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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Reminder: Enforcement of mandatory electronic submission of Medicare claims became effective July 1, 2005. Unless there is an exception in place, paper claims that are submitted for Medicare payment will be denied. Visit our Web site for more information.

News from CMS…

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

Medlearn Matters Number: MM3846
Related Change Request (CR) #: 3846
Related CR Release Date: May 13, 2005
Related CR Transmittal #: 561
Effective Date: April 1, 2005
Implementation Date: July 5, 2005

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

Provider Action Needed

Impact to You

Change Request (CR) 3846 revises payment allowance limits in the January 2005 and the April 2005 drug pricing files. For the codes listed below, the revised payment limits supersede the payment limits cited in any previously published document.

What You Need to Know

Effective 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 average sales price (ASP).

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, revises the payment methodology for Part B covered drugs and biologicals that are not paid on a cost or prospective payment basis. Effective January 1, 2005, these drugs and biologicals are paid based on the new ASP drug payment methodology.

The ASP file, used in the ASP methodology, is based on data that the Centers for Medicare & Medicaid Services (CMS) receives quarterly from manufacturers. Each quarter, CMS will update your carrier and 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. However, you should be aware that 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 quarterly**;
- 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**.

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

- For **influenza, pneumococcal, and hepatitis B vaccines**, payment allowance limits are 95 percent of the AWP as reflected in the published compendia. **The payment allowance limits will be updated quarterly**.
- 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 WAC-based payment limit, carriers/DMERCs/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 lesser of the lowest brand or median generic WAC.

  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 will post them in an MS Excel file on the CMS Web site. If the payment limit is available from CMS, carriers/FIs will substitute the CMS-provided payment limits for pricing based on WAC or invoice pricing.
- For **new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File**, payment allowance limits are based on 106 percent of the WAC. This policy applies *only* to new drugs that were first sold on or after January 1, 2005.

Table 1 below displays the revised 1st Quarter 05 payment allowance limits for the indicated codes, effective for services provided on or after January 1, 2005.

Table 1

HCPCS	Short Description	HCPCS Code Dosage	1Q05 Payment Limit	1Q05 Independent ESRD Limit
90371	Hep B ig, im	1 ML	$115.878	$115.878
J2790	Rho d immune globulin, inj	300 MCG	$101.733	$101.733
J2792	Rho (D) immune globulin	100 IU	$13.101	$13.101
Q0187	NovoSeven	Per 1.2 MG	$1,211.050	$1,211.050

Table 2 below displays the revised 2nd Quarter 05 payment allowance limits for the indicated codes, effective for services provided on or after April 1, 2005.

Table 2

HCPCS	Short Description	HCPCS Code Dosage	2Q05 Payment Limit	2Q05 Independent ESRD Limit	2Q05 Vaccine Limit	2Q05 Blood Limit
90747	Hep B vacc, ill pat 4 dose im	40 MCG	$113.915	$113.915	$113.915	
J0135	Adalimumab injection	20 MG	$294.632	$294.632		
J0287	Amphotericin b lipid complex	10 MG	$11.724	$11.724		
J0725	Chorionic gonadotropin	1000 UNITS	$2.976	$2.976		
J2597	Inj desmopressin acetate	1 MCG	$2.493	$2.493		
J7190	Factor viii	1 IU	$0.641	$0.641		
J7192	Factor viii recombinant	1 IU	$1.063	$1.063		
J7193	Factor IX non-recombinant	1 IU	$0.882	$0.882		
J7194	Factor ix complex	1 IU	$0.650	$0.650		
J7195	Factor IX recombinant	1 IU	$0.982	$0.982		
J7197	Antithrombin iii injection	1 IU	$1.543	$1.543		
J7198	Anti-inhibitor	1 IU	$1.241	$1.241		
J7344	Nonmetabolic active tissue	1 SQ CM	$52.777	$52.777		
J9098	Cytarabine liposome	10 MG	$359.359	$359.359		
J9245	Inj melphalan hydrochl	50 MG	$513.694	$513.694		
J9266	Pegaspargase single dose vial	1 EA	$1,499.306	$1,499.306		
P9041	Albumin (human),5%	50 ML	$14.545	$14.545		$14.545
P9043	Plasma protein fraction, 5%	50 ML	$14.545	$14.545		$14.545
P9046	Albumin (human), 25%	20 ML	$14.545	$14.545		$14.545
P9048	Plasma protein fraction, 5%	250 ML	$29.099	$29.099		$29.099
Q0187	NovoSeven	Per 1.2 MG	$1,228.438	$1,228.438		
Q2002	Elliotts b solution per ml	1ML	$3.350	$3.350		
Q2005	Corticorelin ovine triflutat	1 EA	$379.067	$379.067		
Q2012	Pegademase bovine	25 IU	$158.048	$158.048		
Q2018	Urofollitropin, 75 iu	75 IU	$43.865	$43.865		
Q9941	IVIG lyophil	1 G	$38.735	$38.735		
Q9942	IVIG lyophil	10 MG	$0.387	$0.387		
Q9943	IVIG non-lyophil	1 G	$56.221	$56.221		
Q9944	IVIG non-lyophil	10 MG	$0.562	$0.562		
Q9954	Oral MR contrast	100 ML	$8.844	$8.844		

Notice that J2910 is no longer included in the April 2005 pricing file.

You should note that the new April 2005 ASP drug pricing files will contain three decimal places in the currency fields. You can find more information on the April 2005 ASP data format in CR 3436, which instructs the carriers/DMERCs/FIs to accommodate three (3) places after the decimal point, and to follow standard rounding procedure, round to two (2) decimal places, after multiplying the number in the "units" field of the line item by the payment allowance applicable to the Healthcare Common Procedure Coding System (HCPCS) code.

You should also note that the absence or presence of a HCPCS code and its associated payment limit in the payment files do not indicate Medicare coverage of the drug or biological. Nor does inclusion of a payment limit within a specific column indicate Medicare coverage of the drug in that specific category. The carrier/DMERC/FI processing your claim will make these determinations.

To comply with these requirements, your carrier, DMERC, or FI will:

- Use the new April 2005 ASP drug pricing file to pay for Medicare Part B drugs, effective April 1, 2005, 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 CR 3232, dated December 16, 2004 (corrected). See ***www.cms.hhs.gov/manuals/pm_trans/R397CP.pdf***.
- Use the new April 2005 ASP drug pricing file for (1) those claims where the provider asks the carrier/DMERC/FI to retroactively adjust claims processed with the original April 2005 file, and (2) those claims with dates of service on or after April 1, 2005, and before July 1, 2005, that are processed after July 4, 2005. **Your carrier or FI will not search and adjust claims that have already been processed unless brought to their attention.**

Additional Information

The new April 2005 and revisions to the January ASP pricing files are available at:
www.cms.hhs.gov/providers/drugs/asp.asp

For complete details of CR 3846, on which this article is based, please see the official instruction issued to your carrier/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 3846 in the CR NUM column on the right, and click on the file for that CR.

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

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

Medlearn Matters Number: MM3779
Related Change Request (CR) #: 3779
Related CR Release Date: April 29, 2005 **Revised**
Related CR Transmittal #: 536
Effective Date: January 1, 2005
Implementation Date: July 5, 2005
Note: This article was revised on May 11, 2005, to provide the correct code descriptors for K0731 and K0732.

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

Provider Action Needed

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

Background

The DMEPOS fee schedules are updated on a quarterly basis in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by the Social Security Act (Section 1834 (a), (h), and (i)), and payment on a fee schedule basis is required for parenteral and enteral nutrition (PEN) by regulations contained in the Code of Federal Regulations (42 CFR 414.102).

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

Batteries Used with Cochlear Implant Devices
Code L8620 with the description of "Lithium Ion Battery for Use with the Cochlear Implant Device" was added to the Healthcare Common Procedure Coding System (HCPCS) effective January 1, 2005. When the fee schedule amounts were calculated and implemented for this code on January 1, 2005, pricing information for the different types of batteries used with cochlear implant devices was not included. The fee schedule amounts for L8620 are being revised as part of the quarterly update to include pricing information for the different types of lithium ion batteries used with cochlear implant devices. The Centers for Medicare & Medicaid Services (CMS) is revising the fee schedule for the code using the standard gap-filling process. Local carriers, therefore, do not need to gap fill fees for this code.

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

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

- **K0731** - Lithium Ion Battery for Use With Cochlear Implant Device Speech Processor, Other Than Ear Level, Replacement, Each; **Short Description**: Lith ion bat cid, non-ear level
- **K0732** - Lithium Ion Battery for Use With Cochlear Implant Device Speech Processor, Ear Level, Replacement, Each; **Short Description**: Lith ion batt cid, ear level

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

Controlled Dose Inhalation Drug Delivery System
The following code is also added to the HCPCS on July 1, 2005, and is effective for claims with service dates on or after April 1, 2005: **K0730** - Controlled Dose Inhalation Drug Delivery System

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

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

Parenteral and Enteral Nutrition (PEN) Equipment and Supplies
There are no changes to the PEN fee schedule file for July 2005.

Implementation

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

Additional Information

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

The official instruction issued to your DMERC/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 3779 in the CR NUM column on the right, and click on the file for the desired CR. For additional information relating to this issue, please refer to your DMERC/intermediary. To find their toll-free telephone numbers go to:
www.cms.hhs.gov/medlearn/tollnums.asp

The Number of Durable Medical Equipment Pricing Files That Must Be Maintained Online for Medicare – DMERC, FI, and RHHI Only

Medlearn Matters Number: MM3792
Related Change Request (CR) #: 3792
Related CR Release Date: April 29, 2005
Related CR Transmittal #: 546
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

The following information affects providers and suppliers who bill durable medical equipment regional carriers (DMERCs) and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Provider Action Needed

This article is informational only. Providers/suppliers need take no action, but Medicare encourages you to submit claims to Medicare as soon as possible after services are supplied.

Background

Medicare created a new minimum standard for the number of online price determination files that a Medicare DMERC or RHHI will maintain. The new minimum standard is eight fee screens/pricing files (the current period and seven prior files) for payment on a fee-for-service DMEPOS that you bill. This will allow Medicare to be more precise in paying the rate in effect at the time services are provided.

While this allows for more accurate pricing, this change does not alter Medicare's timely filing requirements and providers/suppliers should bill Medicare as promptly as possible.

Additional Information

The official instruction issued to your DMERC/FI/RHHI 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) 3792 in the CR NUM column on the right, and click on the file for the desired CR. For additional information relating to this issue, please contact your DMERC/FI/RHHI via their toll-free number. That number may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

July Quarterly Update to 2005 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

Medlearn Matters Number: MM3873
Related Change Request (CR) #: 3873
Related CR Release Date: May 27, 2005
Related CR Transmittal #: 568
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

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

Provider Action Needed

Impact to You

This article is based on information from Change Request (CR) 3873, which corrects the effective date of excluded Healthcare Common Procedure Coding System (HCPCS) L5781 for Skilled Nursing Facility (SNF) Consolidated Billing (CB).

What You Need to Know

The correct effective date of excluded HCPCS L5781 for SNF CB should be January 1, 2003.

What You Need to Do

See the "Background" section of this article to find out further details regarding this change.

Background

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes that are subject to the CB provision of the SNF Prospective Payment System (PPS). Claims for services appearing on this list (which are submitted to Medicare fiscal

intermediaries (FIs) and carriers, including durable medical equipment regional carriers (DMERCs)), will not be paid by Medicare to providers, other than an SNF, when **included** in SNF CB.

- For non-therapy services, SNF CB applies only when the services are furnished to an SNF resident during a covered Part A stay;
- For physical and occupational therapies and speech-language pathology services, SNF CB applies whenever they are furnished to an SNF resident, regardless of whether Part A covers the stay; and
- Services **excluded** from SNF Prospective Payment System (PPS) and CB may be paid to providers (other than SNFs) for beneficiaries, even when in an SNF stay.

Separate instructions are published for FIs and carriers/DMERCs for the annual notice on SNF CB each January. The 2005 Annual Update can be found on the following CMS Web sites for:

- FIs at ***www.cms.hhs.gov/manuals/pm_trans/R360CP.pdf*** (Transmittal R360CP, CR 3542, dated November 5, 2004); and
- Carriers at ***www.cms.hhs.gov/medlearn/snfcode.asp***

Quarterly updates now apply to both FIs and carriers/DMERCs. An April 2005 Quarterly Update for FIs and carriers has been published subsequent to the 2005 annual update, and it is available at the CMS Web site for 2005 transmittals at ***www.cms.hhs.gov/manuals/pm_trans/R449CP.pdf*** (transmittal R449CP, CR 3683, dated January 21, 2005).

CR 3873 provides one HCPCS correction under Major Category III. D. Customized Prosthetic Devices. HCPCS L5781 was previously excluded under the 2005 Annual Update to SNF CB with an incorrect effective date of January 1, 2005. The effective date for excluded HCPCS L5781 should be January 1, 2003.

Suppliers may bill L5781 retroactively to January 1, 2003. However, there may be situations in which an SNF has already reimbursed a supplier for L5781. Providers and suppliers cannot collect money from an SNF and Medicare Part B twice for the same service, equipment, or device for the same date of service. Suppliers that now receive payment from Medicare Part B are expected in all cases to refund any money they received from the SNF for the same item. Effective for claims with dates of service on or after January 1, 2003, to December 31, 2004, your Medicare carrier and FI will reopen and reprocess claims with the code L5781 and override timely filing when necessary. The carrier/FI will only do this, however, when you bring such claims to their attention.

Implementation

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

Additional Information

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

From that Web page, look for CR 3873 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***

New Healthcare Common Procedure Coding System (HCPCS) Drug Codes

Medlearn Matters Number: MM3847
Related Change Request (CR) #: 3847
Related CR Release Date: June 30, 2005 **Revised**
Related CR Transmittal #: 600
Effective Date: July 1, 2005
Implementation Date: July 5, 2005
Note: This article was revised on July 1, 2005, because of changes made to Change Request (CR) 3847, which was reissued on June 30, 2005. The article was revised to include additional billing information as noted by the three bullet points (in bold print) in the "Additional Information" section of this article.

The following information affects physicians, providers, and suppliers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), or fiscal intermediaries (FIs) for high osmolar contrast material and iloprost inhalation solution.

Provider Action Needed

Effective July 1, 2005, for dates of service on or after July 1, 2005, Healthcare Common Procedure Coding System (HCPCS) code Q4080, for iloprost inhalation

solution, and HCPCS codes Q9958-Q9964, for high osmolar contrast material, are being added to the HCPCS. Be aware of the new codes for iloprost inhalation solution and high osmolar contrast material when reporting these services to Medicare.

Additional Information

Effective July 1, 2005, the following codes are being added to the HCPCS for iloprost inhalation solution and high osmolar contrast material.

