield of Oregon	Oregon
Trailblazer Health Enterprises, LLC	Texas
United Government Services, LLC	Nevada, Oregon, Washington, California, New York

Provider Action Needed

Impact to You

This article contains information from CR 4100 that describes the CMS CMHCB demonstration project and the associated CMOs programs. These programs are being implemented under the demonstration project to test whether supplemental care management services can improve quality of care and health results, and reduce unnecessary hospital stays and emergency room visits for FFS beneficiaries who have one or more chronic diseases. Care management services provided by the CMOs may include facilitating collaboration among beneficiaries' primary and specialist providers, and enhanced communication of relevant clinical information to providers for the beneficiaries enrolled in a CMHCB program.

What You Need to Know

A beneficiary's participation in this demonstration program will not change his or her FFS Medicare benefits. The beneficiary is not enrolled in a health maintenance organization (HMO), Medicare Advantage Plan, or other non-FFS plan. The beneficiary remains entitled to all FFS benefits. You may be contacted by one of the CMOs in your geographic area.

What You Need to Do

Make sure that your office and billing staffs are aware that these beneficiaries remain eligible for FFS services. **There are no changes to Medicare FFS billing instructions or claims processing as a result of this**

CMHCB program. Provider participation in care plans developed by, and other collaboration with, the CMO is voluntary and at provider discretion.

Background

This article provides information on CMS' implementation of the CMHCB project to conduct a three-year study of various care management models for certain beneficiaries in the traditional Medicare FFS program. These programs will be administered by the CMOs. The CMO programs will support collaboration among demonstration participants' primary and specialist providers and enhance communication of relevant clinical information. The programs are intended to:

- Help increase adherence to evidence-based care;
- Reduce unnecessary hospital stays and emergency room visits; and
- Help participants avoid costly and debilitating complications.

FFS Medicare benefits will continue to be covered, administered, and paid under the traditional FFS Medicare program. Demonstration programs will be offered at no additional charge to the participating beneficiaries beyond their normal original Medicare plan premiums, co-payments, and/or deductibles. The CMOs will not be able to restrict beneficiary access to care, or restrict beneficiary provider choice.

Since the CMO services may include collaboration with the physician on the beneficiary's plan of care, you may be contacted by the CMO regarding any of your patients who enroll in the CMHCB demonstration. It is up to each physician to determine whether he or she wishes to collaborate with the CMO.

Note: Beneficiaries enrolled in these demonstrations remain eligible for FFS services, and physicians and providers of those services should continue to bill as they normally would. There are no changes to Medicare FFS billing instructions or claims processing as a result of this demonstration.

CMO Program Features and Geographic Areas

The following table describes the name, target population, special features, scheduled launch date, and designated geographical areas of each program.

Name of Program	Population Focus and Program Features	Geographic Area
Health Buddy Program	• Serves beneficiaries with congestive heart failure, diabetes, and/or chronic obstructive pulmonary disease. • Uses a technology platform. Patients receive a Health Buddy appliance that coaches them about their health, collects vital signs and symptoms, and transmits results back to multi-specialty medical groups. • Physicians and nurses will use information provided through the Health Buddy program to spot problems early and ensure patients stay healthy. • **Launch date**: Early calendar year (CY) 2006	**Oregon**: Deschutes, Jefferson, Crook, Lake, Malheur, and Harney **Washington**: Chelan, Grant, Okanogan, and Douglas **Nevada**: Clark and Nye
Care Level Management	• Serves beneficiaries who are seniors suffering from advanced, progressive chronic disease(s) and co-morbidities with two or more condition-related hospital admissions in the past year. • Care management via a distributed network of Personal Visiting Physicians (PVPs) who see patients in their homes and nursing facilities and who are available 24 hours a day, 7 days a week. • PVPs are supported by Personal Care Advocate Nurses who are based in nearby regional offices and who provide care coordination and maintain regular telephone contact with beneficiaries. • Utilizes a Web-based electronic medical record. • **Launch date**: October 1, 2005	**California**: Alameda, San Francisco, Marin, San Mateo, Contra Costa, Sacramento, Santa Clara, Sonoma, Solano, San Joaquin, Fresno, Stanislaus, Monterey, Tulare, Madera, Merced, San Benito, Los Angeles, Ventura, Santa Barbara, San Luis Obispo, Riverside, San Bernardino, Kern, Kings, Orange, and San Diego **Texas**: Bexar, Atascosa, Bandera, Comal, Guadalupe, Kendall, Medina, and Wilson **Florida**: Brevard, Indian River, Osceola, Seminole, and Orange
Mass General Care Management	• Serves beneficiaries who seek care from Massachusetts General healthcare system. • Comprehensive care management by a dedicated team of doctors and nurses. • Specialized programs for patients with chronic conditions. • Home visits and home telemonitoring as needed. • Electronic medical record system assures coordination, continuity, and adherence to physician-approved care management plan. • **Launch date**: Early CY 2006	**Massachusetts**: Norfolk, Suffolk, Middlesex, Essex, and Plymouth

Name of Program	Population Focus and Program Features	Geographic Area
Montefiore Care Guidance	• Serves beneficiaries with multiple chronic conditions, residing in naturally-occurring retirement communities regardless of where they currently receive care, and FFS beneficiaries cared for within the Montefiore healthcare network. • Offers enhanced home-based services to participants using telemonitoring equipment and home visit programs. • Also offers medication management, falls prevention, palliative care, and disease management programs. • **Launch date**: Early CY 2006	**New York**: Bronx
RMS KEY to Better Health	• Serves beneficiaries with chronic kidney disease. • Provides intensive disease management directed by nephrologists in supplementary clinics to identify potential problems and avoid complications, coordinate early intervention plans and prevent acute hospitalization. • **Launch date**: November 1, 2005	**New York**: Nassau, Suffolk, and Queens
Texas Senior Trails	• Serves beneficiaries who receive care from the Texas Tech Physician Associates primary care and specialist physicians and who are at greatest risk for readmission and adverse events in largely underserved, rural areas. • Team coordinates a home and office based program. • **Launch date**: Early CY 2006	**Texas**: Armstrong, Bailey, Borden, Briscoe, Carson, Castro, Childress, Cochran, Collingsworth, Cottle, Crosby, Dallam, Dawson, Deaf Smith, Dickens, Donley, Floyd, Gaines, Garza, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Hutchinson, Kent, King, Lamb, Lipscomb, Lubbock, Lynn, Moore, Motley, Ochiltree, Oldham, Parmer, Potter, Randall, Roberts, Scurry, Sherman, Stonewall, Swisher, Terry, Wheeler, and Yoakum

Additional Information

Additional information on the demonstration project may be found at ***www.cms.hhs.gov/researchers/demos/cmhcb.asp*** on the CMS Web site. For complete details, please see the official instruction issued to your carrier/FI/DMERC/RHHI regarding this change, which can be viewed at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 4100 in the CR NUM column on the right, and click on the file for that CR.

