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

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Billing/Finance

If you don't submit your Medicare claims electronically, your payments could be affected. Effective July 1, 2005, paper claims will be denied unless there is an exception in place for you.

News from CMS…

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

The Centers for Medicare & Medicaid Services (CMS) advised Medicare carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs) that certain Medicare systems are being changed on April 18, 2005. Further, CMS advised that certain claims affected by these system changes may not be processed until those system changes are implemented no later than April 18. As a result, CMS instructed carriers and FIs to hold these claims (effective April 1, 2005) and not process them until the system changes are in place.

CMS issued an informational Special Edition Medlearn Matters article, SE0531, to notify all physicians and providers billing Medicare carriers and all providers billing Medicare FIs, for services paid under the outpatient prospective payment system (OPPS), of the circumstances that may cause a slight delay in receiving payment from Medicare for some of their claims. For the complete text, refer to the article on CMS' Web site at:

www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0531.pdf

Revisions to January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File

Medlearn Matters Number: MM3728
Related Change Request (CR) #: 3728
Related CR Release Date: February 3, 2005
Related CR Transmittal #: 140
Effective Date: January 1, 2005
Implementation Date: February 5, 2005

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

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS) is revising certain payment limits included in the first quarter 2005 (1Q05) Medicare Part B Drug Pricing File used by Medicare carriers and intermediaries, including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs).

What You Need to Know

Medicare carriers and intermediaries, including DMERCs and RHHIs, will not apply these limits to claims already processed unless brought to their attention by the provider/supplier.

What You Need to Do

Medicare carriers and intermediaries, including DMERCs and RHHIs, will not apply these limits to claims already processed unless brought to their attention by the provider/supplier.

Background

According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the new average sales price (ASP) method. The ASP method is based on data submitted to CMS by manufacturers at the 11-digit National Drug Code (NDC) level. CMS then determines the number of billable units per NDC based on published drug pricing information, as well as other sources available to CMS. **Through receipt of additional information, CMS has determined certain payment limits in the 1Q05**

Medicare Part B Drug Pricing File need revision. Tables 1 and 2 below identify the revised payment limits. The limits apply to dates of service on or after January 1, 2005, and on or before March 31, 2005. The revised payment limits in this notification supersede the payment limits for these codes in any publication published prior to Change Request (CR) 3728.

Also, note that the ASP-based 1Q05 payment limit for J7510, Q4054, and Q4055 are now provided. The revised payment limit for 90740, a vaccine, is based on 95 percent (95%) of the average wholesale price (AWP). The revised payment limits for the blood clotting factor codes includes the $0.14 per I.U. furnishing fee. The payment limits in Table 2 are for certain new drugs.

Table 1

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit	1Q05 Vaccine Limit
90740	Hepb vacc, ill pat 3 dose im	3 DOSE SCH	$113.91	$113.91	$113.91
J7190*	Factor viii	I.U.	$0.66	$0.66	
J7191*	Factor viii (porcine)	I.U.	$1.86	$1.86	
J7192*	Factor viii recombinant	I.U.	$1.06	$1.06	
J7193*	Factor ix non-recombinant	I.U.	$0.89	$0.89	
J7194*	Factor ix complex	I.U.	$0.63	$0.63	
J7195*	Factor ix recombinant	I.U.	$0.98	$0.98	
J7197*	Antithrombin iii injection	I.U.	$1.72	$1.72	
J7198*	Anti-inhibitor	I.U.	$1.23	$1.23	
J7510	Prednisone oral per 5 mg	5 MG	$0.05	$0.05	
Q0187*	Factor viia recombinant	1.2 MG	$1,051.45	$1,051.45	
Q2022*	Von Willebrand Factr Cmplx per IU	I.U.	$0.86	$0.86	
Q4054	Darbepoetin alfa, ESRD use	1MCG	$3.54	$3.54	
Q4055	Epoetin alfa, ESRD use	1,000 units	$9.32	$9.76	

* The ASP-based payment allowance limit for blood clotting factors and the furnishing fee for the blood clotting factors do not apply to inpatient claims.

Table 2

HCPCS Code	Drug Name	Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit	1Q05 Vaccine Limit
J3490	Pegaptamib sodium	0.3 MG	$1,054.70	$1,054.70	
J9999	Histrelin implant	5 MG	$530.00	$530.00	
J9999	Natalizumab	5 MG	$31.94	$31.94	

Note: 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.

Implementation

The implementation date is February 4, 2005.

Additional Information

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

From that Web page, look for CR 3728 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***

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***

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

Medlearn Matters Number: MM3667
Related Change Request (CR) #: 3667
Related CR Release Date: February 25, 2005
Related CR Transmittal #: 480
Effective Date: January 1, 2005
Implementation Date: April 4, 2005

The following information affects all Medicare providers.

Provider Action Needed

Impact to You

Change Request (CR) 3667 discusses updates to the new methodology of paying for Medicare Part B covered drugs not paid on the basis of cost or prospective payment.

What You Need to Know

Effective January 1, 2005, Part B covered drugs and biologicals (that are not paid on a cost or prospective payment basis) are paid based on the new average sales price (ASP) drug payment system, described below.

What You Need to Do

Make sure that your billing staffs are aware of these changes.

Background

The Medicare Modernization Act of 2003 (MMA), Section 303(c), revises the methodology of paying for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs are paid based on the new 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. However, there are exceptions to this general rule as summarized below:

- For **blood and blood products** (with certain exceptions like blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003. Specifically, the payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. **The payment allowance limits will be updated on a quarterly basis.**
- For **infusion drugs** furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, payment allowance limits will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the DME is implanted. **The payment allowance limits will not be updated in 2005.**
- For **influenza, pneumococcal, and hepatitis B vaccines** payment allowance limits are 95 percent of the AWP as reflected in the published compendia. **The payment allowance limits will be updated on a quarterly basis.**
- For **drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File** payment allowance limits are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, carriers/FIs will follow the methodology specified in the Medicare Claims Processing Manual for calculating the AWP, but substitute WAC for AWP. Please see Pub. 100-04, Chapter 17 (Drugs and Biologicals) at the following CMS Web site:
  www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf
  The payment limit is 100 percent of the WAC for the lesser of the lowest brand or median generic. Your carrier or FI may, at their discretion, contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files. If available, CMS will provide the payment limits either directly to the requesting carrier/FI or via posting an MS Excel file on the CMS Web site. If the payment limit is available from CMS, carriers/FIs will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing.
- For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File**, payment allowance limits are based on 106 percent of the WAC. This policy applies only to new drugs that were first sold on or after December 1, 2004. The April 2005 and new January 2005 ASP drug pricing files will contain three decimal places in the currency fields. In addition, the new January file contains revised payment limits for some drugs. The codes with a revised payment limit are identified in the column titled "Notes."

The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and its associated payment limit in the pricing files do not indicate Medicare coverage of the drug. Similarly, the inclusion of a payment limit within a specific column does not indicate Medicare coverage of the drug in that

specific category. The carrier/FI processing your claim will make these determinations.

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

- Use the April 2005 ASP and NOC drug pricing files to pay for Medicare Part B drugs effective April 1, 2005. This file shall be used for dates of service from April 1, 2005, through June 30, 2005;
- Determine for any drug or biological not listed in the ASP or NOC drug pricing files, the payment allowance limits in accordance with the policies described in this transmittal, CR 3539, dated October 29, 2004 (see ***www.cms.hhs.gov/manuals/pm_trans/R348CP.pdf***), and CR 3232, dated December 16, 2004 (see ***www.cms.hhs.gov/manuals/pm_trans/R397CP.pdf***), and FIs should seek payment allowances from their local carrier;
- Use the new January 2005 ASP drug pricing file for (1) those claims where the carriers/FIs are asked to retroactively adjust claims processed with the original January 2005 file, and (2) those claims with dates of service on or after January 1, 2005, and before April 1, 2005, that are processed after April 4, 2005. **Your carrier or FI shall not search and adjust claims that have already been processed unless brought to their attention**;
- Overlay the old January 2005 file with the new January 2005 file; and
- For any drug or biological for which they (your carrier or FI) calculates a payment allowance limit, forward to CMS the following:
  - The drug name,
  - Dosage,
  - Payment allowance limit, and
  - National Drug Code (if available).

Note: The ASP and NOC drug pricing files will contain the 106 percent ASP, 106 percent WAC, or WAC-based payment allowance limits; therefore, no additional payment calculation is required by your carrier or FI. The payment limits for the blood clotting factor codes includes the $0.14 per I.U. furnishing fee.

Additional Information

The new January 2005 and April 2005 ASP and NOC pricing files are available from the following CMS Web site on or after March 17, 2005:
www.cms.hhs.gov/providers/drugs/asp.asp

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

From that Web page, look for CR 3667 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

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

Medlearn Matters Number: MM3783
Related Change Request (CR) #: 3783
Related CR Release Date: April 22, 2005
Related CR Transmittal #: 528
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

The following information affects all Medicare providers.

Provider Action Needed

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

Background

According to Section 303 of the Medicare Modernization Act of 2003 (MMA), beginning January 1, 2005, drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the average sales price (ASP) plus six (6) percent. The Centers for Medicare & Medicaid Services (CMS) supplies its carriers/intermediaries with the ASP drug pricing file for Medicare Part B drugs. The ASP is based on quarterly drug information supplied to CMS by drug manufacturers. Thus, beginning January 1, 2005, the payment allowance limits for Medicare Part B drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions

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

- The payment allowance limits for blood and blood products, with certain exceptions such as blood clotting factors, are determined in the same manner the payment allowance limits were determined on October 1, 2003. Specifically, the payment allowance limits for blood and products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
- The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment (DME) on or after January 1, 2005, will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, regardless of whether or not the 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.
- The payment allowance limits for influenza, pneumococcal, and hepatitis B vaccines are 95 percent of the AWP as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.
- The payment allowance limits for drugs, other than new drugs, not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on the published wholesale acquisition cost (WAC) or invoice pricing. In determining the payment limit based on WAC, the carriers/intermediaries follow the methodology specified in Chapter 17, Drugs and Biologicals, of the Medicare Claims Processing Manual for calculating the AWP, but substitute WAC for AWP. Chapter 17 may be found on the CMS Web site at:
  www.cms.hhs.gov/manuals/104_claims/clm104c17.pdf
- The payment limit is 100 percent (100%) of the WAC for the lesser of the lowest brand or median generic. Carriers/intermediaries, at their discretion, may contact CMS to obtain payment limits for drugs not included in the quarterly ASP or NOC files or otherwise made available by CMS on the CMS Web site. If the payment limit is available from CMS, carriers/intermediaries will substitute CMS-provided payment limits for pricing based on WAC or invoice pricing. CMS will provide the payment limits either directly to the requesting carrier/intermediary or via posting an MS Excel file on the CMS Web site.
- The payment allowance limits for new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File 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. Medicare carriers/intermediaries will determine payment limits for radiopharmaceuticals based on invoice pricing.