HCPCS Code	Short Descriptor	Long Descriptor
Q4080	Iloprost inhalation solution	Iloprost, inhalation solution, administered through DME, 20 mcg
Q9958	HOCM <=149 mg/ml iodine, 1 ml	High osmolar contrast material (HOCM), up to 149 mg/ml iodine concentration, per ml
Q9959	HOCM 150-199 mg/ml iodine,1 ml	High osmolar contrast material, 150 - 199 mg/ml iodine concentration, per ml
Q9960	HOCM 200-249 mg/ml iodine,1 ml	High osmolar contrast material, 200 - 249 mg/ml iodine concentration, per ml
Q9961	HOCM 250-299 mg/ml iodine,1 ml	High osmolar contrast material, 250 - 299 mg/ml iodine concentration, per ml
Q9962	HOCM 300-349 mg/ml iodine,1 ml	High osmolar contrast material, 300 - 349 mg/ml iodine concentration, per ml
Q9963	HOCM 350-399 mg/ml iodine,1 ml	High osmolar contrast material, 350 - 399 mg/ml iodine concentration, per ml
Q9964	HOCM >= 400 mg/ml iodine,1 ml	High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

Also, please note the following:

- As stated in Section 30 of Chapter 13 of the Medicare Claims Processing Manual (Publication 100-04), payment for HOCMs is included in the payment for the procedure and separate payment for the HOCMs is not allowed.
- As stated in CR 3846, the payment allowance limits for new drugs and biologicals not included in the Average Sales Price (ASP) Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File are based on 106 percent of the Wholesale Acquisition Cost (WAC). A Medlearn Matters article related to CR 3846 is available at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3846.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.
- Those billing Medicare carriers may note that code Q4080 will be assigned to status indicator "E" and codes Q9958-Q9964 will be assigned status indicator "B" in the Medicare Physician Fee Schedule Database.
- While Medicare carriers and DMERCs will accept Q4080 to report iloprost inhalation solution, only Medicare DMERCs will make payment for Q4080.
- **Where appropriate, revenue code 0636 should be assigned when billing these HOCM HCPCS codes.**
- **Critical access hospital (CAH) outpatient departments should bill for codes Q4080 and Q9958-Q9964 using type of bill (TOB) 85X. Payment for such services will be based on reasonable cost and beneficiary deductible and coinsurance does apply.**
- **Skilled nursing facilities (SNFs) billing under Medicare Part B should use TOB 22X (for inpatient Part B) and 23X (outpatient) for codes Q4080 and Q9958-Q9964. Payments to the SNFs will also be made on a reasonable cost basis and beneficiary deductible and coinsurance does apply.**

The official instruction issued to your carrier/DMERC/FI 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 3847 in the CR NUM column on the right, and then click on the file for that CR. If you have questions regarding this issue, contact your carrier/DMERC/FI on 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: June 17, 2005 **Revised**
Related CR Transmittal #: 38 and 588
Effective Date: January 28, 2005
Implementation Date: April 18, 2005, for Medicare carriers; on or before July 5, 2005, for Medicare fiscal intermediaries
Note: This article was revised on June 21, 2005, to reflect a revision to Change Request (CR) 3742. The CR was revised to show that Medicare fiscal intermediaries (FIs) will implement the change on or before July 5, 2005, instead of April 18, 2005. The effective date of CR 3742 and all other information remains the same, but providers should take note that their Medicare FI may not be ready to process claims in accordance with CR 3742 until July 5, 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 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 ***www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=90*** on the CMS Web site.

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, at ***www.cms.hhs.gov/coverage*** on the CMS Web site.

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 ***www.cms.hhs.gov/manuals/103_cov_determ/ncd103index.asp*** on the CMS Web site).

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. Use revenue code 0636 for anti-cancer drugs furnished during a clinical trial for outpatient claims, and use revenue code 0250 for inpatient claims.
- 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 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 R38NCD will contain the NCD information, and the version with a transmittal number of R588CP 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***

Note: Medlearn Matters article MM3742 was revised on May 23, 2005, to reflect the revision of the original Change Request (CR) 3742. The CR was revised to show that revenue code 0636 is used when billing Medicare fiscal intermediaries for anti-cancer drugs furnished during a clinical trial on outpatient claims, but revenue code 0250 should be used when billing for anti-cancer drugs furnished during a clinical trial on inpatient claims. The original version of the article was published on page 9 of the June 2005 *DMERC A Medicare News*.

Coverage of Aprepitant for Chemotherapy-Induced Emesis

Medlearn Matters Number: MM3831
Related Change Request (CR) #: 3831
Related CR Release Date: June 24, 2005 **Revised**
Related CR Transmittal #: 40 and 590
Effective Date: April 4, 2005
Implementation Date: July 5, 2005
Note: This article was revised on July 5, 2005, to add some clarifying language, but no substantive changes were made to the billing or coverage requirements.

The following information affects providers and suppliers rendering services to beneficiaries with cancer chemotherapy-induced nausea and vomiting (CINV).

Provider Action Needed

Impact to You

Effective April 4, 2005, you may submit claims for the use of the oral anti-emetic drug Aprepitant (Emend®),

when used in combination with a 5-HT_3 antagonist and dexamethasone in beneficiaries receiving certain cancer chemotherapeutic agents as outlined below.

What You Need to Know
The Centers for Medicare & Medicaid Services (CMS) has announced a National Coverage Determination (NCD) that covers the use of Aprepitant (Emend®), an orally administered neurokinin-1 (NK_1) antagonist, in both acute and delayed phases of chemotherapy-induced emesis. Effective April 4, 2005, CMS will cover the use of the oral anti-emetic drug combination of Aprepitant (Emend®), a 5-HT_3 antagonist, and dexamethasone in beneficiaries receiving certain cancer chemotherapeutic agents (see "Background" section below).

What You Need to Do
Make sure that your billing staffs are aware of this new coverage.

Background

Aprepitant (Emend®), a human substance P/neurokinin-1 (NK_1) receptor antagonist, is the first Food and Drug Administration (FDA)-approved anti-emetic drug of its type. It has been approved to function in combination with other oral anti-emetics for the prevention of both acute and delayed CINV associated with initial and repeat courses of highly emetogenic chemotherapeutic agents.

CINV can range in severity from mild to severe, with the most severe cases resulting in dehydration, malnutrition, metabolic imbalances, and potentially requiring withdrawal from future chemotherapy treatments. CINV incidence and severity are influenced by the specific chemotherapeutic agent(s) used, their dosage, schedule and route of administration, and by drug combinations. In addition, they can also be affected by patient-specific risk factors such as sex, age, history of motion sickness, and prior exposure to chemotherapeutic agents. While progress has been made in reducing CINV, symptoms that occur more than a day after chemotherapy, during repeat cycles of chemotherapy, and when chemotherapy is given on more than one day or in very high doses remain hard to control. No single anti-emetic agent is completely effective in all patients.

CMS has determined that the evidence is adequate to conclude that use of the oral anti-emetic drug combination of Aprepitant (Emend®), a 5-HT_3 antagonist, and dexamethasone is reasonable and necessary for a specified patient population receiving one or more of the following anti-cancer chemotherapeutic agents:

- Carmustine
- Cisplatin
- Cyclophosphamide
- Dacarbazine
- Mechlorethamine
- Streptozocin
- Doxorubicin
- Epirubicin
- Lomustine

Note: The evidence is adequate to conclude that Aprepitant cannot function alone as a full replacement for intravenously administered anti-emetic agents for patients who are receiving highly emetogenic chemotherapy.

Important Billing Information
You must bill your claims for Aprepitant (Emend®), on form CMS-1450 (UB-92), or the electronic equivalent, with the appropriate cancer diagnosis and Healthcare Common Procedure Coding System (HCPCS) code of J8501 (Aprepitant, oral, 5mg) or appropriate Current Procedural Terminology (CPT) code. Those providers submitting claims to Medicare fiscal intermediaries (FIs) should also include revenue code 0636 (Drugs requiring detailed coding). For FIs, the following payment methodologies apply when Aprepitant is provided by a hospital or skilled nursing facility (SNF) outpatient department:

- Based on Ambulatory Payment Classification (APC) for hospitals subject to the outpatient prospective payment system (OPPS);
- Under current payment methodologies for hospitals not subject to OPPS; or
- On a reasonable cost basis for SNFs.

Critical access hospital (CAH) claims will be paid as follows:

- Method I – technical services are paid at 101 percent (%) of reasonable cost;
- Method II – technical services are paid at 101 percent of reasonable cost, and professional services are paid at 115 percent of the Medicare Physician Fee Schedule DataBase.

Claims submitted to Medicare's durable medical equipment regional carriers (DMERCs) will be paid based on the Average Sales Price (ASP) pricing file for claims with dates of service on or after April 4, 2005. Effective January 1, 2005, the payment allowance limit is based on the ASP plus six percent (ASP + 6%).

Note: Inpatient claims submitted for oral anti-emetic drugs are processed under the current payment methodologies.

Your Medicare DMERC or FI will adjust claims with dates of service April 4, 2005 (effective date), through July 4, 2005 (implementation date), if brought to their attention.

Additional Information

You can find more information about the coverage of Aprepitant (Emend®) for chemotherapy-induced emesis by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***. From that Web page, look for Change Request (CR) 3831 in the CR NUM column on the right, and click on the file(s) for that CR. The file with transmittal number 40 will contain the National Coverage Determination, and the file with transmittal number 590 will contain the claims processing instructions.

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

Supply Codes and Payments for Immunosuppressive Drugs

Medlearn Matters Number: MM3830
Related Change Request (CR) #: 3830
Related CR Release Date: April 29, 2005
Related CR Transmittal #: 551
Effective Date: January 1, 2005, for editing claims submitted to Medicare fiscal intermediaries (FIs), and October 1, 2005, for editing claims submitted to durable medical equipment regional carriers (DMERCs)
Implementation Date: October 3, 2005

The following information affects pharmacies, hospitals not subject to the Outpatient Prospective Payment System (OPPS), and dialysis facilities in the state of Washington billing Medicare for immunosuppressive drugs.

Provider Action Needed

Impact to You

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

What You Need to Know

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

What You Need to Do

To ensure accurate claims processing, review the information included here and stay current with instructions for Medicare dispensing/supply fees.

Background

Section 303(e)(2) of the MMA implements a supplying fee for immunosuppressive drugs. Beginning January 1, 2005, Medicare pays a separately billable supplying fee of $24.00 to a pharmacy or other entity providing an immunosuppressive drug to a Medicare beneficiary. These payments are generally made by the DMERC to the pharmacy. However, in the state of Washington, FIs pay the supplying fee to the dialysis facility that supplies immunosuppressive drugs to kidney transplant beneficiaries. In addition, FIs will pay this $24.00 supplying fee to non-OPPS hospitals supplying 30-day supplies of immunosuppressive drugs. The code for this supplying fee is G0370. The code description is as follows:

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

Effective January 1, 2005, Medicare pays a supplying fee of $50.00 to a pharmacy for the initial supplied prescription of immunosuppressive drugs to the patient during the first month following the transplant. The

code for this supplying fee is G0369. This is a one-time payment per beneficiary, **per transplant**. The code description is as follows:

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

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

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

Implementation

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

Additional Information

Beneficiaries are required to pay the normal co-pay and deductible on both the drug and the supplying fee. Your FI will process any adjustment requests you submit for immunosuppressive drugs with dates of service on and after January 1, 2005, and pay the supplying fee to the dialysis facility or non-OPPS hospital.

For complete details of Change Request (CR) 3830, on which this article is based, please see the official instruction issued to your intermediary regarding this change. That instruction may be viewed at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

From that Web page, look for CR 3830 in the CR NUM column on the right, and click on the file for that CR. Additional information may also be found in Medlearn Matters article MM3620, and the related CR 3620, which addresses New Dispensing/Supply Fee Codes for Oral Anti-Cancer, Oral Anti-Emetic, Immunosuppressive, and Inhalation Drugs when billed to DMERCs. MM3620 may be found at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3620.pdf***

CR 3620 may be found at: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** Once at that site, look for CR 3620 in the CR NUM column on the right, and click on the file for that CR. If you have any questions regarding this issue, please contact your DMERC or FI at their toll-free number, which you will find at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Update to the Place of Service (POS) Code Set to Add a Code for Pharmacy

Medlearn Matters Number: MM3819
Related Change Request (CR) #: 3819
Related CR Release Date: April 29, 2005
Related CR Transmittal #: 549
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

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

Provider Action Needed

Impact to You

The Medicare Claims Processing Manual and claims processing systems are being revised to include a new place of service (POS) code for pharmacy of 01.

What You Need to Know

Claims for covered services rendered using the new POS code for a pharmacy setting will be paid at the non-facility rate. Your carrier's medical directors will develop policies, as needed, to adjudicate claims containing this new code.

What You Need to Do

Stay current on POS coding in order to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Additional Information

The new POS code for pharmacy is 01. In the POS code set, pharmacy is defined as a facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. The POS code set with the pharmacy place of service code can be found in the Medicare Claims Processing Manual, Chapter 26, Section 10.5, which is attached to Change Request (CR) 3819, the official instruction issued to your

carrier/DMERC regarding this change. That instruction may be found by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the Centers for Medicare & Medicaid (CMS) Web site. From that Web page, look for CR 3819 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/DMERC. To find that toll-free telephone number, go to ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

An Algorithmic Approach to Determine if Mobility Assistive Equipment Is Reasonable and Necessary for Medicare Beneficiaries with a Personal Mobility Deficit (CR 3791-Mobility Assistive Equipment (MAE))

Medlearn Matters Number: MM3791
Related Change Request (CR) #: 3791
Related CR Release Date: June 3, 2005
Related CR Transmittal #: 37 and 574
Effective Date: May 5, 2005
Implementation Date: July 5, 2005

The following information affects providers billing Medicare durable medical equipment regional carriers (DMERCs) and/or fiscal intermediaries (FIs) for mobility assistive equipment (MAE).

Provider Action Needed

Impact to You

This article includes information from Change Request (CR) 3791, in which the Centers for Medicare & Medicaid Services (CMS) addresses numerous items that it has termed MAE.

What You Need to Know

MAE includes (but is not limited to) canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. CMS determines that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations **in the home**. Determination of the presence of a mobility deficit will be made by an algorithmic process (as outlined in the Clinical Criteria for MAE Coverage included in this article) to provide the appropriate MAE to correct the mobility deficit.

What You Need to Do

You should sequentially consider specific questions in CR 3791 that provide clinical guidance for the coverage of equipment (of appropriate type and complexity) to restore the beneficiary's ability to participate in Mobility-Related Activities of Daily Living (MRADLs) (toileting, feeding, dressing, grooming, bathing, etc.) in customary locations **in the home**. These questions correspond to the numbered decision points on the Clinical Criteria for MAE Coverage flow chart in CR 3791. That chart is also included in this article.

Background

Recently, considerable public interest has been focused on the provision of wheelchairs under the Medicare benefit. The agency has responded with a multi-faceted plan to ensure the appropriate prescription of wheelchairs to beneficiaries who need them. One facet of this plan is the delineation of suggested clinical conditions of wheelchair coverage. CMS solicited public comment through a number of open door forums and other methods. Many advocacy groups suggested that the agency adopt a function-based interpretation of its historical "bed- or chair-confined" criterion for wheelchair coverage.

CMS believes that an algorithmic process that sequentially considers the appropriate "Mobility Assistive Equipment" that corrects the mobility deficit is the appropriate process to follow in covering MAEs. CMS believes that the Clinical Criteria for MAE Coverage, in Section 280.3, Chapter 1, of Medicare Publication 100-03 (Medicare National Coverage Determinations), sufficiently describes this process. Utilizing such a process will ensure that the beneficiary (or caregiver) is able to maintain as much independence as physically and mentally possible, thereby ensuring the beneficiary's MRADLs are maintained.