If you have any questions, please contact your Medicare contractor at their toll-free number, which may be found at ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Medicare Health Support Programs (Formerly Known as Medicare Chronic Care Improvement Programs)

The Centers for Medicare & Medicaid Services (CMS) issued Medlearn Matters article MM3953, which provides information about CMS' implementation of the Medicare Health Support Programs (MHSPs), formerly known as Chronic Care Improvement Programs. Section 721 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) adds a new Section 1807, "Voluntary Chronic Care Improvement Under Traditional Fee-for-Service (FFS) Medicare," to the Social Security Act. This section requires Medicare to provide for the phased-in development, testing, evaluation, and implementation of chronic care improvement programs (now known as MHSPs) and to proceed with expansion regionally or possibly nationwide if the pilot programs (or program components) are successful. This initiative represents one of multiple strategies developed by the Department of Health and Human Services (DHHS) to help chronically ill beneficiaries stay healthier, accelerate the adoption of health information technology, reduce avoidable costs, and diminish health disparities among Medicare beneficiaries nationally.

For the complete text, please refer to MM3953 on the CMS Web site at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3953.pdf***. Physicians and providers

with questions regarding the programs can find additional information at ***www.cms.hhs.gov/medicarereform/ccip/*** on the CMS Web site.

Informational and Educational Materials for the New Preventive Services

The Centers for Medicare & Medicaid Services (CMS) issued Special Edition article SE0556, which provides an overview of the many informational and educational products developed by CMS to inform and educate physicians, providers, suppliers, and other health care professionals, including non-physician practitioners (for the purpose of this article, non-physician practitioners are physician assistants, nurse practitioners, or clinical nurse specialists), about the array of Medicare-covered preventive services and screenings available. These include the following three new services that became effective January 1, 2005:

- Diabetes Screening Tests
- Cardiovascular Screening Blood Tests
- The Initial Preventive Physical Examination (IPPE)

Note: It is important to emphasize that the diabetes screening tests and cardiovascular screening blood tests are each stand-alone billable services separate from the Initial Preventive Physical Examination (IPPE) or "Welcome to Medicare" Physical Exam. The IPPE is a unique benefit for beneficiaries new to the Medicare program. This benefit must be received in the first six months after the effective date of the beneficiary's first Part B coverage period, which must begin on or after January 1, 2005.

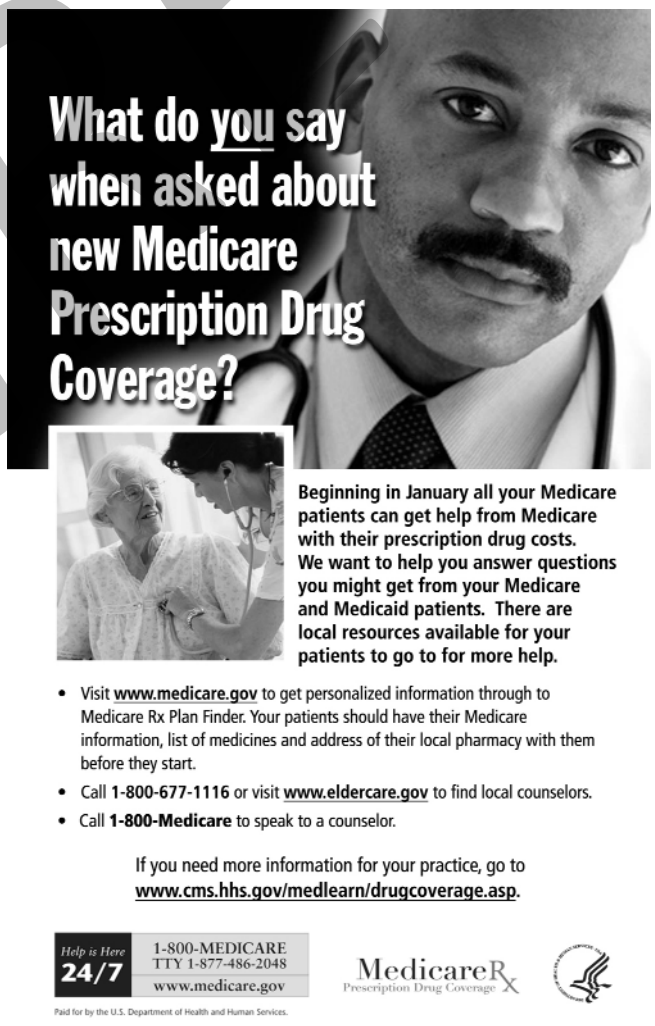
To ensure that your Medicare patients receive the best possible health care, it is important to be aware of the preventive benefits available for these patients. For more information, go to the Preventive Services Educational Resource Web Guide at ***www.cms.hhs.gov/medlearn/preventiveservices.asp*** on the CMS Web site. For the complete text of SE0556, please refer to the article at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3637.pdf*** on the CMS Web site.

Coming in 2006!

Beginning January 1, 2006, Medicare prescription drug coverage will be available to people with Medicare. Health care professionals can find information about this new coverage at ***www.cms.hhs.gov/medlearn/drugcoverage.asp*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Public Service Announcement for Health Care Professionals: What Do You Say When Asked About the New Medicare Prescription Drug Coverage?

The following public service announcement is for the provider community to increase awareness of the new prescription drug coverage and the resources available to assist people with Medicare.



Clarification on Part D and Fee-For-Service (FFS) Providers, New Web-based Educational Products, and the Latest Information on Medicare Prescription Drug Coverage

Medlearn Matters Number: SE0557
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The Seventh in the Medlearn Matters Series

The following information affects physicians, providers, suppliers, and their staff who provide service to people with Medicare.

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.
- It will cover brand name and generic drugs.
- This new drug coverage requires all people with Medicare to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Therefore, we're [CMS] looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients.
- You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.
- If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to ***www.medicare.gov*** for information and assistance.

