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.

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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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Cover Stories

CMS Makes First Awards to Medicare Administrative Contractors

Contracting Reform Will Lower Administrative Costs, Improve Quality and Service for Durable Medical Equipment Benefits

The Centers for Medicare & Medicaid Services (CMS) announced today [January 6, 2006] that it has awarded contracts for four specialty contractors who will be responsible for handling the administration of Medicare claims from suppliers of durable medical equipment, prosthetics, and orthotics. The new contracts awarded represent a first step in CMS' initiatives designed to improve service to beneficiaries and providers, support the delivery of coordinated and quality care, and provide greater administrative efficiency and effectiveness for fee-for-service Medicare.

To view the entire press release, please visit ***www.cms.hhs.gov/apps/media/press/release.asp?counter=1749***.

Introductory Letter From NHIC

February 2006

Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Jurisdiction A Transition 7/1/06

The Centers for Medicare & Medicaid Services (CMS) has announced that it has awarded contracts to four specialty contractors who will be responsible for handling the administration of Medicare claims from suppliers of durable medical equipment, prosthetics and orthotics as of 7/1/2006.

National Heritage Insurance Company (NHIC) is pleased to serve you as the Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) for Region A effective 7/1/06. NHIC will provide its services for Medicare beneficiaries and Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers in DME MAC Region A which includes Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

NHIC, a wholly owned subsidiary of Electronic Data Systems Corporation, entered the Medicare program in 1996 when it was awarded the contract to process Northern California Part B Medicare claims. Today NHIC has a dedicated staff of more than 1,200 employees serving Medicare beneficiaries and providers in California , Maine , Massachusetts , New Hampshire and Vermont . As an existing Medicare Part B contractor, NHIC has extensive experience working with Medicare providers and beneficiaries providing them Medicare program information when they need it.

For the transition to the DME MAC we plan to communicate with you often using newsletters, websites, email list servs, conference calls, professional association communications, supplier workshops, supplier transition hotline and individual contacts where appropriate. We have added a DME transition webpage to our existing Medicare Part B website at **http://www.medicarenhic.com/dme/index.shtml**. Please take a moment to visit the website and bookmark it for future visits. Please help us communicate important transition information by joining the NHIC DME listserv on this webpage. By joining our DME listserv, you will be assured to receive all transition news and important notices via email.

In the coming weeks, we will clearly describe any changes related to this transition. We will provide you with clear and timely instructions for all topics such as claims submission, appeal and inquiry requests. Most importantly, we will listen to your questions or concerns and address them.

Thank you.

Important!

To be sure that you receive all information for the July 1, 2006, transition to the new DME MAC contractor, please join the National Heritage Insurance Company (NHIC) ListServe at *www.medicarenhic.com/dme/index.shtml*.

Notes from DMERC A…

The DMERC A specific information contained within this publication is applicable for claims submitted prior to the transition to the DME MAC, National Heritage Insurance Company (NHIC), effective July 1, 2006. Further details concerning the DME MAC transition will be included in the June edition of the *DMERC A Medicare News*, on our Web site, and on the NHIC Web site.

New and Improved CMS Web Site

The Centers for Medicare & Medicaid Services (CMS) launched its redesigned Web site on December 15, 2005. It employs a user-friendly design to get visitors the information they need with the least amount of clicks and introduces one-stop shopping "centers" targeted to specific professionals, such as providers and partners, who frequent the site.

As a result of the redesign, some of the CMS Web site references contained within this publication may no longer be valid. The following are the current locations of the common references:

- Contractor Toll-Free Telephone Numbers - ***www.cms.hhs.gov/apps/contacts/***
- Internet-Only Manuals (IOMs) - ***www.cms.hhs.gov/Manuals/IOM/list.asp***
- Medicare Home Page (to access varied Medicare information) - ***www.cms.hhs.gov/home/medicare.asp***
- Medlearn Matters Articles - ***www.cms.hhs.gov/MedlearnMattersArticles/***
- National Provider Identifier (NPI) - ***www.cms.hhs.gov/NationalProvIdentStand/01_overview.asp***
- Prescription Drug Coverage - ***www.cms.hhs.gov/PrescriptionDrugCovGenIn/***
- Transmittals - ***www.cms.hhs.gov/Transmittals/***

Billing/Finance

News from CMS…

Update to Medicare Deductible, Coinsurance, and Premium Rates for 2006

Medlearn Matters Number: MM4132
Related Change Request (CR) #: 4132
Related CR Release Date: November 4, 2005
Related CR Transmittal #: 31
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

The following information affects physicians, suppliers, and providers billing Part A and Part B services to Medicare carriers, including durable medical equipment regional carriers (DMERCs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs).

Provider Action Needed

This article is based on Change Request (CR) 4132, which updates the Centers for Medicare & Medicaid Services (CMS) claims processing systems and the Medicare General Information, Eligibility, and Entitlement Manual (Pub.100-01) with the new 2006 Medicare deductible, coinsurance, and premium rates for 2006.

Background

Medicare beneficiaries using covered Part A services (inpatient hospital services, skilled nursing facilities (SNFs), home health services, and hospice care) and Part B services (physician services, outpatient hospital services, medical equipment and supplies, and other health services and supplies) may be subject to deductible and coinsurance requirements.

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

After the 60th day that a beneficiary receives inpatient hospital services (during a spell of illness), he or she is responsible for a coinsurance amount equal to one-fourth of the inpatient hospital deductible per day for the **61st-90th day** spent in the hospital.

After the 90th day spent in the hospital during a spell of illness, the beneficiary may elect to use his or her 60 lifetime reserve days of coverage. The coinsurance

amount for these days is equal to one-half of the inpatient hospital deductible.

For SNF services furnished during a spell of illness, the beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the **21st-100th day in an SNF**.

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

Under Supplementary Medical Insurance (SMI), all enrollees are subject to a monthly premium. Most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. When SMI enrollment takes place more than 12 months after a person's initial enrollment period, there is a permanent 10 percent increase in the premium for each year the beneficiary could have enrolled and failed to enroll.

The following includes Medicare Part A and Part B deductible, coinsurance, and premium amounts for 2006:

A. Medicare Part A Deductible, Coinsurance, and Premium Amounts for 2006:

- **Deductible:** $952.00 per benefit period or spell of illness;
- **Coinsurance:**
  - $238.00 a day for days 61-90 in each period;
  - $476.00 a day for days 91-150 for each "Lifetime Reserve" day used; and
  - $119.00 a day in an SNF for days 21-100 in each benefit period; and
- **Premium:**
  - $393.00 per month for those who must pay a premium;
  - $432.30 per month for those who must pay a premium **and** must pay a 10 percent increase;
  - $216.00 per month for those who have 30-39 quarters of coverage; and
  - $237.60 per month for those who have 30-39 quarters of coverage **and** must pay a 10 percent increase.

The table below compares deductible and coinsurance amounts for 2005 and 2006:

Year	Inpatient Hospital Deductible, 1st 60 Days	Inpatient Hospital Coinsurance, 61st-90th Days	60 Lifetime Reserve Days Coinsurance	SNF Coinsurance
2005	$912	$228	$456	$114
2006	$952	$238	$476	$119

B. Medicare Part B Deductible, Coinsurance, and Premium Amounts for 2006:

- **Deductible:** $124.00 per year;
- **Coinsurance:** 20 percent; and
- **Premium:** $88.50 per month.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 4132 in the CR NUM column on the right and click on the file for that CR.

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

Fee Schedule Update for 2006 for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Medlearn Matters Number: MM4194
Related Change Request (CR) #: 4194
Related CR Release Date: December 2, 2005
Related CR Transmittal #: 770
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

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

Provider Action Needed

This article is based on Change Request (CR) 4194, and it provides specific information regarding the annual update for the 2006 DMEPOS fee schedule.

Background

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

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

Payment on a fee schedule basis is required for:

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

Note: DMERCs will use the 2006 PEN fee schedule payment amounts to pay claims for items furnished from January 1, 2006, through December 31, 2006.

The 2006 DMEPOS Fee Schedule Update factors for Healthcare Common Procedure Coding System (HCPCS) items furnished from January 1, 2006, through December 31, 2006, and are as follows:

HCPCS Codes	Notes
A5120	Modifier "AV" is added for billing items furnished for facial prosthetics. Modifier "AU" is added for billing items furnished for urological supplies.
L2005	Is being revised effective January 1, 2006, to ensure that the code's allowable amount is representative of a full knee, ankle, foot orthosis (KAFO), including the joint component.
L8609 and **L8685 through L8689**	Describe items that are subject to the fee schedule for prosthetics and orthotics (PO) and are being added to the HCPCS effective January 1, 2006. These codes fall under the jurisdiction of the local carriers rather than the DMERCs. The Centers for Medicare & Medicaid Services (CMS) will be calculating the fee schedule amounts for these items using the standard gap-filling process. The description for these codes can be obtained from the 2006 HCPCS file as soon as it becomes available at ***www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage*** on the CMS Web site.

The following codes are being **deleted** from the HCPCS, effective January 1, 2006, and are therefore being removed from the DMEPOS and PEN fee schedule files:

A4254	E0996	K0075	K0670	L8140
A4643 thru A4647	E1000	K0076	K0671	L8150
	E1001	K0078	K0731	L8160
A5119	E1019	K0102	K0732	L8170
A5509	E1021	K0104	L0860	L8180
A5511	E1025 thru E1027	K0106	L1750	L8190
B4184		K0415	L3963	L8195
B4186	E1210 thru E1213	K0416	L8100	L8200
E0169		K0452	L8110	L8230
E0752	E1239	K0600	L8120	L8239
E0754 thru E0759	K0064	K0618 thru K0620	L8130	L8620
	K0066			
E0953	K0067	K0628 thru K0649		
E0954	K0068			
E0972	K0074			

The HCPCS codes listed below are being **added to the HCPCS on January 1, 2006**:

A4218	B4185	E2212 thru E2226	L3961
A4233 thru A4236	E0170 thru E0172	E2371	L3967
A4363	E0485	E2372	L3971
A4411	E0486	L0491	L3973
A4412	E0641	L0492	L3975 thru L3978
A4604	E0642	L0621 thru L0640	L5703
A5120	E0705	L0859	L5858
A5512	E0762	L2034	L5971
A5513	E0764	L2387	L6621
A6457	E0911	L3671 thru L3673	L6677
A6513	E0912	L3702	L6883 thru L6885
A6530	E1392	L3763 thru L3766	L7400 thru L7405
A6531	E1812	L3905	L7600
A6532	E2207 thru E2210	L3913	L8609
A6533 thru A6544	E2211	L3919	L8623
A6549	E2212	L3921	L8624
A9275		L3933	L8680 thru L8689
A9281		L3935	
A9282			

The Medicare DMERCs will gap-fill base fee schedule amounts for each state in their region for the following new HCPCS codes that will be subject to the DMEPOS fee schedules in 2006:

HCPCS Codes	Notes
A4363, A4411, A4412	Ostomy, Tracheostomy, or Urological Supplies (OS)
A4233, A4234, A4235, A4236, A4604, E0485, E0486, E2216, E2217,E2218, E2222, E2223, E2225, E2226, E2371, E2372	Inexpensive or Routinely Purchased DME (IN)
E0170, E0171, E0911, E0912, E1812	Capped Rental DME (CR)
L0624, L0629, L0632, L0634, L2034, L2387, L3671, L3672, L3673, L3702, L3763, L3764, L3765, L3766, L3905, L3913, L3919, L3921, L3933, L3935, L3961, L3967, L3971, L3973, L3975, L3976, L3977, L3978, L5703, L5971, L6621, L6677, L6883, L6884, L6885, L7400, L7401, L7402, L7403, L7404, L7405	Prosthetics and Orthotics (PO)
A6513	Surgical Dressings (SD)

Note: Suppliers should remember to add HCPCS modifier **AV** when billing code A5120 for facial prosthetic items **only when furnished in conjunction with a facial prosthesis**. Also, add modifier **AU** when billing code A5120 for urological items **only when furnished in conjunction with urological supplies**.

Implementation
The implementation date for the instruction is January 3, 2006.

Additional Information
The official instruction issued to your carrier, intermediary, or DMERC regarding this change can be found at ***www.cms.hhs.gov/transmittals/downloads/R770CP.pdf*** on the CMS Web site.

If you have questions regarding this issue, you may also contact your carrier, FI, or DMERC at their toll-free number, which may be found at: ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Reasonable Charge Update for 2006 for Splints, Casts, Dialysis Supplies, Dialysis Equipment, and Certain Ocular Lenses

Medlearn Matters Number: MM4131
Related Change Request (CR) #: 4131
Related CR Release Date: November 8, 2005
Related CR Transmittal #: 749
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

The following information affects physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), for services/supplies related to splints, casts, dialysis supplies and equipment, and certain intraocular lenses.

Provider Action Needed
This article is based on Change Request (CR) 4131, which provides instructions regarding the calculation of reasonable charges for payment of claims for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses furnished in calendar year (CY) 2006. The 2006 payment limits for splints and casts will be based on the 2005 limits, increased by 2.5 percent, the percentage change in the consumer price index for all urban consumers for the 12-month period ending June 30, 2005.

Background
Payment continues to be made on a reasonable charge basis for splints, casts, dialysis supplies, dialysis equipment, and intraocular lenses in CY 2006 as required by regulations contained in 42 CFR 405.501, which can be reviewed at ***www.access.gpo.gov/nara/cfr/waisidx_02/42cfr405_02.html***.

For splints and casts, the Q-codes are to be used when supplies are indicated for cast and splint purposes. The Current Procedural Terminology (CPT) codes should be used as indicated in the CPT section, "Application of Casts and Strapping," for the specified CPT procedure codes in the 29XXX series.

For dialysis supplies, Healthcare Common Procedure Coding System (HCPCS) codes A4215, A6216, and A6402 have been added to the dialysis supplies that require an AX modifier for payment. Therefore, suppliers **must** attach the AX modifier to these codes when they are used to bill for dialysis supplies. HCPCS codes A6216 and A6402, when billed with the HCPCS modifier AX, should be reported as type of service (TOS) "L." HCPCS codes A4215, A6216, and A6402, when billed without the HCPCS modifier AX, should be reported as TOS "S."

HCPCS Code/Modifier	Description
Code A4215	Needle, sterile, any size, each
Code A6216	Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border
Code A6402	Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border
Modifier AX	Item furnished in conjunction with home dialysis services

For intraocular lenses, dialysis supplies, and dialysis equipment, the 2006 customary and prevailing charges will be computed using actual charge data from July 1, 2004, through June 30, 2005. Remember that for intraocular lenses, payment is made only on a reasonable charge basis for lenses implanted while the patient is in a physician's office.

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

Additional Information
For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the Centers for Medicare & Medicaid Services (CMS) Web site. From that Web page, look for CR 4131 in the CR NUM column on the right and click on the file for that CR.

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

January 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File, Effective January 1, 2006, and Revisions to January 2005, April 2005, July 2005, and October 2005 Quarterly ASP Medicare Part B Drug Pricing Files

Medlearn Matters Number: MM4140 **Revised**
Related Change Request (CR) #: 4140
Related CR Release Date: February 15, 2006
Related CR Transmittal #: R856CP
Effective Date: January 1, 2005
Implementation Date: January 3, 2006
Note: This article was revised on February 17, 2006, to delete references to the revised January 2005 pricing file. Change Request (CR) 4140 was revised by the Centers for Medicare & Medicaid Services (CMS) to delete the same references since the revised January 2005 pricing file was not provided as indicated in the original CR 4140. Also, the CR transmittal number, Web address, and release date were also changed. Other Web addresses were changed to conform to the new CMS Web site. All other information remains the same.

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

Provider Action Needed
Impact to You

CR 4140 provides notice of the updated payment allowance limits in the January 2006, April 2005, July 2005, and October 2005 drug pricing files.

What You Need to Know
Be aware that certain Medicare Part B drug payment limits have been revised and that CMS updates the payment allowance on a quarterly basis. The revised payment limits included in the revised average sales price (ASP) and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to this document.

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

Background
According to Section 303 (c) of the Medicare Modernization Act of 2003 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis. Beginning January 1, 2005, Part B drugs (that are not paid on a cost or prospective payment basis) are paid based on 106 percent of the ASP. The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis, and each quarter, CMS will update your carrier/fiscal intermediary (FI) payment allowance limits with the ASP files. On or after December 19, 2005, revised April 2005, July 2005, and October 2005 ASP and NOC payment files and the January 2006 ASP and NOC files will be available for download.

- The revised April 2005 payment allowance limits apply to dates of service April 1, 2005, through June 30, 2005.
- The revised July 2005 payment allowance limits apply to dates of service July 1, 2005, through September 30, 2005.
- The revised October 2005 payment allowance limits apply to dates of service October 1, 2005, through December 31, 2005.
- The January 2006 payment allowance limits apply to dates of service January 1, 2006, through March 31, 2006.

Exceptions
There are, however, exceptions to the general rule, and they were summarized in MM3846, effective July 1, 2005, and may be viewed at ***www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3783.pdf*** on the CMS Web site.

Implementation
The implementation date for the instruction is January 3, 2006.

Additional Information
The official instruction issued to your carrier/intermediary regarding this change may be found at ***www.cms.hhs.gov/Transmittals/downloads/R856CP.pdf*** on the CMS Web site. CMS will also update the Microsoft Excel files on the CMS Web site to reflect these revised payment limits. Those files can be found at ***www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/*** on the CMS Web site.

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

April 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File and Revisions to January 2005, April 2005, July 2005, October 2005, and January 2006 Quarterly ASP Medicare Part B Drug Pricing Files

Medlearn Matters Number: MM4319
Related Change Request (CR) #: 4319
Related CR Release Date: February 24, 2006
Related CR Transmittal #: R876CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

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

Provider Action Needed
Impact to You
Change Request (CR) 4319 provides notice of the updated payment allowance limits for Medicare Part B drugs, effective April 1, 2006, through June 30, 2006, as well as revised payment files for the January 2005, April 2005, July 2005, October 2005, and January 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files.

What You Need to Know
Be aware that certain Medicare Part B drug payment limits have been revised and that the Centers for Medicare & Medicaid Services (CMS) updates the payment allowance quarterly. The revised payment limits included in the revised ASP and Not Otherwise Classified (NOC) payment files supersede the payment limits for these codes in any publication published prior to CR 4319.

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

Background
According to Section 303 (c) of the Medicare Modernization Act of 2003 (MMA), CMS will update the payment allowances for Medicare Part B drugs on a quarterly basis.

Beginning January 1, 2005, Part B drugs that are not paid on a cost or prospective payment basis are paid based on **106 percent** of the ASP. Additionally, in 2006, all end-stage renal disease (ESRD) drugs furnished by both independent and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the Outpatient Prospective Payment System (OPPS), will be paid based on the ASP methodology. The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply Medicare contractors with the ASP drug pricing files for Medicare Part B drugs on a quarterly basis.

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. Beginning January 1, 2006, the payment allowance limits for all ESRD drugs when separately billed by freestanding and hospital-based ESRD facilities, as well as specified covered outpatient drugs, and drugs and biologicals with pass-through status under the OPPS, will be paid based on 106 percent of the ASP. CMS will update the payment allowance limits quarterly.

Exceptions to General Rule
There are exceptions to this general rule as summarized below:

Blood and Blood Products

For blood and blood products (with certain exceptions such as blood clotting factors), payment allowance limits are determined in the same manner they were determined on October 1, 2003. The payment allowance limits for blood and blood products are 95 percent of the average wholesale price (AWP) as reflected in the published compendia. The payment allowance limits will be updated on a quarterly basis.

Infusion Drugs

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 were not updated in 2005.** For infusion drugs furnished through a covered item of DME that were not listed in the published compendia as of October 1, 2003 (i.e., new drugs), the payment allowance limits are 95 percent of the first published AWP.

Influenza, Pneumococcal, Hepatitis B Vaccines

For influenza, pneumococcal, and hepatitis B vaccines, payment allowance limits are 95 percent of the AWP as reflected in the published compendia.

Drugs Not Included in ASP Medicare Part B Drug Pricing File or NOC Pricing File

For drugs (other than new drugs) not included in the ASP Medicare Part B Drug Pricing File or 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, Medicare contractors (carriers, including durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)) will follow the methodology specified in the Medicare Claims Processing Manual for calculating the AWP, but substitute WAC for AWP. (See Publication 100-04, Chapter 17, Drugs and Biologicals at ***www.cms.hhs.gov/manuals/downloads/clm104c17.pdf*** on the CMS Web site.) The payment limit is 100 percent of the lesser of the lowest brand or median generic WAC.

Your Medicare contractor 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 contractor or will post them in an MS Excel file on the CMS Web site. If the payment limit is available from CMS, contractors will substitute the CMS-provided payment limits for pricing based on WAC or invoice pricing.

Radiopharmaceuticals

The payment allowance limits for radiopharmaceuticals are not subject to ASP. Your carrier/FI will determine payment limits for radiopharmaceuticals based on the methodology in place as of November 2003.

New Drugs Produced or Distributed under a New Drug Application Approved by the Food and Drug Administration

The payment allowance limits for new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File are based on 106 percent of the WAC. This policy applies **only** to new drugs that were first sold on or after January 1, 2005.

How the ASP is Calculated

The ASP is calculated using data submitted to CMS by manufacturers on a quarterly basis, and each quarter, CMS will update your carrier payment allowance limits with the ASP files. On or after March 20, 2006, revised January 2005, April 2005, July 2005, October 2005, and January 2006 ASP and NOC payment files and the April 2006 ASP and NOC files will be available for download.

- The revised January 2005 payment allowance limits apply to dates of service January 1, 2005, through March 31, 2005.
- The revised April 2005 payment allowance limits apply to dates of service April 1, 2005, through June 30, 2005.
- The revised July 2005 payment allowance limits apply to dates of service July 1, 2005, through September 30, 2005.
- The revised October 2005 payment allowance limits apply to dates of service October 1, 2005, through December 31, 2005.
- The revised January 2006 payment allowance limits apply to dates of service January 1, 2006, through March 31, 2006.
- The April 2006 payment allowance limits apply to dates of service April 1, 2006, through June 30, 2006.

Note: The absence or presence of a Healthcare Common Procedure Coding System (HCPCS) code and

its associated payment limit does **not** indicate Medicare coverage of the drug or biological. Similarly, the inclusion of a payment limit within a specific column does **not** indicate Medicare coverage of the drug in that specific category. The carrier processing your claim will make these determinations.

For any drug or biological not listed in the ASP or NOC drug pricing files, your Medicare contractor will determine the payment allowance limits in accordance with the policies described in CR 4319, and FIs will seek payment allowances from the local Medicare carrier.

Implementation

The implementation date for the instruction is April 3, 2006.

Additional Information

The official instructions issued to your carrier/FI/RHHI/DMERC regarding this change can be found at ***www.cms.hhs.gov/Transmittals/downloads/R876CP.pdf*** on the CMS Web site.

If you have questions, please contact your Medicare carrier/FI/RHHI/DMERC at their toll-free number, which may be found at ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

More information is available at ***www.cms.hhs.gov/McrPartBDrugAvgSalesPrice/*** on the CMS Web site.

Medicare Part B Drug Pricing Update - Payment Limit for J7620 (Albuterol and Ipratropium Bromide, Non-compounded)

Medlearn Matters Number: MM4333
Related Change Request (CR) #: 4333
Related CR Release Date: February 17, 2006
Related CR Transmittal #: R857CP
Effective Date: January 1, 2006
Implementation Date: March 17, 2006

The following information affects suppliers billing Medicare durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs) for Albuterol and Ipratropium Bromide.

Provider Action Needed

Impact to You

The payment allowance limit for Healthcare Common Procedure Coding System (HCPCS) code J7620 (Albuterol and Ipratropium Bromide, non-compounded) in the January 2006 Quarterly Average Sales Price (ASP) Medicare Part B Pricing File is incorrect.

What You Need to Know

Change Request (CR) 4333, from which this article was developed, corrects the HCPCS code J7620 Medicare Part B pricing file payment allowance limit for dates of service on or after January 1, 2006, and on or before March 31, 2006.

What You Need to Do

Make sure that your billing staffs are aware of this correction.

Background

The payment allowance limit contained in the January 2006 Quarterly ASP Medicare Part B Pricing File for J7620 (Albuterol and Ipratropium Bromide, non-compounded) is incorrect. In order to prevent overpayment, CR 4333 informs the DMERCs and RHHIs to correct this payment allowance limit for dates of service on or after January 1, 2006, and on or before March 31, 2006. The correct payment allowance limit is displayed in the following table:

Correct Payment Allowance Limit for HCPCS Code J7620

HCPCS	Long Description	HCPCS Code Dosage	Payment Allowance Limit
J7620	ALBUTEROL, UP TO 2.5 MG, AND IPRATROPIUM BROMIDE, UP TO 0.5 MG, NON-COMPOUNDED INHALATION SOLUTION, ADMINISTERED THROUGH DME	ALBUTEROL, UP TO 2.5 MG, AND IPRATROPIUM BROMIDE, UP TO 0.5 MG	$1.024

While DMERCs and RHHIs will **not** be routinely searching and adjusting claims that have been processed prior to this CR's implementation date, they will be using this corrected payment allowance limit for HCPCS drug code J7620 when asked to retroactively adjust claims (with dates of service January 1, 2006 - March 31, 2006) that were processed with the January 2006 Medicare Part B ASP Pricing File.