CMS is extending national coverage regarding MAE for beneficiaries who have a personal mobility deficit sufficient to impair their participation in MRADLs such as toileting, feeding, dressing, grooming, and bathing in

customary locations **in the home**. Determination of the presence of a mobility deficit will be made by an algorithmic process, as outlined in the Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters. CR 3791 instructs Medicare carriers, DMERCs, and regional home health intermediaries (RHHIs) to:

- Disregard the "bed- or chair-confined" criterion which has been historically used to determine if a wheelchair is reasonable and necessary as defined by the Social Security Act (Section 1862(A)(1)(a)).
- Use the algorithmic approach as outlined in the Medicare National Coverage Determinations (NCD) Manual (Pub. 100-03, Section 280.3), Clinical Criteria for MAE Coverage (and included below) to determine coverage eligibility of MAE. MAE includes, but is not limited to, canes, crutches, walkers, manual wheelchairs, power wheelchairs, and scooters.

As in other cases, if data analysis indicates potentially aberrant billing, Medicare DMERCs and FIs will use these standards when performing medical review of claims.

Medicare beneficiaries may require mobility assistance for a variety of reasons and for varying durations because the etiology of the disability may be due to a congenital cause, injury, or disease. Thus, some beneficiaries experiencing temporary disability may need mobility assistance on a short-term basis, while in contrast, those living with chronic conditions or enduring disabilities will require mobility assistance on a permanent basis. In addition, Medicare beneficiaries who depend upon mobility assistance are found in varied living situations. Some may live alone and independently while others may live with a caregiver or in a care facility. The beneficiary's environment is relevant to the determination of the appropriate form of mobility assistance that should be employed.

For many patients, a device of some sort is compensation for the mobility deficit. However, some beneficiaries experience co-morbid conditions that can impact their ability to safely utilize MAE independently or to successfully regain independent function even with mobility assistance. The functional limitation (as experienced by a beneficiary) depends on:

- The beneficiary's physical and psychological function,
- The availability of other support, and
- The beneficiary's living environment.

A few examples include muscular spasticity, cognitive deficits, the availability of a caregiver, and the physical layout, surfaces, and obstacles that exist in the beneficiary's living environment.

Nationally Covered Indications

Effective May 5, 2005, CMS finds that the evidence is adequate to determine that MAE is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their performance of MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary areas **in the home**. **Determination of the presence of a mobility deficit will be made by an algorithmic process, Clinical Criteria for MAE Coverage, to provide the appropriate MAE to correct the mobility deficit.**

Clinical Criteria for MAE Coverage

The beneficiary, the beneficiary's family or other caregiver, or a clinician, will usually initiate the discussion and consideration of MAE use. **Sequential consideration of the questions below provides clinical guidance for the coverage of equipment of appropriate type and complexity to restore the beneficiary's ability to participate in MRADLs such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.** These questions correspond to the numbered decision points on the accompanying flow chart.

1. **Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more MRADLs in the home? A mobility limitation is one that:**
   a. Prevents the beneficiary from accomplishing the MRADLs entirely, or,
   b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in MRADLs, or,
   c. Prevents the beneficiary from completing the MRADLs within a reasonable time frame.
2. **Are there other conditions that limit the beneficiary's ability to participate in MRADLs at home?**
   a. Some examples are significant impairment of cognition or judgment and/or vision.
   b. For these beneficiaries, the provision of MAE

might not enable them to participate in MRADLs if the co-morbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with MAE.

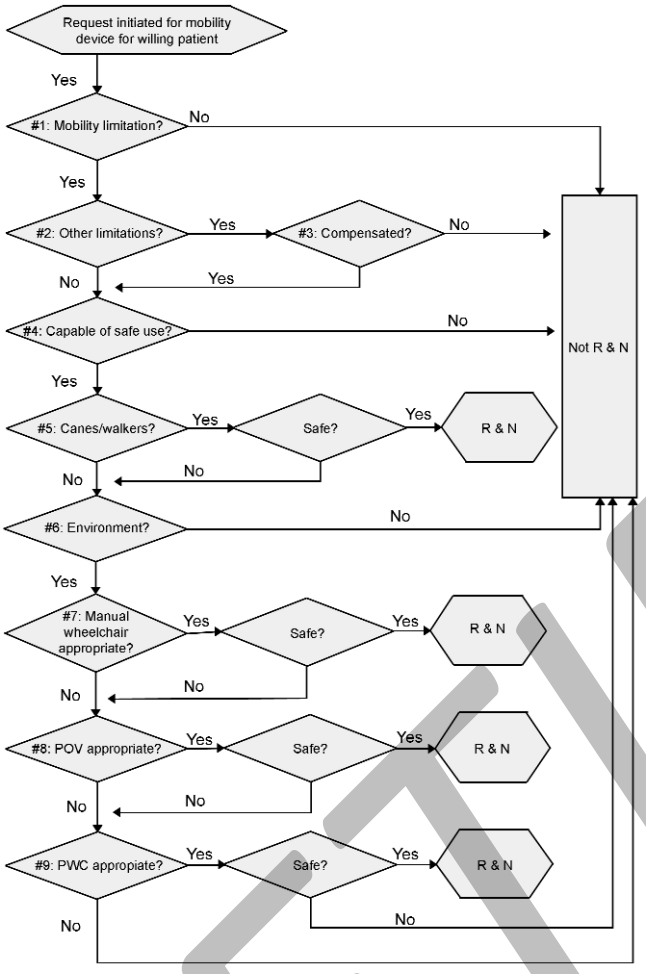
3. **If these other limitations exist, can they be ameliorated or compensated sufficiently such that the additional provision of MAE will be reasonably expected to significantly improve the beneficiary's ability to perform or obtain assistance to participate in MRADLs in the home?**
   a. A caregiver, for example a family member, may be compensatory, if consistently available in the beneficiary's home and willing and able to safely operate and transfer the beneficiary to and from the wheelchair and to transport the beneficiary using the wheelchair. The caregiver's need to use a wheelchair to assist the beneficiary in the MRADLs is to be considered in this determination.
   b. If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair coverage if it results in the beneficiary continuing to have a significant limitation. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of MAE.
4. **Does the beneficiary or caregiver demonstrate the capability and the willingness to consistently operate the MAE safely?**
   a. Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
   b. A history of unsafe behavior in other venues may be considered.
5. **Can the functional mobility deficit be sufficiently resolved by the prescription of a cane or walker?**
   a. The cane or walker should be appropriately fitted to the beneficiary for this evaluation.
   b. Assess the beneficiary's ability to safely use a cane or walker.
6. **Does the beneficiary's typical environment support the use of wheelchairs including scooters/power-operated vehicles (POVs)?**
   a. Determine whether the beneficiary's environment will support the use of these types of MAE.
   b. Keep in mind such factors as physical layout, surfaces, and obstacles, which may render MAE unusable in the beneficiary's home.
7. **Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair in the home to participate in MRADLs during a typical day? The manual wheelchair should be optimally configured (seating options, wheelbase, device weight, and other appropriate accessories) for this determination.**
   a. Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
   b. A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. lightweight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
   c. The beneficiary's home should provide adequate access, maneuvering space, and surfaces for the operation of a manual wheelchair.
   d. Assess the beneficiary's ability to safely use a manual wheelchair.

   (**Note**: If the beneficiary is unable to self-propel a manual wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair may be appropriate.)
8. **Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?**
   a. A POV is a 3- or 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation.
   b. The beneficiary's home should provide adequate access, maneuvering space, and surfaces for the operation of a POV.
   c. Assess the beneficiary's ability to safely use a POV/scooter.
9. **Are the additional features provided by a power wheelchair needed to allow the beneficiary to participate in one or more MRADLs?**
   a. The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
   b. The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
   c. The beneficiary's home should provide adequate access, maneuvering space, and surfaces for the operation of a power wheelchair.
   d. Assess the beneficiary's ability to safely use a power wheelchair.

   Note: If the beneficiary is unable to use a power wheelchair, and if there is a caregiver who is available, willing, and able to provide assistance, a manual wheelchair is appropriate. A caregiver's inability to

operate a manual wheelchair can be considered in covering a power wheelchair so that the caregiver can assist the beneficiary.

Clinical Criteria for MAE Coverage



Nationally Noncovered Indications

Medicare beneficiaries **not** meeting the clinical criteria for prescribing MAE as outlined above, and as determined by the beneficiary's physician, would **not** be eligible for Medicare coverage of the MAE.

Note: All other durable medical equipment (DME) not meeting the definition of MAE as described in this instruction will continue to be covered, or noncovered, as is currently described in the NCD Manual at Section 280, Medical and Surgical Supplies. Also note that CR 3791 revises the Medicare NCD Manual (Pub. 100-03, Section 280.3), and this revision is an NCD made under the Social Security Act (Section 1862(a)(1)). NCDs are binding on all carriers, fiscal intermediaries, quality improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see the Code of Federal Regulations (CFR), Title 42, Sections 405.732, 405.860). An NCD that expands coverage is also binding on a Medicare Advantage organization. In addition, an administrative law judge may not review an NCD. (See the Social Security Act Section 1869(f)(1)(A)(i).)

Implementation

The implementation date for this instruction is July 5, 2005. Your DMERC or FI will adjust claims affected by this change, but processed before July 5, 2005, if you bring such claims to the attention of the DMERC/FI.

Additional Information

For complete details, please see the official instruction issued to your DMERC or FI regarding this change. That instruction includes the complete Section 280.3, and the instruction may be viewed by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

From that Web page, look for CR 3791 in the CR NUM column on the right, and click on the files for that CR. You will note two files for CR 3791. The file reflecting transmittal number 37 contains the revisions to the Medicare NCD Manual, and the file with transmittal number 574 contains the Medicare claims processing business requirements/instructions. If you have any questions, please contact your DMERC/FI at their toll-free number, which may be found at ***www.cms.hhs.gov/medlearn/tollnums.asp***

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

Medlearn Matters Number: MM3843
Related Change Request (CR) #: 3843
Related CR Release Date: May 6, 2005
Related CR Transmittal #: 35
Effective Date: April 4, 2005
Implementation Date: June 6, 2005

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

and fiscal intermediaries (FIs), for obstructive sleep apnea (OSA)-related claims.

Provider Action Needed

Providers need to be aware that on April 4, 2005, the Centers for Medicare & Medicaid Services (CMS) declared that the national coverage policy for continuous positive airway pressure (CPAP) therapy for OSA will remain unchanged. Unattended home sleep testing for the diagnosis of OSA is **not** considered reasonable and necessary. Polysomnography must be performed in a facility-based sleep study laboratory, not in the home or a mobile facility.

Background

Change Request (CR) 3843 is updating and confirming the National Coverage Determination (NCD) policy Section 240.4 of the Medicare NCD Manual (Pub. 100-03), which states that polysomnography must be performed in a facility-based sleep study laboratory, not in the home or a mobile facility. The use of CPAP is covered under Medicare when used in adult patients with moderate or severe OSA for whom surgery is a likely alternative to CPAP. The use of CPAP devices must be ordered and prescribed by the licensed treating physician to be used in adult patients with moderate to severe OSA if either of the following criteria using the apnea-hyopopnea index (AHI) is met:

- AHI greater than or equal to fifteen (15) events per hour, or
- AHI greater than or equal to five (5) and less than or equal to fourteen (14) events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of two (2) hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected). Apnea is defined as a cessation of airflow for at least ten (10) seconds. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent oxygen desaturation.

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

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

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

Implementation

The implementation date of CR 3843 is June 6, 2005.

Additional Information

The Healthcare Common Procedure Coding System (HCPCS) codes that can be used for billing covered Medicare CPAP devices and various accessories are E0601, A7030-A7039, A7044-A7046, and E0561-E0562. For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp***

From that Web page, look for CR 3843 in the CR NUM column on the right, and click on the file for the desired CR. For additional information relating to this issue, please refer to your carrier/DMERC/intermediary. To find their toll-free telephone numbers go to: ***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, 2004
Implementation Date: February 18, 2005
Note: This article was revised on June 6, 2005, to show that the correct effective date (as shown above) was December 17, 2004.

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 Change Request (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, Current Procedural Terminology (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***

Coverage and Billing for Ultrasonic Stimulators for Nonunion Fracture Healing

Medlearn Matters Number: MM3836
Related Change Request (CR) #: 3836
Related CR Release Date: June 24, 2005 **Revised**
Related CR Transmittal #: 41 and 597
Effective Date: April 27, 2005
Implementation Date: August 1, 2005
Note: This article was revised on July 15, 2005, to show that, effective for services performed on or after April 27, 2005, that meet the coverage criteria for Current Procedural Terminology (CPT) code 20979, payment will be made by Medicare carriers and rural home health intermediaries (RHHIs). Originally, the article incorrectly said carriers and fiscal intermediaries (FIs).

The following information affects physicians, providers, and suppliers billing Medicare carriers and intermediaries, including RHHIs and durable medical equipment regional carriers (DMERCs), for ultrasonic osteogenic stimulators.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 3836 which informs physicians, providers, and suppliers that the Centers for Medicare & Medicaid Services (CMS) announced a reconsideration of the National Coverage Determination (NCD) covering the use of ultrasonic osteogenic stimulators, effective April 27, 2005.

What You Need to Know

Upon reconsideration of the existing policy, CMS determined that Ultrasound Stimulation for Nonunion Fracture Healing will remain covered with an additional expansion of coverage to patients without prior surgeries to the non-healing fracture.

What You Need to Do

See the "Background" section of this article for further details regarding this change.

Background

CMS announced a reconsideration of the NCD covering the use of ultrasonic osteogenic stimulators, effective April 27, 2005. An ultrasonic osteogenic stimulator is a non-invasive device that emits low intensity, pulsed ultrasound signal to stimulate fracture healing. The device is applied to the surface of the skin at the fracture site and ultrasound waves are emitted via a conductive coupling gel to stimulate fracture healing. An ultrasonic osteogenic stimulator:

- Is not to be used concurrently with other non-invasive osteogenic devices; and
- Is intended for use with cast immobilization.

Nationally Covered Indications

Ultrasonic osteogenic stimulators are covered as medically reasonable and necessary for the treatment of nonunion fractures when the following is demonstrated:

- A minimum of two sets of radiographs is obtained prior to starting treatment with the osteogenic stimulator, each separated by a minimum of 90 days. Each radiograph must include multiple views of the fracture site accompanied by a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.

The national noncoverage policy relating to ultrasonic osteogenic stimulators for fresh fractures and delayed unions remains in place. In addition, nonunion fractures of the skull, vertebrae, and tumor-related fractures are excluded from coverage.

Effective for services performed on or after April 27, 2005, Medicare will cover an osteogenic stimulator for beneficiaries who meet the criteria described above. Carriers and RHHIs will allow payment for an osteogenic stimulator with the following CPT code:

- 20979 - Low intensity ultrasound stimulation to aid bone healing, noninvasive (nonoperative)

- DMERCs will allow payment for osteogenic stimulators with the following Healthcare Common Procedure Coding System (HCPCS) codes:
  - E0760 for low intensity ultrasound, or
  - E1399 for other ultrasound stimulation.
- RHHIs pay for the ultrasonic osteogenic stimulator only when the services are submitted on types of bills (TOBs) 32X, 33X, or 34X.
- **Home Health Agencies (HHAs) need to know** that this ultrasonic osteogenic stimulator must be in the patient's home health plan of care if billed on TOBs 32X or 33X. HHAs billing on TOBs 32X, 33X, and 34X for the osteogenic stimulator will be paid based on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.
- **Hospitals need to know** that they cannot bill for the ultrasonic osteogenic stimulator. Hospitals may only instruct patients on how to use the ultrasonic osteogenic stimulator and **not** provide the ultrasonic osteogenic stimulator.