Clarifying Information for Fee-For-Service (FFS) Medicare Providers

Billing for Drugs Covered Under Part D

There has been some confusion among FFS providers regarding their ability to bill drugs covered under Part D, commonly referred to as "Medicare Prescription Drug Coverage." In short, being an enrolled provider in the FFS program does **not** impart Part D-related billing privileges. Medicare Part B covers a limited number of prescription drugs and biologicals. Currently, covered Medicare drugs generally fall into three categories:

- Drugs furnished incident to a physician's service;
- Drugs furnished through a Medicare Part B-covered item of durable medical equipment (DME); and
- Drugs specifically covered by statute (for example, oral immunosuppressive drugs).

These drugs continue to be covered and paid for under the FFS Medicare program (i.e., Part B), and FFS providers (e.g., physicians, hospitals, and pharmacies) will continue to bill their carriers, fiscal intermediaries (FIs), and durable medical equipment regional carriers (DMERCs) for these drugs. This coverage under Part B continues after the January 1, 2006, effective date for Part D. (For a more detailed discussion of Medicare Part B-covered drugs, see ***www.cms.hhs.gov/providers/drugs/*** on the CMS Web site.)

How Medicare Prescription Drug Coverage Will be Administered

Medicare prescription drug coverage under Part D will be administered through Medicare Advantage Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs). For a person with Medicare who joins an MA or a PDP, their provider **must** have a contractual relationship with that MA-PD or PDP to bill and receive payment from the MA-PDP or PDP for that individual's covered prescription drugs. This is true regardless of whether or not the provider is enrolled in the FFS Medicare program and billing FFS Medicare for Medicare Part B-covered drugs.

Example: Suppose a pharmacy is currently receiving payment under Medicare Part B for an individual's Medicare Part B-covered drug, albuterol, delivered through a **nebulizer**, which is considered to be DME. The pharmacy would, as they do today, bill the local DMERC for this drug. The same individual has joined a PDP and has coverage of albuterol **delivered through a metered dose inhaler** (which is not considered DME under Part B). The pharmacy can only bill the MA-PD or PDP for covered albuterol delivered through a metered dose inhaler if the pharmacy has a contractual relationship with that MA-PD or PDP.

New Information on the Medicare Prescription Drug Coverage Information for Providers Web Page

The following new information can be found on the *Medicare Prescription Drug Coverage Information for Providers* Web page at ***www.cms.hhs.gov/medlearn/drugcoverage.asp*** on the CMS Web site.

Toolkit for Health Professionals: Medicare Prescription Drug Coverage

CMS has released the *Toolkit for Health Care Professionals: Medicare Prescription Drug Coverage*, available as an Adobe Portable Document Format (PDF) file (860Kb) at ***www.cms.hhs.gov/medlearn/provtoolkit.pdf*** on the CMS Web site. This toolkit includes downloadable educational materials specifically for physicians and other health care professionals and their staff to learn the basics about Medicare prescription drug coverage. It also includes materials that can be distributed to Medicare patients. The kit contains reproducible artwork, a letter from the CMS Administrator, a fact sheet (English and Spanish), a brochure, an article, and a list of other resources. You may add your logo and business information to these materials and copy freely.

Limited Income? SSA Can Help - Posters to Display in Health Care Settings

Flat wall posters directing people with Medicare, who have limited income, to a number they can call to find out if they are eligible for help with prescription drug costs are available now. Posters are suitable for display in a physician's, provider's, or supplier's office, a pharmacy, or other health care setting where people with Medicare will see this information. Easel posters are no longer available. To order, visit the *Medlearn Product Ordering* Page at ***cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=5*** on the CMS Web site.

New Fact Sheets Available On the Medicare Web Site

The following fact sheets are now available at ***www.medicare.gov***. These can help your patients better understand Medicare's new prescription drug coverage:

- **Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Have Coverage from an Employer or Union (Publication Number 11107)** Basic information about Medicare's new prescription drug coverage for people who have prescription coverage from an employer or union. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11107.pdf***
- **Quick Facts about Medicare's New Coverage for Prescription Drugs for People with a Medicare-approved Drug Discount Card (Publication Number 11104)** Basic information about Medicare's new prescription drug coverage for a person with a Medicare-approved drug discount card. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11104.pdf***
- **New Medicare Prescription Drug Coverage-Who Can Help Me Apply and Enroll? (Publication Number 11125)** Explains who can help people with Medicare apply for extra help in paying for prescription drug costs and join a Medicare prescription drug plan. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11125.pdf***
- **Quick Facts about Medicare's New Coverage for Prescription Drugs for People in a Medicare Health Plan with Drug Coverage (Publication Number 11135)** Basic information about Medicare's new prescription drug coverage for people with a Medicare health plan with prescription drug coverage. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11135.pdf***
- **New Medicare Prescription Drug Coverage: A Message for People Who Care for Someone with Medicare (Publication Number 11126)** Explains Medicare's new prescription drug coverage to those who make health care decisions for people with Medicare. (4 pages) ***www.medicare.gov/Publications/Pubs/pdf/11126.pdf***
- **Quick Facts about Medicare's New Coverage for Prescription Drugs for Alaskans with Limited Income and Resources (Publication Number 11105_AK)** Basic information about Medicare's new prescription drug coverage for a person with limited income and resources in Alaska. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11105_AK.pdf***
- **Quick Facts about Medicare's New Coverage for Prescription Drugs for Hawaiians with Limited Income and Resources (Publication Number 11105_HI)** Basic information about Medicare's new prescription drug coverage for a person with limited income and resources in Hawaii. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11105_HI.pdf***
- **Quick Facts About Medicare Prescription Drug Coverage and Protecting Your Personal Information (Publication Number 11147)** Information about how people with Medicare can protect their personal information when dealing with plans and others about Medicare prescription drug coverage. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11147.pdf***

New Publications Available on the CMS Web Site

The following new publications are available by going to ***www.cms.hhs.gov/medicarereform/factsheets.asp*** on the CMS Web site and clicking on the appropriate links described below:

- **Basic Questions and Answers About Prescription Drug Coverage** We encourage you to use these basic questions and answers to respond to inquiries from people with Medicare: ***www.cms.hhs.gov/partnerships/news/mma/qsandas.pdf***
- **What Medicare Prescription Drug Coverage Means to You: A Guide to Getting Started** A new brochure available to explain the basics of prescription drug

coverage: ***www.cms.hhs.gov/medicarereform/91007_MedicareBrochure.pdf***

Additional Information

More information on provider education and outreach regarding drug coverage can be found at ***www.cms.hhs.gov/medlearn/drugcoverage.asp*** on the CMS Web site. Detailed drug coverage information for CMS partners and advocates for people with Medicare can be found at ***www.cms.hhs.gov/partnerships/news/mma/default.asp*** on the CMS Web site. You can also find additional information regarding prescription drug plans at ***www.cms.hhs.gov/pdps*** on the CMS Web site.