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

Implementation

The implementation date is July 5, 2005. The July 2005 ASP and NOC drug pricing files will be used by your carrier/intermediary to pay for Medicare Part B drugs from July 1, 2005, through September 30, 2005.

Additional Information

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

From that Web page, look for Change Request (CR) 3783 in the CR NUM column on the right and click on the file for that CR. Also, if you have any questions, please contact your carrier/intermediary at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Number of Drug Pricing Files That Must Be Maintained Online for Medicare by Durable Medical Equipment Regional Carriers (DMERCs)

Medlearn Matters Number: MM3584
Related Change Request (CR) #: 3584
Related CR Release Date: March 18, 2005 **Revised**

Related CR Transmittal #: 509
Effective Date: July 1, 2005
Implementation Date: July 5, 2005
Note: Change Request (CR) 3584 was reissued on March 18, 2005, and this article was revised on March 21, 2005, to reflect the new CR release date and transmittal number. No other changes were made to the article.

The following information affects durable medical equipment (DME) suppliers that bill Medicare durable medical equipment regional carriers (DMERCs).

Provider Action Needed

None, this article is informational only. Beginning January 1, 2005, the payment limit for Part B drugs and biologicals will be based on the average sales price (ASP). Drugs will be paid based on either the lower of the submitted charge or the ASP and will continue to be priced based on date of service.

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

Additional Information

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

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

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

Medlearn Matters Number: MM3669
Related Change Request (CR) #: 3669
Related CR Release Date: January 28, 2005
Related CR Transmittal #: 451
Effective Date: April 1, 2005, for new codes added to the Healthcare Common Procedure Coding System (HCPCS), and January 1, 2005, for all other HCPCS codes on the fee schedule
Implementation Date: April 4, 2005

The following information affects physicians, providers, and suppliers billing durable medical equipment regional carriers (DMERCs) and/or intermediaries.

Provider Action Needed

This article is based on Change Request (CR) 3669, and it provides specific information regarding the April quarterly update for the 2005 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

Background

This article provides specific information regarding the April quarterly update for the 2005 DMEPOS fee schedule. The DMEPOS fee schedules are updated on a quarterly basis in order to 1) implement fee schedule amounts for new codes, and 2) to revise any fee schedule amounts for existing codes that were calculated in error. Payment on a fee schedule basis is required for:

- Durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (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 April 2005.

HCPCS code K0670 (addition to lower extremity prosthesis…) is added, effective April 1, 2005, to the list of HCPCS accepted by DMERCs and intermediaries.

Also, **HCPCS code K0671 is being added to the HCPCS effective April 1, 2005**, as an accepted code by DMERCs and regional home health intermediaries. This code:

- Describes a rental portable oxygen concentrator system, and
- Is to be used when billing Medicare for the portable equipment add-on fee for patients using lightweight

oxygen concentrators that can function as both the patient's stationary equipment and portable equipment.

The following HCPCS codes are to be used to describe combination stationary/portable oxygen concentrators for Medicare billing purposes.

- For claims for combination stationary/portable oxygen concentrators with **dates of service prior to April 1, 2005**, use:
  - HCPCS code E1390 (stationary oxygen concentrator) **with**
  - HCPCS code E0431 (portable gaseous oxygen system).

- For claims with dates of service **on or after April 1, 2005**, use:
  - HCPCS code E1390 (stationary oxygen concentrator) in conjunction **with**
  - HCPCS code K0671 (portable oxygen concentrator system).

Note: Payment for HCPCS code K0671 will be based on the current add-on fee schedule amounts for portable oxygen equipment.

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

Implementation

The implementation date for this instruction is April 4, 2005.

Additional Information

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

From that Web page, look for CR 3669 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/intermediary at their toll-free number, which may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

Modifications to Duplicate Editing for Dispensing/Supply Fee Codes for Oral Anti-Cancer, Oral Anti-Emetic, Immunosuppressive, and Inhalation Drugs

Medlearn Matters Number: MM3666
Related Change Request (CR) #: 3666
Related CR Release Date: February 4, 2005
Related CR Transmittal #: 467
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

The following information affects pharmacies and suppliers billing Medicare durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Impact to You
If you bill Medicare for services with a Healthcare Common Procedure Coding System (HCPCS) code of E0590, this change may impact you.

What You Need to Know
This article provides information on HCPCS code E0590, for which DMERCs paid dispensing fees for nebulizers.

Although E0590 was discontinued January 1, 2005, the DMERCs could still receive valid claims for the code due to timely filing rules.

What You Need to Do
Be aware of these changes as they could affect your reimbursements.

Background

In addition to the change mentioned relative to HCPCS code E0590, remember that the DMERCs will only pay dispensing fees when also making payment for the associated oral anti-cancer, oral anti-emetic, and immunosuppressive drugs.

Reminder: A pharmacy that submits a claim for G0374 (90-day dispensing fee) may not receive another dispensing fee (G0371 or G0374) until 90 days after the date of service on the claim for G0374.

Additional Information

Beneficiaries are required to pay the normal co-pay and deductibles on dispensing fees.

For further details on these fees, see the Medlearn Matters article MM3620, which was based on Change Request (CR) 3620. That article may be found at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3620.pdf***

To view the official instruction issued to your DMERC on this issue, visit: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

Once at the above page, scroll down the CR NUM column on the right to find the link for CR 3666. Click on the link to open and view that file. If you have any questions, contact your DMERC at their toll-free number, which is available at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Anti-Cancer Chemotherapy for Colorectal Cancer

Medlearn Matters Number: MM3742
Related Change Request (CR) #: 3742
Related CR Release Date: March 29, 2005
Related CR Transmittal #: 30 and 512
Effective Date: January 28, 2005
Implementation Date: April 18, 2005

The following information affects providers and suppliers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs) for anti-cancer chemotherapy.

Provider Action Needed

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

This national coverage decision does not:

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

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

Background

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

Note: The clinical trials for which these drugs and other items and services are covered appear in Appendix A in the NCD at the following CMS Web site: ***www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=90***

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

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

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

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

Under the concept of linking Medicare coverage determinations to clinical studies, the investigational

items and services provided in qualified scientific studies are covered (including clinical trials, practical trials, and systematic data collection systems) when:

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

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

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

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

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

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

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

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

- FIs will accept claims for these drugs on types of bill (TOB) 11x, 12x, 13x, 18x, 21x, 22x, 23x, and 85x. Revenue code 0636 should be used.
- When billing carriers, DMERCs, and FIs on a claim other than an inpatient claim, include the QR modifier to show the drug was furnished during a clinical trial.
- Claims submitted to FIs should also contain an ICD-9-CM diagnosis code of V70.7 in the second diagnosis code position to show that the claim involves a clinical trial.
- When using the QR modifier, also be sure to include a Healthcare Common Procedure Coding System (HCPCS) code of J9035, J9055, J9206, J9263, J8520, J8521, J9190, or J9201, as appropriate for the anti-cancer drug being billed.
- Providers are also to include a QR modifier when billing for non-routine costs associated with these clinical trials.
- DMERCs will accept claims with HCPCS codes of J8520 and J8521 as clinical trial codes for **oral anti-cancer drugs**, when accompanied by the QR modifier to show use in a clinical trial.
- When billing for covered routine costs associated with clinical trials as described in Section 310 of the NCD Manual, be sure to include a QV modifier on the claim.
- Submit an appropriate cancer diagnosis code for the clinical trial on the claim.

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

Additional Information

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

From that Web page, look for Change Request (CR) 3742 in the CR NUM column on the right, and click on the file for that CR. You should see two versions of CR 3742 on this Web site. The version of CR 3742 with a transmittal number of R30NCD will contain the NCD

information, and the version with a transmittal number of R512CP will contain the Medicare claims processing instructions.

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

Infusion Pumps: C-Peptide Levels as a Criterion for Use

Medlearn Matters Number: MM3705
Related Change Request (CR) #: 3705
Related CR Release Date: March 30, 2005 **Revised**
Related CR Transmittal #: 27 and 513
Effective Date: December 17, 2005
Implementation Date: February 18, 2005
Note: This article was revised on April 1, 2005, to reflect a revised transmittal number, since Change Request (CR) 3705 was reissued on March 30, 2005, and again on April 25, 2005, to show that the correct diagnosis codes are 250.00-250.93.

The following information affects physicians, suppliers, and providers providing continuous subcutaneous insulin infusion and related drugs/supplies in the treatment of diabetic patients in the home setting and billing Medicare carriers or fiscal intermediaries (FIs).

Provider Action Needed

Impact to You

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

What You Need to Know

Providers/suppliers treating Medicare diabetic patients with infusion pumps should be aware of this new Medicare coverage policy.

What You Need to Do

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

Background

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

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

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

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

Additional Information

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

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

New HCPCS Codes for Intravenous Immune Globulin (IVIG)

Medlearn Matters Number: MM3745
Related Change Request (CR) #: 3745
Related CR Release Date: March 18, 2005
Related CR Transmittal #: 507
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

The following information affects physicians, providers, and suppliers billing Medicare for intravenous immune globulin (IVIG).

Provider Action Needed

Impact to You

New Healthcare Common Procedure Coding System (HCPCS) codes for IVIG will be effective April 1, 2005.

What You Need to Know

Effective April 1, 2005, for dates of service on or after April 1, 2005, codes J1563 and J1564 will no longer be paid by Medicare fiscal intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs). Codes J1563 and J1564 will be replaced with HCPCS codes Q9941-Q9944.

What You Need to Do

These new HCPCS codes are needed to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG.

Be sure to bill the new codes when providing these services.

Additional Information

Effective April 1, 2005, the following codes are being added to the HCPCS to appropriately distinguish between the lyophilized and non-lyophilized form of IVIG.

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

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

Billing for Syringes Used in the Treatment of End Stage Renal Disease (ESRD) Patients

Medlearn Matters Number: SE0527
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The following information affects physicians, providers, and suppliers billing carriers and intermediaries for end stage renal disease (ESRD) services and supplies.

Provider Action Needed

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

Background

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

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

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

Note that this Special Edition article relates to billing for syringes used in the treatment of ESRD patients.