Implementation

The implementation date for this change is August 1, 2005.

Additional Information

See the Medicare NCD Manual (Pub. 100-03), Section 160.11 (Osteogenic Stimulators) at the following CMS Web site: ***www.cms.hhs.gov/manuals/103_cov_determ/ncd103c1_Part2.pdf***

For more information about the medical coverage of clinical trials, see the following CMS Web site: ***www.cms.hhs.gov/coverage/8d.asp***

For complete details on this change, please see the official instruction issued to your carrier/DMERC/

intermediary regarding this change. That instruction may be viewed by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** From that Web page, look for CR 3836 in the CR NUM column on the right, and click on the files for that CR. You will note two files for CR 3836. The file with transmittal number 41 is the NCD itself, and the file with transmittal number 597 contains the billing requirements.

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

Cochlear Implantation

Medlearn Matters Number: MM3796
Related Change Request (CR) #: 3796
Related CR Release Date: June 24, 2005 **Revised**
Related CR Transmittal #: 42 and 601
Effective Date: April 4, 2005
Implementation Date: July 25, 2005
Note: This article was revised on August 1, 2005, to correct the statement in item 3, under the "Billing Requirements for Cochlear Implantation When Billing FIs and Carriers" subsection of the "Additional Information" section, to reflect the correct usage of the QV modifier.

The following information affects physicians and providers billing Medicare carriers and fiscal intermediaries (FIs) for cochlear implantation services to Medicare patients.

Provider Action Needed

Impact to You

The coverage for cochlear implantation has expanded and is effective for services performed on or after April 4, 2005.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) will cover treatment of bilateral pre- or post-linguistic, sensorineural, moderate-to-profound hearing loss for individuals with hearing test scores equal to or less than 40 percent (%) correct in the best-aided listening condition on tape-recorded tests of open-set sentence recognition. More detailed coverage requirements are further listed in this article.

Additionally, CMS will cover cochlear implants of individuals with open-set sentence recognition test scores of greater than 40 percent to less than or equal to 60 percent correct, where the device was implanted in an acceptable clinical trial/study. See further details listed below.

What You Need to Do

This revision is a binding National Coverage Determination (NCD) made under Section 1862(a)(1) of the Social Security Act. The remainder of this article provides more detailed billing instructions for these services.

Background

A cochlear implant device is an electronic instrument, part of which is implanted surgically to stimulate auditory nerve fibers, and part of which is worn or carried by the individual to capture, analyze, and code sound. The purpose of implanting the device is to provide awareness and identification of sounds and to facilitate communication for persons who are moderately to profoundly hearing impaired. Cochlear implant devices are available in single-channel and multi-channel models.

Additional Information

The information in this section outlines the policy guidelines for cochlear implantation coverage, the coverage criteria for an acceptable clinical trial/study, billing requirements for cochlear implantation, and a listing of Healthcare Common Procedural Coding System (HCPCS) associated with cochlear implantation.

Nationally Covered Indications

Medicare coverage is provided only for those patients who meet **all** of the following selection guidelines.

- Diagnosis of bilateral moderate-to-profound sensorineural hearing impairment with limited benefit (test scores of less than or equal to 40 percent correct in the best-aided listening condition on tape-recorded tests of open-set sentence cognition) from appropriate hearing (or vibrotactile) aids;
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation;
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system;
- No contraindications to surgery; and
- The device must be used in accordance with Food and Drug Administration (FDA)-approved labeling.

Criteria for Acceptable Clinical Trials and Studies

The coverage criteria that allows for services for individuals meeting the above guidelines and with hearing test scores greater than 40 percent and less than or equal to 60 percent requires the provider to participate in and the patient to enroll in an acceptable clinical trial/study, which includes the following:

- FDA-approved category B investigational device exemption clinical trial as defined in 42 CFR 405.201;
- Trial under the CMS clinical trial policy as defined in Section 310.1 of the Medicare National Coverage Determinations Manual; or a
- Prospective, controlled comparative trial approved by CMS as consistent with the evidentiary requirements for national coverage analyses and meeting specific quality standards.

Billing Requirements for Cochlear Implantation When Billing FIs and Carriers

These services should be billed on an approved electronic claim form or a paper CMS-1500 form. For services performed on and after April 4, 2005:

Medicare contractors (FIs and carriers) pay for:

1. Cochlear implant devices and services for moderate-to-profound hearing loss in patients with hearing test scores equal to or less than 40 percent.
2. Cochlear implant devices for patients with hearing test scores of greater than 40 percent to less than or equal to 60 percent hearing provided in a clinical trial setting that is billed with the QR modifier.
3. Other services related to cochlear implantation, but not the device itself, for patients with hearing test scores of greater than 60 percent hearing who are in a clinical trial. (These services must be identified with a QV modifier.)
4. Services for patients with hearing test scores of greater than 40 percent to less than or equal to 60 percent hearing who are in a prospective, controlled comparative trial approved by CMS. (These services must be billed with the QR modifier.)
5. Any covered diagnostic audiology or therapy services related to the cochlear implant. (The QR or QV does not need to be applied to HCPCS 92601-92604, 92506, and 92507.)

Also, when billing FIs for cochlear implantations, follow these additional instructions:

1. Submit claims on the following bill types (TOB):
   a. 11x
   b. 12x
   c. 13x
   d. 83x (for non-Outpatient Prospective Payment System (OPPS) providers)
   e. 85x
2. Report diagnosis code V70.7 (Examination of participant in clinical trial) as the second or subsequent diagnosis code, along with the appropriate principal diagnosis code, for patients in a clinical trial.

HCPCS Associated with Cochlear Implantation

Some of the HCPCS codes used when billing for cochlear implant services and devices provided by audiologists or physicians, and for the services of 92506 and 92507, by speech language pathologists include:

1. 69930 - Cochlear device implantation, with or without mastoidectomy
2. L8614 - Cochlear Device/System
3. L8619 - Cochlear implant external speech processor, replacement
4. L7500 - Repair of prosthetic device, hourly rate (excludes V5335 repair of oral laryngeal prosthesis or artificial larynx)
5. L7510 - Repair of prosthetic device, repair or replace minor parts
6. 92506 - Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
7. 92507 - Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
8. 92601 - Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming
9. 92602 - Diagnostic analysis of cochlear implant, patient under 7 years of age; subsequent programming **(Do not report 92602 in addition to 92601.)**
10. 92603 - Diagnostic analysis of cochlear implant, age 7 years or older; with programming

Note: Codes 92601 and 92603 describe post-operative analysis and fitting of previously placed external devices, connection to the cochlear implant, and programming of the stimulator. Codes 92602 and 92604 describe subsequent sessions for measurements and adjustment of the external transmitter and re-programming of the internal stimulator.

Medicare beneficiaries **not** meeting **all** of the coverage criteria for cochlear implantation specified above, or the specific coverage criteria for cochlear implantation in the context of a clinical trial/study, also specified above, are deemed **not** eligible for Medicare coverage under Section 1862(a)(1)(A) of the Social Security Act. An NCD revision is binding on all carriers, FIs, quality

improvement organizations, health maintenance organizations, competitive medical plans, health care prepayment plans, the Medicare Appeals Council, and administrative law judges (see 42 CFR Sections 405.732, 405.860). Because it expands coverage, the NCD is also binding on a Medicare Advantage organization. In addition, an administrative law judge may not review an NCD. (See Section 1869(f)(1)(A)(i) of the Social Security Act.)

The official instruction issued to your FI or carrier regarding this change may be found by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** From that Web page, look for Change Request (CR) 3796 in the CR NUM column on the right, and click on the file(s) for that CR. You will note two files for CR 3796. The file with transmittal number 42 is the NCD itself, and the file with transmittal number 601 contains the claims processing instructions.

For additional information relating to this issue, please refer to your local carrier or FI. To find the toll-free telephone number for your local carrier, go to: ***www.cms.hhs.gov/medlearn/tollnums.asp***

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

Medlearn Matters Number: MM3888
Related Change Request (CR) #: 3888
Related CR Release Date: June 24, 2005 **Revised**
Related CR Transmittal #: 591
Effective Date: October 1, 2005
Implementation Date: October 3, 2005
Note: This article was revised on July 1, 2005. The original article indicated that Chapter 23, Section 10.2 of the Medicare Claims Processing Manual was revised as a result of Change Request (CR) 3888. In fact, the manual was not revised, but was only referenced by CR 3888.

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

Provider Action Needed

Impact to You

Medicare will soon issue the annual update of the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* to Medicare contractors. This update will apply for claims with service dates on or after October 1, 2005, and discharges and through dates on or after October 1, 2005, for institutional providers.

What You Need to Know

An ICD-9-CM code is required for all professional claims, e.g., physicians, non-physician practitioners, independent clinical diagnostic laboratories, occupational and physical therapists, independent diagnostic testing facilities, audiologist, ambulatory surgical centers (ASCs), and for all institutional claims, but **not** for ambulance supplier claims. **Remember that as of October 1, 2004, Medicare no longer provides a 90-day grace period for physicians, practitioners, and suppliers to use in billing discontinued ICD-9-CM diagnosis codes.**

What You Need to Do

Be ready to use the updated codes on October 1, 2005. Please refer to the "Background" and "Additional Information" sections of this article for further details regarding this instruction.

Background

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

- Dates of service on or after October 1, 2005, and
- Discharges and through dates on or after October 1, 2005, for institutional providers

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

- Beginning in 1979, ICD-9-CM codes became mandatory for reporting provider services on form CMS-1450.
- On April 1, 1989, the use of ICD-9-CM diagnosis codes became mandatory for all physician services submitted on form CMS-1500.
- Effective October 1, 2003, an ICD-9-CM diagnosis code was required on all paper and electronic claims billed to Medicare carriers with the exception of ambulance claims (specialty type 59) (see Change Request (CR) 2725, dated June 6, 2003, at ***www.cms.hhs.gov/manuals/pm_trans/B03045.pdf***).

Important Note: Effective for dates of service on and after October 1, 2004, CMS no longer provided a 90-day grace period for physicians, practitioners, and suppliers to use in billing discontinued ICD-9-CM diagnosis codes on Medicare claims. The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets be date-of-service compliant, and ICD-9-CM diagnosis codes are a medical code set (see CR 3094, dated February 6, 2004, at: ***www.cms.hhs.gov/manuals/pm_trans/R95CP.pdf***).

Additional Information

Publication of ICD-9-CM Codes

- Updated ICD-9-CM codes are published in the Federal Register in April/May of each year as part of the Proposed Changes to the Hospital Inpatient Prospective Payment System, and are effective each October first. Physicians, practitioners, and suppliers **must** use the current and valid diagnosis code that is in effect beginning October 1, 2005.
- After the ICD-9-CM codes are published in the Federal Register, CMS places the new, revised, and discontinued codes on the following Web site: ***www.cms.hhs.gov/medlearn/icd9code.asp***. The update should be available at this site in June.
- The updated ICD-9-CM diagnosis codes can also be viewed at the National Center for Health Statistics (NCHS) Web site at: ***www.cdc.gov/nchs/icd9.htm***. This posting should be available at this site in June.
- Providers are also encouraged to purchase a new ICD-9-CM book or CD-ROM on an annual basis.

Implementation

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

Related Instructions

The ICD-9-CM codes are updated annually as stated in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 23 (Fee Schedule Administration and Coding Requirements), Section 10.2 (Relationship of ICD-9-CM Codes and Date of Service). That manual may be accessed at ***www.cms.hhs.gov/manuals/104_claims/clm104index.asp*** on the CMS Web site.

The official instruction issued to your carrier can be found by going to: ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** From that Web site, look for CR 3888 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 intermediary at their toll-free number which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp***

Correction to the Use of Group Codes for the Enforcement of Mandatory Electronic Submission of Medicare Claims

Medlearn Matters Number: MM3815
Related Change Request (CR) #: 3815
Related CR Release Date: April 29, 2005
Related CR Transmittal #: 541
Effective Date: July 1, 2005
Implementation Date: July 5, 2005

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

Provider Action Needed

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

Background

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

Additional Information

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

From that Web page, look for Change Request (CR) 3815 in the CR NUM column on the right, and click on the file for the desired CR. For additional information relating to this issue, please refer to your local FI, carrier, RHHI, or DMERC. Their toll-free telephone numbers may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

Update to the NCPDP Batch Standard 1.1 Billing Request Companion Document

Medlearn Matters Number: MM3882
Related Change Request (CR) #: 3882
Related CR Release Date: June 10, 2005
Related CR Transmittal #: 579
Effective Date: July 11, 2005
Implementation Date: September 12, 2005

The following information affects durable medical equipment providers, billing agents, or clearinghouses that submit retail pharmacy drug claims electronically to Medicare durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Providers need to be aware that Medicare will *only* accept a value of "1" in field number 337-4C (Coordination of Benefits/Other Payments Count) of the National Council for Prescription Drug Program (NCPDP) Companion Document. Previously, the Coordination of Benefits/Other Payments Count field accepted a value of 1-3. Medicare will only accept one primary payer and will reject claims with any value in field 337-4C other than "1." In addition, please note the following changes:

- For Data Element 412-DC (Dispensing Fee Submitted), the Centers for Medicare & Medicaid Services (CMS) has added codes G0369, G0370, G0371, and G0374 to the NCPDP companion document along with associated pricing information. See the Medlearn Matters article MM3620 for an explanation of these codes. That article is available at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3620.pdf*** on the CMS Web site.
- CMS had added Data Element 438-E3 (Incentive Amount Submitted) to the NCPDP companion document, in which suppliers should include the $50.00 fee allowed by Medicare for G0369.
- For Data Element 451-EG (Compound Dispensing Unit Form Indicator), CMS has added the following values to the NCPDP companion document:
  - 1 = each
  - 2 = gram
  - 3 = milliliters

Implementation

Medicare will implement these changes on September 12, 2005.

Additional Information

CMS published a companion document to supplement the *NCPDP VERSION 5.1 BATCH TRANSACTION STANDARD 1.1 BILLING REQUEST For Exchanges With Medicare DMERCs*. These are revised instructions and the companion document is available at:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp From that Web page look for Change Request (CR) 3882 in the CR NUM column on the right and then click on that file. Within that file are the official instructions issued to your DMERC regarding this CR.

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

DMERC A Billers: The revised National Council for Prescription Drug Program (NCPDP) Batch Standard 1.1 Billing Request Companion Document is also available via the "EDI & HIPAA - Resources" section of the DMERC A Web site or directly at ***www.umd.nycpic.com/NCPDPcompaniondoc.pdf***. (**Note**: This is a Portable Document Format (PDF) file, so please follow the download instructions for proper viewing and printing.)

Clarification for Carriers and Durable Medical Equipment Regional Carriers (DMERCs) About Correction and Recoupment of Payments for Previously Processed Claims

Medlearn Matters Number: MM3772
Related Change Request (CR) #: 3772
Related CR Release Date: July 22, 2005
Related CR Transmittal #: 618

Effective Date: January 1, 2006
Implementation Date: January 3, 2006

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

Provider Action Needed

Impact to You

This is a one-time notice that provides clarification about correction and recoupment of payments for previously processed Medicare claims.