Additional Information

You can find more information about the new payment allowance limit for HCPCS code J7620 by going to ***www.cms.hhs.gov/Transmittals/downloads/R857CP.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

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

Supplying Fee and Inhalation Drug Dispensing Fee Revisions and Clarifications

Medlearn Matters Number: MM3990 **Revised**
Related Change Request (CR) #: 3990
Related CR Release Date: November 10, 2005
Related CR Transmittal #: R754CP
Effective Date: January 1, 2006
Implementation Date: January 3, 2006
Note: This article was revised on February 22, 2006, to show in all places that the correct code for the 30-day dispensing fee is Q0513.

The following information affects physicians, providers, and suppliers billing oral anti-cancer chemotherapeutic drugs, oral anti-emetic drugs, immunosuppressive drugs, or inhalation drugs to Medicare durable medical equipment regional carriers (DMERCs) or fiscal intermediaries (FIs).

Provider Action Needed

This article is based on information contained in Change Request (CR) 3990, which clarifies and revises the policies and fees related to the supply fee and dispensing fee and outlines changes to Healthcare Common Procedure Coding System (HCPCS) codes used for those fees.

Background

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, Section 303(e) (2)) authorized Medicare to pay a supplying fee for the following drugs:

- Immunosuppressive drugs,
- Oral anti-cancer chemotherapeutic drugs, and
- Oral anti-emetic drugs used as part of an anti-cancer chemotherapeutic regimen.

Supplying Fees

Effective January 1, 2006, Medicare will pay the following supplying fees to a pharmacy for each of the above listed drugs:

- **$24.00 for the first prescription** supplied to a beneficiary during a 30-day period. Each pharmacy that supplies the above listed drugs to a beneficiary during a 30-day period will be eligible for one $24 supplying fee in that period.
- **$16.00 for each subsequent prescription** of the above listed drugs supplied to a beneficiary in the same 30-day period.

Notes:

- For a refill prescription, Medicare will allow payment of a $24 supplying fee up to seven days before the end of the 30-day period for which the last $24 supplying fee was paid.
- A pharmacy will be limited to **one** $24 fee per 30-day period even if the pharmacy supplies more than one category of the above-mentioned drugs (for example, an oral anti-cancer drug and an oral anti-emetic drug) to a beneficiary. A supplier will **not** be allowed more than twelve $24 supplying fees per beneficiary per year.
- Medicare will pay a supplying fee for each prescription (including prescriptions for different strengths) of the same drug supplied on the same day. For example, Medicare will pay a supplying fee for both a prescription for 100 mg tablets and a prescription for 5 mg tablets of the same drug supplied on the same day.
- This change does **not** alter the one-time $50 supplying fee (code Q0510 - replacement code for G0369) for the first immunosuppressive prescription after a transplant.

Dispensing Fees

Medicare also pays a dispensing fee for inhalation drugs, in accordance with Section 1842(o)(2) of the Social Security Act. Effective January 1, 2006, Medicare will pay **one** dispensing fee to a pharmacy amounting to:

- **$57.00 for an initial dispensing fee** to a pharmacy for the initial 30-day period of inhalation drugs furnished through durable medical equipment (DME) regardless of the number of shipments or drugs dispensed during that time and regardless of the number of pharmacies used by a beneficiary during that time;
- **One dispensing fee of $33.00 for a 30-day period of inhalation drugs** furnished through DME regardless of the number of shipments or drugs dispensed during that time; and
- **One dispensing fee of $66.00 for each dispensed 90-day period of inhalation drugs** furnished through

DME regardless of the number of shipments or drugs dispensed during that time.

One Dispensing Fee Payment for 90-Day Period
Only **one** dispensing fee payment will be made for the 90-day period, regardless of the number of pharmacies used by a beneficiary. A supplier **cannot** be paid for more than one of the following for a beneficiary for the same period:

- An initial dispensing fee (G0333);
- A 30-day dispensing fee (Q0513); or
- A 90-day dispensing fee (Q0514).

Refill Prescriptions/Supply and Dispensing Fees
For a refill prescription, Medicare will allow payment of the dispensing fee no sooner than seven days before the end of usage for the current 30-day or 90-day script for which a dispensing fee was previously paid. An inhalation drug supplier will **not** be allowed more than 12 months of dispensing fees per beneficiary per year.

Note: The supply fee and dispensing fee **must** continue to be billed on the **same** claim as the drug supplied or dispensed. Also, note that a **supply fee and a dispensing fee is not appropriate for one drug** because:

- The supply fee is for immunosuppressives, oral anti-cancer drugs, and oral anti-emetic drugs; and
- The dispensing fee is for inhalation drugs only.

HCPCS Code Changes
DMERCs and FIs are instructed by CR 3990 to recognize the following HCPCS codes for:

- Supply fees for immunosuppressive, oral anti-cancer, and oral anti-emetic drugs:
  - **Code Q0510** (replaces G0369) - First immunosuppressive prescription after a transplant. ($50.00)
  - **Code Q0511** (replaces G0370) - Pharmacy supplying fee for immunosuppressive, oral anti-cancer, and oral anti-emetic drugs, first prescription in a one-month period. Each pharmacy may receive this fee **once** in a 30-day period. ($24.00)
  - **Code Q0512** (replaces G0370) - Pharmacy supplying fee for immunosuppressive, oral anti-cancer, and oral anti-emetic drugs, each subsequent prescription in a 30-day period. ($16.00)
- Dispensing fee for inhalation drugs (one per month) - Pay the **first claim received** for inhalation drugs:
  - **Code G0333** - Pharmacy dispensing fee for initial inhalation drug(s); initial 30-day supply to a beneficiary.
  - **Code Q0513** (replaces G0371) - Pharmacy dispensing fee for inhalation drug(s); per 30-days. ($33.00)
  - **Code Q0514** (replaces G0374) - Pharmacy dispensing fee for inhalation drugs(s); per 90-days. ($66.00)

A supplier **cannot** be paid for more than one of the above fees (G0333, Q0513, Q0514) for a beneficiary for the same period.

Note: Effective January 1, 2006, Medicare will **no** longer recognize codes G0369, G0370, G0371, and G0374. Also, the Medicare DMERC or FI will downcode G0333 to Q0513 and pay on the basis of Q0513 if a prior claim has been paid to any supplier for that beneficiary for inhalation drugs. Similarly, Medicare will downcode Q0511 to Q0512 if more than one claim for Q0511 is received from the supplier for a beneficiary during the 30-day period (except allowing for the refill within seven days of the end of the 30-day period).

Implementation
The implementation date for the instruction is January 3, 2006.

Additional Information
For complete details, please see the official instruction issued to your FI or DMERC regarding this change. That instruction may be viewed by going to ***www.cms.hhs.gov/Transmittals/downloads/R754CP.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site. From that Web page, look for CR 3990 in the CR NUM column on the right and click on the file for that CR.

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

Change in the Long Descriptor for HCPCS Code Q4080

Medlearn Matters Number: MM4324
Related Change Request (CR) #: 4324
Related CR Release Date: February 10, 2006
Related CR Transmittal #: R209OTN
Effective Date: January 1, 2006
Implementation Date: March 13, 2006

The following information affects physicians, suppliers,

and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for services related to ILOPROST inhalation treatment of Medicare beneficiaries.

Provider Action Needed

This article is based on Change Request (CR) 4324, which provides information on the revised code dosage descriptor for Q4080. This is a non-systems change CR.

Background

The Centers for Medicare & Medicaid Services (CMS) established Healthcare Common Procedure Coding System (HCPCS) code Q4080 that was effective July 1, 2005, with a code descriptor that read:

> "ILOPROST, INHALATION SOLUTION, ADMINISTERED THROUGH DME, **20 MICROGRAMS**."

Effective January 1, 2006, the long code descriptor for HCPCS code Q4080 will read:

> "ILOPROST, INHALATION SOLUTION, ADMINISTERED THROUGH DME, **UP TO 20 MCG**."

The short descriptor for HCPCS code Q4080 will continue to read:

> "Iloprost inhalation solution."

CR 4324 provides clarification on the change in the long descriptor for HCPCS code Q4080 effective January 1, 2006.

Implementation

The implementation date for the instruction is March 13, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary/RHHI regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R209OTN.pdf*** on the CMS Web site.

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

New Temporary Codes for Adjustable Wheelchair Cushions

Medlearn Matters Number: MM4267
Related Change Request (CR) #: 4267
Related CR Release Date: February 3, 2006
Related CR Transmittal #: R835CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

The following information affects durable medical equipment (DME) suppliers and providers who order wheelchair services for Medicare beneficiaries.

Provider Action Needed

Impact to You

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

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) has established four new "K" codes for adjustable wheelchair cushions, effective July 1, 2006.

What You Need to Do

Make sure that your billing staffs are aware of these new "K" codes for wheelchair cushions.

Background

CMS has established four new "K" codes for adjustable wheelchair cushions, effective for services provided on or after July 1, 2006. These new codes are displayed in the following table:

"K" Codes for Adjustable Wheelchair Cushions, Effective July 1, 2006

Code	Description
K0734	Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth
K0735	Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth
K0736	Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth
K0737	Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth

Additional Information

You can find more information about the four new "K" codes for adjustable wheelchair cushions at ***www.cms.hhs.gov/Transmittals/downloads/R835CP.pdf*** on the CMS Web site.

Should you have any questions concerning these codes, you may contact your Medicare DME regional carrier or fiscal intermediary (FI) at their toll-free number, which you can find at ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

2006 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB)

Medlearn Matters Number: MM4086
Related Change Request (CR) #: 4086
Related CR Release Date: October 7, 2005
Related CR Transmittal #: 696
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

The following information affects physicians, suppliers, and providers billing Medicare carriers and fiscal intermediaries (FIs) for services supplied to Medicare patients in skilled nursing facilities (SNFs).

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4086 regarding the annual update of Healthcare Common Procedure Coding System (HCPCS) codes for SNF consolidated billing and how the updates affect edits in Medicare claims processing systems, especially the Common Working File (CWF).

What You Need to Know

CR 4086 provides updates to HCPCS codes that will be used to revise CWF edits to allow carriers and FIs to make appropriate payments in accordance with the policy for SNF consolidated billing that is detailed in Chapter 6 (Section 110.4.1) for carriers, and Chapter 6 (Section 20.6) for FIs.

What You Need to Do

Physicians, suppliers, and providers should review the new coding files that will be posted on the Centers for Medicare & Medicaid Services (CMS) Web site.

Background

The Common Working File (CWF)

Medicare's claims processing systems currently have edits in place for claims received for beneficiaries in a Part A covered SNF stay as well as for beneficiaries in a noncovered stay. These edits allow only those services excluded from consolidated billing to be separately paid by the carrier and/or FI.

For physicians and providers billing carriers: By the first week of December 2005, new code files will be posted to ***www.cms.hhs.gov/medlearn/snfcode.asp*** on the CMS Web site.

For those providers billing FIs: By the first week of December 2005, new Excel and Portable Document Format (PDF) files will be posted to ***www.cms.hhs.gov/providers/snfpps/snffi/*** on the CMS Web site, under the "2006 Annual and Quarterly Updates" section.

Note: It is important and necessary for the provider community billing the FIs to view the "General Explanation of the Major Categories" bullet located under each annual update bullet, at the ***www.cms.hhs.gov/providers/snfpps/snffi/*** link, to understand the Major Categories, including additional exclusions not driven by HCPCS codes.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change, which may be viewed at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 4086 in the CR NUM column on the right and click on the file for that CR.

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

Please note: The SNF consolidated billing information is now available via the CMS Web site at: ***www.cms.hhs.gov/SNFConsolidatedBilling/***

April Quarterly Update to the 2006 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

Medlearn Matters Number: MM4298
Related Change Request (CR) #: 4298
Related CR Release Date: February 1, 2006
Related CR Transmittal #: R826CP
Effective Date: January 1, 2006
Implementation Date: April 3, 2006

The following information affects physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), and/or fiscal intermediaries (FIs) for services provided to Medicare beneficiaries in skilled nursing facilities (SNFs).

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4298, which provides updates to the lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the Consolidated Billing (CB) provision of the SNF Prospective Payment System (PPS).

What You Need to Know

Services included on the SNF CB enforcement list will be paid to SNF Medicare providers **only**. Services excluded from the SNF CB enforcement list may be paid to Medicare providers other than SNFs. See the "Background" and "Additional Information" sections for further explanation.

What You Need to Do

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

Background

The Social Security Act (Section 1888, ***www.ssa.gov/OP_Home/ssact/title18/1883.htm***) codifies both the SNF PPS and CB. The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of HCPCS codes subject to the CB provision of the SNF PPS. Services that appear on this HCPCS code list (that are submitted on claims to both Medicare FIs and carriers, including 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. However, SNF CB applies to the following services whenever they are furnished to an SNF resident, regardless of whether Part A covers the stay:

- Physical and occupational therapies; and
- Speech-language pathology.

Services for beneficiaries that are excluded from SNF PPS and CB may be paid to providers (other than SNFs) even when in an SNF stay. To assure proper payment in all settings, Medicare systems must edit for services provided to SNF beneficiaries both included and excluded from SNF CB.

2006 Annual Update

Each January, CMS publishes a combined instruction for FIs and carriers/DMERCs for the annual notice on SNF CB. The 2006 Annual Update file for FIs can be found at ***www.cms.hhs.gov/SNFConsolidatedBilling/80_2006_FI_Update.asp#TopOfPage*** on the CMS Web site. This 2006 file will be updated with the changes addressed in CR 4298 by March 1, 2006. Information on the 2006 Annual Update for carriers can be found at ***www.cms.hhs.gov/SNFConsolidatedBilling/02m_2006Update.asp#TopOfPage*** on the CMS Web site.

Note: Quarterly updates apply to FIs and carriers/DMERCs. The update provided by CR 4298 affects claims with dates of service on or after the effective date of CR 4298 unless otherwise indicated. The following HCPCS codes are listed as being added or removed from the Annual Update:

HCPCS Codes Added or Removed from Annual Update

Computerized Axial Tomography (CT) Scans (Major Category I, FI Annual Update, EXCLUSION)

HCPCS Code REMOVED	Descriptor
76375	3D/holograph reconstr add-on

Radiation Therapy (Major Category I, FI Annual Update, EXCLUSION)

HCPCS Code REMOVED	Descriptor
C9722	KV imaging w/ir tracking
G0242	Lultisource photon ster plan
G0338	Linear accelerator stero pln

Angiography, Lymphatic, Venous (Major Category I, FI Annual Update, EXCLUSION)

HCPCS Code ADDED	Descriptor
36598	Contrast injection, radiologic eval of existing cent venous access device

Note: This code should be added to the SNF CB file effective April 1, 2006.

Outpatient Surgery and Related Procedures (Major Category I, FI Annual Update, INCLUSION)

HCPCS Code REMOVED	Descriptor
15810	Salabrasion
15811	Salabrasion
G0345	Intravenous infusion, hydration; initial, up to one hour

Ambulance Trips w/Application to Major Category II (Major Category I, FI Annual Update, EXCLUSION)

HCPCS Code REMOVED	Descriptor
Q3019	ALS vehicle used, emergency transport, no ALS service furnished
Q3020	ALS vehicle used, non-emergency transport, no ALS service furnished

Dialysis Supplies (Major Category II, FI Annual Update, EXCLUSION)

HCPCS Code REMOVED	Descriptor
A4656	Needle, any size, for dialysis, each

Chemotherapy Administration (Major Category III, FI Annual Update, EXCLUSION)

HCPCS Code REMOVED	Descriptor
96408	Chemotherapy, push technique
96410	Chemotherapy, infusion method
96412	Chemo, infuse method add-on
96414	Chemo, infuse method add-on
96520	Pump refilling, maintenance
96530	Pump refilling, maintenance
G0357	Intravenous, push technique, single or initial substance/drug
G0358	Intravenous, push technique, each additional substance/drug
G0359	Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance/drug
G0360	Each additional hour, one to eight hours
G0361	Initiation of prolonged chemotherapy infusion (more than 8 hours)
G0362	Each additional sequential infusion (different substance /drug), up to one hour

HCPCS Code ADDED	Descriptor
96409	Chemo admin; IV, push; single/initial drug
96411	Chemo admin; IV, push; each add'l drug
96413	Chemo admin; IV, infusion; up to 1 hr; single/initial drug
96415	Chemo admin; IV, infusion; each add'l hr, 1-8 hrs
96416	Chemo admin; IV, infusion; initiation of prolonged chemo, requiring pump
96417	Chemo admin; IV infusion; each add'l sequential infusion, up to 1 hr

HCPCS Code ADDED	Descriptor
C8953	Chemo admin; IV, push
C8954	Chemo admin; IV, infusion; up to 1 hr
C8955	Chemo admin; IV, infusion; each add'l hr

Implementation

The implementation date for the instruction is April 3, 2006.

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R826CP.pdf*** on the CMS Web site.

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

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

Medlearn Matters Number: MM4114
Related Change Request (CR) #: 4114
Related CR Release Date: October 14, 2005
Related CR Transmittal #: 710
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

The following information affects all Medicare providers billing carriers, including durable medical equipment regional carriers (DMERCs), regional home health intermedi-aries (RHHIs), or fiscal intermediaries (FIs), for medical supply or therapy services.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) periodically updates the lists of Healthcare Common Procedure Coding System (HCPCS) codes subject to the consolidated billing provision of the Home Health Prospective Payment System (HH PPS). This article provides the annual HH consolidated billing (CB) update effective January 1, 2006. Affected providers should be aware of these changes.

Background

Section 1842(b)(6) of the Social Security Act (SSA) requires that payment for home health services provided under a home health plan of care be made to the home health agency (HHA). As a result, billing for all such items and services is to be made by a single HHA overseeing that plan. This HHA is known as the primary agency for HH PPS for billing purposes.

Services appearing on this list that are submitted on claims to Medicare contractors will **not** be paid separately on dates when a beneficiary for whom such a service is being billed is in a home health episode (i.e., under a home health plan of care administered by an HHA). Exceptions include the following:

- Therapies performed by physicians;
- Supplies incidental to physician services; and
- Supplies used in institutional settings.

Medicare periodically publishes Routine Update Notifications, which contain updated lists of non-routine supply and therapy codes that **must** be included in HH consolidated billing. The lists are always updated annually, effective January 1, as a result of changes in HCPCS codes that Medicare also publishes annually. This list may also be updated as frequently as quarterly if required by the creation of new HCPCS codes during the year.

Additional Information

Change Request (CR) 4114 provides the annual HH consolidated billing update effective January 1, 2006. The following table describes the HCPCS codes and the specific changes to each that this notification is implementing on January 3, 2006:

Code	Description of Code	Type Change	Replacement Code or Code Being Replaced
Non-Routine Supplies			
A4656	Needle, any size each	Delete	Replacement code: A4215 with revised definition (code A4215 is already on HH CB list)
A5119	Skin barrier wipes box pr	Delete	Replacement code: A5120
A6025	Gel sheet for dermal or epidermal application (e.g., silicone, hydrogel, other)	Delete	
A6457	Tubular dressing with or without elastic, any width, per linear yard	Add	
A4412	Ostomy pouch, drainable, high output, for use on a barrier with flange (two-piece system), without filter, each	Add	
A5120	Skin barrier, wipes or swabs, each	Add	Replaces code A5119
A4363	Ostomy clamp, any type, replacement only, each	Add	
A4411	Ostomy skin barrier, solid 4x4 or equivalent, extended wear, with built-in convexity, each	Add	
Therapies - No Update			

The last update to the HH consolidated billing was issued under Transmittal 340, CR 3525. The related Medlearn Matters article, MM3525, may be found at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3525.pdf*** on the CMS Web site.

For complete details, please see the official instruction issued to your carrier/DMERC/RHHI/intermediary regarding this change. That instruction may be found by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 4114 in the CR NUM column on the right and click on the file for that CR. A complete historical listing of codes subject to HH CB can be found at ***www.cms.hhs.gov/providers/hhapps/*** on the CMS Web site. The last bullet on this page contains a link to download the list.

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

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

Medlearn Matters Number: MM4098
Related Change Request (CR) #: 4098
Related CR Release Date: October 21, 2005
Related CR Transmittal #: 41
Effective Date: January 21, 2006
Implementation Date: January 21, 2006

The following information affects Medicare providers who, upon inpatient or outpatient admissions of Medicare beneficiaries, use a questionnaire to determine

other insurance coverage that may be primary to Medicare.

Provider Action Needed

Impact to You

Change Request (CR) 4098 clarifies recent changes made to the "Medicare Secondary Payer Questionnaire."

What You Need to Know

This CR identifies all of the changes that were made to CR 3504 **and** makes additional changes to the model questionnaire. These changes will assist providers in identifying other payers that may be primary to Medicare.

What You Need to Do

Please refer to the "Background" and "Additional Information" sections of this article and make certain that, if there are other payers, these situations are identified.

Background

The Centers for Medicare & Medicaid Services (CMS) received information that a prior instruction (CR 3504) did not specifically mention all of the changes that were made to the "Medicare Secondary Payer (MSP) Questionnaire." CR 4098 identifies all of the changes made as part of CR 3504 and makes additional changes to the model questionnaire. The Medicare Secondary Payer Manual, Chapter 3, Section 20.2.1, available as an attachment to CR 4098, provides a model: "Admission Questions to Ask Medicare Beneficiaries." The model contains questions that may be printed out and used as a guide to help identify other payers. (The Web site for accessing CR 4098 is provided in the "Additional Information" section of this article.) The following bullets identify the changes within the model MSP Questionnaire:

- **Parts IV** and **V** of the model questionnaire adds the response: "No, Never Employed."
- In **Parts IV**, **V**, and **VI** of the model questionnaire, providers should use "Policy Identification Number" to mean a number that is sometimes referred to as the health insurance benefit package number.
- **Parts IV**, **V**, and **VI** of the model questionnaire adds "Membership Number," and it refers to the unique identifier assigned to the policyholder/patient.
- **Part V**, question 2 of the model questionnaire uses "spouse" instead of "family member."
- **Part V**, question 4 changes the model questionnaire to read: "Are you covered under the group health plan of a family member other than your spouse? _____Yes _____No.; Name and address of your family member's employer:_____"
- **Part V** of the old question 4 is changed to ask whether the beneficiary is covered under a group health plan (GHP), and a question number 5 is added to gather the pertinent information about the GHP.
- In **Part VI**, question 6 now reads: "Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD [end stage renal disease]?"

Providers who use the model questionnaire to elicit MSP information from their Medicare patients should take special note of these changes.

Implementation

The implementation date for the instruction is January 21, 2006.

Additional Information

The official instructions issued to your Medicare carrier or intermediary regarding this change and the model questionnaire can be found at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. On the above page, scroll down the CR NUM column on the right to find the links for CR 4098. Click on the links to open and view the files for this CR.

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

Durable Medical Equipment Regional Carrier (DMERC) Information Form (DIF)

Medlearn Matters Number: MM4241 **Revised**
Related Change Request (CR) #: 4241
Related CR Release Date: February 17, 2006
Related CR Transmittal #: R867CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Note: This article was revised on February 28, 2006, to correct the reference to Change Request (CR) 4241 in the first bullet point under "Impact to Providers." The original article mistakenly referenced CR 4240.

The following information affects suppliers billing Medicare durable medical equipment regional carriers (DMERCs) for immunosuppressive drugs.

Impact on Providers

- Change Request (CR) 4241 eliminates the need for the DMERC Information Form (DIF), DMERC form 08.02, when billing for immunosuppressive drugs for dates of service on or after April 1, 2006.
- The DIF for immunosuppressive drugs is a form that collects additional data on the beneficiary before Medicare payment is made for immunosuppressive drugs.
- Section 1861(s)(2)(J) of the Social Security Act no longer imposes a limitation on the period of time for coverage of immunosuppressive drugs; thus, the information captured on the DIF (i.e., information regarding the dates of the beneficiary's transplant and other diagnosis information) can be obtained through other means.