Further information on CMS implementation of the Medicare Modernization Act (MMA) can be found at ***www.cms.hhs.gov/medicarereform/*** on the CMS Web site.

New Educational Products Available on Medicare Prescription Drug Coverage

Medlearn Matters Number: SE0559
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A

The Eighth in the Medlearn Matters Series

The following information affects physicians, health care professionals, providers, suppliers, and staff who provide service to people with Medicare.

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to all people with Medicare.
- It will cover brand name and generic drugs.
- Drugs that are currently covered by Medicare Part B will continue to be covered by Part B.
- This new drug coverage is not automatic -all people with Medicare will need to make a decision this fall. Since you're a trusted source, your patients may turn to you for information about this new coverage. Therefore, we're [the Centers for Medicare & Medicaid Services (CMS)] looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients learn more about this new coverage.
- You should encourage all your Medicare patients to learn more about the new prescription drug coverage because it may save them money on prescription drugs. There is extra help available for people with limited income and resources.
- If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE and to ***www.medicare.gov*** for additional information and assistance.

Note: Medicare prescription drug coverage under Part D will be administered through Medicare Advantage Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs). For Medicare beneficiaries who join an MA-PD or a PDP, their provider **must** have a contractual relationship with that MA-PD or PDP to bill and receive payment from the plans for that individual's covered prescription drugs. Fee-for-Service (FFS) providers cannot bill Medicare fiscal intermediaries (FIs) or carriers for Part D covered drugs. Our next article in this series will provide further information on Part B versus Part D billing.

New Products Available on *www.cms.hhs.gov/medlearn/drugcoverage.asp*

New products are available to download at the *Medicare Prescription Drug Coverage Information for Providers* Web page. This page is dedicated to providing the latest drug coverage information for FFS Medicare providers. The new products include the following:

Medicare Rx Training Course: Important Information for Health Care Professionals - Earn CME Credit

This training course covers important information about Medicare prescription drug coverage, including the fundamental components of the program, types of drug plans available, resources for people with Medicare and health care professionals, and important dates in 2005 and 2006.

The University of Kansas Medical Center (KUMC) is offering Continuing Education Credit for this course in coordination with the Centers for Medicare & Medicaid Services (CMS):

- **Doctors**: 1.5 CME Category 1 Credit
- **Nurses**: 1.8 CNE Contact Hours
- **Other Health Care Professionals**: 1.5 Credit Hours

Once you complete the course and receive a passing score on the post-assessment, you will be provided with a link to KUMC. KUMC will charge a nominal fee for credit courses.

Physician Brochure
This publication explains the new Medicare prescription drug coverage for physicians and their staff.

Physician Tear-off Sheet
This resource is appropriate for distribution in physicians' offices and other clinical settings. It contains basic information on the new coverage, as well as contact numbers for each state's State Health Insurance Assistance Program (SHIP). The SHIPs will direct people with Medicare to resources for individual counseling.

"Have Limited Income? SSA Can Help" - Posters for Your Office or Clinic
These posters direct people with Medicare who have limited income and resources to sources for help with prescription drug costs. The posters are suitable for display in healthcare settings where people with Medicare and their caregivers will see the information. To view and order the posters, go to ***www.cms.hhs.gov/medlearn/drugcoverage.asp*** on the CMS Web site.

New Beneficiary Publications Available

New publications for people with Medicare that explain various aspects of the new coverage are available at ***www.cms.hhs.gov/medlearn/drugcoveragepubs.asp*** on the CMS Web site.

Additional Information

To find Medicare prescription drug plans available in each state, visit the **Landscape of Local Plans** on the Medicare Web site for a complete listing. You can use the new **Medicare Prescription Drug Plan Finder** to help people with Medicare learn about the new Medicare prescription drug coverage, find and compare prescription drug plans that meet personal needs, and enroll in the prescription drug plan that is right for him/her. The new **Formulary Finder** on the Medicare Web site will help people with Medicare find plans in each state that match their required drug lists.

Bookmark the *Medicare Prescription Drug Coverage Information for Providers* page, ***www.cms.hhs.gov/medlearn/drugcoverage.asp***, for the latest information and educational resources.

News from DMERC A...

DMERC A Mailing Addresses

Even though the post office (P.O.) box addresses were not affected by the relocation of the Region A Durable Medical Equipment Regional Carrier (DMERC A), there have been a few changes to the previously published information. Namely, the address for submitting general correspondence changed effective August 22, 2005. Please use the new address listed below when submitting written inquiries and Freedom of Information Act (FOIA) requests to DMERC A:

General Correspondence
P.O. Box 5303
Binghamton, NY 13902-5303

Claims Addresses

DMERC A is receiving numerous claims to the incorrect P.O. box. Claims mailed to an incorrect P.O. box will be forwarded to our Claims Entry Department, however, timely processing may be affected. For your information, the DMERC A claims mailing addresses are listed below. Please mail your claims to the appropriate P.O. box.

Drugs Claims P.O. Box 587 Wilkes-Barre, PA 18703-0587	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
Specialty Claims P.O. Box 1246 Wilkes-Barre, PA 18703-1246 *(use for all other claim types not listed above, including MSP claims)*	**Note**: Please refer to the back cover of this publication for additional addresses.

If you have any questions, please call the DMERC A Caller Information Network at 866-419-9458, Monday through Friday between 8:00 a.m. and 4:30 p.m.

DMERC A 2006 Holiday Schedule

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

New Year's Day Holiday	Monday, January 2, 2006
Martin Luther King, Jr. Day	Monday, January 16, 2006
Good Friday	Friday, April 14, 2006
Memorial Day	Monday, May 29, 2006
Independence Day	Tuesday, July 4, 2006
Labor Day	Monday, September 4, 2006
Thanksgiving Day	Thursday, November 23, 2006
Day after Thanksgiving	Friday, November 24, 2006
Day before Christmas Holiday	Monday, December 25, 2006
Christmas Holiday	Tuesday, December 26, 2006

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 or letters of appreciation in place of gifts.

Program Inquiries

News from CMS…

Changes to Chapter 29 - General Appeals Process in Initial Determinations

Medlearn Matters Number: MM4019
Related Change Request (CR) #: 4019
Related CR Release Date: October 7, 2005
Related CR Transmittal #: 695
Effective Date: May 1, 2005
Implementation Date: January 9, 2006

The following information affects physicians, providers, and suppliers who submit Part A or Part B fee-for-service claims to Medicare.

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. It is different from the previous first level of appeal for Part A claims performed by fiscal intermediaries (FIs). Reconsiderations will be processed by qualified independent contractors (QICs).