What You Need to Know

Be aware of actions that could impact your payments.

What You Need to Do

When a previously processed claim needs to be adjusted, a full claim adjustment must be done. This will happen regardless of whether Medicare is primary or secondary.

Background

Previously, Medicare's Change Request (CR) 1523 required that carriers and DMERCs make a full claim adjustment whenever an adjustment was processed for a claim that was previously adjudicated. CR 3772 reiterates CR 1523 by requiring a full claim adjustment when money is recouped from providers whether the claim is a Medicare Secondary Payer (MSP) claim or non-MSP.

If money needs to be recouped, the previous payment is negated, and a new payment is recognized if payment is being reduced, and Medicare creates an account receivable in the amount that was overpaid. If there is no payment due, the previous payment is reversed, and an account receivable is created in the same amount as that previously paid. Should you receive a demand letter from Medicare as a result of such an adjustment and overpayment, the letter will identify:

- The claim,
- The overpayment amount,
- When the overpayment must be repaid, and
- A Financial Control Number for tracking purposes.

If payment is made timely, Medicare will adjust its system to reflect the overpayment was made. However, if payment is not received timely, Medicare will adjust payments on future claims to obtain repayment.

Implementation

The implementation date for this instruction is January 3, 2006.

Related Instructions

Complete details of CR 1523, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification - Implementation of Version 4010 of the Accredited Standards Committee X12 835 (Payment/Remittance Advice) Transaction Standard Format, may be viewed at:
www.cms.hhs.gov/manuals/pm_trans/B0135.pdf

Additional Information

The official instruction issued to your carrier/DMERC regarding this change may be found at:
www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp From that Web page, look for CR 3772 in the CR NUM column on the right and click on the file for the desired CR.

For additional information relating to this issue, please contact your carrier/DMERC via their toll-free number. That number may be found at:
www.cms.hhs.gov/medlearn/tollnums.asp

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Medlearn Matters Number: MM3923
Related Change Request (CR) #: 3923
Related CR Release Date: July 22, 2005
Related CR Transmittal #: 609
Effective Date: October 1, 2005
Implementation Date: October 3, 2005

The following information affects physicians, providers, and suppliers who submit claims to Medicare contractors (carriers, fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), and durable medical equipment regional carriers (DMERCs)) for services.

Provider Action Needed

Impact to You

The complete list, including changes made from November 1, 2004, through February 28, 2005, of X12N 835 Health Care Remittance Advice Remark

Codes and X12N 835 Health Care Claim Adjustment Reason Codes can be found at: ***www.wpc-edi.com/codes***

What You Need to Know
Please refer to the "Additional Information" section of this article for remark and reason code changes approved February 28, 2005.

What You Need to Do
Be sure your staff is aware of these changes.

Background

Two code sets, reason and remark code sets, must be used to report payment adjustments, appeal rights, and related information for transactions 835 (Health Care Claim Payment/Advice), 837 Coordination of Benefits (COB), and on standard paper remittance advice. Medicare contractors must use currently valid codes. An updated code list is published three (3) times per year. Medicare contractors are informed of these changes through recurring code updates (such as this article and corresponding Change Request (CR) 3923), and/or through a specific CR that describes the change in policy that resulted in the code change.

The remittance advice remark code list is maintained by the Centers for Medicare & Medicaid Services (CMS). However additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities.

- Medicare contractors must use **modified codes** for codes currently used by Medicare even if the modification was initiated by an entity other than Medicare.
- Medicare contractors do not have to use **new codes** initiated by an entity other than Medicare, unless otherwise instructed by Medicare.
- Medicare contractors must stop using a code that has been deactivated either by the effective date of deactivation, or the effective date established by the code update CR.

The health care claim adjustment reason code list is maintained by a national Code Maintenance committee that meets three times a year when X12 meets for their trimester meetings to make decisions about additions, modifications, and retirement of existing reason codes. This updated list is posted thrice per year.

- Reason code changes requested by Medicare may be included in a Medicare instruction in addition to the regular code update notification.
- Reason codes may be retired if they are no longer applicable, or if a similar code exists.
- Retirements are effective for a specified future and succeeding versions, but Medicare contractors can also discontinue use of retired codes in prior versions.
- The regular code update notification will establish the deadline for Medicare contractors to retire a reason code that could be earlier than the version specified in the Washington Publishing Company (WPC) posting.

Additional Information

Remark and reason code changes approved by Medicare February 28, 2005, include:

Code Type	Code	New/Modified /Deactivated/ Retired	Current Narrative	Comment
Remark	N345	New	Date range not valid with units submitted	Not Medicare Initiated
Remark	N346	New	Missing/incomplete/invalid oral cavity designation code	Not Medicare Initiated
Remark	N347	New	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.	Medicare Initiated
Remark	MA100	Modified	Missing/incomplete/invalid date of current illness or symptoms	Modified effective as of March 30, 2005
Remark	MA128	Modified	Missing/incomplete/invalid FDA approval number	Modified effective on March 30, 2005
Reason	166	New	These services were submitted after this payer's responsibility for processing claims under this plan ended.	New as of February 2005

Note: Typographic errors were also identified and corrected in reason codes 52, 57, 70, 76, and 146. No codes were retired.

For additional information about remittance advice, please refer to: "Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers," at: ***www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf***

The official instruction issued to your FI/carrier/DMERC/RHHI 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

3923 in the CR NUM column on the right, and click on the file for that CR.

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

Medicare Remittance Advice (RA) Initiative

A reference document titled *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers* is now available on the Medicare Learning Network's (Medlearn) Web page located at ***www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site. Chapters 1 and 2 describe a remittance advice (RA) and the components of an RA. For institutional providers, Chapter 3 includes a sample electronic remittance advice (ERA) and standard paper remittance (SPR) advice with field descriptions. Chapter 4 includes a crosswalk between ERA and SPR fields and a sample SPR with field descriptions, specifically for professional providers. At the end of Chapters 3 and 4, providers can find information on remittance balancing. Print the chapter that fits your needs! The guide also includes informative resources such as an acronym list, a glossary, and important Web sites and telephone numbers. Finally, the guide has three comprehensive indexes: 1) for key terms and concepts; 2) for institutional ERA and SPR field descriptions; and 3) professional SPR field descriptions. Check it out today!

If you are currently receiving the SPR, consider utilizing the technology available to increase productivity by switching to the ERA. Take advantage of faster communication, payment information, and reduction of paperwork by receiving the ERA. If you are receiving both an SPR and ERA, consider canceling the SPR. Please contact our Electronic Data Interchange (EDI) Department at 866-861-7348, and ask to receive the ERA and/or cancel the SPR today!

CMS Releases New Educational Guide on Remittance Advice (RA) Notices

Medlearn Matters Number: SE0540
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The following information affects all Medicare physicians, providers, suppliers, and their billing staff who submit claims to Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs).

Provider Action Needed

This Special Edition article describes the release of a national educational guide for Medicare Fee-For-Service (FFS) providers, physicians, suppliers, and their billing staff who may wish to use the guide to help increase their understanding of the remittance advice (RA). The guide is available at ***www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Background

The Medicare FFS program serves many of the more than 40 million Medicare beneficiaries enrolled in the Medicare program. Under this program, more than 1 billion claims are submitted annually for reimbursement of health care services. The claims are processed by Medicare contractors - FIs, RHHIs, carriers, and DMERCs. These Medicare contractors use the standard RA as their means to communicate to providers claim processing decisions regarding payments, adjustments, and denials, as well as data that was missing or incorrect on the incoming claims which need to be submitted or corrected before a payment decision can be made on a claim.

Every day, Medicare FFS contractors send thousands of RAs to providers. Each of these RAs conveys information that may impact the provider's Medicare business. CMS wants to be certain that providers understand how to read and interpret the RA; therefore, CMS has developed and is pleased to announce the release of *Understanding the Remittance Advice: A Guide for Medicare Providers, Physician,*

Suppliers, and Billers. This educational guide has useful information that is designed to be used as a self-help tool. The guide offers the user the following benefits:

- Easy access to general information about RAs without direct personal assistance from Medicare contractor customer service staff, thus saving valuable time
- Increased ability to understand and interpret the reasons for claim denials and claim adjustments
- Reduction in the resubmission of claims due to errors
- Rapid follow-up action, resulting in quicker payment
- A useful tool for training new staff or a refresher for experienced staff

The guide is comprised of four chapters each highlighting a specific aspect of the RA, an acronym list, a glossary, important Web sites and telephone numbers, and three comprehensive indices: 1) for key terms and concepts; 2) for institutional electronic remittance advice (ERA) and standard paper remittance (SPR) field descriptions; and 3) professional SPR field descriptions. Each chapter and/or section of the guide can be printed according to the provider's specific needs.

Print What Fits Your Needs

- **Chapters 1 and 2** describe an RA and its components.
- **Chapter 3** specifically targets institutional providers, i.e., those who submit claims to FIs and RHHIs, and includes a sample ERA and SPR with field descriptions.
- **Chapter 4** targets providers that submit claims to carriers and DMERCs and includes a crosswalk between ERA and SPR fields and a sample SPR with field descriptions, specifically for professional providers. At the end of Chapters 3 and 4, providers can find information on remittance balancing.
- **Reference A: Acronyms**, a handy tool that contains acronyms used throughout the guide.
- **Reference B: Glossary**, a list that contains terms used throughout this guide.
- **Reference C: Web Sites and Phone Numbers**, a list of Web page references and address and telephone number references that assist with submitting Medicare claims and troubleshooting denials and claim rejections.
- **Reference D: Resources**, a list of the resources that were used to compile the guide and where to find them on the CMS Web site.

Additional Information

Print copies of the guide will be available late summer of 2005. Until print copies are available, *Understanding the Remittance Advice: A Guide for Medicare Providers, Physician, Suppliers, and Billers* can be accessed electronically at ***www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf*** on the CMS Web site.

National Provider Identifier (NPI) Application Information

Starting May 23, 2005, all health care providers can apply for their National Provider Identifier (NPI). The NPI will replace health care provider identifiers in use today in standard health care transactions. All Health Insurance Portability and Accountability Act (HIPAA) covered entities except small health plans must begin using the NPI on May 23, 2007; small health plans have until May 23, 2008. For additional information, and to complete an application, visit ***https://nppes.cms.hhs.gov*** on the Web. It is important to note that the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006. Other health plans with whom you do business will instruct you as to when you may begin using the NPI in standard transactions.

Also, an instructional Web tool, called the NPI Viewlet, is now available for viewing at ***www.cms.hhs.gov/medlearn/npi/npiviewlet.asp***, and under "HIPAA Latest News" at ***www.cms.hhs.gov/hipaa/hipaa2*** on the Centers for Medicare & Medicaid Services' (CMS') Web site. This tool provides an overview of the NPI, a walkthrough of the application, as well as live links to the National Plan and Provider Enumeration System (NPPES) Web site where the learner can apply for an NPI. This tool is designed for all health care providers. In the near future, you will also be able to access the viewlet at ***https://nppes.cms.hhs.gov*** on the Web.

Provider Notification Regarding National Provider Identifier (NPI) Letter from CMS Administrator

Between May 23, 2005, and January 2, 2006, the Centers for Medicare & Medicaid Services (CMS) claims processing systems will accept an existing legacy

Medicare number and reject, as unprocessable, any claim that includes only a National Provider Identifier (NPI).

Beginning January 3, 2006, and through October 1, 2006, CMS systems will accept an existing legacy Medicare number **or** an NPI, as long as it is accompanied by an existing legacy Medicare number.

Beginning October 2, 2006, and through May 22, 2007, CMS systems will accept an existing legacy Medicare number **and/or** an NPI. This will allow for six to seven (6-7) months of provider testing before only an NPI will be accepted by the Medicare program on May 23, 2007.

Beginning May 23, 2007, CMS systems will only accept an NPI.

To apply for an NPI, visit ***https://nppes.cms.hhs.gov*** on the CMS Web site. To request a paper application, call 800-465-3203.

CMS Announces the National Provider Identifier (NPI) Enumerator Contractor and Information on Obtaining NPIs

Medlearn Matters Number: SE0528
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The following information affects all health care providers - Medicare and non-Medicare.

Provider Action Needed

Learn about the National Provider Identifier (NPI) and how and when to apply for one.

Background

The Centers for Medicare & Medicaid Services (CMS) is pleased to announce the availability of a new health care identifier for use in the HIPAA standard transactions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. On January 23, 2004, the Secretary published a Final Rule that adopted the NPI as this identifier.

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

The NPI will replace health care provider identifiers that are in use today in standard transactions. Implementation of the NPI will eliminate the need for health care providers to use different identification numbers to identify themselves when conducting HIPAA standard transactions with multiple health plans. All health plans (including Medicare, Medicaid, and private health plans) and all health care clearinghouses must accept and use NPIs in standard transactions by May 23, 2007 (small health plans have until May 23, 2008). After those compliance dates, health care providers will use only their NPIs to identify themselves in standard transactions, where the NPI is required.

Important Note: While you are urged to apply for an NPI beginning May 23, 2005, the Medicare program is not accepting the NPI in standard transactions yet. Explicit instructions on time frames and implementation of the NPI for Medicare billing will be issued later in 2006.

NPI Enumerator Contract Awarded
Recently, CMS announced the selection of Fox Systems, Inc. as the contractor, to be called the Enumerator, to perform the support operations for the NPI project. Fox Systems, Inc. will process NPI applications from health care providers and operate a help desk to assist health care providers in obtaining their NPIs.

Who may apply for the NPI?
All health care providers including individuals, such as physicians, dentists, and pharmacists, and organizations, such as hospitals, nursing homes, pharmacies, and

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

The NPI Application Process

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

- You may apply through an easy-to-use Web-based application process, beginning May 23, 2005. The Web address will be ***https://nppes.cms.hhs.gov***, but **please note - the Web site is not available until May 23, 2005**.
- Beginning July 1, 2005, you may complete a paper application and send it to the Enumerator. A copy of the application, including the Enumerator's mailing address (where you will send it) will be available on ***https://nppes.cms.hhs.gov***, or you can call the Enumerator to receive a copy. The telephone number is 800-465-3203 or TTY 800-692-2326. **But remember, paper applications may not be submitted until July 1, 2005.**
- With your permission, an organization may submit your application in an electronic file. This could mean that a professional association, or perhaps a health care provider who is your employer, could submit an electronic file containing your information and the information of other health care providers. **This process will be available in the fall of 2005.**

You may apply for an NPI using *only* one of these methods. When gathering information for your application, be sure that all of your information, such as your Social Security Number and the Federal Employer Identification Number, are correct. Once you receive your NPI, safeguard its use. If all information is complete and accurate, the Web-based process could result in you being issued a number within minutes. If there are problems with the information received, it could take longer. The paper application processing time is more difficult to estimate, depending on the information supplied in the application, the workload, and other factors.

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

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

Additional Information

For additional information on NPIs:

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

Quarterly Reminder to Apply for a National Provider Identifier (NPI)

Reminder: Health care providers are **required by law** to apply for a National Provider Identifier (NPI). To apply online, visit ***https://nppes.cms.hhs.gov***, or call 800-465-3203 to request a paper application.