Important Points to Remember

- This policy is effective for services on or after April 1, 2006. Claims submitted for services prior to April 1, 2006, without the fully completed DIF, will be rejected.
- The certificate of medical necessity (CMN) for parenteral nutrition (Centers for Medicare & Medicaid Services (CMS) Form 852) is still required.
- If March 2006 and April 2006 dates of service are on the same claim for immunosuppressive drugs, Medicare DMERCs will replicate the claim to divide the March 2006 services from the April 2006 services on separate claims. Then, the services provided on or after April 1, 2006, will be processed without the DIF.
- The following Healthcare Common Procedure Coding System (HCPCS) codes for immunosuppressive drugs are identified as those no longer requiring the DIF after April 1, 2006:
  Category 11: J0215, J2920, J7500, J7501, J7502, J7504, J7505, J7506, J7507, J7509, J7510, J7511, J7513, J7515, J7516, J7517, J7518, J7520, J7525, J7599, J8530, J8610, J9212, J9213, J9214, J9215, J9216, and J2930

Implementation

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

Additional Information

The official instruction issued to the DMERC regarding this change can be viewed by going to ***www.cms.hhs.gov/Transmittals/downloads/R867CP.pdf*** on the CMS Web site.

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

New Durable Medical Equipment Prosthetic, Orthotics & Supplies (DMEPOS) Certificates of Medical Necessity (CMNs) and DME Medicare Administrative Contractor (MAC) Information Forms (DIFs) for Claims Processing

Medlearn Matters Number: MM4296
Related Change Request (CR) #: 4296
Related CR Release Date: February 10, 2006
Related CR Transmittal #: R138PI
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

The following information affects physicians, providers, and suppliers using certificates of medical necessity (CMNs) and durable medical equipment (DME) information forms (DIFs) when billing to Medicare durable medical equipment regional carriers (DMERCs).

Provider Action Needed

Impact to You

The Centers for Medicaid & Medicare Services (CMS) has developed improved CMNs and DIFs, and consequently, there are changes to the forms.

What You Need to Know

There is a transition period for claims with initial dates of service (DOS) from October 1, 2006, through December 31, 2006, where claims for items requiring an CMN or DIF will be accepted with either the old or the new form. The improved forms also permit the use of a signature and date stamp.

What You Need to Do

Make certain that your billing staff is aware of the changes in Chapters 3 and 5 of the Medicare Program Integrity Manual that are outlined in this article. The

new series of forms is available as part of the official instructions (Change Request (CR) 4296) issued to your DMERC.

Background

CMNs provide a mechanism for suppliers of DME (defined in 42 U.S.C. Section 1395x(n)) and medical equipment and supplies (defined in 42 U.S.C. Section 1395j(5)), to demonstrate that the item they provide meets the minimal criteria for Medicare coverage. Medicare DMERCs review the documentation provided by physicians, suppliers, and providers on the CMNs and DIFs and determine if the medical necessity and applicable coverage criteria for selected DMEPOS were met. The changes to the CMN forms have resulted in the following:

- Medicare Program Integrity Manual, Chapter 5, Items and Services Having Special DME Review Considerations, has been revised.
- The improved forms permit the use of a signature and date stamp, which has resulted in revision of the Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.1, Documentation Specifications for Areas Selected for Prepayment or Post Payment Medical Review.
- These new forms were approved by the Office of Management and Budget (OMB).
- For the CMS-484 form, the OMB # is 0938-0534.
- For the CMS forms 846, 847, 848, 849, 854, 10125, and 10126, the OMB # is 0938-0679.

Claims Accepted During Transition Period

The following table identifies the CMNs for claims with initial DOS that will be accepted during the transition period from October 1, 2006, through December 31, 2006. (As of January 1, 2007, the old forms will no longer be accepted.)

DMERC FORM	CMS FORM	ITEMS ADDRESSED
484.2	484	Home Oxygen Therapy
01.02A	841	Hospital Beds
01.02B	842	Support Surfaces
04.03B	846	Lymphedema Pumps (Pneumatic Compression Devices)
04.03C	847	Osteogenesis Stimulators
06.02B	848	Transcutaneous Electrical Nerve Stimulators (TENS)
07.02A	849	Seat Lift Mechanisms
09.02	851	External Infusion Pumps
10.02A	852	Parenteral Nutrition
10.02B	853	Enteral Nutrition
11.01	854	Section C Continuation Form

Newly Revised CMNs Accepted During Transition Period

The following table identifies the newly revised CMNs that will be accepted during the transition period for claims with initial DOS from October 1, 2006, through December 31, 2006. As of January 1, 2007, these forms will become effective for claims for items requiring an CMN. Noteworthy changes include changing the title of CMS-484 from Home Oxygen Therapy to Oxygen. In addition, the title of CMS-846 was changed from Lymphedema Pumps to Pneumatic Compression Devices.

DME MAC FORM	CMS FORM	ITEMS ADDRESSED
484.03	484	Oxygen
04.04B	846	Pneumatic Compression Devices
04.04C	847	Osteogenesis Stimulators
06.03B	848	Transcutaneous Electrical Nerve Stimulators (TENS)
07.03A	849	Seat Lift Mechanisms
11.02	854	Section C Continuation Form

New DIFs Accepted During Transition Period

The following table identifies the new DIFs that will also be accepted during the transition period for claims with initial DOS from October 1, 2006, through December 31, 2006. As of January 1, 2007, the new forms will become effective for claims for items requiring an DIF. Noteworthy changes include changing CMS-851 for Infusion Pumps to a CMS-10125, External Infusion Pump DIF. In addition, CMS-852 for Parenteral Nutrition and CMS-853 for Enteral Nutrition were combined into a CMS-10126, Enteral and Parenteral Nutrition DIF.

DME MAC FORM	CMS FORM	ITEMS ADDRESSED
09.03	10125	External Infusion Pumps
10.03	10126	Enteral and Parenteral Nutrition

The use of the CMNs for hospital beds (CMS-841) and support surfaces (CMS-842) will be eliminated for claims with initial DOS on or after October 1, 2006.

CMNs Eliminated

The following table identifies the CMNs that will be eliminated for claims with initial DOS on or after October 1, 2006.

DME MAC FORM	CMS FORM	ITEMS ADDRESSED
01.02A	841	Hospital Beds
01.02B	842	Support Surfaces

Note: Medicare is developing a crosswalk to link legacy supplier numbers (National Supplier Clearinghouse (NSC)) to the new National Provider Identifiers (NPI). Until that crosswalk is completed, DMERCs will require you to continue to submit your legacy/NSC number. If you choose to submit your NPI as of October 1, 2006, you **must** still report your legacy/NSC number until that crosswalk is operational. Similarly, treating physicians should report their Unique Physician Identification Number (UPIN) (preceded by an "XX" qualifier) AND their NPI (preceded by a "1G" qualifier) until the crosswalk is operational. CMS will issue further instructions when the crosswalk approaches operational status.

Implementation

The implementation date for the instruction is October 2, 2006.

Additional Information

The official instructions issued to your DMERC regarding this change can be found at ***www.cms.hhs.gov/Transmittals/downloads/R138PI.pdf*** on the CMS Web site. These instructions include copies of the new forms.

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

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Medlearn Matters Number: MM4123 **Revised**
Related Change Request (CR) #: 4123
Related CR Release Date: November 4, 2005
Related CR Transmittal #: 743
Effective Date: January 1, 2006
Implementation Date: January 3, 2006
Note: This article was revised January 11, 2006, to correct Center for Medicare & Medicare Services (CMS) Web references. All other information remains the same.

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 of X12N 835 Health Care Remittance Advice Remark Codes and X12N 835 Health Care Claim Adjustment Reason Codes, including changes made from March 1, 2005, through June 30, 2005, 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 June 30, 2005.

What You Need to Do

Be sure your staff is aware of these changes.

Background

Two code sets - the reason and remark code sets - **must** be used to report payment adjustments in remittance advice transactions. The reason codes are also used in some coordination-of-benefits (COB) transactions. The remittance advice remark code list is maintained by CMS and used by all payers. Additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities. This list is updated three times a year and posted at ***www.wpc-edi.com/codes***.

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 three times per year.

Additional Information

The lists at the end of this article summarize changes made from March 1, 2005, through June 30, 2005.

Note: In September 2005, the Claim Adjustment Status Code Maintenance Committee approved a new reason code of 192 (Non-standard adjustment code from paper remittance advice), effective January 1, 2006. Reason code 192 will be used by providers who **must** submit claims electronically under the Administrative Simplification Compliance Act when:

- Medicare is not the primary payer; and
- Providers have received paper remittance advice containing proprietary codes from the previous payer(s).

For additional information about remittance advice, please refer to "Understanding the Remittance Advice (RA): A Guide for Medicare Providers, Physicians, Suppliers, and Billers" on the CMS Web site. [The RA guide is available at: ***www.cms.hhs.gov/MedlearnProducts/downloads/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/Transmittals/downloads/R743CP.pdf*** on the CMS Web site.

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

Remittance Advice Remark Code Changes

Code	New/Modified/ Deactivated/ Retired	Current Narrative	Comment
N348	New	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.	Medicare Initiated
N349	New	The administration method and drug must be reported to adjudicate this service.	Not Medicare Initiated
N350	New	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or an Unlisted procedure.	Not Medicare Initiated
N351	New	Service date outside of the approved treatment plan service dates.	Not Medicare Initiated
N352	New	There are no scheduled payments for this service. Submit a claim for each patient visit.	Not Medicare Initiated
N353	New	Benefits have been estimated; when the actual services have been rendered, additional payment will be considered based on the submitted claim.	Not Medicare Initiated
N354	New	Incomplete/invalid invoice.	Not Medicare Initiated
N355	New	The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days.	Medicare Initiated
N356	New	This service is not covered when performed with, or subsequent to, a noncovered service.	Not Medicare Initiated
N21	Modified	Your line item has been separated into multiple lines to expedite handling.	Modified effective August 1, 2005
M25	Modified	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	Modified effective August 1, 2005
M26	Modified	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If	Modified effective August 1,

Code	New/Modified/ Deactivated/ Retired	Current Narrative	Comment
		you have collected any amount from the patient for this level of service/any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in §1824(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	2005
M27	Modified	The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	Modified effective August 1, 2005
MA01	Modified	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.	Modified effective August 1, 2005
MA02	Modified	The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days.	Modified effective August 1, 2005
MA03	Modified	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each	Modified effective August 1, 2005
		claim on time. At the reconsideration, you must present any new evidence which could affect our decision.	
MA83	Modified	Did not indicate whether we are the primary or secondary payer.	Modified effective August 1, 2005
MA94	Modified	Did not enter the statement, "Attending physician not hospice employee," on the claim form to certify that the rendering physician is not an employee of the hospice.	Modified effective August 1, 2005
N122	Modified	Add-on code cannot be billed by itself.	Modified effective August 1, 2005
N125	Modified	Payment has been (denied for the/made only for a less extensive) service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The requirements for a refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.	Modified effective August 1, 2005
N29	Modified	Missing documentation/orders/notes/summary/report/chart.	Modified effective August 1, 2005
N225	Modified	Incomplete/invalid documentation/orders/notes/summary/report/chart.	Modified effective August 1, 2005
M23	Modified	Missing invoice.	Modified effective August 1, 2005

Reason Code Changes

Code	New/Modified/ Deactivated/ Retired	Current Narrative	Comment
167	New	This (these) diagnosis(es) is (are) not covered.	New as of June, 2005
168	New	Payment denied as service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.	New as of June, 2005
169	New	Payment adjusted because an alternate benefit has been provided.	New as of June, 2005

Code	New/Modified/ Deactivated/ Retired	Current Narrative	Comment
170	New	Payment is denied when performed/billed by this type of provider.	New as of June, 2005
171	New	Payment is denied when performed/billed by this type of provider in this type of facility.	New as of June, 2005
172	New	Payment is adjusted when performed/ billed by a provider of this specialty.	New as of June, 2005
173	New	Payment adjusted because this service was not prescribed by a physician.	New as of June, 2005
174	New	Payment denied because this service was not prescribed prior to delivery.	New as of June, 2005
175	New	Payment denied because the prescription is incomplete.	New as of June, 2005
176	New	Payment denied because the prescription is not current.	New as of June, 2005
177	New	Payment denied because the patient has not met the required eligibility requirements.	New as of June, 2005
178	New	Payment adjusted because the patient has not met the required spend-down requirements.	New as of June, 2005
179	New	Payment adjusted because the patient has not met the required waiting requirements.	New as of June, 2005
180	New	Payment adjusted because the patient has not met the required residency requirements.	New as of June, 2005
181	New	Payment adjusted because this procedure code was invalid on the date of service.	New as of June, 2005
182	New	Payment adjusted because the procedure modifier was invalid on the date of service.	New as of June, 2005
183	New	The referring provider is not eligible to refer the service billed.	New as of June, 2005
184	New	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	New as of June, 2005
185	New	The rendering provider is not eligible to perform the service billed.	New as of June, 2005
186	New	Payment adjusted since the level of care changed.	New as of June, 2005
187	New	Health savings account payments.	New as of June, 2005
188	New	This product/procedure is only covered when used according to FDA recommendations.	New as of June, 2005
189	New	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	New as of June, 2005
D21	New	This (these) diagnosis(es) is (are) missing or are invalid.	New as of June, 2005
23	Modified	Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments.	Modified June, 2005
47	Retired	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	Inactive as of February, 2006
30	Retired	Payment adjusted because the patient has not met the required eligibility, spend-down, waiting, or residency requirements.	Inactive as of February, 2006
B6	Retired	This payment is adjusted when performed/ billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.	Inactive as of February, 2006

Remittance Advice Remark Code (RARC) and Claim Adjustment Reason Code (CARC) Update

Medlearn Matters Number: MM4314
Related Change Request (CR) #: 4314
Related CR Release Date: February 17, 2006
Related CR Transmittal #: R859CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

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 July 1, 2005, through October 30, 2005, of X12N 835 Remittance Advice Remark Codes and X12N 835 Claim Adjustment Reason Codes have been posted. The most current and complete code list will 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 between July 1, 2005, to October 30, 2005, and in September 2005, respectively. By April 3, 2006, all applicable code text changes and new codes should be in use and the deactivated codes terminated.

What You Need to Do

The above codes are updated three times a year. Be sure your staff is aware of these changes in order to ensure correct interpretation of the electronic or paper remittance advice notices sent by Medicare.

Background

Two code sets - the claim adjustment reason code set and the remittance advice remark code set - **must** be used to report payment adjustments in remittance advice (RA) transactions. The reason codes are also used in some coordination of benefits (COB) transactions.

The remittance advice remark code (RARC) list is maintained by the Centers for Medicare & Medicaid Services (CMS) and used by all payers. Additions, deactivations, and modifications to the code list may be initiated by Medicare and non-Medicare entities. This list is updated three times a year and posted at ***www.wpc-edi.com/codes***. The RARC database has expanded rapidly in the last couple of years. CMS has developed a new Web site to help navigate the database more easily. A tool is provided to help search if you are looking for a specific category of code. You can also find at this site some other information that is available from the WPC Web site. The new Web site address is: ***www.cmsremarkcodes.info/***

Note: This Web site is **not** replacing the WPC Web site as the official site where the most current RARC list resides. If there is any discrepancy, always use the list posted at the WPC Web site.

Implementation

The implementation date for the instruction is April 3, 2006.

Additional Information

The following list summarizes changes made from July 1, 2005, through October 30, 2005:

Code	New, Modified, Deactivated, Retired	Current Narrative	Comment
Remittance Advice Remark Code Changes			
N357	New	Time frame requirements between this service procedure/supply and a related service procedure/supply have not been met.	Medicare Initiated
N358	New	This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.	Not Medicare Initiated
N359	New	Missing/incomplete/invalid height.	Not Medicare Initiated
N360	New	Coordination of benefits has not been calculated when estimating benefits for this predetermination. Submit payment information from the primary payer with the secondary claim.	Not Medicare Initiated
N361	New	Charges are adjusted based on multiple diagnostic imaging procedure rules.	Not Medicare Initiated
N362	New	The number of Days or Units of Service exceeds our acceptable maximum.	Not Medicare Initiated
N363	New	Alert: in the near future we are implementing new policies/procedures that would affect this determination.	Not Medicare Initiated
N364	New	According to our agreement, you must waive the deductible and/or coinsurance amounts.	Medicare Initiated
M16	Modified	Please see our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	Modified effective 11/18/05
MA02	Modified	If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.	Modified effective 12/29/05 (1)
MA03	Modified	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time.	Modified effective 11/18/05 (2)
N9	Modified	Adjustment represents the estimated amount a previous payer may pay.	Modified effective 11/18/05
N34	Modified	Incorrect claim form/format for this service.	Modified effective 11/18/05
N207	Modified	Missing/incomplete/invalid weight.	Modified effective 11/18/05
N355	Modified	The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you re-	Modified effective 11/18/05

Code	New, Modified, Deactivated, Retired	Current Narrative	Comment
		ceive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days.	
M78	Deactivated	Missing/incomplete/invalid HCPCS modifier.	Deactivated effective 5/18/06, consider using reason code 4.
Claim Adjustment Reason Code Changes			
190	New	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	New as of 10/05
191	New	Claim denied because this is not a work-related injury/illness and thus not the liability of the workers' compensation carrier.	New as of 10/05
192 (3)	New	Non standard adjustment code from paper remittance advice.	New as of 10/05
182	Modified	Payment adjusted because the procedure modifier was invalid on the date of service.	Modified 8/8/05
B18	Modified	Payment adjusted because this procedure code and modifier were invalid on the date of service.	Modified 8/8/05
52	Retired	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	Inactive as of 2/1/06
B17	Retired	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.	Inactive as of 2/1/06

1 This modification is effective January 1, 2006, and has been communicated in a separate instruction (CR 4326).

2 Medicare will not use MA03 effective from January 1, 2006, and that has been communicated in CR 4326.

3 This new code was created at the request of Medicare because:

- Providers who do not qualify for Administrative Simplification Compliance Act (ASCA) exemption must submit claims electronically;
- If Medicare is secondary, and the primary payer has sent a paper RA with proprietary code(s), the provider could not send a compliant electronic claim unless a crosswalk between the payer proprietary codes and the standard CARC is available.

In CR 4123, Medicare contractors were instructed to complete entry of 192 as a valid code and accept claims containing this code for adjudication. CMS encourages providers to utilize this code and submit COB claims electronically.

Reason Codes 1 and 2

In September, CMS requested two new codes to be used in lieu of current reason codes 1 ("Deductible") and 2 ("Coinsurance Amount") when a provider is not allowed to collect any deductible and/or any coinsurance. Section 630 of the Medicare Modernization Act (MMA) permits Indian Health Service (IHS) facilities to directly bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Federal government agencies do **not** permit providers to collect coinsurance or deductible payments from IHS patients.

The committee did **not** approve the CMS request for new codes, but suggested that reason codes 1 and 2 should be used with Group Code CO (Contractual Obligation) instead of PR (Patient Responsibility). Currently, in most situations Group Code PR is used with reason codes 1 and 2. Medicare contractors **must** use Group Code CO under this special situation with codes 1 and 2. (See related CR 3845 and the Medlearn Matters article at ***www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3845.pdf*** on the CMS Web site.)

The official instructions (CR 4314) issued to your Medicare carrier, intermediary, DMERC, or RHHI regarding this change can be found at ***www.cms.hhs.gov/Transmittals/downloads/R859CP.pdf*** on the CMS Web site.

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

Remittance Advice Remark Code and Claim Adjustment Reason Code Update

Medlearn Matters Number: MM4326
Related Change Request (CR) #: 4326
Related CR Release Date: February 17, 2006
Related CR Transmittal #: R860CP
Effective Date: May 17, 2006
Implementation Date: May 17, 2006

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

Key Points

- Effective December 29, 2005, **Remark Code MA02** was updated to reflect the following narrative: "If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days."
- Within 30 days of release of Change Request (CR) 4326, **Remark Code MA03** will **not** be used for Medicare Fee-for-Service (FFS), and Medicare will update the current narrative of remark code MA02 in the same timeframe.
- Please use the text posted on the Washington Publishing Company (WPC) Web site if there are discrepancies between any code text included in this article and the corresponding text on the WPC Web site: ***www.wpc-edi.com/codes***

Background

There are two code sets that **must** be used to report payment adjustments, appeal rights, and related information for transaction 835 (Health Care Claim Payment/Advice) and standard paper remittance advice. These code sets, updated on a regular basis, include:

- Claim Adjustment Reason Code (CARC); and
- Remittance Advice Remark Code (RARC).

Additionally, for transaction 837 coordination of benefit (COB), CARC must be used.

Additional Information

CR 4326 is the official instruction issued to your FI/RHHI or your carrier/DMERC regarding changes mentioned in this article, MM4326. CR 4326 may be found by going to ***www.cms.hhs.gov/Transmittals/downloads/R860CP.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Please refer to your local FI/RHHI or your carrier/DMERC if you have questions about this issue. To find their toll-free telephone number, go to ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

Claim Status Category Code and Claim Status Code Update

Medlearn Matters Number: MM4256
Related Change Request (CR) #: 4256
Related CR Release Date: January 20, 2006
Related CR Transmittal #: R814CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

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

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4256, which provides the April 2006 updates of the Claim Status Codes and Claim Status Category Codes for use by Medicare contractors (carriers, DMERCs, FIs, and RHHIs).

What You Need to Know

Medicare contractors are to use codes with the "**new as of 4/06**" designation and prior dates and inform affected providers of the new codes. CR 4256 applies to Chapter 31, Section 20.7, Health Care Claim Status Category Codes and Health Care Claims Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277.

What You Need to Do

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

Background

Claim Status Category Codes indicate the general category of a claim's status (accepted, rejected, additional information requested, etc.), which is then further detailed by the Claim Status Code(s). Under the Health Insurance Portability and Accountability Act (HIPAA), all payers (including Medicare) **must** use Claim Status Category and Claim Status codes approved by a recognized code set maintainer (instead of proprietary codes) to explain any status of a claim(s) sent in the Version 004010X093A1 Health Care Claim Status Request and Response transaction.

The Health Care Code Maintenance Committee maintains the Claim Status Category and Claim Status codes, and as previously mentioned, the Committee meets at the beginning of each X12 trimester meeting and makes decisions about additions, modifications, and retirement of existing codes.

Note: The updated list is posted three times a year (after each X12 trimester meeting) at the Washington Publishing Company Web site at ***www.wpc-edi.com/codes***. Once at the Washington Publishing Company Web site, select "Claim Status Codes" or "Claim Status Category Codes" to access the updated code list. Included in the code lists are specific details, including the date when a code was added, changed, or deleted. All code changes approved in February 2006 are to be listed at this above Web site approximately thirty (30) days after the meeting concludes. For this update, Medicare will begin using the codes in place as of 4/06.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R814CP.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

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/apps/contacts/*** on the CMS Web site.

Correction to Chapter 17, Section 80.2.3 of the Medicare Claims Processing Manual Regarding MSN/ANSI X12 Denial Messages for Anti-Emetic Drugs

Medlearn Matters Number: MM4001
Related Change Request (CR) #: 4001
Related CR Release Date: September 23, 2005
Related CR Transmittal #: 684
Effective Date: December 23, 2005
Implementation Date: December 23, 2005

The following information affects providers and suppliers billing Medicare carriers or durable medical equipment regional carriers (DMERCs) for anti-emetic drugs.

Provider Action Needed

This article is provided for your information only.

Background

Change Request (CR) 4001 corrects an error in the Medicare Claims Processing Manual (Pub. 100-4), Chapter 17, Section 80.2.3 (MSN /ANSI X12N Denial Messages for Anti-Emetic Drugs). The text incorrectly cites Medicare Summary Notice (MSN) 6.3 as a valid MSN denial message for anti-emetic drugs. In response to this correction, your carriers and DMERCs will not use **MSN 6.3**: "Payment cannot be made for oral drugs that do not have the same active ingredients as they would have if given by injection," when an anti-emetic drug is denied.

Rather, if the anti-emetic drug is denied because the Food and Drug Administration (FDA) did not approve it or because the drug is not being used as part of an anti-cancer chemotherapeutic regimen, carriers and DMERCs will use either:

- **MSN 6.2**: Drugs not specifically classified as effective by the Food and Drug Administration are not covered (ANSI X12 Adjustment Code 114); or
- **MSN 6.4**: Medicare does not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours after administration of a Medicare covered chemotherapy drug (ANSI X12 Group Code PR 96 with Remark Code M100).

Additional Information

You can find more information about Denial Messages for Anti-Emetic Drugs by going to ***www.cms.hhs.gov/transmittals/downloads/R684CP.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

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

Medicare System Edits for Respiratory Assist Devices (RADs) with Bi-Level Capability and a Back-Up Rate

Medlearn Matters Number: MM4223
Related Change Request (CR) #: 4223
Related CR Release Date: February 1, 2006
Related CR Transmittal #: R825CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

The following information affects providers and suppliers who bill Medicare regional home health intermediaries (RHHIs) or durable medical equipment regional carriers (DMERCs) for Respiratory Assist Devices (RADs).