Additional Information

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

Revised Manual Language to Item 24G (Days or Units) CMS-1500 Instructions Regarding the Billing of Oxygen and Oxygen Equipment

Medlearn Matters Number: MM3753
Related Change Request (CR) #: 3753
Related CR Release Date: March 18, 2005
Related CR Transmittal #: 506
Effective Date: July 1, 2005
Implementation Date: July 1, 2005

The following information affects providers and suppliers billing carriers and durable medical equipment regional carriers (DMERCs) for oxygen and oxygen equipment.

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

Please see the *Background* and *Additional Information* sections of this instruction for further details regarding these changes.

Background

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

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

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

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

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

Implementation

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

Additional Information

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

From that Web page, look for CR 3753 in the CR NUM column on the right, and click on the file for that CR. If you have any questions, please contact your carrier/DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Unprocessable Unassigned Form CMS-1500 Claims

The Centers for Medicare & Medicaid Services (CMS) revised Medlearn Matters article MM3500 on March 18, 2005, because Change Request (CR) 3500 was reissued. The only changes to the article are to show the new CR release date and transmittal number. No other changes were made to the article.

The original article was published on page 18 of the March 2005 *DMERC A Medicare News*. For the complete text, refer to the revised article on CMS' Web site at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3500.pdf***

Modified Edits for Matching Claims Data to Beneficiary Records

Medlearn Matters Number: SE0516
Related Change Request (CR) #: N/A
Effective Date: N/A **Revised**
Note: This article was revised on April 22, 2005, to show that claims that fail the matching edits will not be denied, but will be determined unprocessable and returned to the provider.

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

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

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

Background

Over the past several months, the Centers for Medicare & Medicaid Services (CMS) reviewed its personal characteristics editing logic for processing Medicare claims. The review identified a weakness where processed claims were approved for payment under the wrong beneficiary account number. One of Medicare's key claims processing systems, known as the Common

Working File (CWF), was approving claims where the beneficiary name and HICN did not match the name and number on the Medicare card.

The Office of the Inspector General in the Department of Health and Human Services recommended that CMS implement a modified process for matching the claim information to the beneficiary information on CWF files to eliminate erroneous payments caused by the existing matching criteria. In October 2004, CMS made a software change to require an exact match on beneficiary first initial, surname, and HICN submitted on the claim. Since this change was implemented, the number of unprocessable claims because of name/number mismatch tripled.

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

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

Importance of Supplying Correct Provider Identification Information Required in Items 17, 17A, 24K, and 33 of the Form CMS-1500, and the Electronic Equivalent

Medlearn Matters Number: SE0529
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

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

Provider Action Needed

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

Additional Information

Please be aware of the following instructions:

Items 17 and 17A

On the CMS-1500 form, or electronic equivalent, the provider must submit the appropriate referring or ordering physician name in Item 17 and the Unique Physician Identification Number (UPIN) of that referring/ordering physician in Item 17A. These are required fields when a service was ordered or referred by a physician. When a claim involves multiple referring and/or ordering physicians, you must prepare a separate claim submission for each ordering/referring physician.

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

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

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

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

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

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

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

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

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

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

Item 24K

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

UPINs are not appropriate identifiers for Item 24K.

Item 33

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

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

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

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

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

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

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

And, if you have questions, please contact your

carrier/DMERC at their toll-free number, available at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Update: *The CMS Administrator has announced a May 23, 2005, start of enumeration for the NPI, which is the standard unique health identifier for health care providers. The Administrator's announcement letter informs providers about the NPI, describes three ways to obtain an NPI, and gives guidance as to what to do once an NPI has been obtained. To view the letter, which also provides contacts/resources, visit:* ***www.cms.hhs.gov/hipaa/hipaa2/npi_provider.asp***

Skilled Nursing Facility Consolidated Billing

The Centers for Medicare & Medicaid Services (CMS) revised Medlearn Matters Special Edition article SE0431 on February 9, 2005, to amend the clarifying language, and the article was revised a third time on February 18, 2005. Specifically, line 4 of the "Clarification" statement below was modified to say "These "excluded" services…" instead of "These included services…" CMS regrets this error.

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

For the complete text, refer to the revised article on CMS' Web site at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0431.pdf

Skilled Nursing Facility (SNF) Consolidated Billing Service Furnished Under an "Arrangement" with an Outside Entity

The Centers for Medicare & Medicaid Services (CMS) revised Medlearn Matters article MM3592 on February 8, 2005, to provide some clarifying language, but no substantive changes were made. This article is informational only and clarifies the instruction contained in Change Request (CR) 3248, issued on May 21, 2004.

It explains that an "arrangement" between a Medicare skilled nursing facility (SNF) and its supplier is validated not by the presence of specific supporting written documentation but rather by their actual compliance with the requirements governing such "arrangements." However, supporting written documentation that provides details regarding the services to be provided "under arrangement" and the manner in which the SNF will pay the supplier for those services can help both parties arrive at a mutual understanding on these important points.

The original article was published on page 12 of the March 2005 *DMERC A Medicare News*. For the complete text, refer to the revised article on CMS' Web site at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2004/MM3592.pdf

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

The Centers for Medicare & Medicaid Services (CMS) revised Medlearn Matters Special Edition article SE0434 a second time on March 1, 2005, to delete the reference to Chapter 17 of the Medicare Benefit Policy

Manual in the *Additional Information* section of the article.

The original article was published on page 10 of the December 2004 *DMERC Medicare News*, and an abbreviated article regarding the first revision was published on page 15 of the March 2005 edition. For the complete text, refer to the revised article on CMS' Web site at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0434.pdf

Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetics and Orthotics

The Centers for Medicare & Medicaid Services (CMS) revised Medlearn Matters Special Edition article SE0437 on February 10, 2005, to include clarifying language (see below), but no substantive changes were made. The original article was published on page 11 of the December 2004 *DMERC Medicare News*.

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

For the complete text, refer to the revised article on CMS' Web site at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf

Prosthetics and Orthotics Ordered in a Hospital or Home Prior to a Skilled Nursing Facility Admission

Medlearn Matters Number: SE0507
Related Change Request (CR) #: N/A
Effective Date: N/A

The following information affects skilled nursing facilities (SNFs), physicians, suppliers, and providers.

Provider Action Needed

This article is informational only and describes who is responsible for billing when a customized device is ordered for a beneficiary while in the hospital or home, but delivered to the beneficiary at a skilled nursing facility.

Background

When a customized device is ordered while a beneficiary is an inpatient at a hospital, and the device is not delivered until after the beneficiary has moved to an SNF, the issue arises as to who is responsible for the billing of the item.

When a beneficiary is going from a hospital stay to an SNF Part A stay and needs an orthotic or prosthetic device, the facility where the medical need occurred is responsible for billing (rather than the supplier or provider of the device, which would bill for instances when need is established while the beneficiary is at home or in the community). Thus, if a prosthetic or orthotic device is medically necessary at the time the beneficiary is in the hospital, in the rare case when the prosthetic or orthotic is not delivered until the beneficiary has arrived at the SNF, the hospital remains responsible for billing for the item.

However, when the medical necessity for the prosthetic or orthotic device occurs after the time the Part A resident enters the SNF, the SNF is responsible for the billing of the prosthesis or orthosis. Given that most prosthetics (and all orthotic devices) are subject to SNF consolidated billing, the cost would be covered in the SNF's global per diem payment unless the item is specifically excluded from SNF consolidated billing. Certain specified, customized prosthetics are excluded

and if the need for these devices was established in the SNF, the supplier is to bill the durable medical equipment regional carrier (DMERC).

When a beneficiary requires a prosthesis or orthosis while in the home and then enters an SNF for a covered Part A stay, the DMERC would be billed by the party which supplied the device (not the SNF). Medical necessity must have been established while the beneficiary was in the home.

If the beneficiary enters an SNF for a noncovered stay and thereafter develops a medical need for a customized device which the SNF orders, the SNF would bill the DMERC for the item, since SNF consolidated billing rules do not apply.

Additional Information

See the Medicare Claims Processing Manual, Pub. 100-4, Chapter 20, Section 110.3, "Pre-Discharge Delivery of DMEPOS for Fitting and Training," which covers instances in which a beneficiary may take delivery of durable medical equipment (DME), a prosthetic, or an orthotic for use at home during his or her last two days in an inpatient facility before returning home. This publication can be found at: ***www.cms.hhs.gov/manuals/104_claims/clm104index.asp***

Also, see Medlearn Matters Special Edition SE0437 for an article that provides specifics on how SNF consolidated billing applies to prosthetics and orthotics. This article can be found at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0437.pdf***

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

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

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

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

Processing Durable Medical Equipment (DME), Orthotics, Prosthetics, Drugs, and Surgical Dressings Claims for Indian Health Services (IHS) and Tribally Owned and Operated Hospitals or Hospital-Based Facilities, including Critical Access Hospitals (CAHs)

Medlearn Matters Number: MM3674
Related Change Request (CR) #: 3674
Related CR Release Date: February 4, 2005
Related CR Transmittal #: 461
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

The following information affects all Indian Health Services (IHS) and tribally owned and operated hospitals or hospital-based facilities, including critical access hospitals (CAHs), billing Medicare durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs).

Provider Action Needed

Impact to You

Effective July 1, 2005, IHS hospitals and tribally owned and operated hospitals and hospital-based facilities, including CAHs, may begin billing for durable medical equipment (DME), prosthetics and orthotics, surgical dressings, drugs, and therapeutic shoes, as further discussed in this article.

What You Need to Know

Affected providers may need to enroll with the National Supplier Clearinghouse (NSC), as some of

these services must be billed to a Medicare DMERC. Other services will be billable to the Medicare FI.

What You Need to Do

Please be aware of the changes addressed in this instruction and ensure that billing staffs submit claims accordingly.

Background

This article advises affected providers and suppliers that beginning July 1, 2005, IHS and tribally owned and operated hospitals and hospital-based facilities, including CAHs, may begin billing for:

- DME used in the patient's home;
- Orthotics and prosthetics;
- Drugs paid by DMERCs;
- Surgical dressings; and
- Therapeutic shoes furnished in accordance with the requirements of Section 1861(s)(12).

Note: For the remainder of this article, the term IHS/tribal facilities will be used and will refer to facilities owned by the IHS and to tribally owned and operated hospitals and hospital-based facilities, including CAHs.