Visit ***www.cms.hhs.gov/hipaa/hipaa2*** for the latest information regarding the NPI, including a transcript from the Centers for Medicare & Medicaid Services' (CMS') recent NPI Roundtable conference call.

Note*: In order for providers to easily access information about the National Provider Indentifier (NPI), including online application, DMERC A added a direct link to the home page of our Web site at: *www.umd.nycpic.com/dmerc.html

News from DMERC A…

Fee Schedule Updates

The 2005 fee schedules and subsequent updates are available via the "Fee Schedules" section of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site, ***www.umd.nycpic.com/dmfees.html***. The following notices have been posted this quarter:

- 3rd Quarter 2005 Update: Oral Anti-cancer Drug Fees
- 3rd Quarter 2005 Update: Drug Fees and Nebulizer Drug Fees

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

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

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

EDI Services

Enforcement of Mandatory Electronic Submission of Medicare Claims

Section 3 of the Administrative Simplification Compliance Act (ASCA), PL107-105, and the implementing regulation at 42 CFR 424.32, requires **all** Medicare claims for reimbursement be submitted electronically, with limited exception. Starting in July 2005, Medicare contractors, including the Region A Durable Medical Equipment Regional Carrier (DMERC A), will begin verifying that providers submitting large numbers of claims on paper fall under one of the specified exceptions. Refer to the Centers for Medicare & Medicaid Services (CMS) Medlearn Matters article MM3440, "Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims" (***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3440.pdf***), for additional information on this process.

Any provider who does not substantiate valid exception criteria for mandatory electronic submission of Medicare claims will be notified by mail of their ineligibility to submit paper claims to DMERC A. This Medicare decision is **not subject to appeal**.

One option for electronic Medicare claims submission is to acquire the low-cost software for Health Insurance Portability and Accountability Act (HIPAA)-compliant billing that is available from DMERC A - ExpressPlus. There is no charge for the software and support; there is a $25.00 fee to cover the cost of materials and processing. There are also commercial billing software programs, billing agents, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your business needs. Please visit ***www.cms.hhs.gov/providers/edi/hipaavendors.asp*** to see a list of HIPAA vendor services in your state.

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

Using the Electronic Remittance Advice (ERA)

If you are currently receiving the Standard Paper Remittance Advice (SPR), you should seriously consider switching to the Electronic Remittance Advice (ERA). As a leader in implementation of the Administrative Simplification components of the Health Insurance Portability and Accountability Act (HIPAA), the Centers for Medicare & Medicaid Services (CMS) is clearly moving toward the exclusive use of electronic Medicare transactions whenever possible. This includes discontinuing use of the SPRs in favor of the ERAs.

Beyond compliance with CMS billing requirements,

there are many factors that make it good business practice for Medicare providers to take full advantage of the ERA, such as:

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

Any provider or supplier who submits claims electronically to the Region A Durable Medical Equipment Regional Carrier (DMERC A) is eligible to receive ERAs. Providers and suppliers who currently receive both SPRs and ERAs need to initiate an implementation strategy for eliminating the use of the SPR.

More information on "Understanding the Remittance Advice: A Guide for Medicare providers, Physicians, Suppliers, and Billers" can be found on the CMS Web site at ***www.cms.hhs.gov/medlearn/RA_Guide_05-27-05.pdf***. In addition, there is an online tutorial titled, "Remittance Notices," available via the DMERC A Web site at: ***www.umd.nycpic.com/dme-eduonline.html***

Electronic Funds Transfer (EFT)

If you are currently receiving payments for Medicare claims from the Region A Durable Medical Equipment Regional Carrier (DMERC A) by paper checks, consider using Electronic Funds Transfer (EFT) instead. Your payments will be directly deposited into your bank account on a more timely basis, and you eliminate the potential for a delayed, lost, or misdirected check.

WHO: Any provider or supplier who submits claims to Medicare may elect to receive payments electronically.

HOW: The information you need to sign up for Medicare payment by EFT from DMERC A is available via the "Documents and Files" subsection, within the "Electronic Data Interchange (EDI)" section of our Web site (***www.umd.nycpic.com/dmedi.html***), under the document heading of "Electronic Funds Transfer Package." The EFT enrollment and set up process takes approximately three to four (3-4) weeks.

Bulletin Board System (BBS) Questions & Answers

The Electronic Data Interchange (EDI) Department has implemented a new telecommunications gateway (a.k.a. Bulletin Board System (BBS)) for electronic Medicare claims transactions at the Region A Durable Medical Equipment Regional Carrier (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. The following are frequently asked questions regarding the new BBS:

Q1 When I am trying to download a report, I get the error "No File Downloaded-File Skipped by Receiver." What does this mean?

A1 This error indicates that the report you are trying to download has already been downloaded and is on your hard drive.

Q2 Can I send multiple claim files in one transmission?

A2 Yes. Once a file is successfully transmitted, you may return to the main menu and send another.

Q3 How do I pull my ERAs (Electronic Remittance Advices) from the new BBS?

A3 Select option R on the main menu for Remittance and Claim Status functions. (This will bring up the menu formerly seen on the old Remittance Board.)

Q4 Do I still have to wait until after 2:00 p.m. to pull my ERAs?

A4 No, your ERAs will usually be available at or after 7:00 a.m.

Q5 Does the new BBS still shut down between 5:00 p.m. and 6:00 p.m.?

A5 No, the BBS will not shut down; however, the same operations rules apply. All files that are successfully submitted to and accepted into the BBS after 5:00 p.m. will receive a date of receipt of the following business day and will not be processed until the following business day.

Q6 How long will my reports remain on the new BBS?

A6 Your reports will be available for fifteen (15) calendar days after the date of posting to the BBS.

Q7 What do I do if I forget my BBS password?

A7 You must fax, on your company letterhead, a request to reset your BBS password to the DMERC A EDI Department at 570-735-9510. Include your submitter number and contact name and telephone number, which will be used to authenticate access privileges and maintain required security protocols.

Electronic Data Interchange (EDI) Online Training

The Electronic Data Interchange (EDI) Department has recently introduced Web-based training materials that are available via the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site (***www.umd.nycpic.com/dme-eduonline.html***). There are currently two tutorials offered under the "EDI-Specific Topics" section:

- **Installation of ExpressPlus Software** (Duration: 7 minutes)
  A step-by-step guide to installing the low-cost Medicare billing software supplied and supported by DMERC A.
- **ExpressPlus File Submission - A Guide to Submitting Claims** (Duration: 9 minutes)
  A step-by-step guide for creating batches of Medicare claims generated in ExpressPlus and for transmitting these claim batches to the DMERC A Bulletin Board System (BBS).

These tutorials supplement the information contained in the ExpressPlus User Guide, which is available via the "EDI" section of the DMERC A Web site (***www.umd.nycpic.com/dmedi.html***).

A third tutorial is under development - **How to Read the VMS Report** - a guide to locating and understanding the results of the pre-processing edits applied to electronic claims. This report is critical to detecting and correcting claims submission errors.

Additional offerings will be added on a regular basis, and the DMERC A EDI Department welcomes suggestions for new topics or for improvements to existing tutorials. Call the EDI Department at 866-861-7348 to submit any suggestions and/or improvements.

HIPAA Information

News from CMS…

Termination of HIPAA Contingency Plan for Incoming Claims

Medicare implemented a contingency plan on October 16, 2003, that allowed providers and other electronic billers to continue sending pre-Health Insurance Portability and Accountability Act (HIPAA) format electronic claims. As of June 2005, over 99.5 percent (%) of the electronic claims Medicare receives each month are now submitted in the HIPAA-compliant format. This means that less than one percent of the Medicare electronic billing providers are submitting non-HIPAA-compliant claims. Based on this progress, the Centers for Medicare & Medicaid Services (CMS) will end the Medicare HIPAA contingency plan for incoming claims.

Effective October 1, 2005, any incoming electronic claim that is in a non-HIPAA-compliant format will be rejected on the front-end. A message will be sent indicating that the claim was rejected because a non-HIPAA-compliant version or format was used.

We are committed to helping providers and other electronic billers become HIPAA-compliant. Please contact us at 866-861-7348 if we can be of assistance.

For further information, refer to the related Medlearn Matters article MM3956, "Medicare Announces End of HIPAA Contingency Plan for Claims Submissions," which can be found on the CMS Web site at: ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3956.pdf***

Access Process for Beneficiary Eligibility Inquiries/Replies (HIPAA 270/271 Transactions) (Extranet Only)

On May 20, 2005, the Centers for Medicare & Medicaid Services (CMS) released Change Request (CR) 3883, which states that CMS is making changes to its Information Technology (IT) infrastructure. The goal is to address standards for Medicare beneficiary eligibility inquiries to create the necessary database and infrastructure to provide a centralized Health Insurance Portability and Accountability Act (HIPAA)-compliant 270/271 health care eligibility inquiry and response on a real-time transaction.

On June 3, 2005, CMS released Medlearn Matters article MM3883, which presents an overview of the changes provided in CR 3883. This article was revised on June 17, 2005, because related CR 3883 was reissued on June 15, 2005. The CR release date and transmittal number have been revised, but no other changes were made to the article. The revised article may be viewed by going to CMS' Web site at:
www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3883.pdf

For complete details, including a list of data elements that will be provided in response to the 270 transaction, please see the below related article.

X12N Health Care Eligibility Benefit Inquiry and Response 270/271 Implementation

The following information is from revised Pub. 100-04, Medicare Claims Processing Manual, Chapter 31, Sections 10.1 and 10.2. The implementation date for the revision is August 22, 2005. The official instruction 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 Change Request (CR) 3883 in the CR NUM column on the right to find the link for CR 3883. Click on the link to open and view the file for the CR.

10.1 – Background

This section provides information on Medicare's implementation of the ANSI ASC X12N 270/271, version 4010A1 implementation guide, which was adopted as the national standard for the health care eligibility benefit inquiry and response under the Health Insurance Portability and Accountability Act (HIPAA). Current carriers, intermediaries, and their data centers will **not** be responding to or processing 270 transactions for Medicare beneficiaries.

10.2 – Eligibility Extranet Workflow

The Centers for Medicare & Medicaid Services (CMS) is making changes to its Information Technology infrastructure to address standards for Medicare beneficiary eligibility inquiries. This approach will create the necessary database and infrastructure to provide a centralized HIPAA-compliant 270/271 health care eligibility inquiry and response in real-time.

CMS is using a phased approach for providing this eligibility transaction on a real-time basis:

1. **Extranet**: In June of 2005, clearinghouses, certain providers, and trading partners (as described below) will be permitted to submit 270s via the CMS AT&T communication extranet (the Medicare Data Communication Network (MDCN)). This extranet is a secure, closed private network currently used to transmit data between Medicare fee-for-service (FFS) contractors and CMS.
2. **Internet**: We [CMS] expect to provide limited Internet access to the 270/271 transaction later this year. Instructions on accessing eligibility data via this method will be provided prior to the time Internet access becomes available.

All electronic 270 files will be processed at the CMS data center. The CMS data center will use a single consolidated national eligibility database to respond to the eligibility inquiries.

Access Process for Clearinghouses/Provider

To obtain access to the MDCN via the extranet, clearinghouses and providers **must** complete the 270/271 Access Form that can be found on the CMS Web site at ***www.cms.hhs.gov/it***. The 270/271 Access Form should be completed in full and submitted electronically. The electronic submitted form will be directed to both CMS staff and the CMS' Medicare Eligibility Integration Contractor (MEIC).

CMS staff will ensure that all of the necessary information is provided on the form, as well as ensure the complete connectivity to the 270/271 application. The MEIC will be responsible for contacting the clearinghouses, providers, and trading partners to authenticate the accessing entity's identity. Once authentication has been completed, the MEIC will provide the clearinghouses, providers, and trading partners with a submitter ID that is **required** to be used on all 270/271 transactions. Testing will be coordinated by the MEIC. After successful testing, 270 production inquiries may be sent real-time. Please note that in order to access the MDCN, an entity **must on its own** obtain the necessary telecommunication software from the AT&T reseller. The current AT&T resellers and contact numbers are listed below:

- IVANS: ***www.ivans.com*** 800-548-2675
- McKesson: ***www.mckesson.com*** 800-782-7426, option 5, then key option 8

Future Requirement

CMS is developing an attestation that all clearinghouses and providers will be required to agree to provisions concerning adherence of the HIPAA Privacy and Security Rule. This attestation will be available for review through the Paperwork Reduction Act Process and will be available for public comment in the near future. If you have any questions, please contact Kim Suhr at 410-786-1023 or **Kim.Suhr@cms.hhs.gov**.

Helpdesk Support

The MEIC will provide helpdesk support during the hours of 7:00 a.m.-9:00 p.m. eastern time, Monday through Friday. The telephone number is: 866-324-7315. The email address for the helpdesk is: **MCAREHD@Webmd.net**.

Telecommunications Wrapper

Communications through the extranet to the CMS data center will be via the TCP/IP streaming socket protocol. Trading partners can submit multiple 270 transactions; it will not be necessary to wait for a response before triggering the next 270. Trading partners must ensure that the session remains connected until all responses are received. Each submitted transmission shall contain one 270 transaction with only one ISA and IEA segment, along with a transmission wrapper around the 270 transaction. There will be no handshake after the connection is accepted with the first submitted transmission.

Outbound response transactions will have the same format transmission wrapper. The response to the submitter will be returned in the same session in which the 270 was submitted.

Standard Format of the TCP/IP Transaction Wrapper

SOHLLLLLLLLLLSTX<HIPAA 270 Transaction>ETX
SOH = Required (1 position), must be EBCDIC or ASCII - 01
LLLLLLLLLL = Required (10 positions), Right justified with zero padded
Note: Length of the HIPAA 270 transaction not including Transmission wrapper data.
STX = Required (1 position), must be EBCDIC or ASCII - 02
<HIPAA 270 Transaction> = Required (HIPAA 270 - ISA - IEA),
ETX = Required (1 position), Must be EBCDIC or ASCII - 03

Note: For more detail about SOH, STX and ETX, see the Health Care Eligibility Benefit Inquiry and Response 270/271 ASC X12 Extended Control Set.

270 Inquiry Requirements

The ISA08 (interchange receiver id) and the GS03 (application receiver's code) on the 270 transactions must contain "CMS," left justified, space filled.

CMS will return certain data elements on the 271 response only when certain service type codes are sent on the 270. Other core data elements will be included in each 271 response, regardless of service type codes, when applicable. Both the core and the additional data elements are listed below.

CMS will utilize the search option as listed in the 270/271 implementation guide (Section 1.3.8) requiring the patient's member ID (HIC number), patient's full first name, patient's full last name, and patient's date of birth.

Proprietary Error Messages

Proprietary error messages will be sent only when the ISA segment of the 270 transaction cannot be read, making it impossible to formulate an ISA segment for the response. The format of the proprietary message is described below.