Change Request (CR) 4019 focuses on the general appeals process in initial determinations. CR 4019 contains a considerable amount of information that is pertinent to the entire process of Medicare claims appeals, and focuses specifically on the additions of Sections 200 to 260 to Chapter 29 of the *Medicare Claims Processing Manual.*

Key Points

Centers for Medicare & Medicaid Services (CMS) Decisions Subject to the Administrative Appeals Process

The Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. These decisions are subject to appeal with the SSA.

Minor Errors and Omissions

Providers should be aware that there is no need to appeal a claim if the provider has made a minor error or omission in filing the claim, which, in turn, caused the claim to be denied. In the case where a minor error or omission is involved, the provider can request that the Medicare contractor reopen the claim so the error or omission can be corrected, rather than having to go through the appeals process.

Who May Appeal

CR 4019 (Additions to Chapter 29) defines and describes the individuals and entities who have the right to appeal a Medicare contractor's initial determination. (Medicare contractors are carriers, including durable

medical equipment regional carriers (DMERCs), and FIs, including regional home health intermediaries (RHHIs).) An individual who has a right to appeal is referred to as a "party."

Provider or Supplier Appeals When the Beneficiary Is Deceased

When a provider or supplier appeals on behalf of a deceased beneficiary, and the provider or supplier otherwise does not have the right to appeal, it is the contractor's responsibility to determine whether another party is available to appeal. CR 4019 describes what must be done in this situation.

Parties to an Appeal

Any of the persons/entities who may appeal Medicare's decision to deny or reduce payment are parties to an appeal of a claim for items or services payable under Part A or Part B.

Steps in the Appeals Process: Overview

The process of appeal described in CR 4019 is effective for all redeterminations issued on or after May 1, 2005, by Medicare FIs and all redeterminations issued on or after January 1, 2006, by carriers. The appeals process consists of five levels. Each level **must** be completed for each claim at issue prior to proceeding to the next level of appeal. No appeal can be accepted until an initial determination has been made for the claim. The following chart outlines the steps in the Medicare appeal process:

The Medicare Fee-for-Service Appeals Process

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold to be Met or Amount in Controversy (AIC)
1. Redetermination			
♦ Performed by the Medicare contractor	120 days from date of receipt of the notice initial determination (MSN or RA). (The notice of initial determination is presumed to be received five days from the date of the notice unless there is evidence to the contrary.)	**Part A** – FI (MAC) **Part B** – Carrier (MAC)	None
2. Reconsideration			
♦ Performed by QIC ♦ Case file prepared by the Medicare contractor and forwarded to the QIC.** ♦ Medicare contractor may have effectuation responsibilities for decisions made by the QIC.	180 days from date of receipt of the redetermination	**Part A** and **B** – QIC	None
3. Administrative Law Judge (ALJ) Hearing			
♦ Case file prepared by the QIC and forwarded to the Health and Human Services (HHS) Office of Medicare Hearings and Appeals (OMHA). ♦ Medicare contractor may have effectuation responsibilities for decisions made at the ALJ level.	60 days from the date of receipt of the reconsideration notice	**Part A** and **B** – HHS OMHA Field Office	At least $100 remains in controversy*** *For requests made on or after January 1, 2006, at least $110 remains in controversy*
4. Departmental Appeals Board (DAB) Review			
♦ Contractor may have effectuation responsibilities for decisions made at the DAB level.	60 days from the date of receipt of the ALJ hearing decision/ dismissal	**Part A** and **B** – DAB or ALJ Hearing Office	None
5. Federal Court (Judicial) Review			
♦ Medicare contractor may have effectuation responsibilities for decisions made at the Federal Court level.	60 days from date of receipt of DAB decision or declination of review by DAB		At least $1,050 remains in controversy*** *For requests made on or after January 1, 2006, at least $1,090 remains in controversy*

*Where to Appeal - Part A includes Part B claims filed with the FI.
** In accordance with the appropriate manual section and the Joint Operating Agreement (JOA).
***Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy (AIC) requirement will increase by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Where to Appeal

Where a party must file an appeal depends on the level of appeal. The above chart indicates where appellants should file appeal requests for each level of appeal.

When to Appeal - Time Limits for Filing Appeals and Good Cause for Extension of the Time Limit for Filing Appeals

The time limits for filing appeals vary according to the type of appeal. The table above indicates the time limits for filing appeal requests for each level of appeal. These time limits may be extended if good cause for late filing is shown.

Good Cause - General Procedure to Establish Good Cause for Late Filing

Procedures to establish good cause are effective for all requests for redeterminations received by FIs on or after May 1, 2005, and all requests for redeterminations received by the carrier on or after January 1, 2006. The new Section 240 of Chapter 29 of the *Medicare Claims Processing Manual* lists the general procedure for establishing good cause for late filing; when a favorable decision for good cause is made; and when an unfavorable decision for good cause is made. A listing of conditions and examples that may establish good cause for late filing by beneficiaries, **or** by providers, physicians, and suppliers, can be found in Section 240, which is attached to CR 4019.

Amount in Controversy (AIC) Requirements

The amount in controversy requirements apply only to the ALJ and federal court levels. The chart above indicates the AIC as well as the method of calculating the AIC, for the Medicare appeals process.

Additional Information

The official instruction issued to your FI or carrier regarding this change may be found by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the Centers for Medicare & Medicaid Services (CMS) Web site. From that Web page, look for CR 4019 in the CR NUM column on the right, and click on the file for that CR.

All of the new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR 4019. These sections provide excellent detail that explains the revised appeals process.

Please refer to your local FI or carrier for more information about this issue. To find their toll-free telephone number, go to ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Changes to Chapter 29 - Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Date May 1, 2005)

Medlearn Matters Number: MM3942
Related Change Request (CR) #: 3942
Related CR Release Date: October 7, 2005
Related CR Transmittal #: 697
Effective Date: May 1, 2005
Implementation Date: January 9, 2006

The following information affects physicians, providers, and suppliers who submit claims to Medicare for services.

Provider Action Needed

Impact to You

The new second level in the administrative appeals process is called a "**reconsideration**." It is different from the previous first level of appeal for Part A claims performed by Medicare fiscal intermediaries (FIs). Reconsiderations will be processed by qualified independent contractors (QICs).

What You Need to Know

Medicare contractors (FIs, including regional home health intermediaries (RHHIs), or carriers, including durable medical equipment regional carriers (DMERCs)) may consider as **good cause for late filing**, written redetermination requests that are:

- Mailed or personally delivered to CMS, Social Security Administration (SSA), Railroad Retirement Board (RRB) office or another government agency; and
- Mailed in good faith and within the time limit, **but**
- Do not reach the appropriate Medicare contractor until after the time period to file a request expired.