The **appropriate DMERC** should be **billed for DME, therapeutic shoes, and drugs** and the **designated FI billed for prosthetics, orthotics, and surgical dressings**. All **suppliers** should have a **supplier number** from the NSC to bill the DMERC. For information on the process for enrolling as a supplier with the NSC, visit: ***www.cms.hhs.gov/providers/enrollment/forms/*** **Note**: To bill drugs to the Medicare DMERC, IHS/tribal facilities must be registered with the NSC as a pharmacy and have a pharmacy license number on file with the NSC.

Prior to the enactment of Section 630 of the Medicare Modernization Act (MMA) in 2003, IHS facilities were not permitted to bill for Part B services unless covered under Section 1848 of the Social Security Act. The new MMA legislation expands the scope of the items and services paid to IHS hospital-based facilities to include all Part B covered items and services that are not paid under the Medicare Physician Fee Schedule and are not included in the Medicare IHS all-inclusive rate for a five-year period beginning January 1, 2005.

Additional Information

Some key billing information for IHS/tribal facilities is as follows:

- Beginning with services provided on or after July 1, 2005, IHS/tribal facilities may send claims to their Medicare DMERC for DME, therapeutic shoes, and drugs showing a specialty code of A9 (IHS/tribal facility) and a place of service code of 12 to indicate patient's home on the claim. If a claim is received with **a date of service prior to July 1, 2005, the DMERC will deny the claim with reason code 26**. Also, coinsurance and deductibles are waived for these claims.
- Payment for DME will be based on the DME fee schedule and payment for drugs will be based on the average sales price (ASP) drug file.
- Beginning for services provided on or after July 1, 2005, IHS/tribal facilities may begin billing their Medicare FI for orthotics, prosthetics, and surgical dressings.
- When billing orthotics, prosthetics, and surgical dressings to the FI, IHS/tribal facilities should use the following revenue codes:
  - 0274 for orthotics with the appropriate Healthcare Common Procedure Coding System (HCPCS) code,
  - 0274 for prosthetics with the appropriate HCPCS code, and
  - 0623 for surgical dressings and the appropriate HCPCS code.
- When billing for prosthetics, orthotics, and surgical dressings to the FI, IHS/tribal facilities should show only those items on the TOB13X bill that are payable under the DME fee schedule.

Clarification of Rules for Drug Administration

In addition to the changes described above, IHS/tribal facilities need to note that related Change Request (CR) 3674 also clarifies the All Inclusive Rate (AIR) billing rules for drug administration (injections) occurring without a medically indicated outpatient encounter. In an effort to ensure that the AIR is paid appropriately, any injection (e.g., B-12) that requires only a licensed professional's administration must not be billed as a visit payable at the AIR. A visit cannot be billed if the injection is the only service the facility provides.

If the patient receives an injection and no qualifying visit takes place, the charges/expenses for the injection should be combined with the expenses/charges for the next qualifying visit. The qualifying visit should be for the condition being treated with the injection or drug.

For complete details, including the revised sections of

the Medicare Claims Processing Manual, please see the official instruction issued to your FI/DMERC regarding this change. This instruction may be viewed at:
www.cms.hhs.gov/manuals/transmittals/cr_num_dsc.asp

Once at that site, scroll down the CR NUM column on the right looking for CR 3674 and click on the file for that CR. For details regarding enrollment as a supplier for the purpose of billing a DMERC, please visit:
www.cms.hhs.gov/providers/enrollment/forms/

See Sections 100 through 140 of Chapter 15 of the Medicare Benefit Policy Manual for a detailed description of DME, prosthetics, and orthotics. This manual can be accessed at:
www.cms.hhs.gov/manuals/102_policy/bp102index.asp

IHS/tribal facilities should note that they may not bill for items or services that fall outside the scope of the benefits described in these sections. If you have any questions, please contact your FI or DMERC at their toll-free number, which may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

The Centers for Medicare & Medicaid Services (CMS) Consolidation of the Claims Crossover Process

Medlearn Matters Number: SE0504
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

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

Provider Action Needed

Physicians, providers, and suppliers should note that this Special Edition article is to inform you of system changes to implement a switch from 1) Medicare intermediaries, carriers, and durable medical equipment regional carriers (DMERCs) crossing supplemental claims to supplemental insurers to 2) a single entity, the Coordination of Benefits Contractor (COBC), doing the same from one location.

Background

The Centers for Medicare & Medicaid Services (CMS) is consolidating the Medicare claims crossover process under a special COBC by means of the Coordination of Benefits Agreement (COBA) initiative.

Currently, supplemental payers/insurers (including eligibility-file-based Medigap, Medicaid, and employer plans) **must sign multiple crossover agreements** with Part A intermediaries and Part B carriers and DMERCs to accomplish an automatic, or eligibility-file-based, crossover to other insurers that pay after Medicare has made its payment decision on a claim.

In the future (under the new consolidated claims crossover process), **supplemental payers/insurers will sign one national crossover agreement** and work directly with the COBC (which represents CMS). The supplemental payer/insurer will:

- Send eligibility files to identify its covered members, and
- Receive outbound Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12N 837 Coordination of Benefits (COB) claims and National Council for Prescription Drug Programs (NCPDP) claims for use in calculating their secondary payment liability.

On July 6, 2004, CMS began testing the consolidated crossover process with approximately ten (10) supplemental payers/insurers. Note the following:

- Testing is focused on the outbound HIPAA ANSI X12N 837 COB claims that are translated from Medicare's Part A intermediary, Part B carrier, and DMERC processed claims.
- Initial-implementation will take place after successful testing is completed, and the ten supplemental payers/insurers will be moved to full COBA crossover production through one entity, the COBC.
- Throughout the course of fiscal year 2005, CMS will begin transitioning all supplemental payers/insurers from the existing eligibility-file-based crossover process to the national COBA process.

Detailed requirements for 1) eligibility-file-based crossover and 2) claim-based (mandatory Medigap) crossover were previously issued by CMS in Change Request (CR) 3109 (Transmittal 98), and CMS subsequently issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. Transmittal 138 may be accessed at:

www.cms.hhs.gov/manuals/pm_trans/R138CP.pdf CR 3218 (Transmittal 138) provided:

- Major changes to many of the requirements previously published in CR 3109 (Transmittal 98), and
- Moved the implementation of claim-based crossover to a future date.

Physician, Provider, and Supplier Action

NOTE: Physicians, providers, and suppliers will not need to take any new actions with respect to the COBA automatic (or eligibility-file-based) crossover process.

The key difference between the existing automatic crossover process and the new COBA automatic crossover process is that, when a supplemental payer/insurer provides CMS with specific claim types and member information for those claims they wish to receive, **the claims will be crossed over to the supplemental payers/insurers only after the claims have left the Medicare claims payment floor**. Thus, **physician, provider, and supplier offices should receive payment and/or processing information** from a patient's supplemental payer/insurer **after the Medicare payment has been received** (once the supplemental payer/insurer has transitioned to the COBA crossover process).

Physicians, providers, and suppliers will be able to reference a listing of eligibility-file-based COBA trading partners on the COBA portion of the following CMS COB Web site as supplemental payers/insurers are scheduled to move to full eligibility-file-based crossover production under the COBC:
www.cms.hhs.gov/medicare/cob/coba/coba.asp (This listing is not currently available, but will be available after supplemental payers/insurers have moved to full production with the COBC.)

Physicians, providers, and suppliers should note that the following important information will require your attention when a supplemental payer/insurer 1) has transitioned to the COBA eligibility-file-based crossover process and 2) is listed on the Web site noted in the previous paragraph.

- Although the claim may cross to multiple supplemental payers/insurers, only one will print on your remittance advice. In this situation, if one of the supplemental payers/insurers is Medigap, the Medigap insurer will always print.
- Since payment from the supplemental payer/insurer should occur only after the Medicare payment has been issued, it is advised that you do not bill the supplemental payer/insurer for a minimum of fifteen (15) work days after receiving the Medicare payment. This will allow sufficient time for the claim to cross to the supplemental payer/insurer and the subsequent actions necessary to issue payment from the supplemental payer/insurer.
- In addition, prior to submitting a claim to the supplemental payer/insurer, it is advised that you use available self-service tools to research the status of your supplemental payment, e.g., the supplemental payer/insurer's Web site, claims automated "hot line," etc.
- There may be situations (**such as claim errors related to HIPAA**) that prevent the automatic crossover from occurring after you have received a Medicare remittance advice (electronic or supplemental paper) notifying you that the claim has crossed to the supplemental payer/insurer.
- Again, it is advised that you allow a minimum of 15 work days after Medicare payment has been issued before billing the supplemental payer/insurer to ensure that an automatic supplemental payment will not be issued. In addition, it is advised that you use the self-service tools of the supplemental payer/insurer to research the status of your supplemental claim prior to submitting it for supplemental payment.
- As a reminder, only the "official" Medicare remittance advice or HIPAA 835 electronic remittance advice should be used for supplemental billing purposes. CMS requests that copies of screen prints from any system that is used to access Medicare claim status not be submitted to a supplemental payer/insurer for billing purposes even if:
  - You are billing the supplemental payer/insurer after the 15 work days from the Medicare-issued payment have expired, and
  - You have used the available self-service tools to research the status of your supplemental payment.

Special Note for Physicians and Suppliers

Currently, Part B carriers and DMERCs assign identification numbers (known as In-key or Other Carrier Name and Address (OCNA) numbers) to Medigap insurers that do **not** participate in the automatic, or eligibility-file-based, crossover process. **There are no current changes to this process and no current action is required of physicians, providers, and suppliers to change internal procedures related to Medigap claim-based crossovers.**

Participating physicians and suppliers that bill Part B carriers and DMERCs for claim-based crossover will be informed approximately 90 days prior to implementing any changes to the claim-based crossover process. CMS expects this method of crossover to decrease sharply under the consolidated COBA crossover process, since most Medigap insurers will now have a single entity to which they can submit eligibility files to identify their covered members.

Related Instructions

On April 9, 2004, CMS issued CR 3218 (Transmittal 138) to communicate the new implementation strategy for the COBA initiative. CR 3218 (Transmittal 138), may be viewed at:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

From that Web page, look for CR 3218 in the CR NUM column on the right, and click on the file for that CR.

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

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

Medlearn Matters Number: MM3709
Related Change Request (CR) #: 3709
Related CR Release Date: February 11, 2005
Related CR Transmittal #: 474
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

The following information affects all physicians, providers, and suppliers billing Medicare fiscal intermediaries (FIs) and carriers.

Provider Action Needed

This instruction includes information contained in Change Request (CR) 3709 which directs Medicare contractors (carriers, intermediaries, and durable medical equipment regional carriers (DMERCs)) to issue special automated correspondence from their internal systems to physicians, providers, and suppliers informing them that claims that were expected to be crossed over to supplemental payers/insurers (as indicated on a previous remittance advice) were not crossed.