Provider Action Needed

Please be aware of this payment change for RADs with bi-level capability and a back-up rate.

Key Points

- The Final Rule, CMS-1167-F, "Payment for Respiratory Assist Devices (RADs) with Bi-Level Capability and a Back-Up Rate," states that RADs with bi-level capability and a back-up rate **must** be paid as capped rental (CR) items or durable medical equipment (DME) under the Medicare program.
- RADs should **not** be paid as items requiring frequent and substantial servicing (FSS), as defined in Section 1834(a)(3) of the Social Security Act.
- Effective April 1, 2006, Medicare will move the Healthcare Common Procedure Coding System (HCPCS) codes E0471 and E0472 from the FSS category to the capped rental (CR) category.

Additional Information

The first claim received for each beneficiary for these codes with a date of service on or after April 1, 2006, will be counted as the first rental month in the capped rental period. Suppliers should begin submitting capped rental modifiers KH, KI, or KJ, as appropriate, with all rental claims for these codes with dates of service on or after April 1, 2006.

The official instruction issued to your RHHI or DMERC regarding this change may be found by going to ***www.cms.hhs.gov/Transmittals/downloads/R825CP.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Please refer to your local RHHI or DMERC if you have any questions. To find their toll-free telephone number, go to ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

Healthcare Provider Taxonomy Codes (HPTC) Update

Medlearn Matters Number: MM4254
Related Change Request (CR) #: 4254
Related CR Release Date: January 20, 2006
Related CR Transmittal #: R815CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

The following information affects physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for Part A and Part B services.

Provider Action Needed

Impact to You

This article is based on Change Request (CR) 4254, which informs Medicare contractors (carriers, DMERCs, FIs, and RHHIs) to obtain the most recent Healthcare Provider Taxonomy Codes (HPTC) and use it to update their internal HPTC tables.

What You Need to Know

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

compliant. Because health care provider taxonomy is a named code set in the 837 Institutional and Professional implementation guides, Medicare **must** validate the inbound taxonomy codes against their internal HPTC tables.

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

Background

The HPTC set is an external non-medical data code set designed for use in classifying health care providers according to provider type or practitioner specialty in an electronic environment (specifically, within the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) health care claim transaction).

HPTCs are scheduled for update twice per year (April and October). The HPTC list is available from the Washington Publishing Company at ***www.wpc-edi.com/codes/taxonomy*** in two forms:

- A free Adobe Portable Document Format (PDF) download of the HPTC list; and
- An electronic representation of the list (available for purchase) which facilitates the automatic loading of the code set.

Note: Claims received with invalid data are non-compliant with HIPAA and will **not** be processed by Medicare.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R815CP.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

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/apps/contacts/*** on the CMS Web site.

Requirements for Voided, Canceled, and Deleted Claims

Medlearn Matters Number: MM3627
Related Change Request (CR) #: 3627
Related CR Release Date: June 17, 2005 **Revised**
Related CR Transmittal #: 159
Effective Date: October 1, 2005
Implementation Date: October 3, 2005
Note: This article was revised on November 10, 2005, to clarify language in item 4 under "Acceptable Claims Deletions" within the "Background" section. All other information remains the same.

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

Provider Action Needed

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

Background

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

- Deny or reject claims that do **not** meet CMS requirements for payment for unacceptable reasons;
- Cancel, void, or delete claims that are unprocessable for acceptable reasons;
- Return as unprocessable claims that meet conditions mentioned below for the return of unprocessable claims; and
- Maintain an audit trail for all canceled, voided, or deleted claims that Medicare systems have processed far enough

to have assigned a Claim Control Number (CCN) or Document Control Number (DCN).

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

Acceptable Claims Deletions

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

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

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

Unacceptable Claims Deletions

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

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

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

Return as Unprocessable Claims

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

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

Summary

In summary, CMS believes the following:

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

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

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

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

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

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/intermediary regarding this change. That instruction may be viewed by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 3627 in the CR NUM column on the right and click on the file for that CR.

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

Medical Review Matching of Electronic Claims and Additional Documentation in the Medical Review Process

Medlearn Matters Number: MM4052
Related Change Request (CR) #: 4052
Related CR Release Date: November 10, 2005 **Revised**
Related CR Transmittal #: 131
Effective Date: February 10, 2006
Implementation Date: February 10, 2006
Note: This article was revised on November 24, 2005, to show the correct effective and implementation dates to be February 10, 2006. The original article incorrectly showed 2005. All other information remains the same.

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

Provider Action Needed

Impact to You

Other than certain limited exceptions, such as for providers that employ very few employees, the Centers for Medicare & Medicaid Services (CMS) currently instructs all initial claims to be filed electronically. This is true even when the claim will be subjected to prepayment medical review.

What You Need to Know

Generally, Medicare contractors (carriers, durable medical equipment regional carriers (DMERCs), and fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs)) **cannot** require or permit the voluntary submission of paper claims. If any supporting paper documentation is necessary for medical review, it can **only** be solicited by the contractor and submitted through the Additional Documentation Request (ADR) or alternate contractor process that permits matching. This supporting documentation **must** be submitted separately from an electronic claim, at the contractors' request. **Exception**: At their discretion, some contractors accept unsolicited paper supporting documentation, if they can match the electronic claim and paper documentation.

What You Need to Do

File initial claims electronically when subjected to prepayment medical review unless you are in an "excepted" category. Unless your contractor informs you that they accept supporting paper documentation with the electronic claim, submit all supporting documentation through the regular ADR process, or alternate contractor process that permits matching.

Background

Although Medicare contractors may use any information they deem necessary to make a prepayment or post-payment claim review determination, contractors may **not** require providers or suppliers to file initial claims on paper to Medicare when the claim requires additional documentation. The Administrative Simplification Compliance Act requires providers, with very few exceptions, to submit claims electronically.

Medicare contractors may **not** require or request of any provider the submission of supporting documentation with the initial claim(s) through contractor developed forms, local policies, or any other communication with providers. Medicare contractors may **only** request

supporting documentation through the ADR process or alternate contractor process that enables matching of the documentation to the initial claim.

Additional Information

The Medicare Claims Processing Manual, Chapter 24, Section 90, contains information regarding the limited circumstances under which your contractor may request paper claims. The manual is available at ***www.cms.hhs.gov/manuals/104_claims/clm104c24.pdf*** on the CMS Web site.

The official instruction issued to your carrier/intermediary/DMERC/RHHI regarding this change may be found by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for Change Request (CR) 4052 in the CR NUM column on the right and click on the file for that CR. You may also wish to refer to Medlearn Matters article MM3440 on the requirements to submit claims electronically. That article is available at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3440.pdf*** on the CMS Web site.

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

Eliminate the Use of Surrogate Unique Physician Identification Numbers (UPINs) on Medicare Claims

Medlearn Matters Number: MM4177 **Revised**
Related Change Request (CR) #: 4177
Related CR Transmittal #: 752
Related CR Release Date: November 10, 2005
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Note: This article was revised on February 16, 2006, to remove a reference to fiscal intermediaries (FIs) in the second bullet point under the "Background" section.

The following information affects physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), using surrogate Unique Physician Identification Numbers (UPINs).

Provider Action Needed

This article is based on Change Request (CR) 4177, which directs your carrier or DMERC to **no** longer accept the surrogate UPIN OTH000 to identify ordering or referring physicians on claims submitted by billers, suppliers, physicians, and non-physician practitioners. (Beneficiary submitted claims and mass immunization claims are excluded.)

Background

The Social Security Act (Section 1833(q)) requires that all physicians who meet the definition of a physician (Section 1861(r)) **must** have an UPIN and that all claims for services ordered or referred by one of these physicians include the name and UPIN of the ordering/referring physician. Currently, suppliers, physicians, and non-physician practitioners are allowed to bill for diagnostic, radiology, consultation services, and equipment with the use of surrogate UPIN OTH000. Surrogate UPINs were intended to be used during an interim period when an UPIN has been requested but has **not** yet been received.

CR 4177 announces that the Centers for Medicare & Medicaid Services (CMS) will **no** longer accept the surrogate UPIN OTH000 to identify the ordering or referring physicians on claims submitted by billers, suppliers, physicians, and non-physician practitioners, effective for dates of service April 1, 2006, and later (Beneficiary submitted claims and mass immunization claims are excluded.):

- Durable medical equipment (DME) suppliers, physicians, non-physician practitioners, and billers **must** submit the UPIN assigned to the ordering or referring physician; and
- Medicare carriers and DMERCs will return, as unprocessable, all claims submitted with surrogate UPIN OTH000.

Implementation

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

Additional Information

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

That instruction may be viewed at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 4177 in the CR NUM column on the right and click on the file for that CR. If you need to obtain another physician's UPIN for billing purposes, you may find that UPIN by going to ***www.upinregistry.com***.

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

Change Payment Floor Date for Paper Claims

Medlearn Matters Number: MM4284
Related Change Request (CR) #: 4284
Related CR Release Date: February 10, 2006
Related CR Transmittal #: R850CP
Effective Date: January 1, 2006
Implementation Date: March 13, 2006

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

Important Points to Remember

- Change Request (CR) 4284 changes the payment floor date for paper claims from the 27th day to the 29th day after receipt of a claim.
- Effective January 1, 2006, Medicare carriers, DMERCs, FIs, and RHHIs will **not** pay paper claims prior to the 29th day after receipt of the claim.

Background

The Social Security Act Section 1816b (c) (3) (B) (ii) and Section 1842 (c) (3) (B) (ii) provides for payment waiting periods for Medicare claims before a claim is paid by the Medicare contractor. Congress has amended the Social Security Act to extend the waiting period for paper claims from 27 to 29 days, effective January 1, 2006.

Implementation

The implementation date for this instruction is March 13, 2006.

Additional Information

The official instructions issued to your carrier regarding this change can be found at ***www.cms.hhs.gov/Transmittals/downloads/R850CP.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

If you have questions, please contact your Medicare carrier, DMERC, FI, or RHHI at their toll-free number, which may be found at ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

Erroneous Guidance - Basis to Waive Penalty

Medlearn Matters Number: MM3898
Related Change Request (CR) #: 3898
Related CR Release Date: November 1, 2005
Related CR Transmittal #: 739
Effective Date: July 24, 2003
Implementation Date: January 19, 2006

The following information affects physicians, suppliers, and providers who bill Medicare and who face penalties as a result of such billings.

Provider Action Needed

Impact to You

Providers and suppliers may **not** be subject to a penalty if the basis for the penalty that would have otherwise been applicable was that the provider acted in accordance with erroneous guidance from the Medicare program.

What You Need to Know

Medicare can grant a waiver of a penalty when **ALL of the following conditions are present**:

- The guidance was erroneous.
- The guidance was issued by the Secretary of the Department of Health and Human Services or was issued by a Medicare contractor (carrier, fiscal intermediary, durable medical equipment regional carrier (DMERC), or regional home health intermediary (RHHI)) acting within the scope of the contractor's Medicare contract authority.
- The guidance was in writing.
- The guidance related to the furnishing of an item or service or to the submission of a claim for benefits for furnishing such item or service with respect to the provider or supplier submitting such claim.

- The guidance was issued timely.
- The provider or supplier accurately and fully presented the circumstances relating to such items, services, and claim to the Medicare contractor or to the Centers for Medicare & Medicaid Services (CMS) and did so in writing.
- The provider or supplier followed the guidance provided by the Medicare contractor (or by CMS).

What You Need to Do
Review Change Request (CR) 3898 if you feel you are being subjected to a penalty for acting in accordance with erroneous guidance from the Medicare program.

Background

Section 903 (c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, referred to as MMA, establishes a basis for waiving penalties and interest charges levied on providers and suppliers who incurred such penalties and/or interest as a result of following Medicare guidance, which turned out to be erroneous. **CR 3898 details the conditions under which a provider or supplier may seek a waiver of a penalty due to such erroneous guidance. CR 3898 does *not* address the waiver of interest charges.**

Additional Information

Full details of the process for seeking and obtaining a waiver can be found in Chapter 33 (Miscellaneous Hold Harmless Provisions), Section 10 (Erroneous Program Guidance: Basis to Waive Penalty) of the Medicare Claims Processing Manual. That material is attached to CR 3898, which can be found by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web site, look for CR 3898 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*** on the CMS Web site.

Hold on Medicare Payments

Medlearn Matters Number: MM4349
Related Change Request (CR) #: 4349
Related CR Release Date: February 10, 2006
Related CR Transmittal #: R847CP
Effective Date: September 22, 2006
Implementation Date: July 3, 2006

The following information affects providers and physicians who bill Medicare contractors - fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), and carriers - for their services.

Provider Action Needed

Impact to You
A brief hold will be placed on Medicare payments for all claims for the last nine days of the federal fiscal year, i.e., September 22, 2006 - September 30, 2006. Claims held as a result of this one-time policy will be paid on October 2, 2006. **No** interest or late penalty will be paid to an entity or individual for any delay in a payment by reason of this one-time hold on payments.

What You Need to Know
Additionally, Medicare contractors will continue to apply the Centers for Medicare & Medicaid Services (CMS) regulations for the 14-day electronic claim payment floor and the 29-day paper claim payment floor.

What You Need to Do
Please note that this policy applies *only* to claims subject to payment. It does **not** apply to full denials and no-pay claims. Essentially, **no** payments on claims will be made from September 22-30, 2006, and providers should be aware of these payment delays, which are mandated by Section 5203 of the Deficit Reduction Act of 2006.

Additional Information

Change Request (CR) 4349 is the official instruction issued to your FI, RHHI, or carrier regarding changes mentioned in this article. CR 4349 may be found at ***www.cms.hhs.gov/Transmittals/downloads/R847CP.pdf*** on the CMS Web site.

Please refer to your local FI/RHHI or carrier if you have questions about this issue. To find their toll-free telephone number, go to ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

Stage 1 Use and Editing of National Provider Identifier Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or Paper Claim Forms

Medlearn Matters Number: MM4320
Related Change Request (CR) #: 4320
Related CR Release Date: February 1, 2006
Related CR Transmittal #: R204OTN
Effective Date: January 1, 2006
Implementation Date: January 3, 2006

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

Provider Action Needed

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414)). To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began accepting applications for and issuing NPIs on May 23, 2005. Applications can be made by mail and online at ***https://nppes.cms.hhs.gov*** on the CMS Web site.

CMS has endorsed the Workgroup for Electronic Data Interchange (WEDI) Dual NPI-Legacy Identifier strategy for cross-health care industry implementation of the NPI. The Dual Use of NPI & Legacy Identifiers paper is available at ***www.wedi.org/snip/public/articles/***. (Once at the site, scroll down and look for the paper issued on January 22, 2006 (01/22/2006).)

The remainder of this article describes CMS' current plans for a staged process leading to full implementation of the adoption of the NPI in Medicare transactions involving providers.

Background

Implementation involves acceptance and processing of transactions that use the NPI in lieu of the previously used Online Survey Certification and Reporting (OSCAR), Unique Physician Identification Number (UPIN), Provider Identification Number (PIN), and National Supplier Clearinghouse (NSC) numbers. The WEDI strategy provides for four stages during which system change schedules of trading partners will occur independently of each other.

Medicare fee-for-service (FFS) transaction implementation for NPI will occur in the following stages:

Stage 1 (January 1, 2006 – October 1, 2006)

During this stage, the NPI will be accepted on inbound claims, other than National Council of Prescription Drug Plan (NCPDP) claims, and other transactions but will **not** be used for Medicare processing. Change Request (CR) 4320 focuses primarily on stage 1 of the NPI implementation process. During stage 1:

- The "Legacy Identifier" (pre-NPI provider identifiers) will be used to identify providers while Medicare carriers, DMERCs, and intermediaries make sure that X12 837 version 4010A1 claims and other X12 HIPAA adopted transactions are **not** rejected due to the presence of an NPI. (Transactions may be submitted with or without an NPI during stage 1, as long as the Medicare legacy identifier is still reported.)
- Additionally, NPIs will be edited to verify that they meet basic structure requirements established for NPIs.
- Medicare will allow NPIs on the X12 270 version 4010A1 eligibility inquiry and the 276 claim status inquiry and return them in the respective X12 271 or 277 response, as long as the legacy identifier is also reported in the 270 or the 276.
- NPIs, as well as legacy identifiers, will be reported in coordination of benefit claims sent to trading partners when submitted on claims submitted to Medicare.
- NPIs will NOT be reported in the following outbound transactions during stage 1, even if an NPI was submitted on related claims:
  - X12 835 claims; or
  - SPR (standard paper remittance) formats.
- Medicare carriers, DMERCs, and intermediaries **must reject the following transactions if submitted with NPIs**, since it is **not** possible to report both NPIs and legacy identifiers for providers in these transactions:
  - **NCPDP claims**;
  - **DDE (direct data entry) claims, claim status, and eligibility inquiries**;
  - **UB-92 (CMS-1450) paper claims** (the National Uniform Billing Committee [NUBC] announced that the use of the UB-04, which is able to report the NPI and a legacy identifier for each provider

involved with a claim, will begin March 1, 2007, and that May 22, 2007, is the last day that a payer should accept a UB-92 form). Since it is **not** possible to report both a legacy identifier and an NPI on the UB-92, submitters of the UB-92 will be limited to reporting of their legacy identifier on those claims; and

- **CMS-1500 paper claims** until the National Uniform Claim Committee (NUCC) implements a revised 1500, and CMS announces its implementation of that revised form.

  The NUCC has approved a revised CMS-1500 form and has announced that payers should begin to accept the revised form effective October 1, 2006. Between October 1, 2006, and January 31, 2007, payers should accept either the current or the revised CMS-1500 form. Effective February 1, 2007, and later, payers should accept **only** the revised CMS-1500 form. Both the NPI and the legacy identifier can be reported on the revised CMS-1500 form, but **not** on the form currently in use. Until a provider begins to use the revised form, that provider will be limited to submission of legacy identifiers on the non-revised CMS-1500 form.

Stage 2 (October 2, 2006 – May 22, 2007)

During this stage:

- Providers, clearinghouses, and billing services will be directed to provide a Medicare legacy identifier as a secondary identifier when NPIs are submitted as the primary provider identifiers in their X12 837 claims.
- The legacy identifier alone can still be used to identify those providers that have **not** yet obtained an NPI.
- The transitional Dual NPI-Legacy Identifier strategy includes the development of a crosswalk between Medicare legacy numbers and their associated NPIs. The crosswalk should help Medicare validate most NPIs to ascertain that they were actually issued to the providers for which reported and will help to identify transcription errors in a reported NPI. The crosswalk will begin operating at the onset of stage 2.
- If you use free billing software supplied by your carrier, DMERC, or intermediary/RHHI, it will be modified for stage 2 to permit reporting of your NPI, once received, and your legacy Medicare provider identifier. You will need to download the new version of the software when notified it is available.

  The 835 PC-Print and Easy Print software for printing of remittances will also be updated for stage 2 to permit reporting of NPIs as well as legacy numbers when both are reported in an 835 transaction. Be sure to download the new version of that software when notified it is available.
- DDE screens will be modified for this stage to accept and return both NPIs, when available, and legacy identifiers.
- NPIs, when available in Medicare provider files, as well as legacy identifiers will be returned in 835 transactions and SPRs during stage 2.

Stage 3 (May 23, 2007 and Later)

Stage 3 involves the transition to full use of the NPI for acceptance and processing of transactions, **except** for coordination of benefits (COB) claims that Medicare sends to small trading partners.

- HIPAA prohibits the reporting of any provider legacy identifiers to other than small health plans during this period (e.g., plans with less than $5 million in annual receipts).
- All claims, including NCPDP claims and 270, 276, and 277 attachment transactions sent to Medicare, **must** contain the NPI in lieu of the legacy identifier (please see stage 4 below regarding claims). Those that do **not** are to be rejected.
- Legacy identifiers will **no** longer be sent to COB trading partners or on outbound electronic or paper Medicare transactions or correspondence.

Stage 4 (May 23, 2007 – May 22, 2008)

Stage 4 involves completion of transition to the full use of NPI by all small trading partners. NPIs, rather than legacy identifiers, will be reported in all 837 version 4010A COB and NCPDP claims sent to small trading partners.

Additional Information

CR 4320 is the official instruction issued to your FI, including RHHI, or carrier, including DMERC, regarding changes mentioned in this article. CR 4320 can be found at ***www.cms.hhs.gov/Transmittals/downloads/R204OTN.pdf*** on the CMS Web site. You may also want to review Medlearn Matters Special Edition article SE0555 concerning the NPI. That article is available at ***www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0555.pdf*** on the CMS Web site.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find their toll-free telephone number, go to ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

Stage 2 Requirements for Use and Editing of National Provider Identifier (NPI) Numbers Received in Electronic Data Interchange Transactions, via Direct Data Entry Screens, or Paper Claim Forms

Medlearn Matters Number: MM4023 **Revised**
Related Change Request (CR) #: 4023
Related CR Transmittal #: 190
Related CR Release Date: November 3, 2005
Effective Date: April 1, 2006
Implementation Date: April 3, 2006
Note: This article was revised on November 29, 2005, to clarify that the end date of the transition period for the revised CMS-1500 form is February 1, 2007. (See the paper claims form section under "Additional Information.")

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

Provider Action Needed

The requirements for Stage 2 apply to all transactions that are first processed by Medicare systems on or after October 2, 2006, and are **not** based on the date of receipt of a transaction, unless otherwise stated in a business requirement.

Please note that the effective and implementation dates shown above reflect the dates that Medicare systems will be ready, but the key date for providers regarding the use of the national provider identifier (NPI) in Stage 2 is October 1, 2006.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires issuance of a unique NPI to each physician, supplier, and other provider of health care (45 CFR Part 162, Subpart D (162.402-162.414)). To comply with this requirement, the Centers for Medicare & Medicaid Services (CMS) began to accept applications for, and to issue NPIs, on May 23, 2005. Applications can be made by mail and also online at ***https://nppes.cms.hhs.gov***.

NPI and Legacy Identifiers

The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do **not** carry other information about healthcare providers, such as the state in which they live or their medical specialty. **Beginning May 23, 2007 (May 23, 2008, for small health plans), the NPI *must* be used in lieu of legacy provider identifiers.**

Legacy provider identifiers include:

- Online Survey Certification and Reporting (OSCAR) system numbers;
- National Supplier Clearinghouse (NSC) numbers;
- Provider Identification Numbers (PINs); and
- Unique Physician Identification Numbers (UPINs) used by Medicare.

They do **not** include taxpayer identifier numbers (TINs) such as:

- Employer Identification Numbers (EINs); or
- Social Security Numbers (SSNs).

Primary and Secondary Providers

Providers are categorized as either "primary" or "secondary" providers:

- ***Primary providers*** include billing, pay-to, rendering, or performing providers. In the DMERCs, primary providers include ordering providers.
- ***Secondary providers*** include supervising physicians, operating physicians, referring providers, and so on.

Crosswalk

During Stage 2, Medicare will utilize a crosswalk between NPIs and legacy identifiers to validate NPIs received in transactions, assist with population of NPIs in Medicare data center provider files, and report NPIs on remittance advice (RA) and coordination of benefit (COB) transactions. Key elements of this crosswalk include the following:

- Each primary provider's NPI reported on an inbound claim or claim status query will be crosswalked to the Medicare legacy identifier that applies to the owner of that NPI.
- The crosswalk will be able to do a two-directional search, from a Medicare legacy identifier to NPI and from NPI to a legacy identifier.
- The Medicare crosswalk will be updated daily to reflect new provider registrations.

NPI Transition Plans for Medicare Fee-for-Service (FFS) Providers

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

Stage	Medicare Implementation
May 23, 2005 - January 2, 2006:	Providers should submit Medicare claims using **only** their existing **Medicare** numbers. They should **not** use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.
January 3, 2006 - October 1, 2006:	Medicare systems will accept claims with an NPI, but an existing legacy Medicare number **must** also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes **only** an NPI. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.
October 2, 2006 - May 22, 2007: ***(This is Stage 2, the subject of Change Request (CR) 4023)***	CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and **no** Medicare legacy identifier is submitted, the provider may **not** be paid for the claim. *Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier.* Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.
May 23, 2007 – Forward:	CMS systems will **only** accept NPI numbers. Coordination of benefit transactions sent to small health plans will continue to carry legacy identifiers, if requested by such a plan, through May 22, 2007.

Claim Rejection

Claims will be rejected if:

- The NPI included in a claim or claim status request does **not** meet the content criteria requirements for a valid NPI; this affects:
  - X12 837 and Direct Data Entry (DDE) screen claims (DDE claims are submitted to Medicare intermediaries only);
  - National Council of Prescription Drug Plan (NCPDP) claims (submitted to Medicare DMERCs only);
  - Claims submitted using Medicare's free billing software;
  - Electronic claim status request received via X12 276 or DDE screen; and
  - Non-X12 electronic claim status queries;
- An NPI reported **cannot** be located in Medicare files;
- The NPI is located, but a legacy identifier reported for the same provider in the transaction does **not** match the legacy identifier in the Medicare file for that NPI;
- Claims include the NPI but do **not** have a TIN reported for the billing or pay-to provider in electronic claims received via X12 837, DDE screen (FISS only), or Medicare's free billing software.