In this case, the Medicare contractor may extend the period for filing.

What You Need to Do

Please refer to the "Background" section of this article for additional new policy information about the time limit for filing a request for redetermination.

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improve-

ment and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, now requires a new second level in the administrative appeals process called a reconsideration. Requests for redeterminations of appeal decisions (determinations) should go either to the QIC, the administrative law judge (ALJ), or the hearing officer (HO), depending on whether the claim is a Part A or Part B claim, whether the Medicare contractor who issued the initial claim decision is an FI or a carrier; and the date the claim was issued.

Time Limit for Filing a Request for Redetermination

A request for redetermination must be filed within 120 days of the date of receipt of the notice of initial determination (either the Medicare Summary Notice (MSN) supplied to the beneficiary or the Remittance Advice (RA) supplied to the provider).

- For requests filed in writing - the date received is defined as the date received by the Medicare contractor in the corporate mailroom.
- For requests filed in person - the date received is defined as the date of the office's date stamp on the request.

Please refer to the following table for clarification.

Appeal Rights for Requests for Redeterminations
The First Level of Appeal

Medicare Claims	Medicare Contractor Issuing Redetermination	Date Redetermination Issued and Mailed	Where to Appeal the Redetermination*
Part A/ Part B	FI	On or after May 1, 2005	QIC
Part B	Carrier	On or after January 1, 2006	QIC
Part A	FI	Before May 1, 2005	ALJ
Part B	FI	Before May 1, 2005	HO
Part B	Carrier	Before January 1, 2006	HO

*Qualified Independent Contractor (QIC); Administrative Law Judge (ALJ); Hearing Officer (HO)

Additional Information

Medicare Claims Processing Manual, Chapter 29 - Appeals of Claims Decisions, Sections 310.2-310.3 can be found at ***www.cms.hhs.gov/manuals/104_claims/clm104c29.pdf*** on the Center for Medicare & Medicaid Services (CMS) Web site. Medlearn Matters article MM3530, "MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries" (Change Request (CR) Title - Appeals Transition - BIPA 521 Appeals) **Revised: 4/12/2005**, can be found at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3530.pdf*** on the CMS Web site. CR 3530, "Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title - Appeals Transition - BIPA 521 Appeals) **Revised: 4/12/2005**, can be found at ***www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf*** on the CMS Web site.

The official instruction issued to your FI, DMERC, or carrier regarding this change may be found by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 3942 in the CR NUM column on the right, and click on the file for that CR. The new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR 3942.

Please refer to your local carrier/DMERC/FI for more information about this issue. To find the toll-free telephone number, go to ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Program Education & Training

Claim Submission Errors for the Fourth Quarter of Fiscal Year 2005

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, 2005, through September 30, 2005, are provided in the following chart. The total number of ANSI errors for this period was **183,789**.

ANSI Error Number - Narrative (Total Errors)	Reason for Error
1) 40068 - Invalid/Unnecessary Certificate of Medical Necessity (CMN) Question. (27,965 errors)	The question number entered is not valid for the DMERC CMN you are sending.
2) 40022 - Procedure Code/ Modifier Invalid. (24,917 errors)	The procedure code and/or modifier used on this line is invalid.
3) 20269 - Pointer 1 Diagnosis Invalid. (11,404 errors)	Diagnosis pointer is invalid.

ANSI Error Number - Narrative (Total Errors)	Reason for Error
4) 20193 - Invalid Carrier Code. (10,336 errors)	The carrier code is incorrect for DMERC A.
5) 40073 - Dates of Service Invalid with Procedure Code. (7,876 errors)	The procedure code used is not valid for the dates of service used.
6) 20270 - Pointer 2 Diagnosis Invalid. (7,078 errors)	Diagnosis pointer is invalid.
7) 20025 - Subscriber ID Code Invalid. (5,249 errors)	The qualifier identifying the subscriber is invalid.
8) 40037 - Service Date Greater Than Receipt Date. (5,064 errors)	Service date is greater than date claim was received.
9) 20143 - Ordering Provider Secondary ID Invalid. (4,272 errors)	The provider number or Unique Physician Identification Number (UPIN) is invalid.
10) 40036- Service From Date Does Not Equal To Date. (4,246 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 2005. 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 code(s) and/or rates. (8,041 claims)	**Item 24D**
2) CO 16 M78 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid Healthcare Common Procedure Coding System (HCPCS) modifier. (6,928 claims)	**Item 24D**
3) CO 16 MA83 Claim/service lacks information which is needed for adjudication. Did not indicate whether we are the primary or secondary payer. (5,093 claims)	**Item 11**
4) CO 16 MA102 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/ supervising provider. (3,973 claims)	**Item 17**
5) 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 telephone number. (3,956 claims)	**Item 33**
6) 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. (3,224 claims)	**Item 21**
7) CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different. (2,653 claims)	**Item 24A**

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form Entry Requirement
8) CO 16 M77 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid place of service. (987 claims)	**Item 24B**
9) CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid information on where the services were furnished. (541 claims)	**Item 32**
10) CO 16 M79 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid charge. (253 claims)	**Item 24F**

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!

Fall 2005 Educational Seminars in Retrospect

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department completed a very successful round of seminars during the fall of 2005. A total of 20 seminars were conducted throughout our ten-state region. Topics included DMERC Essentials I, DMERC Essentials II, What's New with the Medicare Program - Keeping Up with DMERC Changes, and Troubleshooting DMERC Claims - Getting it Right the First Time. Attendees registered via our online registration process, and materials for the seminars were provided in advance via the "Events" section of the DMERC A Web site (***www.umd.nycpic.com/dmprovcaln.html***). These materials have been archived and can be retrieved via the "Education - Seminar Materials" section at: ***www.umd.nycpic.com/dmeduc_seminars.html***.

Seminar attendees are asked to complete an evaluation form at the end of each educational session. Among other things, the form asks participants to respond to their overall satisfaction. The overall satisfaction rate for the fall 2005 seminars was **95 percent** (%) for met/exceeded expectations. Additionally, the evaluations are compiled into comprehensive data packages,

which are reviewed for opportunities for improvement with future seminars and for areas where training may be needed to strengthen the skills of the PET ombudsmen staff. The entire PET staff would like to thank all of the attendees for their enthusiastic participation, and we look forward to seeing you in the future.