Background

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

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

The correspondence sent to the physician, supplier, or provider will contain specific claim information, including the Internal Control Number (ICN)/Document Control Number (DCN), Health Insurance Claim (HIC) number, Medical Record Number (if the letter is from an intermediary and the claim was for Part A services), Patient Control Number (if present on the claim), beneficiary name, date of service, and the date the claim was processed. In addition, the letter will include the following message:

> "The above claim(s) was/were not crossed over to the patient's supplemental insurer due to claim data errors."

Upon receipt of such correspondence, the physician, supplier, or provider is advised that the claim is not being crossed automatically, and the provider may take appropriate action to obtain payment from the supplemental payer/insurer.

Implementation

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

Additional Information

Complete details of the COBA Error Notification process are included in the official instruction issued to

your carrier/DMERC/intermediary. That instruction may be viewed at:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp

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

Electronically Requesting and Receiving Information Regarding Claims Using the ASC X12N276/277 Claims Status Inquiry/Response Transactions

Medlearn Matters Number: SE0524
Related Change Request (CR) #: N/A

The following information affects physicians, providers, and suppliers billing Medicare carriers and intermediaries.

Provider Action Needed

Impact to You

This Special Edition discusses how health care providers may want to implement the ASC X12N 276/277 Claims Status Inquiry/Response Transactions and benefit by being able to request and receive the status of claims **in one standard format, for all health care plans**.

What You Need to Know

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

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

What You Need to Do

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

Background

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

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

1) Directed the federal government to adopt national standards for the transfer of certain health care data; and
2) Requires all payers to use national standard transaction formats and code sets, such as the health care claims status category codes and the health care claim status codes issued by the Claim Adjustment Status Code Maintenance Committee.

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

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

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

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

Most health care providers who are currently using an electronic format and who wish to request claim status electronically using the ASC X12N 276/277 may incur some conversion costs. However, after implementation, providers will benefit by being able to request and receive the status of claims **in one standard format, from all health care plans**. This would make electronic claim status requests and receipt of responses feasible for small providers, and eliminate the need to:

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

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

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

Additional Information

An informative article entitled "Realizing Savings from the HIPAA Transaction Standards: How to Get There from Here," which was prepared by Martin A. Brutscher, Partner, McBee Associates, Inc., can be reviewed at the following Web site: ***www.mcbeeassociates.com/HFMA_white_paper.pdf*** The article shows the types of results that may be available to providers who implement the ASC X12N 276/277, as well as other HIPAA transactions.

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

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

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

Claims Status Code/Claims Status Category Code Update

Medlearn Matters Number: MM3715
Related Change Request (CR) #: 3715
Related CR Release Date: March 4, 2005
Related CR Transmittal #: 490
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

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).

Provider Action Needed

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

Background

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

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

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

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

Additional Information

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

On the above page, scroll down the CR NUM column on the right to find the link for CR 3715. Click on the link to open and view the file for the CR. If you have questions regarding this issue, you may also contact your carrier or intermediary at their toll-free number, which may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

Update to the Healthcare Provider Taxonomy Codes (HPTC) Version 5.0

Medlearn Matters Number: MM3716
Related Change Request (CR) #: 3716
Related CR Release Date: February 18, 2005
Related CR Transmittal #: 479
Effective Date: April 1, 2005
Implementation Date: April 4, 2005

The following information affects providers who bill carriers, including durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS) has released the summary of changes reflected in the Healthcare Provider Taxonomy Code (HPTC) list version 5.0. Medicare carriers and DMERCs will update their HPTC tables with this new version effective on April 1, 2005.

What You Need to Know

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

What You Need to Do

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

Background

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

HIPAA requires that submitted data, which is part of a named code set, must be valid data from that code set. The health care provider taxonomy is a named code set in the 837 professional implementation guide, thus carriers must validate the inbound taxonomy codes against their internal HPTC tables. The HPTCs are updated twice per year, in April and October. The summary of changes for version 5.0 is noted in the table below:

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

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

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

Additional Information

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

On the above page, scroll down while referring to the CR NUM column on the right to find the link for Change Request (CR) 3716. Click on the link to open and view the file for the CR. If you have questions regarding this issue, you may also contact your carrier/DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Centers for Medicare & Medicaid Services (CMS) Comprehensive Error Rate Testing (CERT) Program - The Importance of Complying with Requests for Claim Documentation

Medlearn Matters Number: SE0526
Special Edition #: SE0526
Related Change Request (CR): N/A **Revised**
Effective Date: N/A
Note: This article was revised on May 2, 2005, to show the 2004 national gross paid claims error rate in the "Impact to You" section and to correct the telephone number provided in the "Additional Information" section.

The following information affects Medicare Fee-for-Service (FFS) physicians, providers, and suppliers.

Provider Action Needed

Impact to You

The 2004 national gross paid claims error rate was 10.1 percent. A portion of this error rate was due to providers not sending requested supporting documentation to the designated Comprehensive Error Rate Testing (CERT) contractor. Medicare FFS physicians, providers, and suppliers **must** provide documentation and medical records that support their claims for covered Medicare services to the designated CERT contractor upon request. If you fail to submit documentation, the claim will be considered an error, and you will receive a demand letter requesting refund of payment received for the "erroneous" claim.

What You Need to Know

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

What You Need to Do

If you receive a letter from the Centers for Medicare & Medicaid Services (CMS) regarding a CERT request for medical documentation, you should respond promptly by submitting the requested supporting documentation within the time frame outlined in the request. Physicians, providers, and suppliers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.

This Special Edition article provides an overview of the CERT program and stresses the importance of providing the requested medical documentation for the CERT review.

Background

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

Methodology

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

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

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

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

Your Role Is Critical To Improvement

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

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

Medicare beneficiaries have consented to the release of medical information necessary to process their Medicare claims. **Providers do not need to obtain additional beneficiary authorization to forward medical records to the designated CERT contractor.** Be assured that forwarding specifically requested records to the designated CERT contractor does not violate HIPAA Privacy statutes.

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

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

Additional Information

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

- CERT Web page (***www.cms.hhs.gov/cert***)
- CERT Newsletters (***www.cms.hhs.gov/cert/letters.asp***)
- A designated telephone number for Medicare physicians, providers, and suppliers for general information and questions regarding the CERT initiative - 804-864-9940.

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

REMEMBER:
Review can result in identification of overpayments, as well as underpayments. If CERT changes the payment decision on your claim by denying or reducing payment, you can still file an appeal with your Medicare contractor. It is in everyone's interest to code and pay claims correctly. Your support of this process helps protect the solvency of the Medicare program. Your cooperation also allows your Medicare contractor to provide individualized education to you on your specific CERT errors.

News from DMERC A…

Attention Providers: Important Articles You Should Read

Providers who bill the Region A Durable Medical Equipment Regional Carrier (DMERC A) are encouraged to review the following articles from the Region A Program Safeguard Contractor (PSC):

- C.E.R.T. Non-Response Reminder (posted 03/16/2005)
- Physician Letter (posted 03/24/2005)

To access these articles, visit the "What's New" section of the PSC Web site at ***www.tricenturion.com/content/whatsnew_dyn.cfm*** and click on the appropriate links.

If you have any questions, please contact the DMERC A supplier toll-free line at 866-419-9458.

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 at ***www.umd.nycpic.com/dmfees.html***. The following notices have been posted:

- 2nd Quarter 2005 Update: Drug Fees and Nebulizer Drug Fees
- 2nd Quarter 2005 Update: Oral Anticancer Drug Fees
- Implementation of 2005 Fee Schedule Amounts for Oxygen and Oxygen Equipment - Correction (Revised 4-15-05)

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

- July 2005 DMEPOS Revised Fees
- April 2005 Fee Revision for K0671
- April 2005 Fee Schedule Updates
- Fee for J9000

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

EDI Services

New Bulletin Board System for the Region A DMERC

On April 18, 2005, the Region A Durable Medical Equipment Regional Carrier (DMERC A) Electronic Data Interchange (EDI) Department implemented a new telecommunications gateway (a.k.a. Bulletin Board System) for electronic Medicare claims transactions at DMERC A. This upgrade to our technology resulted in increased efficiency and reliability, and it positions DMERC A for current and future support of state-of-the-art EDI.

Among the benefits of the new Bulletin Board System (BBS) is a combined Claims BBS and Remittance BBS. Therefore, submitters enrolled to receive electronic remittance advices (ERAs) will dial into a single BBS to send claims and to receive ERAs.

The other significant advantages of this new BBS technology include:

- Submitters have the ability to submit multiple claims files within a single transmission.
- Submitters will only have to dial into one BBS to submit files, retrieve reports, and download American National Standards Institute (ANSI) ERAs.
- Submitters will no longer have to wait until after 2:00 p.m. to download their ERAs; they will be available in the morning.
- There is a more stable environment for support of successful and uninterrupted connections.
- The new BBS will not shut down for maintenance between 5:00 p.m. and 6:00 p.m.
  Note: The same operations rules apply; all files

submitted/accepted after 5:00 p.m. will receive the date of receipt and be processed on the following business day.

The user interfaces of the new BBS are nearly identical to those of the old BBS. Our goal was to limit the noticeable changes for users to a new dial-up number and to minimize the impact of the transition for both manual and scripted users.

All existing DMERC A BBS users were notified by letter, on February 18, 2005, of the upcoming transition to the new BBS. Starting on April 18, 2005, EDI Representatives began contacting submitters to provide the new dial-up number in order to begin an orderly and controlled migration to the new BBS. All submitters are required to use the new system for submission of Health Insurance Portability and Accountability Act (HIPAA)-compliant ANSI claims by July 1, 2005. All access to the old BBS system for ANSI transactions will be eliminated by the July 1 deadline. (Although the old BBS will continue to support submitters who have not yet become HIPAA-compliant and who still use the National Standard Format (NSF) Claims and Electronic Remittance Notices (ERN) formats, this system will be **deactivated immediately** when the Centers for Medicare & Medicaid Services (CMS) revokes its HIPAA-EDI Contingency Plan.)

The dial-up number for the new BBS is 607-766-6100. The updated BBS Manual can be accessed via the "EDI" section of the DMERC A Web site at ***www.umd.nycpic.com/edidocfiles.html***. You can contact the EDI Department toll-free at 866-861-7348 for additional information and support.

Online EDI Resources

The Region A Durable Medical Equipment Regional Carrier (DMERC A) Electronic Data Interchange (EDI) Department has a number of online resources available to better serve and support our electronic submitters. Most of these resources are available 24 hours a day, 7 days a week.