Description	Content	Size	Comments
Transaction	Transaction ID	04 characters	"HETS"
Transaction Reference Number	Reference #	30 characters	Reference Number for tracking
Date Stamp	System Date	08 Characters	CCYYMMDD
Time Stamp	System Time	09 Characters	HHMMSSSSS
Response Code	Error Code	02 Characters	See below
	ISA Response Code	" I"	Incoming ISA cannot be read
	Delimiter Response Code	" D"	Delimiter could not be identified
Message Code	Error Code	08 Characters	Error code
Message Text Description	Error Descriptions	70 Characters	Description of error

271 Response Data Elements

If no service type codes are contained on the 270 transaction, or if a service type code is submitted in a 270 that does not trigger additional Medicare data

elements, the following data elements will be returned in the 271 as applicable.

271 Information Returned	Loop	Segment	Element	Data Value
Part A/B Entitlement/Term Dates	2110C	EB	EB01 EB02 EB04	1 IND MB or MA
	2110C	DTP	DTP01 DTP02 DTP03	307 RD8 or D8 Date(s)
Beneficiary Address	2100C	N3 N4	N301 N302 N401 N402 N403	Address Address City State Code Zip Code
Deductible - Part B	2110C	EB	EB01 EB03 EB04 EB06 EB07	C 96 MB 29 Amount
	2110C	DTP	DTP01 DTP02 DTP03	292 RD8 Applicable Calendar Year
MCO Data	2110C	EB	EB01 EB03 EB04	R 30 HN
	2110C	REF	REF01 REF02	18 MCO ID
	2110C	DTP	DTP01 DTP02 DTP03	290 RD8 or D8 Date(s)
	2120C	NM1	NM101 NM102 NM103	PRP 2 Insurer Name
	2120C	N3	N301 N302	Address Address
	2120C	N4	N401 N402 N403	City State Code Zip Code
MSP Data	2110C	EB	EB01 EB02 EB03 EB04	R Ind 30 12, 13, 14, 15, 16, 41, 42, 43, 47
	2110C	REF	REF01 REF02	IG Policy Number
	2110C	DTP	DTP01 DTP02 DTP03	290 RD8 or D8 Date(s)
	2120C	NM1	NM01 NM102 NM103	PRP 2 Name
	2120C	N3	N301 N302	Address Address
	2120C	N4	N401 N402 N403	City State Code Zip Code
Home Health Data	2110C	EB	EB01 EB03 EB04 EB06	X 42 MA 26
	2110C	DTP	DTP01 DTP02 DTP03	193 or 194 D8 Date(s)
	2110C	MSG	MSG01	HHEH Start Date HHEH End Date HHEH DOEBA HHEH DOLBA

If one or more of the following service type codes are submitted in a 270, the following additional data elements will be returned in the 271, as applicable.

Service Type Code	Loop	Segment	Element	Data Value
14	2110C	EB	EB01 EB03 EB04	D 14 MB
	2110C	DTP	DTP01 DTP02 DTP03	356 D8 Date
	2110C	DTP	DTP01 DTP02 DTP03	198 D8 Date
	2120C	MSG	MSG01	Transplant Discharge Date
15	2110C	EB	EB01 EB03 EB04	D 15 MA
	2110C	DTP	DTP01 DTP02 DTP03	356 D8 Date
	2110C	DTP	DTP01 DTP02 DTP03	198 D8 Date
	2120C	MSG	MSG01	Transplant Discharge Date
42	2110C	EB	EB01 EB03 EB04	X 42 MA
	2120C	NM1	NM101 NM102 NM103 NM108 NM109	PR 2 Name of RHHI PI 00011, 00180, 00380, 00450, 00454
	2120C	PRV	PRV01 PRV02 PRV03	HH 9K Provider number
47	2110C	EB Part A Deductible DTP Hospital Admission	EB01 EB03 EB04 EB06 EB07 DTP01 DTP02 DTP03	C 47 MA 29 Amount 435 RD8 Dates
	2110C	EB Hospital Days Remaining DTP Hospital Admission	EB01 EB03 EB04 EB06 EB09 EB10 DTP01 DTP02 DTP03	F 47 MA 29 DY Days 435 RD8 Dates
	2110C	EB Co-Insurance Days Remaining DTP Hospital Admission	EB01 EB03 EB04 EB06 EB07 EB09 EB10 DTP01 DTP02 DTP03	A 47 MA 29 Amount per day DY Days 435 RD8 Dates
	2110C	EB Lifetime Reserve Days	EB01 EB03 EB04 EB06 EB09 EB10	K 47 MA 33 LA Days

Service Type Code	Loop	Segment	Element	Data Value
AG	2110C	EB Hospital Days Remaining DTP Hospital Admission	EB01 EB03 EB04 EB06 EB09 EB10 DTP01 DTP02 DTP03	F 47 MA 29 DY Days 435 RD8 Dates
	2110C	EB Co-Insurance Days Remaining/Deductible DTP Hospital Admission	EB01 EB03 EB04 EB06 EB07 EB09 EB10 DTP01 DTP02 DTP03	A 47 MA 29 Amount per day DY Days 435 RD8 Dates
	2110C	EB Lifetime Reserve Days	EB01 EB03 EB04 EB06 EB09 EB10	K 47 MA 33 LA days
	2110C	EB SNF Days Remaining DTP SNF Admission	EB01 EB03 EB04 EB06 EB09 EB10 DTP01 DTP02 DTP03	F AG MA 29 DY Days 435 RD8 Dates
	2110C	EB Co-Insurance SNF Days Remaining DTP SNF Admission	EB01 EB03 EB04 EB06 EB07 EB09 EB10 DTP01 DTP02 DTP03	A AG MA 29 Amount per day DY Days remaining 435 RD8 Dates

HIPAA Security Educational Paper Series

The Centers for Medicare & Medicaid Services (CMS) have now posted five papers in their Health Insurance Portability and Accountability Act (HIPAA) Security Educational Paper Series. The five papers currently available are: "**Security 101 for Covered Entities**," "**Security Standards - Administrative Safeguards**," "**Security Standards - Physical Safeguards**," "**Security Standards - Technical Safeguards**," and "**Security Standards - Organizational, Policies and Procedures and Documentation Requirements**." When a new paper in the series is available, it will be immediately posted to the CMS Web site. To view the papers go to: ***www.cms.hhs.gov/hipaa/hipaa2***

General Information

News from CMS…

New Educational Products Available

Medlearn Matters Number: SE0537
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The Fourth in the Medlearn Matters Series of Articles on the Medicare Prescription Drug Coverage

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

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.
- You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs.
- If your Medicare patients ask you questions about the new coverage, you can refer them to **1-800-MEDICARE** and to ***www.medicare.gov*** for additional information and assistance.

This article announces new educational resources available to assist Medicare beneficiaries in their understanding of the new Medicare prescription drug coverage.

Release of Notices to Medicare Beneficiaries Who Automatically Qualify for Extra Help

Starting at the end of May through June, the Centers for Medicare & Medicaid Services (CMS) is mailing notices to people who are automatically eligible for extra help paying for a Medicare prescription drug plan, including people with Medicare and Medicaid, Supplemental Security Income, and Medicare Savings Program coverage. The notices will let these people know that Medicare prescription drug coverage is coming and that they will get extra help without needing to apply for it. The notices can be viewed at ***www.cms.hhs.gov/medicarereform/lir.asp*** on the CMS Web site.

This summer, the Social Security Administration (SSA) will mail a different letter to other people who do not automatically qualify for the extra help but may be potentially eligible for it. The letter will include an application that people can fill out and return to find out if they qualify for extra help paying for a Medicare prescription drug plan. This letter can viewed at ***www.ssa.gov/organizations/medicareoutreach2/*** on the SSA Web site. Select "Application for Help with Medicare Prescription Drug Plan Costs."

Posters - Now Available for Display

Posters titled, "Have Limited Income? Social Security Can Help with Prescription Costs," can be ordered **free of charge** on the 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 and resources to a toll-free number where they can find out if they are eligible for help with prescription drug costs. To view and order the posters, go to the Medlearn Prescription Drug Coverage Web page located at ***www.cms.hhs.gov/medlearn/drugcoverage.asp*** on the CMS Web site. We [CMS] need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

Information Tool Available on Web

The new prescription drug coverage informational tool, "Learn About Your Medicare Prescription Coverage Options," was recently released on ***www.medicare.gov***. This awareness tool for people with Medicare provides information about what is coming and what actions they will need to take with regard to the new prescription drug coverage. By answering two to three (2-3) questions, the individual will be provided with information such as: eligibility for extra help for people with limited income and resources, customized information based on the individual's current coverage, as well as educational resources and links to publications about the new drug coverage.

Summary

CMS understands the pressure on your clinical time with patients, which is why we ask that you inform your Medicare patients that this new prescription drug coverage could be valuable to them and worth exploring. In addition to the products discussed in this article, CMS plans to provide you with access to information you could make available to your patients in your offices.

Additional Information

More information on provider education and outreach regarding drug coverage can be found at ***www.cms.hhs.gov/medlearn/drugcoverage.asp*** on the CMS Web site. Detailed drug coverage information for CMS partners and beneficiary advocates can be found at ***www.cms.hhs.gov/partnerships/news/mma/default.asp*** on the CMS Web site. You can also find additional information regarding prescription drug plans at ***www.cms.hhs.gov/pdps/*** on the CMS Web site. Further information on CMS implementation of the Medicare Modernization Act (MMA) can be found at the following CMS Web site: ***www.cms.hhs.gov/medicarereform/***

More Web-based Educational Products Available on Medicare Prescription Drug Coverage

Medlearn Matters Number: SE0541
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The Fifth in the Medlearn Matters Series

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

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare patients.
- It will cover brand name and generic drugs.
- This new drug coverage requires all people with Medicare to make a decision this fall. As a trusted source, your patients may turn to you for information about this new coverage. Because of this, we're [the Centers for Medicare & Medicaid Services (CMS)] looking to you and your staff to take advantage of this "teachable moment" and help your Medicare patients.
- You should encourage your Medicare patients to learn more about this new coverage because it may save them money on prescription drugs. There is extra help

available for people with limited income and resources.

- If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE (1-800-633-4227) and to ***www.medicare.gov*** for additional information and assistance.

New Fact Sheets Available on *www.medicare.gov*

There are fact sheets now available that explain Medicare's new prescription drug coverage that can help your patients understand this new coverage:

- *Quick Facts about Medicare's New Coverage for Prescription Drugs* - Publication Number 11102. This fact sheet provides basic information about Medicare's new prescription drug coverage. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11102.pdf***
- *Quick Facts about Medicare's New Coverage for Prescription Drugs for People with Limited Income and Resources* - Publication Number 11105. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person with limited income and resources. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11105.pdf***
- *Quick Facts about Medicare's New Coverage for Prescription Drugs If You Applied for Extra Help* - Publication Number 11130. This fact sheet explains what you need to know after applying for extra help paying Medicare prescription drug coverage costs. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11130.pdf***
- *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Get Supplemental Security Income* - Publication Number 11116. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person who gets Supplemental Security Income benefits or help from their state Medicaid program paying their Medicare premiums. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11116.pdf***
- *Quick Facts about Medicare's New Coverage for Prescription Drugs for People with Medicare and Medicaid* - Publication Number 11106. This fact sheet provides basic information about Medicare's new prescription drug coverage for a person with full Medicaid benefits. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11106.pdf***
- *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who are Nursing Home Residents* - Publication Number 11121. This fact sheet explains how the new Medicare prescription drug coverage works for nursing home residents. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11121.pdf***
- *Quick Facts about Medicare's New Coverage for Prescription Drugs for People Who Get Help From Their State Pharmacy Program* - Publication Number 11108. This fact sheet explains what people who get help from their state pharmacy program to pay for their prescriptions need to know about the new Medicare prescription drug coverage. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11108.pdf***
- *Do You Have a Medigap Policy with Prescription Drug Coverage?* - Publication Number 11113. This fact sheet explains how the new Medicare prescription drug coverage works for people who have a Medigap policy with prescription drug coverage. (4 pages) ***www.medicare.gov/Publications/Pubs/pdf/11113.pdf***
- *Medicare Covers America* - Publication Number 11141. This brochure provides basic information for people with Medicare about Medicare prescription drug coverage. This information includes how Medicare prescription drug coverage works, how to get coverage, and how to join a Medicare prescription drug plan. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11141.pdf***
- *Introducing Medicare Prescription Drug Coverage* - Publication Number 11142. This brochure provides basic information to people with Medicare about Medicare prescription drug coverage. This information includes who can join, when people can join, and when more information will be available. (2 pages) ***www.medicare.gov/Publications/Pubs/pdf/11142.pdf***

New Fact Sheets and Tip Sheets Available on the CMS Web site at *www.cms.hhs.gov/medicarereform/factsheets.asp*

- *The Facts about Medicare Prescription Drug Plans* - Publication Number 11065. This fact sheet provides basic introductory information about Medicare's new prescription drug coverage. (2 pages) ***www.medicare.gov/Publications/pubs/pdf/11065.pdf***
- Quick Facts about Medicare's New Coverage for Prescription Drugs (en Espanol) - Publication Number 11102-S. This fact sheet provides basic information about Medicare's new prescription drug coverage, in Spanish. ***www.cms.hhs.gov/medicarereform/elnewcovprescdrug.pdf***
- *Medicaid Spend Down - Tip Sheet* (3 pages) This tip sheet provides an example of the spend down requirement for patients who have Medicaid because of high medical expenses. This sheet shows the qualifications for patients to receive extra help. ***www.cms.hhs.gov/medicarereform/medicaid%20spend%20down.pdf***
- *Food Stamps - Tip Sheet* (3 pages) This tip sheet provides information on income limits, resource limits, and qualifications for extra help for people who have Medicare and are also on food stamps. ***www.cms.hhs.gov/medicarereform/foodstamps.pdf***
- *Medicare Prescription Drug Coverage and other Federal Means-Tested Programs - Tip Sheet* (2 pages) This tip sheet is intended to help explain how Medicare prescription drug

coverage will work with other federal means-tested programs such as food stamps, Housing and Urban Development (HUD) housing assistance, Medicaid, low income home energy assistance, and supplemental security income.
www.cms.hhs.gov/medicarereform/lowincome.pdf

Other Publications/Products

- *Introducing Medicare's New Coverage for Prescription Drugs* (bi-fold) - This pamphlet provides general information about the new Medicare prescription drug coverage, such as who can join, when, and the cost to join, as well as providing sources for additional information. This pamphlet is available at
www.medicare.gov/Publications/Pubs/pdf/11103.pdf
- *Vignettes/Bios/Case Studies* - These vignettes can be used to help explain how Medicare prescription drug coverage works with and affects other types of health care coverage. They can be used to supplement other outreach materials (10 pages). These vignettes are available at
www.cms.hhs.gov/partnerships/news/mma/vignettesfinal.pdf
- *Introducing Medicare's New Coverage for Prescription Drugs (Russian, Korean, Vietnamese, and Chinese)* - To access this product, go to
www.medicare.gov/medicarereform/default.asp. At the middle of the Web page, select the language desired from the drop-down menu. This will reveal a link to the document in the desired language.

Outreach Toolkit

A new Outreach Toolkit is also available. This toolkit is designed to equip community-level organizations with the materials needed to provide clear, accurate information and assistance about Medicare prescription drug coverage for their clients. The toolkit contains basic, straightforward information that can be easily conveyed to people with Medicare. You can view and download this kit online from the CMS Web site, as well as order a copy to be shipped to your office, by visiting:
www.cms.hhs.gov/partnerships/tools/materials/medicaretraining/MPDCoutreachkit.asp on the CMS Web site.