Note: If **only** provider legacy identifiers are reported on an inbound transaction prior to May 23, 2007, pre-NPI provider legacy number edit rules will be applied to those legacy identifiers.

Additional Information

X12 837 Incoming Claims and COB

During Stage 2, an X12 837 claim may technically be submitted with **only** an NPI for a provider, **but you are strongly encouraged to also submit the corresponding Medicare legacy identifier for each NPI** in X12 837 Medicare claims.

Use of both numbers could facilitate investigation of errors if one identifier or the other **cannot** be located in the Medicare validation file. When an NPI is reported in a claim for a billing or pay-to provider, a TIN **must** also be submitted in addition to the provider's legacy identifier as required by the claim implementation guide.

National Council of Prescription Drug Plans (NCPDP) Claims

The NCPDP format was designed to permit a prescription drug claim to be submitted with either **an NPI or a legacy identifier, but *not* more than one identifier** for the same retail pharmacy or prescribing physician. The NCPDP did provide qualifiers, including one for NPIs, to be used to identify the type of provider identifier being reported.

- For Stage 1, retail pharmacies were directed to continue filing their NCPDP claims with their individual NSC number and to report the UPIN of the prescribing physician.
- During Stage 2, retail pharmacies will be allowed to report their NPI, and/or the NPI of the prescribing physician (if they have the prescribing physician's NPI), in their claims.

When an NPI is submitted in an NCPDP claim, it will be edited in the same way as an NPI submitted in an X12 837 version 4010A1 claim. The retail pharmacy will be considered the primary provider and the prescribing physician as the secondary provider for NPI editing purposes.

Paper Claim Forms

The transition period for the revised CMS-1500 is currently scheduled to begin October 1, 2006, and end February 1, 2007. The transition period for the UB-04 is currently scheduled for March 1, 2007 - May 22, 2007. Pending the start of submission of the revised CMS-1500 and the UB-04, **providers *must* continue to report legacy identifiers, and *not* NPIs, when submitting claims on the non-revised CMS-1500 and the UB-92 paper claim forms**.

Provider identifiers reported on those claim forms are presumed to be legacy identifiers and will be edited accordingly. "Old" form paper claims, received through the end of the transition period that applies to each form, may be rejected if submitted with an NPI. Or, if they are **not** rejected - since some legacy identifiers were also 10-digits in length - could be incorrectly processed, preventing payment to the provider that submitted that paper claim.

Standard Paper Remits (SPRs)

The SPR FI and carrier/DMERC formats are being revised to allow reporting of both a provider's NPI and legacy identifier when both are available in Medicare's files. If a provider's NPI is available in the data center provider file, it will be reported on the SPR, even if the NPI was **not** reported for the billing/pay-to or rendering provider on each of the claims included in that SPR. The revised FI and carrier/DMERC SPR formats are attached to CR 4023:

- CR 4023 Attachment 1: FI Standard Paper Remit (SPR) Amended Format for Stage 2; and
- CR 4023 Attachment 2: Carrier/DMERC SPR Amended Stage 2 Format.

Remit Print Software

The 835 PC-Print and Medicare Remit Easy Print software will be modified by October 2, 2006, to enable either the NPI or a Medicare legacy number, or both, if included in the 835, to be printed during Stage 2.

Free Billing Software

Medicare will ensure that this software is changed as needed by October 2, 2006, to enable reporting of both an NPI and a Medicare legacy identifier for each provider for which data is furnished in a claim and to identify whether an entered identifier is an NPI or a legacy identifier.

In-Depth Information

Please refer to CR 4023 for additional detailed NPI-related claim information about the following topics:

- Crosswalk
- X12 837 Incoming Claims and COB
- Non-HIPAA COB Claims
- NCPDP Claims
- DDE Screens
- Paper Claim Forms
- Free Billing Software
- X12 276/277 Claim Status Inquiry and Response Transactions
- 270/271 Eligibility Inquiry and Response Transactions
- 835 Payment and Remittance Advice Transactions
- Electronic Funds Transfer (EFT)
- Standard Paper Remits (SPRs)
- Remit Print Software
- Claims History
- Proprietary Error Reports
- Carrier, DMERC, and FI Local Provider Files, including Electronic Data Interchange (EDI) System Access Security Files
- Med A and Med B Translators
- Other Translators
- Stages 3 and 4

CR 4023, the official instruction issued to your FI/regional home health intermediary (RHHI) or carrier/durable medical equipment regional carrier (DMERC) regarding this change, may be found by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 4023 in the CR NUM column on the right and click on the file for that CR.

You may also wish to review Medlearn Matters article SE0555, "Medicare's Implementation of the National Provider Identifier (NPI): The Second in the Series of Special Edition Medlearn Matters Articles on NPI-Related Activities," which is available at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0555.pdf*** on the CMS Web site. This article contains further details on the NPI and how to obtain one.

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

NPI - Medicare Policy on Subpart Designation

Medlearn Matters Number: SE0608
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A

The following information affects provider types that include organization health care providers and suppliers who are covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and who are enrolled in the Medicare program. These are certified providers and suppliers, supplier groups and supplier organizations, and suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). (This information does **not** apply to health care providers who are enrolled in Medicare as individual practitioners, such as physicians and nurse practitioners, **nor** does it apply to sole proprietors.)

Key Points

- Medicare is transitioning from the provider identifiers it currently uses in HIPAA standard transactions to the new National Provider Identifier, or NPI.
- For Medicare organization health care providers, the current identifiers could include:
  - Online Survey Certification and Reporting (OSCAR) system numbers;
  - National Supplier Clearinghouse (NSC) numbers;
  - Provider Identification Numbers (PINs); and
  - Unique Physician Identification Numbers (UPINs) used by Medicare.

  These numbers are now considered **legacy identifiers or legacy numbers**. Medicare is transitioning from these legacy identifiers to **NPIs**. **Note**: When applying for an NPI, Medicare providers are urged to include their legacy numbers, particularly their Medicare legacy number, on the NPI application form.
- By regulation, Medicare organization health care providers who are HIPAA covered entities **must** obtain NPIs. The NPIs will replace the identifiers currently in use in standard transactions with Medicare and with other health plans. Additionally, these **health care providers *must* determine if they have subparts that need to be uniquely identified** in standard transactions with their own NPIs.

Background

Organization health care providers are corporations, partnerships, or other types of businesses that are considered separate from an individual by the state in which they exist. Subparts of such organization health care providers are also Organizations. All of these health care providers would apply for NPIs as Organizations (Entity Type 2). **Note**: In terms of NPI assignment, an Individual is an Entity Type 1 (Individual) and is eligible for a single NPI. As an Individual, a physician or nurse practitioner, for example, as well as a sole proprietor/sole proprietorship, **cannot** have subparts and **cannot** designate subparts.

Most Medicare organization health care providers (Entity Type 2 providers) send electronic claims to Medicare (standard transactions), making them covered health care providers (HIPAA covered entities).

Subpart Designation Guidelines

Covered organization health care providers are responsible for determining if they have "subparts" that need to have NPIs. If they do, the covered organization health care providers **must** ensure that the subparts obtain their own unique NPIs, or they **must** obtain them for them. Below are some guidelines to help determine if an enrolled Medicare organization health care provider has a subpart, which will need its own unique NPI.

Regarding all of the entities that could be considered subparts:

- A subpart is **not** itself a separate legal entity, but is a part of a covered organization healthcare provider that is a legal entity. (All covered entities under HIPAA are legal entities.)
- A subpart furnishes health care as defined at 45 CFR 160.103. (This information can be found at ***www.hhs.gov/ocr/regtext.html*** on the Department of Health and Human Services (DHHS) Web site.)

Regarding some or all of the entities that a Medicare covered organization health care provider could consider as subparts:

- A subpart may or may not be located at the same location as the covered organization health care provider of which it is a part.
- A subpart may or may not have a Taxonomy (Medicare specialty) that is the same as the covered organization health care provider of which it is a part. Federal

statutes or regulations pertaining to requirements for the unique identification of enrolled Medicare providers may relate to entities that could be considered subparts according to the discussion in the NPI Final Rule. If such statutes or regulations exist, the health care providers to whom they apply would need NPIs in order to ensure they can continue to be uniquely identified.

- A subpart that conducts any of the HIPAA standard transactions separately from the covered organization health care provider of which it is a part **must** have its own unique NPI.

Medicare Organization Subpart Examples

Enrolled Certified Providers and Suppliers

An enrolled provider (a hospital) owns 10 home health agencies, all operating under the TIN (Tax Identification Number) of the hospital. Because the hospital and each of the 10 home health agencies is separately surveyed and enters into its own provider agreement with Medicare, Medicare encourages that the hospital mirror its Medicare enrollment and obtain a total of 11 unique NPIs in order to help avoid claims processing delays (one NPI for the hospital, and one for each of the 10 home health agencies).

Enrolled Supplier Group or Supplier Organization

An enrolled Independent Diagnostic Testing Facility (IDTF) has four different locations, and each one must be separately inspected by the carrier. All four locations operate under a single TIN. Because each location is separately inspected in order to enroll in Medicare, Medicare encourages the IDTF to mirror its Medicare enrollment and obtain a total of four unique NPIs in order to help avoid claims processing delays (one NPI for each location).

Enrolled Suppliers of DMEPOS

Each enrolled supplier of DMEPOS that is a covered entity under HIPAA **must** designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI. Federal regulations require that each location of a Medicare DMEPOS supplier have its own unique billing number. In order to comply with that regulation, each location **must** have its own unique NPI.

Please note that regardless of how subparts are determined and NPIs obtained, Medicare payments, by law, may be made **only** to an enrolled Medicare provider or supplier.

Important Medicare NPI Implementation Dates

January 3, 2006 - October 1, 2006

Medicare systems will accept claims with an NPI, but an existing legacy Medicare number **must** also be on the claim. Note that Centers for Medicare & Medicaid Services (CMS) claims processing systems will reject, as unprocessable, any claim that includes **only** an NPI. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

October 2, 2006 - May 22, 2007

CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and **no** Medicare legacy identifier is submitted, the provider may **not** be paid for the claim. Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the Medicare legacy identifier as a secondary identifier. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.

May 23, 2007 - Forward

CMS systems will **only** accept NPI numbers. Small health plans have an additional year to be NPI compliant.

Final Notes About NPIs

With regard to enrolled organization health care providers or subparts who **bill more than one** Medicare contractor:

- An enrolled organization health care provider or subpart is expected to use a single (the same) NPI when billing more than one Medicare contractor.
- For example, a physician group practice billing a Maryland carrier and also billing a Pennsylvania carrier would use a single (the same) NPI to bill both carriers.

With regard to enrolled organization health care providers or subparts who **bill more than one type** of Medicare contractor:

- Generally, the type of service being reported on a Medicare claim determines the type of Medicare

contractor who processes the claim. Medicare will expect an enrolled organization health care provider or subpart to use a single (the same) NPI when billing more than one type (fiscal intermediary, carrier, regional home health intermediary (RHHI), durable medical equipment regional carrier (DMERC)) of Medicare contractor.

- In certain situations, Medicare requires that the organization health care provider (or possibly even a subpart) enroll in Medicare as **more than one type of provider.** For example, an ambulatory surgical center enrolls in Medicare as a Certified Supplier and bills its services to a carrier. If the ambulatory surgical center also sells durable medical equipment, it must also enroll in Medicare as a Supplier of Durable Medical Equipment (DME) and bill the DME to a DMERC. This ambulatory surgical center would obtain a single NPI and use it to bill the carrier and the DMERC.
- Medicare expects that this ambulatory surgical center would report two different taxonomies when it applies for its NPI:
  - Ambulatory Health Care Facility: Clinic/Center - Ambulatory Surgical (261QA1903X); and
  - Suppliers: Durable Medical Equipment & Medical Supplies (332B00000X) or the appropriate sub-specialization under the 332B00000X specialization.

With regard to enrolled organization health care providers who determine subparts for **reasons unrelated to** Medicare statutes, regulations, or policies:

- Consistent with the NPI Final Rule, covered organization health care providers may designate subparts for reasons that are **not** necessarily related to Medicare statutes or regulations.
- If a Medicare organization health care provider designates as subparts entities other than those who are enrolled Medicare providers, and those subparts obtain their own NPIs and use those NPIs to identify themselves in HIPAA standard transactions with Medicare, **those NPIs will *not* identify enrolled Medicare providers**. Medicare is **not** required to enroll them. NPI Final Rule, page 3441, says the following: "If an organization health care provider consists of subparts that are identified with their own unique NPIs, a health plan may decide to enroll none, one, or a limited number of them (and to use only the NPIs of the one(s) it enrolls)."

Additional Information

Medicare's NPI Responsibilities

Medicare will:

- Use NPIs to **identify** health care providers and subparts in HIPAA standard transactions; (NPI Final Rule, page 3469, Section 162.412(a): "A health plan must use the NPI of any health care provider (or subpart(s), if applicable) that has been assigned an NPI to identify that health care provider on all standard transactions where that health care provider's identifier is required.")
- Ensure that the NPIs it receives in HIPAA standard transactions are valid;
- Reject HIPAA standard transactions that contain invalid NPIs.

Valid NPIs, however, like the provider identifiers used today, **must** be "known" to Medicare. Medicare is **not** permitted to make payments for services rendered by non-Medicare providers, **nor** is it permitted to reimburse providers who are **not** enrolled in the Medicare program. Medicare will return, with appropriate messages, any HIPAA standard transactions containing valid but unrecognizable NPIs.

Related Links

In preparation for the release of the Electronic File Interchange (EFI) system, CMS released several documents on the EFI process. EFI, also referred to as "bulk enumeration," is a process by which a health care provider or group of providers can have a particular organization (the "EFIO") apply for NPIs on their behalf. EFI documents posted to the Web include a summary, user's guide, and technical companion manual. Visit ***www.cms.hhs.gov/NationalProvIdentStand/07_efi.asp*** to download these new items.

NPI-related information, including how to apply for an NPI and a new fact sheet for health care providers who are individuals, is available at ***www.cms.hhs.gov/NationalProvIdentStand/*** on the CMS Web site. The NPI Final Rule can be found at ***www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIfinalrule.pdf*** on the CMS Web site.

Announcement of Redesigned National Provider Identifier (NPI) Web Page

Announcing the redesigned Centers for Medicare & Medicaid Services (CMS) Web page dedicated to providing all the latest National Provider Identifier

(NPI) news for health care providers! Visit ***www.cms.hhs.gov/NationalProvIdentStand/*** on the Web. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A new fact sheet with answers to questions that health care providers may have regarding the NPI is now available on the Web page; bookmark this page as new information and resources will continue to be posted.

For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative Web site at ***www.wedi.org/npioi/index.shtml*** on the Web.

Explanation of Systems Used by Medicare to Process Your Claims

Medlearn Matters Number: SE0605
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A

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

Introduction

This Special Edition article provides a high-level overview of the software systems Medicare uses to process your claims. Frequently, Medlearn Matters articles reference Medicare systems, and this article will help explain briefly what those systems are.

Sometimes, you may see documents from the Centers for Medicare & Medicaid Services (CMS) that reference the "Shared Systems" or system acronyms, such as FISS, MCS, or CWF. The purpose of this Special Edition article is to provide you with some understanding of these systems and how they are used to process your claims.

Overview

When a beneficiary visits a physician, hospital, or other supplier of health care services, a claim is sent by the provider of the service to a Medicare fiscal intermediary (FI) or carrier, including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs). Collectively, the carriers, FIs, DMERCs, and RHHIs are referred to as Medicare contractors. Using certain systems, known within CMS as "Shared Systems," the Medicare contractors perform traditional claims processing services and send claims to another Medicare system, known as the Common Working File (CWF) System for verification, validation, and payment authorization. Responses are returned from the CWF concerning payments to the FI, RHHI, DMERC, or carrier, who subsequently pays for the service, if appropriate. **Only** CMS and the Medicare contractors have direct communication with the CWF System. CWF provides an interface between CMS and its contractors.

The Medicare Claims Flow Diagram at the end of this article illustrates the claims processing flow. In brief, the various systems that process Medicare claims are described as follows:

Shared Systems

There are three "Shared Systems" that process Medicare claims:

- One processes Medicare claims submitted to FIs and RHHIs;
- Another processes claims submitted to carriers; and
- The third processes claims submitted to DMERCs.

All three of the "Shared Systems" interface with the CWF, which is addressed below. These systems apply certain edits to claims received. Claims that do **not** pass those edits are returned to the provider (RTP) and are often referred to as RTP claims. Examples of claims that may be RTPed include those where an invalid health insurance claim number (HICN) or an invalid provider number is supplied on the initial claim.

Fiscal Intermediary Standard System (FISS)

FISS is a mainframe system that FIs and RHHIs use to process Medicare Part A claims nationwide, including outpatient claims submitted under Part B. Within FISS, claims are entered, corrected, adjusted, or canceled. Inquiries for status of claims, for additional development requests, or for eligibility and various codes are processed.

Multi-Carrier System (MCS)

MCS is a mainframe system that Medicare Part B carriers use to process Medicare Part B claims

nationwide. It processes claims for physician care, durable medical equipment, and other outpatient services. Like its Part A counterpart, claims are entered, corrected, adjusted, or canceled. Inquiries for status of claims, for additional development requests, or for eligibility and various codes are processed.

VMS Shared System
This system has some of the same characteristics as the MCS, but processes claims submitted by suppliers to the Medicare DMERCs.

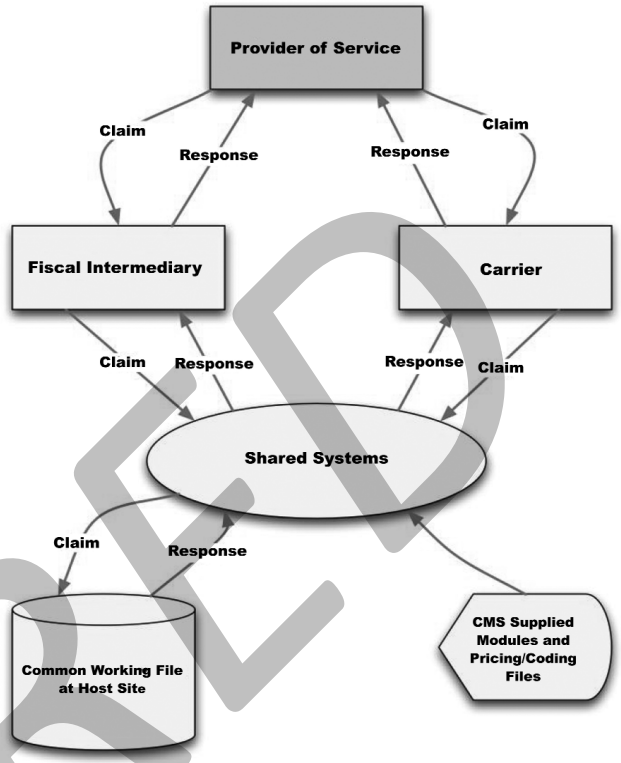
CMS-Supplied Modules and Pricing/Coding Files
In addition to the "Shared Systems," CMS supplies other uniform modules to FIs, RHHIs, DMERCs, and carriers, and these modules are used by the shared systems in processing Medicare claims. By and large, these modules establish rates (or prices) and processing logic according to type of service. These modules or programs include the following:

- Those referred to as the PRICERs (there are several PRICERs, such as an inpatient PRICER, an outpatient PRICER, and so on);
- OCE (Outpatient Code Editor);
- MCE (Inpatient Code Editor); and
- GROUPER, which translates variables such as age, diagnosis, and surgical codes into a diagnosis related group (DRG).

In addition, fee schedules and codes are supplied by CMS in the form of downloadable files which are used by the shared systems in processing Medicare claims. Some of these files include: MPFSDB (Medicare Physician Fee Schedule) and its various forms; DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule); Ambulance Fee Schedule; and HCPCS (Healthcare Common Procedure Coding System).

Common Working File (CWF)
The CWF contains information about all Medicare beneficiaries. The shared systems interface with the CWF to verify beneficiaries' entitlement to Medicare, deductible status, and benefits available, such as lifetime reserve days. The CWF actually approves payment of each claim. Under CWF, Part A and Part B data for each beneficiary is combined into a single, common working file.

Medicare Claims Processing



Shared Systems Medicare Secondary Payer (MSP) Balancing Edit and Administrative Simplification Compliance Act (ASCA) Enforcement Update

Medlearn Matters Number: MM4261
Related Change Request (CR) #: 4261
Related CR Release Date: February 2, 2006
Related CR Transmittal #: R831CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

The following information affects physicians, suppliers, and providers billing Medicare Secondary Payer (MSP) claims to Medicare carriers, fiscal intermediaries (FIs), durable medical equipment regional carriers (DMERCs), and regional home health intermediaries (RHHIs).

Key Points for Providers

Change Request (CR) 4261 makes two key changes to Medicare claims processing as follows:

- First, CR 4261 states that inbound MSP claims will be rejected if the paid amounts and the adjusted amounts paid by the primary payer do **not** equal the billed amounts at the line level and if the claim lacks standard claim adjustment reason codes to identify adjustments performed.

  While Medicare may be able to handle such a discrepancy because it does **not** always use this information, it may pass such claims to other payers. Such other payers may then reject the claims because they do **not** comply with the 837 version 4010A1 institutional and professional implementation guides. As a result, Medicare will **not** accept such claims in order to be fully compliant with the Health Insurance Portability and Accountability Act (HIPAA).
- Second, if a provider's paper claims have been denied due to Administrative Simplification Compliance Act (ASCA) electronic claims provision enforcement by Medicare contractors (carriers, FIs, RHHIs, and DMERCs), the provider may resubmit the paper claims if they submit appropriate documentation that establishes that they meet the criteria for submitting paper claims.

  Providers have until the 91st day after the initial ASCA letter to submit documentation that proves eligibility for submission of paper claims. If a provider establishes eligibility later than the 91st day of the initial enforcement letter and then resubmits paper claims, payment will be denied for dates of service between the 91st day and the effective date for submission of claims.

Implementation

The implementation date for the instruction is July 3, 2006.

Additional Information

For details of enforcement of the ASCA, please see related Medlearn Matters article MM3440, "Administrative Simplification Compliance Act (ASCA) Enforcement of Mandatory Electronic Submission of Medicare Claims," at ***www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3440.pdf*** on the Centers for Medicare & Medicaid Services (CMS) Web site. The official instruction on this change, CR 4261, may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/ R831CP.pdf*** on the CMS Web site.

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

Enrolling Indian Health Service (IHS) Facilities as Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers

Medlearn Matters Number: MM3845
Related Change Request (CR) #: 3845
Related CR Release Date: November 18, 2005
Related CR Transmittal #: 133
Effective Date: January 1, 2005
Implementation Date: April 3, 2006

The following information affects Indian Health Services (IHS) facilities wishing to enroll as Medicare suppliers.

Provider Action Needed

Impact to You

Section 630 of the Medicare Modernization Act (MMA) permits IHS facilities to directly bill for itemized durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as of January 1, 2005. Previously, IHS facilities could **not** directly bill Medicare for DMEPOS.

What You Need to Know

This article is based on information from Change Request (CR) 3845, which provides Medicare manual instructions describing how IHS facilities enroll as DMEPOS suppliers.

What You Need to Do

See the "Background" and "Additional Information" sections of this article to find out further details regarding these changes.

Background

The MMA (Section 630) permits IHS facilities to directly bill for itemized DMEPOS as of January 1, 2005. Previously, IHS facilities could not directly bill Medicare for DMEPOS. The MMA also provides for all Medicare Part B services to be billed including all preventive services. To enable direct billing of DMEPOS, an IHS facility **must** enroll with the National Supplier Clearinghouse (NSC) and secure a Medicare supplier billing number. For enrollment purposes, Medicare recognizes two types of IHS facilities:

- Those facilities wholly-owned and operated by the IHS; and
- Facilities that are owned by the IHS but tribally operated or totally-owned and operated by a tribe.

The Application

To enroll, the IHS facility **must** complete a **Medicare Supplier Enrollment Application: CMS-855S Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers**. CMS-855S **must** be completed in accordance with its associated instructions, except as follows:

- Facilities that are totally-owned and operated by the IHS are considered a governmental organization. An Area Director of the IHS **must** sign the Section 15 Certification Statement of the CMS-855S, be listed in Section 6 of the form, and sign the letter required by Section 5 of the form, which attests that the IHS will be legally and financially responsible in the event that there is any outstanding debt owed to the Centers for Medicare & Medicaid Services (CMS).
- Facilities that are tribally operated are considered tribal organizations. The Section 15 Certification Statement of the CMS-855S **must** be signed by a tribal official who meets the definition of an authorized official in accordance with the page 2 definitions shown on the CMS-855S. The same authorized official **must** be listed in Section 6 of the CMS-855S and **must** sign the letter required by Section 5 of the form, which attests that the tribe will be legally and financially responsible in the event that there is any outstanding debt owed to CMS.