"EDI" Section of DMERC A Web site

For information pertaining to DMERC A EDI services, visit ***www.umd.nycpic.com/dmedi.html***. These pages have reference documents, forms, and instructional information such as EDI enrollment, certified vendor listing, and software order forms.

EDI ListServe

Visit ***www.umd.nycpic.com/edilistserve.html*** to subscribe to the EDI ListServe in order to receive automatic email messages with important information related to EDI topics. These messages often provide timely notification of Bulletin Board activities and known systems issues that are being or have been corrected, as well as the latest guidelines and requirements related to the implementation of Health Insurance Portability and Accountability Act (HIPAA)-mandated electronic transactions. (An online satisfaction and feedback tool is currently being developed to enhance this service.)

EDI Email Address

Written service requests, inquiries, and processing forms can be sent to EDI Service Representatives via email at **team.edi@healthnow.org**. Please note, HIPAA Privacy Rule mandates do not permit the use of the Internet for transmission of protected health information (PHI), nor can data protected by the Privacy Act of 1974 be sent over the Internet. Therefore, any correspondence that has or could have this type of information, including Medicare beneficiary numbers (i.e., Health Insurance Claim Numbers (HICNs)), cannot be sent via email. Use hard copy mail options or call the EDI Department support line (866-861-7348) if you need to communicate this type of data.

EDI Online Training

Visit ***www.umd.nycpic.com/dme-eduonline.html*** and look under "EDI-Specific Topics" for Web-based tutorials on EDI products and services. Additional offerings will be added on a regular basis, and we welcome suggestions for new topics or improvements to existing programs.

New Reference Tool Available via the "EDI" Section of DMERC A's Web Site

"How to Read the VMS Submitter Report"

The Submitter Report of the VIPS Medicare System (VMS) is the primary tool used to identify errors in submitter claims. An example of and instructions on how to read the Submitter Report have been added to the Electronic Data Interchange ("EDI") section of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site. This helpful reference can be accessed at ***www.umd.nycpic.com/VMSReport.pdf***.

The instructions provide a better understanding of the VMS Submitter Report, a fast and easy means of identifying what information is on the report, and an explanation of the rejection codes. It is an invaluable tool to identify claims that have been rejected by front-end editing and to determine the error conditions that need to be fixed prior to resubmission and successful processing. This tool can be used as part of your operations procedures and as a tool to train your staff.

The VMS Submitter Report is available for downloading by the submitter from the Bulletin Board System (BBS) approximately 24 hours after the claims are submitted to and accepted by the BBS. Errors in claims that are rejected during front-end editing can be resolved and corrected for immediate resubmission.

If you have any questions, contact the DMERC A EDI Department toll-free at 866-861-7348.

General Information

News from CMS…

CMS Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

Medlearn Matters Number: SE0513
Related Change Request (CR) #: N/A
Effective Date: N/A

The following information affects a sample of 8,200 (or 2 percent of) Medicare providers served by twelve (12) Medicare Fee-for-Service (FFS) contractors (carriers and fiscal intermediaries), including hospitals, skilled nursing facilities (SNFs), rural health clinics, home health clinics, end-stage renal disease (ESRD) facilities, physicians, non-physicians, durable medical equipment (DME) suppliers, and ambulance service providers.

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS) would like to provide a channel for you to voice your opinions about the services you receive from your Medicare FFS contractors (carriers and fiscal intermediaries (FIs), including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs)). The Medicare Contractor Provider Satisfaction Survey (MCPSS) will be CMS' initial effort to use provider satisfaction as a standard of measurement to evaluate our FFS contractors' performance. CMS values the opinions of the Medicare physician and provider community and understands the important role that FFS contractors play in representing the Medicare program to providers. The MCPSS represents an important opportunity for you to be heard.

What You Need to Know

The first year of the MCPSS is a pilot. CMS has selected 12 FFS contractors to participate in the pilot: four (4) FIs: AdminaStar Federal, Noridian Administrative Services L.L.C., Riverbend GBA, and Empire Medicare Services; four (4) carriers: National Heritage Insurance Company (NHIC), Wisconsin Physician Services (WPS), TrailBlazer Health, and Empire Medicare Services; two (2) DMERCs: HealthNow New York and AdminaStar Federal; and two (2) RHHIs: Palmetto GBA and Anthem Health Plans of Maine. A random sample of 8,200 providers (approximately 2 percent of providers) served by these 12 FFS contractors have been selected to participate in the pilot. If you have been selected, you should have received a notification packet with background information about the pilot, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet Web site. The letter also includes a telephone number that you can call to request a paper copy of the survey instrument to submit your responses by mail or fax, if you prefer to do so.

What You Need to Do

Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the time to complete and submit your survey responses as soon as possible. The data collection period for the pilot will continue through the end of March.

Background

On January 17, 2005, CMS launched a pilot of the MCPSS. The survey will give providers the opportunity to rate their Medicare contractor on seven administrative functions: provider communications, provider inquiries, claims processing, appeals, provider enrollment, medical review, and provider reimbursement. The survey contains a total of 76 questions and takes approximately 22 minutes to complete. Sampled providers will be able to access the survey on a secure Internet Web site or may request a paper copy of the survey and submit via mail or fax. Data collection for the pilot will continue through March 2005.

CMS will use the results of the pilot to evaluate and refine the survey instrument, data collection procedures, analysis, and reporting of results for the national survey implementation. The results of the pilot will not be used to evaluate the Medicare contractors' performance. In the future, CMS plans to use the MCPSS to support and assist contractors in using provider feedback to identify and implement "best practices" and quality or process improvement initiatives.

CMS has awarded a contract to Westat, a survey research firm, to administer the MCPSS.

Additional Information

For questions or additional information about the MCPSS, please visit:
www.cms.hhs.gov/providers/mcpss/default.asp

Use of Group Health Plan Payment System for Medicare Disease Management Demonstration Serving Medicare Fee-For-Service Beneficiaries

The Centers for Medicare & Medicaid Services (CMS) revised Medlearn Matters Special Edition article SE0425 on March 10, 2005, to add "OPTION 4" as a code to help differentiate demonstration enrollees from health maintenance organization (HMO) enrollees. This article describes a four-state Medicare Disease Management Demonstration that CMS has initiated to improve care for chronically ill Fee-for-Service (FFS) Medicare beneficiaries who suffer from advanced stage heart disease or diabetes. The disease management programs that are currently enrolling beneficiaries are: CorSolutions in Louisiana; XLHealth in Texas; and HeartPartners in California and Arizona. With the exception of how CMS is paying these private organizations, beneficiaries enrolled in these programs will be considered covered under the traditional Medicare FFS program for all other purposes.

For the complete text, refer to the revised article on CMS' Web site at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2004/SE0425.pdf

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

The Centers for Medicare & Medicaid Services (CMS) has begun a population-based Medicare Disease Management Demonstration to improve care for chronically ill Fee-for-Service (FFS) Medicare beneficiaries who suffer from advanced stage heart disease or diabetes. The disease management organization, LifeMasters, is currently enrolling beneficiaries in Florida. With the exception of how CMS is paying this private organization, beneficiaries enrolled in this program will be considered covered under the traditional Medicare FFS program for all other purposes. Beneficiaries are not restricted in any way on how they receive their other Medicare services and will only receive coordinated care/disease management services from the chronic care organization.

For more information on this project, refer to Medlearn Matters Special Edition article SE0519, which can be found on CMS' Web site at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0519.pdf***

The Facts for Providers Regarding the Medicare Prescription Drug Plans That Will Become Available in 2006

Medlearn Matters Number: SE0502
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

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

The following information affects all Medicare providers and any staff who have contact with Medicare beneficiaries.

Provider Action Needed

This Special Edition article provides updated information regarding the Medicare prescription drug plans that will be available to Medicare beneficiaries in 2006. This new benefit was established by the Medicare Modernization Act (MMA), which was enacted in 2003.

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

The Basic Plan

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

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

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

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

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

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

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

When can your patients enroll in this new plan?

If a beneficiary currently has Medicare Part A (hospital insurance) and/or Medicare Part B (medical insurance), the beneficiary can join a Medicare prescription drug plan between November 15, 2005, and May 15, 2006. In general, a beneficiary can join or change plans once each year between November 15 and December 31. If they join a Medicare prescription drug plan:

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

Even if a beneficiary does not use many prescription drugs now, he/she still should consider joining a plan. If he/she doesn't join a plan by May 15, 2006, and

he/she doesn't have a drug plan that covers as much or more than a Medicare prescription drug plan, he/she will have to pay more each month to join later.

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

Some people with an income at or below a set amount and with limited assets (including their savings and stocks, but not counting their homes) will qualify for extra help. The exact income amounts will be set in early 2005. People who qualify will get help paying for their drug plan's monthly premium, and/or for some of the cost they would normally have to pay for their prescriptions.

The type of extra help received will be based on income and assets. In mid-2005, the Social Security Administration (SSA) will send people with certain incomes information about how to apply for extra help in paying for their prescription drug costs. If they think they may qualify for extra help, they can sign up with the SSA or their local Medicaid office as early as the summer of 2005.

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

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

- Medicare prescription drug plans that add coverage to the original Medicare plan (these plans will be offered by insurance companies and other private companies); and
- Medicare prescription drug plans that are a part of Medicare Advantage plans (like health maintenance organizations (HMOs)) in some areas.

What if a Medicare beneficiary has a Medigap policy with drug coverage or prescription drug coverage from an employer or union?

The Medicare beneficiary will get a detailed notice from his/her insurance company or the employer or union informing him/her whether or not his/her policy covers as much or more than a Medicare prescription drug plan. This notice will explain his/her rights and choices.

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

- Keep his/her current drug plan. If he/she joins a Medicare prescription drug plan later, his/her monthly premium won't be higher; or
- Drop his/her current drug plan and join a Medicare prescription drug plan. However, he/she may not be able to get his/her employer or union drug plan back.

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

- Keep his/her current drug plan and join a Medicare prescription drug plan to give him/her more complete prescription drug coverage; or
- Keep his/her current drug plan. However, if he/she joins a Medicare prescription drug plan later, he/she will have to pay more for the monthly premium; or
- Drop his/her current drug plan and join a Medicare prescription drug plan. However, he/she may not be able to get his/her employer or union drug plan back.