Educational seminars are only one of the avenues used by PET for the dissemination of information about the Medicare program. We also participate in numerous state and national outreach events, giving us the opportunity to partner with colleagues and reach a broader spectrum of the provider community. Providers should check the "Events" section of our Web site for announcements and schedules of upcoming seminars and outreach events, including our Web-based seminars.

DMERCs Attend the AOPA National Assembly and Medtrade

Staff from the Region A Durable Medical Equipment Regional Carrier (DMERC A) Program Education & Training (PET) Department attended the American Orthotic and Prosthetic Association (AOPA) National Assembly in Las Vegas, NV, held September 24-29, 2005, and Medtrade, held October 16-18, 2005, in Atlanta, GA. AOPA is a national trade association committed to providing high-quality, unprecedented business services and products to orthotic and prosthetic (O&P) professionals. Through government relations efforts, AOPA works to raise awareness of the profession and impact policies that affect the future of the O&P industry. For more information, please visit the AOPA Web site at ***www.aopanet.org***.

At Medtrade, DMERC A staff provided access to our Web site, along with assistance in the navigation of the site, the Region A Program Safeguard Contractor Web site, and various Centers for Medicare & Medicaid Services (CMS) Web sites. DMERC A also participated in the "DMERC Issues Update" educational session, along with representatives from the other DMERCs. Each representative gave an update on their respective activities and initiatives and provided updates on some of the "hot topics" within the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) industry. In addition, members from the DMERC A Electronic Data Interchange (EDI) Department participated in an "EDI Update" session.

PET recognizes these events as ideal opportunities to personally interact with and offer continued availability to the DMEPOS community, and we look forward to seeing you at next year's events.

Supplier Manual News

The 2003 edition of the Region A Durable Medical Equipment Regional Carrier (DMERC A) supplier manual was reprinted on CD-ROM in September 2005. The *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 manual, including revised chapters and archived revisions. The 2005 reprint is available to current suppliers via the DMERC A Web site only. Newly-enrolled suppliers will receive their initial manuals on CD-ROM. The option to request additional copies **for a fee** is available via our Web site. Go to ***www.umd.nycpic.com/dmprovpublcopy.html*** for details.

The downloadable version of the 2005 reprint cover was posted to the DMERC A Web site. Additional corrections/updates have been made to the manual as indicated below:

Revision 2005-01 (October 2005)

- Chapter 1 (Contact Information) - updated for changes related to the relocation of DMERC A

Revision 2005-02 (December 2005)

- Chapter 8 (Appeals) - updated to reflect current information, as in CMS Online Manual System, including changes as amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and Section 1869(c) of the Social Security Act., as amended by BIPA.

(**Note**: The table of contents was updated under revision 2005-02.)

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. Be sure to follow the download instructions to print the revised pages.

Printed Copies of the *DMERC A Medicare News*

The Region A Durable Medical Equipment Regional Carrier (DMERC A) will continue to offer our provider bulletin, the *DMERC A Medicare News*, in electronic format via our Web site in fiscal year 2006, 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. You can be notified via email when bulletins are posted on our Web site, as well as the latest Medicare updates, by subscribing to the DMERC A ListServes, our electronic mailing lists. To subscribe to the ListServes, visit the "ListServes" section at ***www.umd.nycpic.com/dmlistserve.html***.

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 2005, March 2006, June 2006, and September 2006. Please complete the following form and submit with payment, via check only, to the address listed on the form.

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 A Medicare News* via *(Includes the December 2005, March 2006, June 2006, and September 2006 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.

* The CD version of the bulletin is a Portable Document Format (PDF) file. To view PDFs, you must have Adobe® Acrobat® Reader® installed on your computer. If your computer does not have this program, you can install the free version included on the CD.

Web Site Resources

News from CMS…

Quarterly Reminder to Apply for a National Provider Identifier (NPI) and Announcement of New NPI Web Page

Announcing the new Centers for Medicare & Medicaid Services (CMS) Web page dedicated to providing all the latest NPI news for Fee-For-Service (FFS) Medicare providers! Visit ***www.cms.hhs.gov/providers/npi/default.asp*** on the Web! While this page is dedicated to the Medicare FFS community, it contains helpful information and links that may benefit all health care providers.

Reminder - Health care providers are required by law to apply for a National Provider Identifier (NPI). To apply online, visit: ***https://nppes.cms.hhs.gov***

Posters Now Available!

Posters titled, "Have Limited Income? Social Security Can Help with Prescription Costs," can be ordered free-of-charge on the Centers for Medicare & Medicaid Services' (CMS) Web site. The posters are suitable for display in a physician's, provider's, or supplier's office, a pharmacy, or other health care setting where Medicare beneficiaries will see this information. The posters direct Medicare beneficiaries with limited income to a toll-free number where they can find out if they are eligible for help with prescription drug costs. Flat posters are suitable for wall display. Easel posters are suitable for counter display *(update: easel posters are no longer available)*. Order the size and style appropriate for your use. Artwork cannot be specified as posters will be sent based on availability at the time the order is

received. To view and order the posters, go to the Medlearn Prescription Drug Coverage Web page located at ***www.cms.hhs.gov/medlearn/drugcoverage.asp*** on the CMS Web site. We [CMS] need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

Quarterly Provider Update

The Quarterly Provider Update (QPU) is a comprehensive resource published by the Centers for Medicare & Medicaid Services (CMS) on the first business day of each quarter. It is a listing of all non-regulatory changes to Medicare including program memoranda, manual changes, and any other instructions that could affect providers. Regulations and instructions published in the previous quarter are also included in the update. The QPU can be accessed at ***www.cms.hhs.gov/providerupdate***. We [CMS] 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 QPU ListServe at: ***list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1***

Hurricanes Katrina and Rita - Frequently Asked Questions - Medicare Issues

Medlearn Matters Number: SE0563
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The following information affects all providers who are affected by Hurricanes Katrina and Rita or serving Medicare patients affected by those hurricanes.

Key Points

This article contains important information about Medicare issues resulting from Hurricanes Katrina and Rita. The Centers for Medicare & Medicaid Services (CMS) has posted pertinent information on its Web site at ***www.cms.hhs.gov/hki***. This Web site is updated on a daily basis. The information on this site includes the following:

A Question and Answer Document
This document was created to answer frequently asked questions about Medicare issues resulting from Hurricanes Katrina and Rita. Please review each question and answer and take appropriate action to implement them into your claims process. Account and document all activities associated with implementing these instructions. (To view this information, scroll down to the Question and Answer section on the page (***www.cms.hhs.gov/hki***) and select the category desired (e.g., Section 1135, General, Ambulance, etc.).