Facility Requirements

IHS facility requirements include the following:

- **Site visits** will be required for all IHS facilities enrolling for DMEPOS. This includes all hospitals and pharmacies. All IHS facilities enrolled by the NSC **must** meet all required standards as verified by the review procedures for all other DMEPOS suppliers except as discussed in this article.
- All IHS facilities, whether operated by the IHS or a tribe, **must** be exempt from the comprehensive liability **insurance requirements** under 42 CFR Sec. 424.57(c)(10).
- All IHS facilities, whether operated by the IHS or a tribe, will be exempt from the requirement to provide any **state licenses** for their facility/business. For example, if the DMEPOS supplier indicates on its application that it will be providing hospital beds and is located in a state that requires a bedding license, such licensure is **not** required for Medicare enrollment. However, if they provide a DMEPOS item that requires a licensed professional in order to properly provide the item, the IHS facility **must** provide a copy of the professional license. The licensed professional can be licensed in any state or have a federal license. For example, a pharmacy does **not** need a pharmacy license, but **must** have a licensed pharmacist.

Assignment of Specialty Codes and Appropriate Billings

Upon successful enrollment, the NSC will provide identifiers identifying IHS enrollments and IHS hospitals in order to facilitate proper reimbursement by durable medical equipment regional carriers (DMERCs). The NSC will enroll all IHS facilities including all hospitals and clinics (freestanding or hospital-based). This includes all facilities whether wholly-owned and operated by the IHS or tribally owned and/or operated. For any IHS facility that enrolls, the NSC will issue a supplier number with:

- An A9 specialty code for newly-enrolled IHS DMEPOS suppliers which are **not** hospitals; or
- An A9/A0 specialty code for newly-enrolled IHS DMEPOS suppliers which are IHS/tribal hospitals and hospital-based facilities to include critical access hospitals (CAHs).

The specialty indicator will ensure that the claims are paid appropriately by either the fiscal intermediary (FI) or DMERC. IHS facilities with a specialty code of A9/A0 **must** submit claims for prosthetics, orthotics, and surgical dressings to their Medicare FI for payment and **not** to a DMERC.

Implementation

The implementation date for CR 3845 is April 3, 2006.

Additional Information

IHS facilities that are tribally owned and/or operated are advised that their Medicare beneficiaries are **not** responsible for deductibles or coinsurance. However, Medicare still pays these IHS facilities a payment that is at 80 percent of the DMEPOS fee schedule. The remaining 20 percent will be shown as a CO denial on the remittance advice with an adjustment reason code of B6 indicating: "This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty."

For further details, please see the official instruction issued to your DMERC/carrier/intermediary regarding

this change. That instruction may be viewed by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 3845 in the CR NUM column on the right and click on the file for that CR.

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

Revisions to Instructions for Contractors Other Than the Religious Nonmedical Health Care Institutions (RNHCI) Specialty Contractor Regarding Claims for Beneficiaries with RNHCI Elections

Medlearn Matters Number: MM4218
Related Change Request (CR) #: 4218
Related CR Release Date: February 10, 2006
Related CR Transmittal #: R35GI, R45BP, and R851CP
Effective Date: May 11, 2006
Implementation Date: May 11, 2006

The following information affects physicians, providers, and suppliers who may treat Medicare patients who have elected Religious Nonmedical Health Care Institutions (RNHCI) care and bill Medicare fiscal intermediaries (FIs), regional home health intermediaries (RHHIs), carriers, and durable medical equipment regional carriers (DMERCs) for those services.

Provider Action Needed

Impact to You

This Change Request (CR): (1) replaces the current process that develops claims via telephone inquiry for beneficiaries with RNHCI elections with a letter using "yes" or "no" questions; (2) places into the Medicare Claims Processing Manual RNHCI claims processing instructions; (3) restructures much of the existing RNHCI manual material to be more complete and accessible; (4) defines the RNHCI; and (5) lists the qualifying criteria for RNHCI benefits.

What You Need to Know

Note the business requirements in this CR that apply to your billing area.

What You Need to Do

For providers other than RNHCIs, use the letter issued by your contractor that asks questions key to determining excepted versus nonexcepted care. For RNHCIs, incorporate the new claims submission instructions into your billing procedures.

Background

The transmittal publishes enhancements to Medicare manuals to more clearly explain the RNHCI benefit. The majority of these manual changes do **not** create any new business requirements. However, the transmittal revises instructions from Program Memorandum (PM) AB-03-145. That PM changed the development process for claims for beneficiaries with RNHCI elections from a review of medical records to a telephone contact process. The intent of PM AB-03-145 was to simplify the development process. Since the issuance of PM AB-03-145, a number of Medicare contractors (i.e., carriers and fiscal intermediaries) other than the RNHCI specialty contractor have expressed sufficient concerns about the telephone contact process to cause the Centers for Medicare & Medicaid Services (CMS) to revise that process.

Non-specialty contractors with high volumes of RNHCI-related claims rejects reported difficulty contacting providers. In addition, they reported beneficiaries were **not** willing or able to supply the necessary information to enable the contractor to determine whether the care was excepted or nonexcepted care under RNHCI benefit policies. These contractors also expressed concerns about the lack of written documentation from the provider in the telephone-based process. To address these concerns without reverting to a review of medical records, CMS has developed the requirements listed below that will be incorporated into the letter issued to providers.

Briefly, if you bill Medicare for services provided to a patient who has elected RNHCI coverage, the following requirements of CR 4218 will apply.

Requirements of CR 4218

Development Letters for Providers Other than RNHCIs

Upon receipt of a claim rejected by Medicare systems due to an RNHCI election on file for that Medicare beneficiary, contractors **must** issue a development letter designed to determine whether care was excepted or nonexcepted. Contractors **must** issue RNHCI development letters that ask questions about the following:

- Whether the beneficiary paid for the services out-of-pocket in lieu of requesting payment from Medicare;
- Whether the beneficiary was unable to make his/her beliefs and wishes known before receiving the services that have been billed; and
- Whether, for a vaccination service, the vaccination performed was required by a government jurisdiction.

The letters will phrase questions in RNHCI to be answered with a Yes or No response. The wording and format of this letter will be based on the experience of your contractor in effectively communicating with their community of providers.

Determinations Based on Development Letter

- Contractors will make determinations of excepted or nonexcepted care based on provider responses to development letters.
- Contractors will make determinations within 30 days of receipt of the provider's response.
- Contractors will make determinations of excepted care when a provider responds 'Yes' to any of the questions in the letter.
- Contractors will make determinations of nonexcepted care when a provider responds 'No' to all of the questions in the letter.
- Contractors will make an excepted/nonexcepted determination based on the evidence presented by the claim itself if the provider does **not** reply in a timely manner to the development letter.
- For claims for which **no** timely response was received, contractors will make a determination of nonexcepted care if the claim contains durable medical equipment or prosthetic/orthotic devices.
- For claims for which **no** timely response was received, contractor staff with a clinical background will use the diagnoses and procedures reported on the claim to make their best determination whether the services were excepted or nonexcepted care.
- For claims for which **no** timely response was received, contractors will make determinations of excepted or nonexcepted care within 30 days of the end of the timely response period.

For RNHCI Providers

CR 4218 provides complete instructions for completion of claims to Medicare. RNHCIs should review the instructions in CR 4218 and ensure their current billing processes are consistent with these instructions. The "Related Instructions" section of this article provides information on accessing the transmittals that comprise CR 4218.

Implementation

The implementation date for the instruction is May 11, 2006.

Related Instructions

For a beneficiary to receive benefits under Section 1821 of the Social Security Act (the Act) and payment under the Medicare program upon admission to an RNHCI and prior to the RNHCI billing for services, the beneficiary **must** make a written election. The document detailing the process for a beneficiary to elect RNHCI care or to terminate that election is attached to transmittal R45BP of CR 4218. CR 4218 may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R45BP.pdf*** on the CMS Web site.

The ten qualifying provisions that **must** be met for a provider to de defined as an RNHCI, as contained in Section 1861 (ss) (1) of the Act for RNHCIs, are defined in transmittal R35GI of CR 4218. The transmittal may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R35GI.pdf*** on the CMS Web site.

Chapter 3 of the Medicare Claims Processing Manual, Inpatient Hospital Billing, was also completely revised and is contained in transmittal R851CP of CR 4218. Transmittal R851CP is available at ***www.cms.hhs.gov/Transmittals/downloads/R851CP.pdf*** on the CMS Web site.

Additional Information

The official instructions issued to the RNHCI intermediary regarding this change can be found in three parts, i.e., the transmittals parts as shown in the Web addresses provided above. If you have questions, please contact your carrier/intermediary/DMERC at their toll-free number, which may be found at ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

News from DMERC A...

Fee Schedule Updates

The 2006 fee schedules and supplementary 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 updates have been posted:

- 1st Quarter 2006 Update: Oral Anticancer Drug Fees
- 2006 Parenteral and Enteral Fees
- January 2006 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File - Revised 01-09-06
- 4th Quarter 2005 Update: Oral Anticancer Drug Fees - Revised 1-4-06
- 3rd Quarter 2005 Update: Oral Anticancer Drug Fees - Revised 1-4-06

In addition, the following notices can be accessed via the "2006 Fee Schedule Article/Information" link:

- January 2006 Quarterly Average Sales Price (ASP) Fee for Code J7620
- 2006 Fees For Code E1010

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

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

Requirements for MSP Claims

In accordance with the Administrative Simplification Compliance Act (ASCA) requirements, and subsequent to the elimination of the Centers for Medicare & Medicaid Services (CMS) Contingency Plan for Health Insurance Portability and Accountability Act (HIPAA)-compliant Claims Transaction as of October 1, 2005, **all Medicare Secondary Payer (MSP) claims *must* be submitted to the Region A Durable Medical Equipment Regional Carrier (DMERC A) electronically** in an HIPAA-compliant format (American National Standards Institute (ANSI) X12 837, version 4010A1, or National Council for Prescription Drug Programs (NCPDP) Batch Version 1.1/Telecommunications Standard Version 5.1). Currently, the ***only*** **exception** for MSP is for claims with more than one primary payer; these claims may be submitted as paper claims.

All information required for processing MSP claims can be submitted in an HIPAA-compliant electronic claims transaction, including data contained in the explanation of benefits (EOB) statement from the primary payers. Providers who submit MSP claims **must** provide the primary payer data in the required transaction data elements.

To ensure successful and timely processing, DMERC A strongly recommends that you **submit your MSP data at the Line Level**. If your billing software, clearinghouse, or billing service requires you to submit MSP data at both the Claim Level and the Line Level, the total of the line level amounts ***must*** equal the corresponding total amount for the claim level. If the line and claim level totals do **not** match, the MSP claim **cannot** be processed. For example, the Primary Payer Allowed amount given at the claim level must **equal exactly** the total of all the Allowed Amounts given for every line item.

For additional information on ASCA requirements, please visit the CMS Web site at: ***www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3440.pdf***

Finding Billing Information Made Easier

In order to better serve our provider community, the "Billing" section of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site has been separated into five subsections: Billing, Coordination of Benefits, General, Item-specific, and Payment. The former "Billing" page is now a table of contents for these new subsections.

The subsections provide easier navigation and access to the different types of information, as defined below:

- **Billing** - articles that pertain to billing, which are general in nature, and apply to all audiences.
- **Coordination of Benefits** - articles that pertain to coordination of benefits (COB) issues, including Medicare Secondary Payer (MSP).
- **General** - articles that pertain to Medicare fee-for-service (FFS) claims processing, including Centers for Medicare & Medicare Services (CMS) demonstration projects.
- **Item-specific** - articles that pertain to specific durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items.
- **Payment** - articles that pertain to payment, which are general in nature, and apply to all audiences.

Please take a few moments to visit this enhanced section of the DMERC A Web site.

CERT

CERT News

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

EDI Services

News from CMS…

2005 Revised American National Standards Institute X12N 837

Professional Health Care Claim Companion Document

Medlearn Matters Number: MM4260
Related Change Request (CR) #: 4260
Related CR Release Date: February 24, 2006
Related CR Transmittal #: R871CP
Effective Date: March 24, 2006
Implementation Date: March 24, 2006

The following information affects physicians and suppliers who submit electronic X12N 837 claim forms to Medicare carriers, including durable medical equipment regional carriers (DMERCs).

Background

The Centers for Medicare & Medicaid Services (CMS) is updating the current inbound 837 Professional companion document to provide revisions, correct errors, and implement additional language to cover the new National Provider Identifier (NPI). This companion document, which is attached to Change Request (CR) 4260, supplements (but does **not** contradict) the X12N 837 Professional Implementation Guide (IG) and clarifies Medicare carrier and DMERC expectations regarding data/claim submission, processing, and adjudication.

The revised companion guide will be available through your Medicare carrier and DMERC via their newsletter, Web site, and and/or ListServe postings.

Key Points

The most important changes to the X12N 837 Professional Health Care Claim Companion Document clarify the specific processing or adjudication of the X12 837 and include the following:

Additions

- New NPI information statement - "The National Provider Identifier (NPI) must be submitted in the NM109 segment (NM108 = XX);"
- Revised taxonomy code set statement for an updated Washington Publishing Company Uniform Resource Locator (URL), which is ***www.wpc-edi.com/codes/taxonomy***;
- New "Application Receiver Code" title to GS03 statement;

Corrections/Clarifications

- Corrected qualifier statement to show that **only** valid qualifiers may be submitted and qualifiers submitted for

Medicare processing that are **not** defined for use by Medicare could result in claim/transaction rejection;
- Correction of the SV104 anesthesia value statement - changing "units" to "minutes" and correcting the IG page reference from "400" to "403;"
- Clarification of the SV104 and PS102 language to show that negative values submitted in these fields could result in claim rejection.

Additional Information

Please note the following message, which will be included in the revised X12N 837 companion document:

> "The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicare, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The X12N 837 implementation guides have been established as the standards of compliance for submission of claims for all services, supplies, equipment, and health care other than retail pharmacy prescription drug claims. The implementation guides for each X12 transaction adopted as a HIPAA standard are available electronically at ***http://www.wpc-edi.com***. This companion document supplements, but does not contradict any requirements in the X12N 837 Professional Implementation Guide."

Relevant Links

CR 4260 is the official instruction issued to your carrier, including your DMERC, regarding this change. CR 4260 may be found by going to ***www.cms.hhs.gov/Transmittals/downloads/R871CP.pdf*** on the CMS Web site.

Please contact your local carrier or DMERC if you have questions about this issue. To find the toll-free telephone number, go to ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

National Council for Prescription Drug Program (NCPDP) Coordination of Benefits (COB) Workaround Instructions

Medlearn Matters Number: MM4290
Related Change Request (CR) #: 4290
Related CR Release Date: February 10, 2006
Related CR Transmittal #: R845CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

The following information affects suppliers who submit claims to Medicare durable medical equipment regional carriers (DMERCs) for prescription drugs provided to Medicare beneficiaries that are also sent to other Medicare trading partners for coordination of benefits.

Background

Certain Medicare trading partners **cannot** accept the National Council for Prescription Drug Program (NCPDP) version 5.1 batch standard 1.1 for coordination of benefits (COB) crossover purposes due to missing data elements within the transaction. Change Request (CR) 4290 contains workaround instructions that provide current trading partners with the data elements in the NCPDP version 5.1 batch standard 1.1 for COB crossover purposes. This will enable affected supplier claims to be processed by these trading partners.

Key Points

The following information is important for trading partners regarding the NCPDP version 5.1 batch standard 1.1 for COB crossover purposes:
- Drugs will always be paid as mandatory assignment.
- Health Insurance Claim (HIC) numbers will always be passed in the "Patient ID" field (332-CY) with a "99" (Other) qualifier in the Patient ID Qualifier field (331-CX).
- For non-claim-based Medigap crossovers, the "Cardholder ID" field (302-C2) in the "Insurance Segment" will contain the beneficiary's policy number as submitted on the carrier's eligibility file.
- When the "Patient Location" field (307-C7) is **not** "1" (Home), the Supplier Name and Address will be populated in lieu of the Facility Name and Address in the 500-byte-free formatted field.

Additional Information

CR 4290 is the official instruction issued to your DMERC regarding this change. CR 4290 may be found by going to ***www.cms.hhs.gov/MedlearnMattersArticles/2005MMA/List.asp#TopOfPage*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Please refer to your local DMERC if you have questions about this issue. To find their toll-free telephone number, go to ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

Medicare Remit Easy Print (MREP) Software

Medlearn Matters Number: SE0611 **Revised**
Related Change Request (CR) #: N/A
Related CR Release Date: N/A
Related CR Transmittal #: N/A
Effective Date: N/A
Implementation Date: N/A
Note: The "Additional Information" section of this article was revised February 16, 2006, to refer providers to Medicare's Electronic Data Interchange (EDI) Helpline numbers if more information is needed.

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

Provider Action Needed

Impact to You

This Special Edition article provides an overview of the new Medicare Remit Easy Print (MREP) software developed by the Centers for Medicare & Medicaid Services (CMS), which is now available for you to view and print the Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic remittance advice (ERA).

What You Need to Know

With the new MREP software, you can view and print as many or as few claims as needed. This is especially helpful when you need to print **only** one claim from the remittance advice (RA) when forwarding the claim to a secondary payer.

What You Need to Do

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

Background

In June 2005, CMS announced to carriers (including DMERCs) their Remittance Advice (RA) Initiative, which included plans to reduce the number of standard paper remittance (SPR) advices printed and mailed as well as increase usage of the ERA.

Medicare Remit Easy Print (MREP) Software

As part of the RA initiative, CMS developed MREP software to enable physicians and suppliers to read and print the HIPAA-compliant ERA (also known as Transaction 835 or "the 835"). MREP software uses the ERA file that is sent to you by your carrier/DMERC in the HIPAA-compliant 835 format.[1] Other electronic formats **cannot** be used.[2]

With the new MREP software, you will be able to:

- Navigate and view the ERA using your personal computer;
- Search and find ERA/claims information easily;
- Print the ERA in the SPR format;
- Print and export reports about ERAs including denied, adjusted, and deductible applied claims; and
- Archive, restore, and delete imported ERAs.

To utilize the MREP software, you will need to receive an HIPAA-compliant ERA (HIPAA 835). Contact your carrier/DMERC to find out more about MREP and/or for information on how to receive HIPAA-compliant ERAs. **Note**: MREP software will be revised three times per year to accommodate Claim Adjustment Reason and Remittance Advice Remark Code set changes. You can sign up to be notified automatically when a new version of MREP is available at your carrier's/DMERC's Web site.

Availability and Cost

MREP software can save you time resolving Medicare claim issues, and it provides features unavailable with the SPR. MREP is available to you **free-of-charge**, and further information on the software (including how to obtain a free copy) is available at your carrier's or DMERC's Web site.

Benefits of Using MREP Software

1. Save Time and Money

You can print remittance information directly from your computer the day the HIPAA 835 is available. **No** more time is spent waiting for the mail!

2. Create and Print Special Reports

With MREP, you can run several useful reports including:

- **Deductible Service Lines Report**: Shows claim service lines that have a deductible amount.
- **Adjusted Service Lines Report**: Shows claims within a single remittance that have a claim status 22 (reversed claim).
- **Denied Service Lines Report**: Shows **only** claim service lines that have an allowed amount of zero and are associated with a claim that does **not** have a claim status 22 (reversed claim).

3. Print and Forward Claims for Other Payers

MREP provides the ability to print remittance information for individual or multiple selected claims, and it allows you to forward **only** those claims that are needed by other payers for secondary payment. You may view and/or print as many or as few claims as needed. This eliminates the need for you to darken individually identifiable data on the SPR, as you may do today, that does **not** pertain to the claim for which you are requesting payment.

4. Navigate and View Remittance Information

MREP organizes and presents information in a manner that makes it easy for you to view. It also provides separate tabs to access the following:

- A list of claims;
- Details for individually selected claims;
- Summary information;
- Glossary information containing Claim Adjustment Reason Codes, Remittance Advice Remark Codes, and their definitions;
- A data view that allows you to look at the various loops and segments containing data in the HIPAA 835; and
- A search function to find claims containing specific information.

5. Search for Claim(s) Information Quickly and Easily

MREP's search function can help you find a claim (or multiple claims) based on your customized search criteria. Using it, you can search by names, numbers, and even portions of information such as:

- Health Insurance Claim Number (HICN);
- Beneficiary Last Name;
- Internal Control Number (ICN);
- Beneficiary Account Number;
- Procedure Code;
- Service Date; and
- Rendering Provider Number.

Note: MREP's search capability provides a powerful way to save time and money when examining remittance information.

6. Eliminate Need for Physical Filing and Storage Space

MREP software imports an HIPAA 835 (once you have received it from your carrier/DMERC) and saves the information as a separate Import file to help ensure that the original HIPAA 835 file remains intact. It also provides an easy-to-use method to archive, restore, and delete these Import files as you maintain your remittance records (further reducing the need for physical filing of printed copies and additional storage space).

As you gain familiarity with the MREP software, you will be able to take advantage of the numerous keystroke shortcuts designed to streamline use of the software and save you time while viewing your remittance information.

Installing and Using MREP Software

To install and use the MREP software, your computer system(s) **must** meet the following minimum criteria:

- IBM-compatible PC;
- Windows XP (Recommended), Windows 2000, Windows NT, or Windows 98 SE;
- 2.0 GHz processor;
- 256 MB RAM;
- 3 MB hard disk space; and
- .NET Framework version 1.1 or higher.

Additional Information

For more information about the MREP software and how to receive the HIPAA 835, please contact your carrier/DMERC. Medicare Part B EDI Helpline telephone numbers are available at ***www.cms.hhs.gov/ElectronicBillingEDITrans/*** on the CMS Web site.

[1] Beginning October 1, 2005, new Medicare contractors are called Medicare Administrative Contractors (MACs). Also, from October 2004 through October 2011, all existing fiscal intermediaries (FIs) and carrier contracts will be transitioned into MAC contracts, using competitive procedures. Providers may access the most current Medicare Contracting Reform information to determine the impact of these changes at ***www.cms.hhs.gov/MedicareContractingReform/*** on the CMS Web site.

[2] CMS plans to end the use of other formats soon.

Disclaimer: This software was developed by the Centers for Medicare & Medicaid Services (CMS) for use by Medicare providers/suppliers to view and print a Health Insurance Portability and Accountability (HIPAA)-compliant Medicare 835. Medicare has **no** liability and takes **no** responsibility for any other use of this software.

Medicare Remit Easy Print (MREP) Software Update

Medicare Remit Easy Print (MREP) Version 1.6 is now available for download! Version 1.6 includes the latest version of the Claim Adjustment Reason Codes and the Remittance Advice Remark Codes, as well as an enhancement to display Glossary information on the Claim Detail tab. From this tab, providers and suppliers can view and print as many or as few claims as needed. This is especially helpful when you need to print only one claim from the remittance advice to be forwarded to a secondary payer. MREP Version 1.6 also consists of fixes to the PROV ADJ AMT, LATE FILING, and FCN fields and the ability to scroll on the SPR Summary tab for more than 13 occurrences. In addition, there are some documentation changes to the User Guide regarding installing/uninstalling the software, locating MREP on your PC/network, and the Import File naming convention. Remember, you can save time and money by taking advantage of **FREE** Medicare Remit Easy Print software now available to view and print the Health Insurance Portability and Accountability Act (HIPAA)-compliant 835!

Providers and suppliers can access the MREP Version 1.6 via the "Electronic Remittance Advice and Easy Print Software" section of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site at ***www.umd.nycpic.com/dmedi_mrep.html***. Or, you can directly access it via the Centers for Medicare & Medicaid Services (CMS) Web site at ***www.cms.hhs.gov/AccesstoDataApplication/***. From this page, click on "Medicare Remit Easy Print (MREP)" from the left navigation bar. See the Downloads section for the MREP software Zip file, the User Guide, the MREP demonstration, and other instruction files.

Medicare Remit Easy Print (MREP) Enhancements and Clarification of Check Issue/Electronic Funds Transfer (EFT) Effective Date

Medlearn Matters Number: MM4289
Related Change Request (CR) #: 4289
Related CR Release Date: February 3, 2006
Related CR Transmittal #: R833CP
Effective Date: July 1, 2006
Implementation Date: July 3, 2006

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

Provider Action Needed

This article is based on Change Request (CR) 4289, which instructs ViPs (the company that maintains the Medicare Remit Easy Print (MREP) software), carriers, and DMERCs to add enhancements to the current version of the MREP software and provides clarification of the check issue/electronic funds transfer (EFT) effective date.