Additional Information

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

The information contained in this article is based on a fact sheet for beneficiaries. To obtain a copy of this fact sheet for your patients visit: ***www.medicare.gov/Publications/Pubs/pdf/11065.pdf***

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

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

Your Important Role

Medlearn Matters Number: SE0520
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

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

The following information affects Medicare physicians, institutional providers, pharmacists, and any staff who have contact with Medicare beneficiaries.

Provider Action Needed

Impact to You

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

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

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

Background

You and your staff are trusted sources of information for your patients. You may be the first source of information that Medicare beneficiaries use to explain Medicare prescription drug coverage. Please encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. **If a beneficiary fails to actively choose a prescription drug plan, he/she may miss out on cost savings for prescription drugs.** Medicare prescription drug coverage will:

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

CMS will include Medicare prescription drug coverage details in the *2006 Medicare & You Handbook*, and send it to beneficiaries in October 2005.

Your Role and Involvement – You Choose

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

- **Basic** - You know that Medicare prescription drug coverage exists and where to send people to learn about benefit details. You may display a poster (available later this spring) in your office or clinic, and make beneficiary-focused materials available in your office.
- **Intermediate** - You know more about Medicare prescription drug coverage, such as:
  - How beneficiaries can enroll;
  - Co-payment amounts;
  - Where to find additional help for people with limited income and resources;
  - Where to find information on the following Web sites:
    www.medicare.gov
    www.cms.hhs.gov/medlearn/drugcoverage.asp
  - How to answer the basic questions.
- **Advanced** - You know detailed information about Medicare prescription drug coverage and the plans available in your area. You, or someone on your staff, can answer detailed questions about the drug benefit. In some cases, you or your staff may counsel beneficiaries on their particular situation and the options that will work best for them.

To Stay Updated on New Information and Educational Resources

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

Get Your Staff Involved

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

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

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

Summary

CMS asks you to:

- Respond to questions from your patients in a way that encourages them to seek more information from the Medicare program;
- Inform members of your staff who interact with Medicare patients about the information resources available to them and where they may refer patients to learn more about Medicare prescription drug coverage; and
- At a minimum, refer your Medicare patients who are looking for information on Medicare prescription drug coverage to **1-800-MEDICARE** or ***www.medicare.gov*** on the Web.

Program Education & Training

KX Modifier Use

Currently, the following medical policies include instructions on proper use of the KX modifier. Durable medical equipment regional carriers (DMERCs) and DMERC Program Safeguard Contractors (PSCs) may identify other circumstances for which they will require the use of a KX modifier.

- Automatic External Defibrillators
- Cervical Traction Devices
- Commodes
- Continuous Positive Airway Pressure System (CPAP)
- Epoetin
- External Infusion Pumps
- Glucose Monitors
- High Frequency Chest Wall Oscillation Devices
- Home Dialysis Supplies and Equipment
- Negative Pressure Wound Therapy Pumps
- Orthopedic Footwear
- Osteogenesis Stimulators
- Pressure Reducing Support Surfaces – Group 1
- Pressure Reducing Support Surfaces – Group 2
- Refractive Lenses
- Respiratory Assist Devices
- Speech Generating Devices
- Therapeutic Shoes for Persons with Diabetes
- Urological Supplies
- Walkers
- Wheelchair Seating

Refer to the individual medical policies for instruction on proper use of the KX modifier. The medical policies for Region A are available via the DMERC PSC Web site at: ***www.tricenturion.com/content/lmrp_current_dyn.cfm***

Items That Require a Certificate of Medical Necessity (CMN)

At present, a certificate of medical necessity (CMN) is required for the following items. Durable medical equipment regional carriers (DMERCs) and DMERC Program Safeguard Contractors (PSCs) may identify other items for which they will require an CMN.

Medical Policy	CMS Form Number	CMN Number	Healthcare Common Procedure Coding System (HCPCS) Codes
Enteral Nutrition	853	10B	B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162, B9000, B9002, E0776
External Infusion Pumps	851	09A	E0776, E0779, E0780, E0781, E0784, E0791, K0455, J0285, J0287, J0288, J0289, J0895, J1170, J1250, J1325, J1455, J1457, J1570, J1817, J2175, J2260, J2270, J2271, J2275, J3010, J7799, J9000, J9040, J9065, J9100, J9110, J9190, J9200, J9360, J9370, J9375, J9380
Hospital Beds and Accessories	841	01A	E0250, E0251, E0290, E0291, E0255, E0256, E0292, E0293, E0260, E0261, E0294, E0295, E0265, E0266, E0296, E0297, E0301, E0302, E0303, E0304
Manual Wheelchair Bases	844	02B	E1161, E1229, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0009

Medical Policy	CMS Form Number	CMN Number	Healthcare Common Procedure Coding System (HCPCS) Codes
Motorized/ Power Wheelchair Bases	843	02A	E0983, E1239, K0010, K0011, K0012, K0014
Osteogenesis Stimulators	847	04D	E0747, E0748
Oxygen and Oxygen Equipment	484	484.2	K0671, E0424, E0425, E0430, E0431, E0434, E0435, E0439, E0440, E0441, E0442, E0443, E0444, E1390, E1391
Parenteral Nutrition	852	10A, 10B*	E0776*, B4164, B4168, B4172, B4176, B4178, B4180, B4184, B4186, B4189, B4193, B4197, B4199, B4216, B5000, B5100, B5200, B9004, B9006
Pneumatic Compression Devices	846	04C	E0650, E0651, E0652, E0655, E0660, E0665, E0666, E0667, E0668, E0669, E0671, E0672, E0673
Power Operated Vehicle (POV)	850	07B	E0984, E1230
Pressure Reducing Support Surfaces–Grp 3	842	01D	E0194
Seat Lift Mechanism	849	07A	E0627, E0628, E0629
Wheelchair Options and Accessories	843 or 844	02A or 02B	E0973, E0990, K0017, K0018, K0020, E1226, K0046, K0047, K0053, K0195

Refer to the individual medical policies for those items requiring an CMN. The medical policies for Region A are available via the DMERC PSC Web site at: ***www.tricenturion.com/content/lmrp_current_dyn.cfm***

Items Requiring a Written Order Prior to Delivery (WOPD)

At this time, a written order prior to delivery (WOPD) is **required** for the following items. Durable medical equipment regional carriers (DMERCs) and DMERC Program Safeguard Contractors (PSCs) may identify other items for which they will require a written order prior to delivery.

Local Coverage Determination (LCD)/Local Medical Review Policy (LMRP)	Healthcare Common Procedure Coding System (HCPCS) Codes
Negative Pressure Wound Therapy Pumps	E2402, A6550, A6551
Pressure Reducing Support Surfaces – Group 2	E0193, E0277, E0371, E0372, E0373, E1399
Pressure Reducing Support Surfaces – Group 3	E0194
Seat Lift Mechanisms	E0627, E0628, E0629
Transcutaneous Electrical Nerve Stimulators (TENS)	E0720, E0730, E0731, A4557, A4595
Wheelchair Seating	E2601, E2602, E2603, E2604, E2605, E2606, E2607, E2608, E2609, E2610, E2611, E2612, E2613, E2614, E2615, E2616, E2617, E2620, E2621, E0955, E0956, E0957, E0960, E0966, E1028, A9900, E0992, E2291, E2292, E2293, E2294, E2618, E2619, K0108, K0669
Power Operated Vehicle (POV)	E0984, E1230

For these items, the supplier **must** have received a written order that has been both signed **and** dated by the treating physician, and meets the requirements for written orders, **before** dispensing the item. If a supplier bills for an item without a written order, when the supplier is required to have a WOPD, the item will be denied as not meeting the benefit category, and is therefore not appealable by the supplier.

Refer to the individual medical policies for those items requiring a WOPD. The medical policies for Region A are available via the DMERC PSC Web site at: ***www.tricenturion.com/content/lmrp_current_dyn.cfm***

Reminder Regarding Pre-Discharge Delivery of DMEPOS Items and Proof of Delivery Requirements

Recently, the Region A Durable Medical Equipment Regional Carrier (DMERC A) office has been receiving many calls from suppliers and beneficiaries regarding delivery of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items. Several of these calls are referred to our Complaint Screening Unit, and subsequently, result in refunds to the beneficiary or overpayments to the Medicare program.

In the past five years, DMERC A and TriCenturion, the Region A Program Safeguard Contractor (PSC), have published various bulletin articles regarding pre-

discharge delivery of DMEPOS items and proof of delivery requirements. The following is a list of some of these articles. Please refer to them and share them with your staff.

DMERC A articles (via ***www.umd.nycpic.com***):

- June 2000 (page 10); "Pre-Discharge Delivery of DMEPOS for Fitting and Training"
  Please note condition five (#5): The supplier ensures that the item is taken home by the beneficiary or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge.
- December 2001 (page 31); "Prostheses and Orthoses Related to a Hospital Stay"
- September 2003 (page 5); "DMEPOS Claims During an Inpatient Stay"
- March 2004 (page 18); "Clarification of Proof of Delivery Requirements"
- December 2004 (page 11); "Skilled Nursing Facility Consolidated Billing as It Relates to Prosthetics and Orthotics"

Region A PSC articles (via ***www.tricenturion.com***):

- June 2003 (Bul20030601 DELDOC); "Delivery Documentation Requirements – Reminder"
- September 2003 (Bul20030901 IMNO); "Early Delivery of Immunosuppressive Drugs"

Claim Submission Errors for the Second 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 January 1, 2005, through March 31, 2005, are provided in the following chart. The total number of ANSI errors for this period was **208,184**.

ANSI Error Number - Narrative (Total Errors)	Reason for Error
1) 40068 - Invalid/Unnecessary Certificate of Medical Necessity (CMN) Question (34,801 errors)	The question number entered is not valid for the DMERC CMN you are sending.
2) 40022 - Procedure Code/Modifier Invalid (26,000 errors)	The procedure code and/or modifier used on this line is invalid.
3) 40073 - Dates of Service Invalid with Procedure (25,000 errors)	The procedure code used is not valid for the dates of service used.
4) 20143 - Ordering Provider Secondary ID Invalid (8,883 errors)	If indicating that you are sending in a Medicare provider number, you must send in a valid provider number. When indicating you are sending a provider Unique Physician Identification Number (UPIN), you must send in a valid UPIN number.
5) 40036 - Service Date Does Not Equal "To" Date (6,669 errors)	The procedure code submitted does not allow for spanned dates of service.
6) 20025 - Subscriber ID Code Invalid (5,957 errors)	Subscriber ID code entered is not in a valid format.
7) 40037 - Service Date Greater Than Receipt Date (5,711 errors)	Service date is greater than date claim was received.
8) 40067 - Invalid/Unnecessary CMN Version Submitted (5,250 errors)	The DMERC CMN version number entered is not valid for the Healthcare Common Procedure Coding System (HCPCS) code submitted.
9) 40066 - Invalid/Unnecessary CMN Submitted (5,237 errors)	The DMERC CMN form number entered is not valid for the HCPCS code submitted.
10) 20110 - Procedure Code Invalid (4,993 errors)	The procedure code submitted on this line is invalid.