Hurricane Katrina Electronic Mailing List
This is an electronic mailing list service for those interested in receiving news automatically via email from CMS.

Hurricane Katrina: What Government Is Doing
This Department of Homeland Security Web site focuses on the government's response to Hurricane Katrina - including links to:

- How to Get Help;
- Donations and Volunteering;
- Finding Friends and Information;
- Health and Safety; and
- A link to Hurricane Katrina-related information in Spanish.

Fact Sheet: CMS Actions to Help Beneficiaries, Providers in Katrina Stricken Areas
This link leads to specific Medicare-related hurricane relief information for healthcare providers who furnish medical services related to Hurricane Katrina.

Phone Numbers for State Medical Assistance Offices
This Web page contains contact information for all states, related Web sites, and resources (a download of the Helpful Contacts tool).

State Health Officials Letter and 1115 Model Waiver Template
This links to state Medicaid directors' information, including:

- A Letter to State Medicaid Directors and State Children's Health Insurance Program Directors;
- An Application Template - Medicaid and SCHIP Coverage for Evacuees of Hurricane Katrina;
- Information on Evacuee Eligibility Simplification Based on Home State Eligibility Rules; and

- Medicaid Eligibility Groups - Income and Resource Limits.

Approved Katrina 1115 Waiver Information
This Web page contains approved Katrina 1115 Waiver documents for the states of Alabama, Arkansas, District of Columbia, Florida, Georgia, Idaho, Mississippi, and Texas, including an Approval Letter, the Terms and Conditions, and the Attachments for each of the states.

Hurricane Information from the Department of Health and Human Services (HHS)
Topics on this page include:
- What HHS is Doing;
- Health and Safety;
- How to Get Help;
- Donate and Volunteer;
- Finding Friends and Information;
- What Other Federal Agencies are Doing; and
- Key State Government Agencies in the Region.

Hurricane Katrina Medicare Contractor and CMS Regional Office Contacts
This Web page informs Medicare providers about relevant contact points for those in the affected areas, and notifies providers about a list of questions and answers available online at ***www.cms.gov*** in the "Spotlight" section.

Signed Waiver Under Section 1135 of the Social Security Act 9/4/2005
Section 1135 of the Social Security Act allows the Secretary of Health and Human Services to waive or modify certain Medicare, Medicaid, or State Children's Health Insurance Program requirements in order to protect the public health and welfare in times of national crisis. On Wednesday August 31, 2005, Secretary Michael Leavitt notified the Congress that he was invoking this authority, as a consequence of Hurricane Katrina, in order to protect the health and welfare of the public in areas impacted by this crisis. CMS is taking action consistent with this authority to ensure that the people in these areas receive all necessary health care services.

Hurricane Katrina Recovery Information from FirstGov.gov
Links on this page include:
- Find Family and Friends;
- How to Get Help;
- Shelter and Housing for Survivors;
- Donate and Volunteer;
- Health and Safety;
- What [the] Government is Doing; and
- Frequently Asked Questions.

Katrina Information Resources
Links on this page include:
- National Voluntary Organizations Active in Disaster (NVOAD) Resources; and
- CCD information related to Tetanus Prevention, non-01 and non-0139 Vibro cholerae; and
- Cancer Patient Resources for Hurricane Katrina.

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 summer 2005 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.)

News from DMERC A...

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 and supplier manual revisions become available on our Web site. Additionally, there are specialty/area of interest ListServes that 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 email 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***. Also, to receive email notification of medical policy updates and other important articles, subscribe to the Region A Program Safeguard Contractor (PSC) ListServe by visiting: ***www2.palmettogba.com/cgi-bin/mojo/mojo.cgi***

Changing Email Addresses

If you change your email address, and you are subscribed to the DMERC A ListServes, you will need to update your information by doing the following:

- Visit ***www.umd.nycpic.com/dmlistserve.html***
- Go to the appropriate ListServe section
- Follow the directions to Unsubscribe with your **old** email address
- Follow the directions to Subscribe with your **new** email address

These steps will need to be followed each time you change your email address. If you do not, you will not receive email notification when updates are made to the DMERC A Web site. (**Note**: If you are subscribed to the Region A PSC ListServe as well, you will need to Unsubscribe/Subscribe in order to continue receiving medical policy update email notification.)

Reminders

As a convenience, the DMERC A Program Education & Training (PET) Department has subscribed suppliers/providers to our ListServes. If the PET Department subscribed you to our ListServes, and you changed your email address, **you** will need to Unsubscribe/Subscribe to the appropriate ListServe(s) as per the instructions in the above section.

DMERC A strives to limit our email notifications to **one** message a day for each ListServe account, as applicable. Therefore, you will only receive messages that are important for your business needs.

Region A DMERC and PSC Affiliate Web Sites

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 our quarterly bulletins and supplier manual 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/content/psc_dmerc_reg_a.cfm***. Providers should access the PSC Web site for information on Bulletins, Fraud and Abuse, Healthcare Common Procedure Coding System (HCPCS), Medical Policies, and Progressive Corrective Action/Local Provider Education & Training (PCA/LPET). Recent updates involving medical policy development, medical review, benefit integrity, or fraud alerts can be accessed by visiting the PSC "What's New" section at: ***www.tricenturion.com/content/whatsnew_dyn.cfm***

Reminder

When accessing medical policies on the PSC Web site, providers should ensure that they are viewing the most recent revision available which is applicable for the date of service in question. Revision dates can be found under the "Revision History Explanation" section of the medical policy. The revision history is broken down by the "Revision Effective Date" and includes a description of the change(s). Current medical policies for Region A are available at ***www.tricenturion.com/content/lmrp_current_dyn.cfm***.

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Please remember:

Be sure to visit the "What's New" section of our Web site at ***www.umd.nycpic.com/dme_what's_new.html*** for the latest information and updates regarding the Medicare program and DMERC A.

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	570-255-9666
Program Inquiries	
Telephone Redeterminations Line	866-420-6906
FAX Numbers	
Check Control/MSP	570-255-9594
Electronic Data Interchange	570-255-9510
Extra Documentation/ADMC	570-255-9402
Program Education & Training	570-255-9442
Program Inquiries (Hearings & Redeterminations)	570-255-9599
National Supplier Clearinghouse	866-238-9652
SADMERC	877-735-1326
Web Sites	www.umd.nycpic.com www.tricenturion.com www.cms.hhs.gov

Addresses

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

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 5303
Binghamton, NY 13902-5303
[*for Written Inquiries, Freedom of Information Act (FOIA) Requests*]

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

Redeterminations
P.O. Box 1068
Wilkes-Barre, PA 18703-1068

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

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