Background

On October 11, 2005, the Centers for Medicare & Medicaid Services (CMS) made available the MREP software to enable Medicare providers and suppliers to view and print the Health Insurance Portability and Accountability Act (HIPAA)-compliant 835 (electronic remittance advice (ERA)). Using the HIPAA 835 files, MREP enables providers and suppliers to view and print Medicare Part B and DMERC 835 in a human readable format. The format is on the current standard paper remittance (SPR) format Medicare uses. MREP provides the ability to:

- View the 835
- Search the 835;
- Print the 835 in a format providers are familiar with; and
- View and print special reports.

Providers who use MREP can print reports to reconcile accounts receivable as well as create document(s) that can be included with claim submission to coordination of benefits (COB) payers. MREP is available free to Medicare providers and suppliers, and it can be installed on a personal computer (PC) or network. Please contact your Medicare contractor to download a copy of the MREP software.

Keeping MREP Up to Date

In order to continuously improve this product, CMS set up a process to collect valuable suggestions and recommendations to improve MREP's functionality and effectiveness from providers, contractors (carriers and

DMERCs), and CMS staff. Using the suggestions and recommendations received before the cutoff date of November 15, 2005, CMS determined enhancements that were needed for MREP, and CR 4289 includes a summary page attachment listing the MREP enhancements to be implemented in the MREP software release in July 2006. ViPs will update the MREP software to incorporate the listed enhancements.

Enhancement updates to be implemented in October 2006 will include suggestions/recommendations received between November 16, 2005, and the next cutoff date. Annual enhancement updates to MREP will be scheduled for each year in October.

Note: If you are on the contractor ListServe, you will be notified when the Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) file is updated three times a year, in April, August, and December. This file is the master listing of CARC and RARC used in printing the glossary on the MREP printout. Washington Publishing Company (WPC) publishes updates to this list three times a year. An update to the MREP application will be issued to correspond to the WPC updates. Your Medicare carrier will post a notification when these updates will be available, and a Medlearn Matters article is usually published to explain the changes in these updates.

Clarification of the Check Issue/EFT Effective Date

An issue was reported to contractors by providers receiving both electronic and paper RAs.

- The MREP software populates the "Check Issues/EFT Effective Date" from the BPR16 data field (in the 835 transaction).
- The SPR uses the information contained in the "Production Date" from the DTM 02 data field (in the 835 transaction).

These two dates are the same if:

- The qualifier in the BPR 04 data field (in the 835 transaction) is either "CHK" or "NON"

However, if the qualifier in BPR 04 data field is "ACH" (for EFT), then the BPR 16 data field may be different than the "Production Date." This acknowledges the fact that it may take a few days to have the funds electronically moved from the Medicare financial institution to the provider's financial institution.

CMS requires that the paper RA **must** mirror the electronic RA, and any software reading the electronic RA **must** have the same information in the output as in the electronic RA. CR 4289 repeats the instruction originally included in CR 1953 (Transmittal B-01-76, dated December 11, 2001, ***www.cms.hhs.gov/Transmittals/Downloads/B0176.pdf***), which states that **the information for Check Issue/EFT Effective Date *must***:

- Be populated from the BPR16 data field, and
- **Not** from the DTM 02 data field.

Implementation

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

Additional Information

For complete details, please see the official instruction issued to your carrier/DMERC regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R833CP.pdf*** on the CMS Web site. Attached to that instruction is the list of enhancements that will be incorporated in the July 3, 2006, version of the MREP software.

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

Revision to Chapter 31 – Attestation Form for Conducting Real-Time Eligibility Inquiries with Medicare

Medlearn Matters Number: MM4093 **Revised**
Related Change Request (CR) #: 4093
Related CR Release Date: October 7, 2005
Related CR Transmittal #: 700
Effective Date: October 1, 2005
Implementation Date: November 7, 2005
Note: This article was revised on January 31, 2006, to change the effective date (shown above) from October 1, 2006, to October 1, 2005. All other information remains the same.

The following information affects providers who access the 270/271 health care eligibility inquiry and response application in real-time.

Provider Action Needed

Impact to You

Beginning September 1, 2005, an online attestation form (Trading Partner Agreement for Submission of 270s to Medicare on a Real-Time Basis) **must** be completed by submitters authenticated by the Centers for Medicare & Medicaid Services (CMS) to conduct 270/271 transactions with CMS before providers may access the real-time 270/271 health care eligibility inquiry and response application.

What You Need to Know

Submitters requesting access to the Medicare beneficiary database **must** follow the procedure outlined in the "Additional Information" section below.

What You Need to Do

Please be sure to fill out this new agreement form, located at ***www.cms.hhs.gov/it***, so you can conduct 270/271 transactions with Medicare.

Background

The purpose of Change Request (CR) 4093 is to alert Medicare providers to the revision in the Medicare Claims Processing Manual, Chapter 31 (ANSI X12N Formats Other than Claims or Remittance).

This revision addresses the standards for Medicare beneficiary eligibility inquiries and creates the database and infrastructure needed to provide a real-time, centralized Health Insurance Portability and Accountability Act (HIPAA)-compliant Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

Additional Information

Access Process for Clearinghouses/Provider

Beginning September 1, 2005:

- The Medicare Eligibility Integration Contractor (MEIC) will email the online attestation form outlining security and privacy procedures for submitters already submitting authenticated 270 transactions on a real-time basis.
- Each submitter should complete the form in its entirety and transmit it back via email to **MCAREHD@emdeon.com**.

Beginning October 1, 2005:

- Submitters will be able to access the appropriate forms for the CMS 270/271 Medicare Eligibility transaction at: ***www.cms.hhs.gov/AccessToDataApplication***
- The submitter **must** provide the information requested on the form electronically and click on the appropriate assurances. If the submitter does **not** consent to the terms of the agreement, by appropriately completing the form, the access process will be terminated.
- A copy of the appropriately completed form **must** be electronically submitted to CMS. Once CMS has the completed form, it will be authenticated, at which time the submitter will then be directed to complete a Medicare Data Communications Network (MDCN) connectivity form and submit it electronically in order to be connected to the 270/271 eligibility database.

CMS staff will make sure that all of the necessary information is provided on the form and will ensure the complete connectivity to the 270/271 application. A CMS contractor, known as the Medicare Eligibility Integration Contractor (MEIC), will contact the submitter in order 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 identification (ID) that **must** be used on all 270/271 transactions.

The MDCN extranet application is suitable for many providers that can create, send, and receive complete X12 eligibility transactions. CMS will soon offer a second solution for providers that desire to conduct the transaction using the Direct Data Entry (DDE) version. The DDE version will allow all approved providers to conduct eligibility transactions over the public Internet at no cost to the provider. **Please note** that in order to access the MDCN, an entity **must** obtain the necessary telecommunication software from the AT&T reseller on its own. AT&T resellers and contact numbers include the following:

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

MEIC Helpdesk Support

You may also contact the MEIC helpdesk for connectivity issues on Monday through Friday, 7:00 a.m. - 9:00 p.m. Eastern Standard Time (EST); Telephone: 866-324-7315; Email address: **MCARE@cms.hhs.gov**.

Related Links

The official instruction issued to your fiscal intermediary (FI), regional home health intermediary

(RHHI), carrier, or durable medical equipment regional carrier (DMERC) regarding this change may be found by going to ***www.cms.hhs.gov/Transmittals/downloads/R700CP.pdf*** on the CMS Web site.

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

News from DMERC A…

EDI Help Desk Services

You can contact the Region A Durable Medical Equipment Regional Carrier (DMERC A) Electronic Data Interchange (EDI) Services using any of the following methods:

- **By telephone**: Toll-free at 866-861-7348, Monday through Friday, 8:30 a.m. - 12:00 p.m. and 1:00 p.m. - 4:00 p.m. (EST/EDT); **Note**: Callers can leave a voicemail message at any time when the Help Desk is not active. Messages will be returned within one business day.
- **By email**: Team.EDI@HealthNow.org
- **By fax**: 570-255-9510

Medicare Remit Easy Print Software and Electronic Remittance Advice

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

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

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

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

In order to utilize the MREP software, you need to receive an HIPAA-compliant ERA. Contact the Region A Durable Medical Equipment Regional Carrier (DMERC A) Electronic Data Interchange (EDI) Department at 866-861-7348 to find out more about MREP and/or for information on how to receive an HIPAA-compliant ERA. You may also visit the "Electronic Remittance Advice and Easy Print Software" section of our Web site at ***www.umd.nycpic.com/dmedi_mrep.html***. Take full advantage of this new software. Begin using MREP today!

Realizing the Benefits of the Electronic Remittance Advice

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

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

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

Any provider or supplier who submits claims electronically to DMERC A, either directly or through a third party (e.g., billing service, clearinghouse), is

eligible to receive ERAs. ERA implementation plans need to be considered by providers and suppliers who:

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

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

Electronic Funds Transfer (EFT)

You can take advantage of all the benefits of "direct deposit" by electing to receive your payments for Region A Durable Medical Equipment Regional Carrier (DMERC A) Medicare claims through electronic funds transfer (EFT).

Overview

- Any provider or supplier who bills Medicare may elect to receive payments electronically.
- Funds are sent from Medicare's originating bank to the provider's receiving bank for deposit into a checking or savings account.
- The EFT payment is in the Automated Clearing House (ACH) CCD+ format. Most banks belong to the National Automated Clearing House (NACHA) and accept this format. The provider's bank must accept the CCD+ format.

Benefits

- **Fast**: On the claim payment date, the electronic payment is sent from the originating bank. Your bank receives it the next day, and most banks will post it to your account the following day. This means that in most cases the funds are in your account and ready for your use three days after the claim payment date. No more taking it to the bank in a deposit and waiting for it to clear before you have access to the funds.
- **Secure**: Direct deposit through EFT eliminates the potential for a check "lost in the mail" or misdirected to an incorrect address.
- **Accurate**: Less chance on incorrect amounts being posted to your account by using the electronic payment system.
- **Free**: No cost to you for EFT from the originating bank.
- **Clean**: Eliminate excess paper. Once you are setup on EFT, you can eliminate receiving standard paper remittance (SPR) notices. If you are receiving an electronic remittance advice (ERA), you will still continue to do so. If you want to receive an ERA, but do not have the software to do so, visit the "Electronic Remittance Advice and Easy Print Software" section of the DMERC A Web site for information about obtaining FREE Medicare Remit Easy Print (MREP) software.

Enrollment Procedure

1. Obtain an Authorization Agreement for Electronic Funds Transfer (Form CMS-588) located at ***www.cms.hhs.gov/forms/cms588.pdf***. Follow the instructions included on the form to complete the agreement.
2. Provide a voided check that shows your business name, your bank account number, and the name and address of the bank in which the Medicare funds will be deposited.
3. Mail the signed authorization agreement, along with the voided check, to:

   HealthNow New York Inc. DMERC A
   Attention: EDI Department
   P.O. Box 6800
   Wilkes-Barre, PA 18773-6800

   You **must** submit all documents by mail; faxed forms and signatures **cannot** be accepted. We suggest you retain a copy for your records.
4. It will take three to four weeks to setup the systems and conduct testing, at which time deposits will go automatically into your account.
5. To eliminate your SPR, write that request on your company letterhead and fax it to the DMERC A Electronic Data Interchange (EDI) Department at 570-255-9510.

Any Questions?

Contact the EDI Help Desk toll-free at 866-861-7348.

Reminder: Current Forms for EDI Functions

The currently accepted versions of all forms used to set up or maintain electronic data interchange (EDI) functions are located in the "EDI" section of the Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site: ***www.umd.nycpic.com/dmedi.html***

Avoid unnecessary delays in EDI processing by using only the valid version of all forms as posted on the Web site. In particular, any outdated EFT forms received in the DMERC A EDI Department will not be processed and will be returned by mail with a note to that effect.

Please be advised that an updated version of our EDI enrollment form has been posted on our Web site. Please begin using this form immediately and discontinue using any other versions of the enrollment form. Only **new** enrollees need to fill out the new form. This form can be found via the "EDI - Documents and Files" section at:
www.umd.nycpic.com/edidocfiles.html

Electronic Claims Transmission Reports: What They Are and How to Use Them

As a submitter of electronic claims to Medicare, you are expected to implement acceptable business practice standards to ensure timely and accurate claims processing. Electronic Claims Transmission Reports provided by the Region A Durable Medical Equipment Regional Carrier (DMERC A) are one of the tools available to assist submitters with establishing effective controls to monitor the processing status of the claims that are submitted electronically. This article provides important information about those reports and how they are intended to be used by submitters.

The expectation is that submitters will access the DMERC A Bulletin Board System (BBS) on a daily basis to retrieve the Electronic Media Claims (EMC) Transmission Reports. It is also expected that submitters will be equally prompt in reviewing them and requesting Electronic Data Interchange (EDI) Help Desk Services on a timely basis, if these services are needed. Please make note of the following to ensure that you realize the full benefits of electronic claims submission:

- EMC Transmission Reports are available on the BBS for **only 15 calendar days** from the day they are posted to the BBS. These reports are **not** permanently archived and **cannot** be retrieved or recreated after the active posting period has expired.
- Files or claims that do not successfully make it through all the front-end EMC processes and edits can be corrected and resubmitted as soon as the next business day after the errors are detected and reported.

Electronic Claims Transmission Reports

Report	What It Is	When You Get It	How You Use It
Step 1 Scrubber Report	This report tells you if your claim **file** was taken in by the BBS.	If the BBS accepted your file: a. Before 5:00 p.m. (Monday - Friday); Report available the next business day. b. After 5:00 p.m. Monday - Friday and anytime on weekends and holidays; Report available on the second business day.	Review this report **every day** to see if the claim file you sent was accepted by the BBS and passed on to Step 2.
Step 2 997 Report	This report tells you if the claim **file** was translated.	If the BBS accepted your file (Step 1) and the file was translated: ♦ The report is available the same business day as Scrubber Report for the corresponding file.	Review this report **every day** to see if the claim file was translated and passed on to Step 3.
Step 3 VMS Report	This report tells you the number of **claims** received by the front-end editor and how many claims were: ♦ accepted ♦ rejected ♦ transferred to another DMERC region	If the BBS accepted your file (Step 1) and the file was translated (Step 2): ♦ The report is available the same day as the 997 Report for the corresponding file.	Review this report **every day**: 1 to see which claims ***passed*** all front-end edits and were sent on for processing and adjudication, 2. to see which claims ***did not pass*** all front-end edits and what the errors were, and 3. to see which claims ***were sent on*** to another DMERC.

You can obtain additional information related to the electronic claims processing flow and the reports that are available to help the submitter monitor the status of electronic claims files. The documents are all available via the "EDI" section of the DMERC A Web site (***www.umd.nycpic.com/dmedi.html***).

Resource	Content
American National Standards Institute (ANSI) Error Code Manual ***www.umd.nycpic.com/ANSI-Error-code.pdf***	A list of all errors that could be generated on the Scrubber, 997, or VMS reports.

Resource	Content
National Council for Prescription Drug Plans (NCPDP) Error Code Manual ***www.umd.nycpic.com/NCPDPmanual.pdf***	An explanation of errors that could be generated for claims submitted in the NCPDP format.
VIPS Medicare System (VMS) Submitter Report Example ***www.umd.nycpic.com/VMSReport.pdf***	An example of the VMS Submitter Report, with instructions on how to read the report and determine submission errors.
Understanding the VMS Report ***www.umd.nycpic.com/dme-eduonline.html#edituts***	A 9-minute online tutorial explaining how to read the VMS Submitter Report and determine submission errors.
EDI Support Guidelines ***www.umd.nycpic.com/edidocfiles.html#ediwhatdo***	A list of the support services that the EDI Help Desk can or cannot provide to submitters.

A downloadable version of this article, which includes an electronic claims transmission flow chart, is also available via the "EDI" section.

HIPAA Information

News from CMS…

Termination of the Medicare Health Insurance Portability & Accountability Act (HIPAA) Incoming Claim Contingency Plan, Addition of a Self-Assessable Unusual Circumstance, Modification of the "Obligated to Accept as Payment in Full"(OTAF) Exception, and Modification of Administrative Simplification Compliance Act (ASCA) Exhibit Letters A, B and C

Medlearn Matters Number: MM4119

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Related CR Release Date: December 30, 2005
Related CR Transmittal #: R802CP
Effective Date: April 1, 2006
Implementation Date: April 3, 2006

The following information affects physicians, providers, and suppliers who submit claims to the Centers for Medicare & Medicaid Services (CMS) Medicare contractors (carriers, fiscal intermediaries (FIs), durable medical equipment regional carriers (DMERCs), or regional home health intermediaries (RHHIs)).

Background

This article, based on Change Request (CR) 4119, summarizes some of the key revisions to electronic data interchange (EDI) requirements contained in the Medicare Claims Processing Manual, Chapter 24 (General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims). Some of these changes have already been reported in earlier Medlearn Matters articles and are mentioned here only as reminders. The EDI policy revisions are necessary for:

- Health Insurance Portability and Accountability Act (HIPAA) compliancy, including contingency plan termination, and free claim software changes; and
- Administrative Simplification Compliance Act (ASCA) compliancy, including unusual circumstance, "Obligated to Accept as Payment in Full" (OTAF) modification, and modified ASCA letters.

Note: Medicare providers **must** adhere to these EDI requirements. Electronic transactions that do **not** fully comply with the implementation guide (IG) requirements for these formats will be rejected.

Key Points

Medicare HIPAA Incoming Claim Contingency Plan

The Medicare HIPAA incoming claim contingency plan has been terminated. **All electronic claims sent to Medicare on or after October 1, 2005, that do *not* comply with the 837 version 4010A1 IG or the National Council for Prescription Drug Program (NCPDP) Telecommunication Standard requirements and the Batch Standard 5.1 (DMERCs *only*) will be rejected.** Please refer to the "Additional Information" section of this article for more information.

Until the Medicare contingency plan for **HIPAA-mandated transaction types other than claims sent to Medicare is terminated**, Medicare contractors **will support** the pre-HIPAA electronic transaction formats listed in the Medicare Claims Processing Manual, Chapter 24, Section 40.2 (attached to CR 4119). Please refer to the "Additional Information" section of this article for more information.

NCPDP Claims

NCPDP claims submitted to DMERCs may contain modifiers for compound drugs in the **narrative portion** in the prior authorization segment on the NCPDP standard since it does **not** currently support reporting modifiers in the compound segment. Please refer to the attachment to CR 4119, Medicare Claims Processing Manual, Chapter 24, Section 40.2 - B, for further instructions and a list of the modifiers.

Currently, Coordination of Benefits (COB) trading partners are **not** able to accept NCPDP format transmissions for **secondary payment**. CMS is working with the NCPDP to develop a "workaround" to resolve this problem, however, until then, NCPDP claims will **not** be crossed over to other payers. **Retail pharmacies will need to bill secondary payers directly to collect supplemental benefits that may be due for those claims.** Transmission of pre-HIPAA electronic format claims to other payers under a COB agreement will end when (the earliest of the date) a trading partner completes successful testing on the use of the X12 837 version 4010A1 and/or the HIPAA NCPDP format (as appropriate) or the Medicare HIPAA COB contingency plan ends.

Other Issues

Medicare secondary payer claims may be submitted **non-electronically** when a primary payer has made an OTAF adjustment **and there is more than one primary payer**. Providers have been directed to report OTAF adjustments in a CN1 segment of a claim, but it is **not** possible to either identify which primary payer owns a reported OTAF adjustment or to report more than one OTAF adjustment in the event they apply to each primary payer.

The free billing software (from your Medicare contractor) should be able to **identify when Medicare is a secondary payer**. It should also be able to collect standard claim adjustment reason codes and adjustment amounts made by a primary payer when Medicare is the secondary payer. If it is **not** collecting this information, the software **must** be modified to enable this requirement.

Unusual Circumstances

Certain "unusual circumstances" are automatically waived from the electronic claim submission requirement for either the indicated claim type or for the period when an "unusual situation" exists. CMS has added a circumstance to the self-assessable Unusual Circumstance list in which **paper claim submission is permitted. Home oxygen therapy claims** for which the CR5 segment is required in an X12 837 version 4010A1 claim, but for which the requirement notes in either CR513, CR514, and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO2 is more than 60 mmHg, but a combination of factors necessitates use of oxygen. The X12 work group responsible for development of the version 4010A1 implementation guide recognizes that there is a deficiency in the guide pertaining to home oxygen therapy claims. This will be corrected in a later version of that implementation guide, but in the interim, covered entities are bound by the existing version 4010A1 requirements. As result, CMS will permit claims that meet this situation to be submitted on paper.

Modified examples of ASCA exhibit letters A, B, and C can be found in the manual attachment to CR 4119 (Medicare Claims Processing Manual, Chapter 24, Exhibits of Form Letters). Your Medicare contractor will send these revised letters, as appropriate.

- Exhibit A-Response to a non- "unusual circumstance" waiver request
- **Exhibit B-Denial of an "unusual circumstance" waiver request**
- Exhibit C-Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper

Additional Information

Medicare HIPAA Incoming Claim Contingency Plan Termination

All electronic claims sent to Medicare on or after October 1, 2005, that do **not** comply with the 837 version 4010A1 IG or the NCPDP requirements will be rejected. The Medicare contingency plan for the

X12 835, 276/277 (version 4010 support will need to be terminated), 837 claims that Medicare sends to another payer as provided for in a trading partner agreement, and the 270/271 version 4010A1 transactions remain in effect pending further notice. CMS will issue advance notice to the health care industry when a decision is reached to terminate the remaining Medicare contingency plans.

HIPAA-Mandated Transaction Types Other Than Claims Sent to Medicare

Until the Medicare contingency plan (mentioned above) is terminated, Medicare contractors will support the pre-HIPAA electronic transaction formats listed in the Medicare Claims Processing Manual, Chapter 24, Section 40.2. These include for claims submitted to:

- All Medicare contractors - UB-92 version 6.0 claims for coordination of benefits (COB) sent to other payers under trading partner agreements; proprietary format for eligibility data responses using the CMS standard eligibility data set; and X12 276/277 version 4010.
- FIs - X12 837 institutional version 4010 and 3051; X12 835 versions 3030Ma, 3051.3A, and 3051.4A for remittance advice.
- Carriers and DMERCs - X12 837 professional version 4010 and 3051; National Standard Format (NSF) version 3.01; X12 835 IG versions 3030Mb, 3051.3B, and 3051.4B for remittance advice; and NSF version 3.01.
- Carriers only - X12 270/271 IG version 3051 for eligibility query and response.
- Please note - Specifications for each of these transactions can be found on the Washington Publishing Company Web site at ***www.wpc-edi.com/HIPAA*** for those X12 IGs (other than the NCPDP) adopted as national standards under HIPAA.

The official instruction, CR 4119, issued to your FI/RHHI or carrier/ DMERC regarding this change may be found by going to ***www.cms.hhs.gov/Transmittals/downloads/R802CP.pdf***. Attached to CR 4119, you will find the revised portions of the Medicare Claims Processing Manual referenced in this article.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find the toll-free telephone number, go to ***www.cms.hhs.gov/apps/contacts/*** on the CMS Web site.

Revision to Chapter 31 - Addition of Hospice Data to HIPAA 270/271 Eligibility Inquiry and Response Transactions

Medlearn Matters Number: MM4193
Related Change Request (CR) #: 4193
Related CR Release Date: December 29, 2005
Related CR Transmittal #: R793CP
Effective Date: January 23, 2006
Implementation Date: January 23, 2006

The following information affects physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for hospice services.

Provider Action Needed

This article is based on Change Request (CR) 4193, which adds hospice data to the Centers for Medicare & Medicaid Services (CMS) Health Insurance Portability and Accountability Act (HIPAA) Health Care Eligibility Benefit Inquiry and Response transaction (270/271). Hospice will be part of the core data elements returned on the 271 response.

Background

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:

- **Extranet**: 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, or MDCN). This extranet is a secure, closed private network currently used to transmit data between Medicare Fee-for-Service (FFS) contractors and CMS.
- **Internet**: CMS expects to provide limited Internet access to the 270/271 transaction 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, and the CMS data center will use a single consolidated national eligibility database to respond to the eligibility inquiries.

CR 4193 revises the Medicare Claims Processing Manual (Pub. 100-04), Chapter 31 (ANSI X12 Formats Other than Claims or Remittance), Section 10.2 (Eligibility Extranet Workflow) by adding the following hospice data to the CMS HIPAA Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

271 Response Data Elements

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
Hospice Data	2110C	EB	EB01	X
			EB03	45
			EB04	MA
			EB06	26
		DTP	DTP01	292
			DTP02	D8 or RD8
			DTP03	Dates

Implementation

The implementation date for the instruction is January 23, 2006.