In an effort to reduce other initial claim denials, the below information represents the top ten return/reject denials for the second 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) 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. (16,816 claims)	**Item 21** - Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number, coded to the highest level of specificity. You may enter up to four codes in priority order (i.e., primary, secondary condition).

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form Entry Requirement
2) CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid procedure codes(s) and/or rates. (12,052 claims)	**Item 24D** - Enter the procedures, services, or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.
3) CO 16 M78 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid HCPCS modifier. (6,559 claims)	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable, show HCPCS modifiers with the HCPCS code.
4) CO 16 MA 83 Claim/service lacks information which is needed for adjudication. Did not indicate whether we are the primary or secondary payer. (5,705 claims)	**Item 11** - Enter the name of the enrollee in a Medigap policy if different from Item 2. Otherwise, write "SAME." If no Medigap benefits are assigned, leave blank. Item 11 **must** be completed. If other insurance is primary to Medicare, enter the insured's policy or group number. If no insurance primary to Medicare exists, enter "NONE."
5) CO 16 MA 102 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider. (4,745 claims)	**Item 17** - Enter the name of the referring or ordering physician, if the service or item was ordered or referred by a physician.
6) CO 16 M77 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid place of service. (4,537 claims)	**Item 24B** - Enter the appropriate place of service code(s). Identify the location, using a place of service code, for each item used or service performed.
7) 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. (4,221 claims)	**Item 33** - Enter the provider of service/supplier's billing name, address, zip code, and telephone number. Enter the Physician Identification Number (PIN) for the performing provider of service/supplier who is not a member of a group practice. Enter the group PIN for the performing provider of service/supplier who is a member of a group practice.
8) CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different. (2,613 claims)	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.
9) N127 This claim/service is not payable under our claims jurisdiction. We have notified your provider to send your claim for these services to the United Mine Workers of America for processing. (315 claims)	**Items 11-11C** - If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to Items 11A-11C.
10) CO 16 M79 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid charge. (285 claims)	**Item 24F** - Enter the charge for each listed service.

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!

Stay informed: Web-based training opportunities are available via the DMERC A Web site.

For our online tutorials, visit the "Education-Tutorials" section at:
www.umd.nycpic.com/dme-eduonline.html

For our live interactive sessions, visit the "Events" section at:
www.umd.nycpic.com/dmprovcaln.html

***Please note:** There are live interactive sessions scheduled, beginning June 21, 2005, through July 28, 2005, for the following topics: DMERC 101, Documentation, Continuous Positive Pressure Airway (CPAP)/Respiratory Assist Device (RAD) Billing, Enteral Nutrition Billing, Oxygen and Oxygen Equipment Billing, Refractive Lens Billing, and Medicare Billing Updates. Register today!*

Web Site Resources

News from CMS…

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. 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 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***, and CMS encourages 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***

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 spring 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 in order to properly view and/or print this publication.)

News from DMERC A…

News Regarding CERT

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. Lifecare Management Partners, the CERT Documentation Contractor (CDC), began producing monthly newsletters in December 2004, to provide a better understanding of the CERT process and its activities.

In support of CERT, the Region A Durable Medical Equipment Regional Carrier (DMERC A) is making these newsletters accessible to our supplier community via our Web site. To view the editions listed below, visit ***www.umd.nycpic.com/dmeduc.html#CERT*** and follow the download instructions:

- December 2004
- January 2005
- February 2005
- March 2005
- April 2005

DMERC suppliers, please note the following in regards to an article within the January 2005 CERT newsletter: Any changes or updates to supplier addresses, telephone numbers (including area code changes), or tax information **must** be reported **in writing** to the National Supplier Clearinghouse (NSC) **within 30 days** after such changes have taken place. Visit the NSC Web site (***www.palmettogba.com***), call the toll-free telephone number (866-238-9652), or write to the NSC (at the address below) for instructions.

National Supplier Clearinghouse (NSC)
NSC, AG-495
P.O. Box 100142
Columbia, SC 29202-3142

Supplier Manual News

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

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

Revision 2003-09 (March 2005)

- Chapter 1 (Contact Information) - updated for post office box changes and to include Program Inquiries Fair Hearings/Administrative Law Judge (ALJ) Voicemail telephone number
- Chapter 9 (Durable Medical Equipment) - updated to reflect current information, as in CMS Online Manual System, and availability of the DMERC A "ADMC Request" form for use in submitting Advance Determination of Medicare Coverage (ADMC) requests

Revision 2003-10 (June 2005)

- Chapter 6 (Pricing) - updated to reflect current information, as in CMS Online Manual System, including recent average sales price (ASP) methodology for payment of drugs and biologicals (**Note:** The table of contents was updated under revision 2003-10.)

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. In order to avoid potential viewing and/or printing problems, be sure to follow the download instructions to access the revised pages.

Forms on DMERC A Web Site

In response to suppliers' needs and inquiries, a "Request for Redetermination" form was created for use in submitting written redetermination requests to the Region A Durable Medical Equipment Regional Carrier (DMERC A). This form can be found on our Web site at ***www.umd.nycpic.com/RedeterminationForm.html*** and is the latest DMERC A has created to assist the supplier community in transactions with us. While use of the forms is not mandatory, it will help to ensure that all necessary information is included for the most efficient processing of requests to DMERC A.

In order to easily access the forms, DMERC A enhanced our Web site by adding "Forms" to the link for certificates of medical necessity (CMNs) on the main menu for suppliers. When suppliers click on this revised link (CMNs & Forms), they now have three options to choose from: 1) CMNs; 2) Centers for Medicare & Medicaid Services (CMS) forms; and 3) DMERC forms. The CMNs and CMS forms options provide links to these federal forms, whereas, the DMERC forms option provides access to the forms created and maintained by DMERC A.

The following are the DMERC forms that are available at this time:

- Advance Determination of Medicare Coverage (ADMC) Request Form
- Electronic Data Interchange (EDI) Forms
- Extra Documentation Request Form
- Fair Hearing Request Form
- Overpayment Refund Form
- Request for Redetermination Form

For the EDI forms, links are available to access the following:

- EDI Change Form
- EDI Enrollment Form
- Electronic Funds Transfer (EFT) Agreement
- Eligibility Inquiry Agreement
- Electronic Remittance Advice (ERA) Addendum
- Health Insurance Portability and Accountability Act (HIPAA) Compliant Software
- IVANS Service Agreement
- On-line Claims Status Inquiry (CSI) Agreement
- Region A DMERC EDI Existing Customer Profile
- Statement of Understanding for Charges

Some of the above links are associated with online instructions that should be read prior to downloading the forms in order to understand their content and for submission of the forms.

If you have any questions regarding the DMERC forms, please feel free to contact us by visiting the "Contact Us" section at:
www.umd.nycpic.com/contactdme.html

Contact Us

In additon to the forms enhancement, the "Contact Us" section of the DMERC A Web Site has been reorganized. This section now features four subsections, which include "By Phone," "By Mail," "By Email," and "DMERC A Resources."

The main "Contact Us" page contains links to each of the new subsections, a link to the "Web Site Satisfaction Survey," and our 2005 holiday schedule.

The "By Phone" section contains a list of telephone and fax numbers that suppliers can use to contact DMERC A. This section also contains a link to the Automated Response Unit (ARU) guide.

The "By Mail" section contains a list of mailing addresses for DMERC A (as on the back cover).

The "By Email" section contains information about submitting inquiries to DMERC A via email and a link to our online inquiries form.

The "DMERC A Resources" section contains a list of resources and customer service options available to suppliers. A downloadable version of the "Information Resources and Customer Service Options" guide is also available. Please be sure to follow instructions for downloading and viewing Portable Document Format (PDF) files. (These instructions can be accessed by clicking on the PDF icon.)

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***. Provideers should visit this section often, since the information that is posted can have a significant impact on their businesses.

Please Remember

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

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.

At a minimum, you are encouraged to subscribe to the following ListServes:

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

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, such as drug coverage, mobility/support surfaces, oxygen, parenteral/enteral nutrition (PEN), prosthetics & orthotics, specialty items, and vision related topics. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

Signing up for the DMERC A ListServes gives you immediate notification of important information on Medicare changes impacting your business. Subscribe today by visiting the "ListServes" section of our Web site at ***www.umd.nycpic.com/dmlistserve.html***. Also, to receive 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
- 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 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.

Coming Attractions...

The Region A Durable Medical Equipment Regional Carrier (DMERC A) posts articles and information to our Web site prior to publishing them in our bulletin. The following can be accessed via the "What's New" section at ***www.umd.nycpic.com/dme_what's_new.html***, and they will be included in our September 2005 bulletin:

- July Quarterly Update for 2005 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule
- Correction to the Use of Group Codes for the Enforcement of Mandatory Electronic Submission of Medicare Claims
- Supply Codes and Payments for Immunosuppressive Drugs
- Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA)
- New April 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File and Revisions to January 2005 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File
- CMS Announces the National Provider Identifier (NPI) Enumerator Contractor and Information on Obtaining NPIs

Effective July 1, 2005, if you don't submit your Medicare claims electronically, your payments could be affected. Visit the DMERC A Web site for additional information regarding this issue.

Telephone Numbers

Caller Information Network	
Supplier Toll-Free Line	866-419-9458
[*TTY Hearing Impaired*	866-374-6848]
Beneficiary Toll-Free Line	1-800-MEDICARE (1-800-633-4227)
[*TTY Hearing Impaired*	1-877-486-2048]
EDI Services Help Desk	866-861-7348
Program Education & Training	570-735-9666
Program Inquiries	
Telephone Redeterminations Line	866-420-6906
Fair Hearings/ALJ Voicemail Line	866-861-7350
FAX Numbers	
Check Control/MSP	570-735-9594
Electronic Data Interchange	570-735-9510
Extra Documentation/ADMC	570-735-9402
Program Education & Training	570-735-9442
Program Inquiries (Hearings & Redeterminations)	570-735-9599
National Supplier Clearinghouse	866-238-9652
SADMERC	877-735-1326
Web Sites	www.umd.nycpic.com www.cms.hhs.gov

Addresses

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

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

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

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

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

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

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

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*]

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