Additional Information

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

Message to Nursing Home Administrators on Medicare Prescription Drug Coverage

Medlearn Matters Number: SE0544
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The Sixth in the Series of Medlearn Matters Articles on the New Prescription Drug Coverage

Attention Skilled Nursing Facilities (SNFs) - This article contains important information for nursing home staff about the impact of the new prescription drug coverage on people who receive both Medicare and Medicaid.

Important Points to Remember

- On January 1, 2006, new prescription drug coverage will be available to your Medicare residents. It will cover brand name and generic drugs.
- Starting January 1, 2006, state Medicaid programs will **no** longer provide drug coverage for people also covered by Medicare.
- All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid **must** enroll in a Medicare prescription drug plan to get continuous coverage of their prescription drug costs.
- If Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid do not enroll in a Medicare prescription drug plan by December 31, 2005, Medicare will enroll them in a plan automatically to make sure they do not miss a day of coverage.
- Medicaid beneficiaries who live in a nursing home will pay nothing out of their pocket for Medicare prescription drug coverage.
- If your Medicare patients ask you questions about the new coverage, you can refer them to 1-800-MEDICARE (1-800-633-4227) and to ***www.medicare.gov*** for additional information and assistance.

Information for Nursing Home Administrators

The Centers for Medicare & Medicaid Services (CMS) released the following information via the Minimum Data Set (MDS) submission system's Welcome Page on July 6, 2005:

- Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. Also starting January 1, 2006, state Medicaid programs will **no** longer provide drug coverage for people also covered by Medicare (also known as Full Benefit Dual Eligibles, or FBDEs); instead, prescription drug coverage for people in this group will be provided by Medicare. Since two-thirds of residents in nursing homes fall into this category, this federal program will be critically important. State Medicaid coverage for **health care** coverage is not affected.
- All Medicaid beneficiaries who are eligible to receive benefits through both Medicare and Medicaid **must** enroll in a Medicare prescription drug plan to get this coverage. They will receive information from Medicare and from the plans in their area this fall, and they will need to choose and enroll in a plan that meets their needs. However, if they haven't joined a plan by December 31, 2005, Medicare will enroll them in a plan to make sure they don't miss a day of coverage. People in this group can switch to another plan at any time.
- CMS will use the MDS distribution system to keep nursing home administrators informed about Medicare prescription drug coverage as it applies to nursing home residents.
- All Medicare prescription drug plans will provide at least a standard level of coverage to all enrollees. Coverage will be available through both Medicare "Prescription Drug Plans" (PDPs), and as part of Medicare Advantage plans or other Medicare health plans (MA-PDs). All plans will be **required** to cover enrollees in all nursing homes in their regions. They will also be **required** to meet specific service and performance criteria to ensure safe prescription drug administration in the nursing home setting. While plans may offer different formularies (lists of covered drugs), CMS will require plans to cover a range of drugs in the most commonly prescribed classes to make sure that people with different medical conditions can get the treatment they need.

  An "exceptions and appeals" process will be in place to ensure access to non-formulary drugs. The plans will arrange for medications to be packaged and made available to nursing homes through long-term care pharmacy providers. These will most likely include current pharmacy providers to nursing homes, as well as new organizations that are able to meet the CMS long-term care pharmacy standards. Nursing homes will be able to select from these pharmacy vendors to ensure that all of the residents have appropriate drug coverage.
- People who receive both Medicare and Medicaid and reside in a nursing home will receive continuous prescription drug coverage, with no premiums, no deductibles, and no co-payments.
- People with limited income and resources, who are **not** eligible for full Medicaid benefits, may qualify for extra help paying for Medicare prescription drug coverage. If they qualify, they will receive extra help to pay for premiums, deductibles, and co-payments. They **will** have to pay a co-payment or coinsurance amount, depending on their income and resources.
- More information concerning Medicare prescription drug coverage as it applies to the long-term care population, and operational steps that will be necessary to ensure a seamless transition in 2006, will be forthcoming through the MDS distribution system. Additional information and resources are also available at ***www.cms.hhs.gov*** on the CMS Web site.

Additional Information

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

Note*: In order for providers to easily access information on the Medicare Prescription Drug Coverage, DMERC A added a direct link to the home page of our Web site at: *www.umd.nycpic.com/dmerc.html

Program Education & Training

Clarification to Billing Units of Oxygen and Oxygen Equipment

The Centers for Medicare & Medicaid Services (CMS) has clarified previously published information regarding

billing units of oxygen and oxygen equipment. The article, "Revised Manual Language to Item 24G (Days or Units) CMS-1500 Instructions Regarding the Billing of Oxygen and Oxygen Equipment," was published on page 13 of the June 2005 *DMERC A Medicare News*. It instructed suppliers and providers that 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 (Pub. 100-04).

The material in Chapter 20, Section 130.6 is outdated information. CMS will be updating and revising the manual in the future. Suppliers and providers are to continue to follow the instructions in the current Oxygen and Oxygen Equipment Local Coverage Determination medical policy article that states under the coding guidelines section:

> For gaseous or liquid oxygen systems or contents, report one unit of service for one month rental. Do not report in cubic feet or pounds.

Notification will be sent out when Chapter 20, Section 130.6 of the manual is updated by CMS.

Claim Submission Errors for the Third 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 April 1, 2005, through June 30, 2005, are provided in the following chart. The total number of ANSI errors for this period was **265,462**.

ANSI Error Number - Narrative (Total Errors)	Reason for Error
1) 40022 - Procedure Code/Modifier Invalid (42,489 errors)	The procedure code and/or modifier used on this line is invalid.
2) 40068 - Invalid/Unnecessary Certificate of Medical Necessity (CMN) Question (34,581 errors)	The question number entered is not valid for the DMERC CMN you are sending.
3) 20269 - Pointer 1 Diagnosis Invalid (17,505 errors)	Diagnosis pointer is invalid.
4) 40073 - Dates of Service Invalid with Procedure (14,607 errors)	The procedure code used is not valid for the dates of service used.
5) 20270 - Pointer 2 Diagnosis Invalid (14,570 errors)	Diagnosis pointer is invalid.
6) 20271 - Pointer 3 Diagnosis Invalid (7,917 errors)	Diagnosis pointer is invalid.
7) 40037 - Service Date Greater Than Receipt Date (7,111 errors)	Service date is greater than date claim was received.
8) 20274 - Header Diagnosis 2 Invalid (6,827 errors)	Header Diagnosis 2 is invalid.
9) 40036 - Service Date Does Not Equal "To" Date (6,482 errors)	The procedure code submitted does not allow for spanned dates of service.
10) 20025 - Subscriber ID Code Invalid (6,192 errors)	Subscriber ID code entered is not in a valid format.

In an effort to reduce other initial claim denials, the below information represents the top ten return/reject denials for the third 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. For more information, please refer to Chapter 1, Section 80.3.1, of Pub. 100-04, Medicare Claims Processing Manual.

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form (or electronic equivalent) Entry Requirement
1) CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid procedure codes(s) and/or rates. (9,620 claims)	**Item 24D** - Enter the procedures, services, or supplies using the Healthcare Common Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.
2) CO 16 M78 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid HCPCS modifier. (7,621 claims)	**Item 24D** - Enter the procedures, services, or supplies using the HCPCS. When applicable, show HCPCS modifiers with the HCPCS code.
3) CO 16 MA 83 Claim/service lacks information which is needed for adjudication. Did not indicate whether we are the primary or secondary payer. (5,482 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."

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form (or electronic equivalent) Entry Requirement
4) CO 16 MA82 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number. (4,254 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.
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. (4,097 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. (4,000 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) M81 Patient's diagnosis in a narrative form is not provided on an attachment or diagnosis code(s) is truncated, incorrect, or missing; you are required to code to the highest level of specificity. (3,466 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).
8) CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates must be different. (3,112 claims)	**Item 24A** - Enter the precise eight-digit date (MMDDCCYY) for each procedure, service, or supply in Item 24A.
9) CO 16 MA 114 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid information on where the services were furnished. (985 claims)	**Item 32** - Enter the name, address, and zip code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.
10) CO 16 M52 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid "from" date(s) of service. (183 claims)	**Item 24A** - Enter the eight-digit date (MMDDCCYY) for each service when "from" and "to" dates are shown for a series of identical services.

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

Provider Communications (PCOM) Advisory Group

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

The third quarterly meeting for fiscal year 2005 was held on May 25, 2005, at the Embassy Suites Hotel Philadelphia Airport. Participants included representatives from the Centers for Medicare & Medicaid Services (CMS), billing services, state provider associations, and individual provider organizations. Topics discussed at the meeting included:

- Member expectations and requirements
- Purpose of the PCOM meeting
- DMERC bulletins
- Medicare Contractor Provider Satisfaction Survey (MCPSS)
- DME MAC (Medicare Administrative Contractor)
- Updates from CMS
- WebEx™ online seminars
- Spring 2005 seminar recap
- Current outreach
- Future educational opportunities and plans
- Data analysis
- Comprehensive Error Rate Testing (CERT)
- Helpful Web site Resources and Navigation
- Medicare E-Gateway (MEG)
- Electronic submission reminders

The meeting also included a presentation by Dr. Doran Edwards, SADMERC Medical Director, on the Durable Medical Equipment Coding System (DMECS) and the wheelchair coding initiative.

Minutes from the quarterly meetings are available on the DMERC A PCOM Advisory Group Web page at ***www.umd.nycpic.com/dmerc_PCOM.html***. In addition to meeting minutes, this site contains supplementary information on the PCOM Advisory Group, a list of member organizations, and instructions on becoming a member. There are currently **membership openings** for fiscal year 2006, and **membership is free**.

The next PCOM Advisory Group meeting is scheduled for November 10, 2005, in Philadelphia, PA. Members will be notified via email of the details and registration process prior to the meeting. If you would like more information regarding the PCOM Advisory Group, or if you wish to become a member, please visit our Web page or contact the PET Department at 570-735-9666, and select option 1.

Fall 2005 Seminars

The Region A Durable Medical Equipment Regional Carrier (DMERC A) announces the fall 2005 continuing education seminars. These sessions are being offered at **no charge**. Topics for the sessions include DMERC Essentials I, DMERC Essentials II, What's New with the Medicare Program-Keeping Up with DMERC Changes, and Troubleshooting DMERC Claims. (Please note: Refreshments will **not** be served.) Please visit the "Events" section of the DMERC A Web site (***www.umd.nycpic.com/dmprovcaln.html***) for more information, including details on what will be covered in each session.

Dates and Locations

Date	Location	Address	Telephone
October 4, 2005	Sheraton Station Square	300 West Station Square Drive Pittsburgh, PA	412-261-2000
October 12, 2005	Marriott Rochester Airport	1890 West Ridge Road Rochester, NY	585-225-6880
October 24, 2005	Boston Marriott Newton	2345 Commonwealth Avenue Newton, MA	617-969-1000
November 2, 2005	Wyndham Garden Hotel LaGuardia Airport	100-15 Ditmars Boulevard East Elmhurst, NY	718-426-1500
November 10, 2005	Embassy Suites Philadelphia Airport	9000 Bartram Avenue Philadelphia, PA	215-365-4500

Please contact the hotels directly for information regarding overnight accommodations, parking, and driving directions.

Please visit the "Events" section of our Web site (***www.umd.nycpic.com/dmprovcaln.html***) for complete information on seminar times and course agendas.

How to Register

All attendees **must** be registered in advance. Online registration is available via the DMERC A Web site. **Registrations are due no later than one week prior to the seminar (registrations will not be accepted at the seminars)**. Due to limited space, registration is on a first-come, first-served basis. In the event that a particular session is filled to capacity, you will be notified by telephone. DMERC A reserves the right to cancel any seminar. If this occurs, you will be notified.

Note: Confirmations will be sent **via email to the contact person** for the registrants. If you do not receive your confirmation within five (5) days of the event for which you have registered, please call the Program Education & Training Department at 570-735-9666 and select option 1.

If you do not have Internet access, please call 570-735-9666, option 1, and **leave your name, company name, telephone number, and fax number,** and a registration form will be sent to you.

DMERC A Participation at Trade Shows and Other Special Events

The Program Education & Training (PET) Department attends trade shows and other special events throughout the year. Please look for the PET Department at the following events:

- **American Orthotics and Prosthetics Association (AOPA) National Assembly**: September 25-28, 2005, Las Vegas, Nevada - Booth #818
  For more information about the National Assembly, please visit the American Orthotics and Prosthetics Association (AOPA) Web site at: ***www.aopanet.org/***

- **Fall Medtrade Conference & Exposition**: October 18-20, 2005, Atlanta, Georgia - Booth #362
  For more information about the Fall Conference & Exposition, please visit the Medtrade Web site at: ***www.medtrade.com/medtrade/index.jsp***

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 [CMS] need your help in getting this information out to Medicare beneficiaries with limited income and resources. We encourage you to order and display the posters where Medicare beneficiaries will see them.

Quarterly Provider Update

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

The Pulse of CMS

The Centers for Medicare & Medicaid Services (CMS) provided the Region A Durable Medical Equipment Regional Carrier (DMERC A) with a copy of the summer 2005 edition of "The Pulse of CMS." This quarterly regional publication, for health care professionals, is available via the "Education - Articles and Publication Highlights" section of the DMERC A Web site at ***www.umd.nycpic.com/dmeduc.html***. (**Note**: This is a Portable Document Format (PDF) file, therefore, please follow the PDF download instructions.)

News from DMERC A…

More 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. In support of this CMS initiative, the Region A Durable Medical Equipment Regional Carrier (DMERC A) is making CERT newsletters accessible to our supplier community via our Web site in order to provide a better understanding of the CERT process and its activities. To view the most current editions, visit ***www.umd.nycpic.com/dmerc_cert_pub.html*** and follow the download instructions.

Note: Due to the importance of this initiative and to make CERT information easier to access, DMERC A added a "CERT" section to our Web site. Further details regarding this Web site enhancement will be provided in the December 2005 edition of the *DMERC A Medicare News*.

DMERC A ListServes

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

What are the benefits of joining the DMERC A ListServes? By joining, you will be the first to learn about upcoming educational opportunities and training events. You will also be the first to know when our quarterly bulletins and supplier manual revisions become available on our Web site. Additionally, there are specialty/area of interest ListServes that enable DMERC A to send targeted information to specific supplier/provider audiences when the information is posted on our Web site. If you are a specialty supplier/provider, we encourage you to join the appropriate ListServe(s).

Signing up for the DMERC A ListServes gives you immediate email notification of important information on Medicare changes impacting your business. Subscribe today by visiting the "ListServes" section of our Web site at ***www.umd.nycpic.com/dmlistserve.html***. Also, to receive email notification of medical policy updates and other important articles, subscribe to the Region A Program Safeguard Contractor (PSC) ListServe by visiting: ***www2.palmettogba.com/cgi-bin/mojo/mojo.cgi***

Changing Email Addresses

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

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

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

Reminders

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

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

Region A DMERC and PSC Affiliate Web Sites

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

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

Reminder

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

Telephone Numbers

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

Addresses

Accounting
P.O. Box 6900
Wilkes-Barre, PA 18773-6900
[*for Check Control/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 5303
Binghamton, NY 13902-5303
[*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*]

(*) Effective August 22, 2005, the address for submitting general correspondence to DMERC A has changed. Please use the new address indicated 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