Additional Information

Medlearn Matters article MM3883 provides information regarding the access process for beneficiary eligibility inquiries and replies (HIPAA 270 and 271 Transactions, Extranet Only). It can be reviewed at ***www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3883.pdf*** on the CMS Web site. For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed at ***www.cms.hhs.gov/Transmittals/downloads/R793CP.pdf*** on the CMS Web site.

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/apps/contacts/*** on the CMS Web site.

General Information

News from CMS…

CMS Launches First Survey of Provider Satisfaction with Medicare Fee-For-Service Contractors

The Centers for Medicare & Medicaid Services (CMS) today [January 3, 2006] announced a new initiative designed to measure how satisfied providers in the fee-for-service (FFS) program are with the services of the contractors that are responsible for processing their claims, educating them about changes in Medicare policies, and responding to provider inquiries.

The initiative, the Medicare Contractor Provider Satisfaction Survey (MCPSS), will be administered on an annual basis. It is designed to garner quantifiable data on provider satisfaction levels with key services performed by the 42 FFS contractors that process and pay more than $280 billion in Medicare claims each year.

"The Medicare program depends on health care providers all over the country to serve our beneficiaries, and this new survey will help us work with the Medicare contractors to help us serve our providers as effectively as possible," said CMS Administrator Mark B. McClellan, M.D., Ph.D. "As we implement the most significant contractor reforms in the history of the Medicare program, provider satisfaction will be one of the key considerations."

The MCPSS is one of the tools CMS will use to measure provider satisfaction levels, as a result of the Medicare Modernization Act of 2003 (MMA). It was developed with extensive input from providers, and information about the survey has been disseminated to providers through a variety of channels, including Open Door Forum conference calls with providers and Medlearn Matters articles posted on the CMS Web site. CMS will conduct ongoing outreach to providers throughout the survey process.

"We are bringing satisfaction measures and other quality measures to many aspects of Medicare, to get the best possible performance for the dollars we spend," added Dr. McClellan. "This survey is very important provider feedback, and so we are identifying ways in which we can get the maximum provider participation."

The MCPSS will query 25,000 randomly selected providers (e.g., physicians, suppliers, healthcare practitioners, and institutional providers), a statistically valid and representative sample of the 1.2 million who serve Medicare beneficiaries. Those providers selected to participate in the survey will be notified by mail during the first week of January 2006. The survey is designed so that it can be completed in less than a half-hour. Survey responses can be submitted via a secure Web site, mail, or fax and will be accepted through January 25, 2006.

The survey questions will focus on seven key areas of provider-contractor interactions, including:

- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

CMS will use the MCPSS results for Medicare contractor oversight. Contractors will be able to use the survey results to improve the services they offer to providers. CMS plans to make the survey results available via an online reporting system in early July 2006. Further information about the MCPSS is available at: ***www.cms.hhs.gov/MCPSS/***

Centers for Medicare & Medicaid Services (CMS) Seeks Provider Input on Satisfaction with Medicare Fee-for-Service Contractor Services

Medlearn Matters Number: SE0602 **Revised**
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Note: This article was revised on January 20, 2006, to show the effective and implementation dates (see above) as January 3, 2006.

The following information affects a sample of 25,000 Medicare providers served by 42 Medicare Fee-for-Service (FFS) contractors, including fiscal intermediaries (FIs), carriers, durable medical equipment regional carriers (DMERCs), and regional home health intermediaries (RHHIs).

Provider Action Needed

Impact to You

The Centers for Medicare & Medicaid Services (CMS) would like to provide a channel for you to voice your opinions about the services you receive from your FFS contractors. The Medicare Contractor Provider Satisfaction Survey (MCPSS) is designed to garner quantifiable data on provider satisfaction with the performance of FFS contractors. The MCPSS is one of the tools CMS will use to carry out the measurement of provider satisfaction levels, a requirement of the Medicare Modernization Act (MMA). Specifically, the survey will enable CMS to gauge provider satisfaction with key services performed by the 42 contractors that process and pay the more than $280 billion in Medicare claims each year. Those Medicare contractors will use the results to improve service. CMS will use the results to improve its oversight of and increase the efficiency of the administration of the Medicare program.

What You Need to Know

The first national implementation of the MCPSS will begin January 3, 2006. If you have been selected, you will receive a notification packet in the mail with background information about the survey, as well as an instruction sheet with information on how to access and complete the survey instrument via a secure Internet Web site. The letter will also include a telephone number that you can call to request a paper copy of the survey instrument to submit your responses by mail or fax, if you prefer to do so.

What You Need to Do

Be alert for a notification packet in the mail. If you are selected and receive the notification packet, please take the time to complete and submit your survey responses as soon as possible. The data collection period will continue through January 25, 2006.

Background

The 2006 survey will query approximately 25,000 randomly selected providers - those physicians, healthcare practitioners, and facilities that serve Medicare beneficiaries across the country - on the seven key areas of the provider-contractor interface:

- Provider communications
- Provider inquiries
- Claims processing
- Appeals
- Provider enrollment
- Medical review
- Provider audit and reimbursement

It contains a total of 76 questions and takes approximately 21 minutes to complete. The deadline for survey submission is January 25, 2006. CMS will analyze the data and release a summary report in July that will be made available on the Internet. Each contractor will also receive an individual report on their performance in June. The MCPSS will be conducted on an annual basis.

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

Additional Information

For questions or additional information about the MCPSS, please visit ***www.cms.hhs.gov/MCPSS/*** on the CMS Web site.

Important Information about Medicare Coverage of Drugs under Part B and the New Medicare Prescription Drug Coverage (Part D), and Vaccines Administered in a Physician's Office

Medlearn Matters Number: SE0570
Related Change Request (CR) #: N/A
Related CR Release Date: N/A

The Ninth in the Medlearn Matters Series on the New Prescription Drug Plans

Table of Contents

The following information affects physicians, healthcare professionals, providers, suppliers, and their staff.

Key Points to Remember

- Drugs covered under Fee-for-Service (FFS) Medicare Parts A/B that are paid to institutional providers (hospitals, skilled nursing facilities (SNFs), etc.) as part of a bundled payment are paid by fiscal intermediaries (FIs).
- Drugs covered under FFS Medicare Part B that are billed by physicians and suppliers are paid by carriers (including durable medical equipment regional carriers (DMERCs)).
- FIs and carriers do **not**, ***and will not***, pay claims for Part D drugs. Providers should **not** submit claims for Part D covered drugs to FIs or carriers.
- Drugs covered under Part D are paid by Medicare Part D Drug Plans, such as Prescription Drug Plans (PDPs) or Medicare Advantage Prescription Drug Plans (MA-PDs), for enrolled beneficiaries.
- Providers **must** have a contractual relationship with a Medicare Part D Drug Plan to bill these plans for drugs provided to enrolled beneficiaries. A state-specific list of Medicare Part D Drug Plans can be found at ***www.medicare.gov/medicarereform/map.asp*** on the Centers for Medicare & Medicaid Services (CMS) Web site.

Highlights

This article highlights the differences in how drugs are covered and which drugs are covered by Medicare Part B and the new Medicare prescription drug coverage (Part D). It also offers additional guidance on the effect of Part D on vaccines given to Medicare patients in a physician's office. Those currently billing Medicare Part B for drugs or for vaccines may wish to pay particular attention to this article.

Drugs Covered Under Part B and Part D

Part A/B Covered Drugs Set by Statute

Traditional Part A/B Medicare does **not** cover most outpatient prescription drugs. Under Part A, Medicare bundled payments made to hospitals and SNFs generally cover all drugs provided during a covered Part A stay. (An exception is clotting factor supplied during

a stay, which is paid separately from the bundled payment.) Medicare also makes payments under Part B to physicians for drugs or biologicals that are **not** usually self-administered. Coverage is usually limited to drugs or biologicals **administered by infusion or injection**. If the injection is self-administered (e.g., Imitrex), it is **not** covered.

Physicians, healthcare professionals, providers, and suppliers may also bill Medicare Part B for other limited types of drugs as follows:

Durable Medical Equipment (DME) Supply Drugs
These are drugs that require administration by the use of a piece of covered DME (e.g., a nebulizer, or external or implantable pump). The statute does **not** explicitly cover DME drugs; they are covered as a supply necessary for the DME to perform its function.

The largest Medicare expenditures for drugs furnished as a DME supply are for inhalation drugs (e.g., albuterol sulfate, ipratropium bromide), which are administered in the home through the use of a nebulizer. The other category of drugs Medicare covers as a DME supply are drugs for which administration with an infusion pump in the home is medically necessary (e.g., some chemotherapeutic agents).

Immunosuppressive Drugs
These include drugs used in immunosuppressive therapy (such as cyclosporine) for a beneficiary who has received a Medicare-covered organ transplant.

Hemophilia Clotting Factors
These include hemophilia clotting factors for hemophilia patients competent to use such factors to control bleeding without medical supervision and items related to the administration of such factors.

Oral Anti-Cancer Drugs
These are drugs taken orally during cancer chemotherapy, provided they have the same active ingredients and are used for the same indications as are chemotherapy drugs that would be covered if they were **not** self-administered, but were administered instead as incident to a physician's professional service.

Oral Anti-Emetic Drugs
These are oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen as a full therapeutic replacement for an intravenous anti-emetic drug within 24 or 48 hours of chemotherapy administration depending on the drug.

Pneumococcal Vaccine
This refers to the vaccine and its administration to a beneficiary if ordered by a physician.

Hepatitis B Vaccine
This includes the vaccine and its administration to a beneficiary who is at high or intermediate risk of contracting Hepatitis B. High-risk groups include the following:

- Individuals with end-stage renal disease (ESRD);
- Individuals with hemophilia who received Factor VIII or IX concentrates;
- Clients of institutions for mentally handicapped individuals;
- Persons who live in the same household as a Hepatitis B Virus (HBV) carrier;
- Homosexual men; and
- Illicit injectable drug abusers.

Intermediate-risk groups include staff in institutions for the mentally handicapped and workers in healthcare professions who have frequent contact with blood or blood-derived body fluids during routine work.

Influenza Vaccine
This refers to the vaccine and its administration when furnished in compliance with any applicable state law. The beneficiary may receive the vaccine upon request without a physician's order and without physician supervision.

Antigens
These are prepared by a physician (usually an allergist) for a specific patient. The physician or physician's nurse generally administers them in the physician's office. In some cases, the physician prepares antigens and furnishes them to a patient who has been taught to self-administer them at home.

Erythropoietin (EPO)
EPO is used for treating anemia in persons with chronic renal failure who are on dialysis.

Parenteral Nutrition

Parenteral nutrients are covered under the prosthetic benefit. They are available to beneficiaries who **cannot** absorb nutrition through their intestinal tract. Parenteral nutrition is administered intravenously and is regulated as a drug by the Food and Drug Administration (FDA).

Intravenous Immune Globulin Provided in the Home

The Medicare Modernization Act of 2003 (MMA) created a benefit for the provision of intravenous immune globulin (IVIG) for beneficiaries with a diagnosis of primary immune deficiency disease. Coverage is provided if a physician determines that the administration of IVIG in the patient's home is medically appropriate. Payment is limited to that for the IVIG itself and does **not** cover items and services related to administration of the product.

Part B Covered Drugs in the Context of a Professional Service

Drugs Furnished "Incident to" a Physician's Service

These are injectable or intravenous drugs that are administered predominantly by a physician or under a physician's direct supervision as "incident to" a physician's professional service. The statute limits coverage to drugs that are **not** usually self-administered. (If a drug is not self-administered by more than 50 percent of Medicare beneficiaries, it is considered "not usually self-administered.")

Separately Billable ESRD Drugs

Most drugs furnished by dialysis facilities are separately billable. The largest Medicare expenditures for such drugs are for EPO, which is covered for dialysis beneficiaries when it is furnished by independent and hospital-based ESRD facilities, as well as when it is furnished by physicians.

Separately Billable Drugs Provided in Hospital Outpatient Departments

For calendar year 2005, Medicare continues to pay separately for drugs, biologicals, and radiopharmaceuticals whose median cost per administration exceeds $50, while packaging the cost of drugs, biologicals, and radiopharmaceuticals whose median cost per administration is less than $50 into the procedures with which they are billed.

Drugs Covered as Supplies or "Integral to a Procedure"

Some drugs are covered as supplies that are an integral part of a procedure that is a diagnostic or therapeutic service, including radiopharmaceuticals (both diagnostic and therapeutic) and low osmolar contrast media. Other examples of drugs covered under the "integral to a procedure" provision include eye drops administered before cataract surgery.

Blood

Medicare does make separate payment for blood and blood products, and these products are regulated as biological agents by the FDA.

Drugs Furnished as a Part of a Service in Provider Settings

Also covered are drugs furnished as a part of a service in the following provider settings:

- Drugs packaged under the Hospital Outpatient Prospective Payment System;
- Drugs furnished by ESRD facilities and included in Medicare's ESRD composite rate;
- Osteoporosis drugs provided by home health agencies under certain conditions;
- Drugs furnished by critical access hospitals' (CAH) outpatient departments;
- Drugs furnished by a Rural Health Clinic (RHC);
- Drugs furnished by Federally Qualified Health Centers (FQHC);
- Drugs furnished by Community Mental Health Centers (CMHC);
- Drugs furnished by ambulances; and
- Separately billable drugs provided in Comprehensive Outpatient Rehabilitation Facilities (CORF).

Part D Covered Drugs

Definition of a Part D Covered Drug

A Part D covered drug is a drug that is:

- Available **only** by prescription;
- Approved by the FDA (or is a drug described under Section 1927(k)(2)(A)(ii) or (iii) of the Social Security Act (the Act));
- Used and sold in the United States; and
- Used for a medically accepted indication (as defined in Section 1927(k)(6) of the Act).

A covered Part D drug includes prescription drugs, biological products, insulin as described in specified paragraphs of Section 1927(k) of the Act, and vaccines

licensed under Section 351 of the Public Health Service Act. The definition also includes "medical supplies associated with the injection of insulin (as defined in regulations of the Secretary)." CMS defines those medical supplies to include syringes, needles, alcohol swabs, and gauze.

Part D Excluded Drugs

The definition of a covered Part D drug excludes any drug for which, as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual, even though a deductible may apply. In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Medicaid under Section 1927(d)(2) of the Act, with the exception of smoking cessation agents.

The drugs or classes of drugs that may currently be otherwise restricted under Medicaid include the following:

- Agents when used for anorexia, weight loss, or weight gain;
- Agents when used to promote fertility;
- Agents when used for cosmetic purposes or hair growth;
- Agents when used for the symptomatic relief of cough and colds;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
- Non-prescription drugs;
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale;
- Barbiturates; and
- Benzodiazepines.

While these drugs or uses are excluded from basic Part D coverage, Medicare Part D drug plan sponsors can generally include them as part of supplemental benefits, provided they otherwise meet the definition of a Part D drug.

Because non-prescription drugs do **not** otherwise meet the definition of a Part D drug, the Part D drug plans may **not** include such drugs as part of supplemental benefits; however, under certain conditions as part of a plan utilization management program (including a step-therapy program), non-prescription drugs can be provided at **no** cost to enrollees. The cost of these drugs to the plan would be treated as administrative costs under such programs.

Note: For more detailed information about Part B drugs and Part D coverage, please refer to the report at ***www.cms.hhs.gov/pdps/PartBandPartDdoc-revised7-27-05.pdf*** on the CMS Web site. [It is now located at: ***www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartBandPartDdoc_07.27.05.pdf***] This report provides excellent detail on the overall issue of Part B and Part D drugs. For example, this report discusses the following:

- Situations in which a billing entity would have to decide whether, for a given drug, to bill Part B or Part D, based on characteristics of the beneficiary or medical use of the drug;
- Situations where the form of the drug determines where it is covered; and
- Situations where Part B coverage is in the context of another service.

Vaccines Administered in a Physician's Office

This section discusses the vaccines currently covered by Medicare Part B and includes a few commonly asked questions regarding vaccine coverage under Medicare Part B and Part D. Basically, if a vaccine is currently covered under Part B, the vaccine will remain covered under Part B when the new Part D goes into effect on January 1, 2006.

Medicare Part B currently covers the following immunizations (as discussed earlier in this article):

- Pneumococcal pneumonia vaccine;
- Hepatitis B vaccine;
- Influenza virus vaccine; and
- Other vaccines (e.g., tetanus toxiod) when directly related to the treatment of an injury or direct exposure to a disease or condition.

Key Questions

Will All Vaccines be Covered under Part D, Effective January 1, 2006?

No. As just mentioned, if a vaccine was previously covered under Part B, it will continue to be covered under Part B. If it was previously **not** covered, then it will need to be covered under Part D. Pneumococcal and influenza vaccines are **not** covered under Part D because of Part B coverage.

Hepatitis B vaccine is covered under Part B for individuals at high or intermediate risk; for all other individuals, it would be covered under a Part D benefit. All other currently available vaccines and all future vaccines would be covered under Part D, but could be subject to plan prior authorization requirements to determine medical necessity.

If a Company That Offers Medicare Part D Drug Plans Determines, Through a Prior Authorization Program, that a Hepatitis B Vaccine is Going to be Administered by a Physician, Can This Company Deny the Claim Based on Part B Coverage in the Setting?

No. Since the Part B benefit for Hepatitis B vaccine is separate from the "incident to" benefit, the determination about whether it is a Part D drug depends solely on characteristics of the beneficiary. However, if the plan sponsor determines based on Medicare Part B guidelines that the individual is at high or medium risk for Hepatitis B, the company should deny the claim. For all other individuals, the vaccine would be a "Part D drug" and would be covered unless the plan had otherwise established medical necessity criteria for the vaccine as part of its approved prior authorization program. In this case, only low-risk individuals who meet the plan's criteria would be eligible to receive the vaccine.

Additional Information

Web Sites for Part B and Part D Coverage Information

Medicare Claims Processing Manual	***www.cms.hhs.gov/manuals/104_claims/clm104index.asp***
Medicare Benefit Policy Manual	***www.cms.hhs.gov/manuals/102_policy/bp102index.asp***
Medicare Coverage Database	***www.cms.hhs.gov/mcd/search.asp***
Carrier, DMERC, and Fiscal Intermediary Contacts by Region	***www.cms.hhs.gov/medlearn/tollnums.asp***
Medicare Drug Information Resource	***www.cms.hhs.gov/providers/drugs/default.asp***
Hospital Outpatient Prospective Payment System 2005	***www.cms.hhs.gov/providers/hopps/fr2005.asp***
Palmetto GBA	***www.palmettogba.com***
AdminaStar	***www.adminastar.com***
CIGNA	***www.cignamedicare.com***
National/Local Coverage Determinations	***www.cms.hhs.gov/coverage***
Medicare Part B versus Part D Coverage Issues	***www.cms.hhs.gov/pdps/PartBandPartDdocrevised7-27-05.pdf***
Medicare Prescription Drug Coverage Information for Providers	***www.cms.hhs.gov/medlearn/drugcoverage.asp***
Prescription Drug Plans	***www.cms.hhs.gov/pdps/***

Important Message to Nursing Home Administrators About Medicare Prescription Drug Coverage

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Note: This article was revised on November 15, 2005, to provide a new Web address for viewing a copy of the letter sent by the Centers for Medicare & Medicaid Services (CMS) to nursing home residents who are Medicare beneficiaries who also have full Medicaid coverage.

The Tenth in the Medlearn Matters Series

The following information affects skilled nursing facilities (SNFs) and nursing homes with Medicare residents.

Impact on Providers

This article contains information on Medicare prescription drug coverage as it applies to nursing home residents. CMS will continue to use Medlearn Matters articles, where appropriate, to supplement the Minimum Data Set (MDS) channel to communicate important information and recommended action steps. The goal is to ensure that the long-term care population has a seamless transition to Medicare prescription drug coverage beginning January 2006.

Important Points to Remember

Key points to remember about the new Medicare prescription drug coverage include the following:

- On January 1, 2006, new prescription drug coverage, also known as Part D, will be available to all of your Medicare residents. It will cover brand name and generic drugs.
- Everyone with Medicare is eligible to join a Medicare drug plan in their area.
- Your residents can first enroll in a Medicare drug plan from November 15, 2005 - May 15, 2006.
- This new drug coverage requires all persons with Medicare to make a decision this fall. As a trusted source, your residents may turn to you for information about this new coverage.

- Please encourage your Medicare residents to learn more about this new coverage because it may save them money on prescription drugs.
- There is extra help for people with limited income and resources.

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

Background

At the end of October 2005, CMS mailed a letter to nursing home residents with Medicare and full Medicaid coverage (full-benefit dually eligible beneficiaries). This letter explained that Medicare, instead of Medicaid, will start paying for their prescription drugs beginning January 1, 2006. The letter explained that if they don't enroll in a plan by December 31, 2005, Medicare will enroll them in a plan to make sure they don't miss a day of coverage. The letter provided the name and contact information for the plan in which Medicare would enroll them. A sample copy of this letter can be found at: ***www.cms.hhs.gov/medicarereform/Enrollment-Q&A-10-20-05-with-cover-sheet.pdf*** on the CMS Web site. Generally, residents with full Medicaid coverage who are enrolled in a Medicare Advantage plan or the Program of All-Inclusive Care for the Elderly (PACE) will receive their Medicare drug coverage through that plan. CMS is establishing a Web-based system through which nursing homes can access residents' plan enrollment information. This will enable the nursing facility, with the resident's permission, to identify the Medicare drug plan in which the resident is enrolled.

Everyone with Medicare is eligible to join a Medicare drug plan in their area. Many of your residents may want to join a plan to help with the high costs of medications. Your residents can first enroll in a Medicare prescription drug plan from November 15, 2005 - May 15, 2006.

Action Item

Residents with limited income and resources can apply for extra help paying for their prescription drugs. They can apply for this extra help through the Social Security Administration or their state Medical Assistance Office. For more information on who can get extra help with prescription drug costs and how your residents can apply for that help, call the Social Security Administration at 800-772-1213. TTY users should call 800-325-0778. You may also find this information at ***www.socialsecurity.gov/*** on the Web.

Remember, your facility may request applications for the extra help and help residents who may qualify apply. It is important to submit applications for the extra help for new residents who are "Medicaid pending." Residents who have Medicare and full Medicaid coverage, get help from Medicaid paying their Medicare premiums, or receive Supplemental Security Income (SSI) benefits, automatically qualify for extra help and **do *not* need to apply** for it.

Additional Information

More information concerning Medicare prescription drug coverage and the nursing home population will continue to be supplied through articles such as these and through the MDS channel. Additional information and resources are available at ***www.cms.hhs.gov/medicarereform/pdbma/*** on the CMS Web site.

Medicare Prescription Drug Coverage: Essential Information and Resources for Prescribing Health Care Professionals

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The Eleventh in the Medlearn Matters Series on the New Prescription Drug Plans

The following information affects all health care professionals who prescribe prescription medications for Medicare beneficiaries.

Impact on Providers

The new Medicare prescription drug coverage began on January 1, 2006. Already, pharmacists have filled

millions of prescriptions for people with Medicare. During this important transition period to the new prescription drug coverage, the Centers for Medicare & Medicaid Services (CMS) understands that there is much that prescribing health care professionals need to know about this new coverage in order to help their Medicare patients.

Essential Information for Prescribing Health Care Professionals

CMS has compiled a list of information, resources, and tools that will allow health care professionals and their support staff to help their Medicare patients during this transition period.

Finding Formulary Information

CMS has a formulary finder that provides direct access to all plan Web sites at ***formularyfinder.medicare.gov/formularyfinder/selectstate.asp*** on the Web. In addition, we [CMS] have worked with Epocrates to provide free software, which makes the formulary selection process very simple. You can load this program into your personal digital assistant (PDA) or run the software on a desktop. This tool is available at ***www.epocrates.com/*** on the Web.

Coverage Determination

CMS defines a coverage determination as the first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under the plan, including a decision **not** to provide or pay for a Part D drug, a decision concerning an exception request, and a decision on the amount of cost sharing for a drug. An exception request is a type of coverage determination request. Through the exceptions process, an enrollee can request an off-formulary drug, an exception to the plan's tiered cost sharing structure, and an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction, or prior authorization requirement). CMS does **not** have the authority to mandate a standard exception process for each Medicare drug plan or Medicare Advantage Prescription Drug Plan (MA-PD); however, the agency is working to simplify the exceptions process. Like typical commercial payers, health care professionals may occasionally need to help a patient file a prior authorization for a medication or appeal a medication's tier. CMS is working with medical specialty societies to address these issues.

A form has been created by a coalition of medical societies and advocacy groups that can be faxed to your office by a pharmacist when he or she is given a prescription that is either **not** on the formulary or on a higher tier. This form streamlines communication between the pharmacist and the physician and reduces the need for time-consuming telephone calls to the doctor's office. The form is located at ***www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartDPharmacyFaxForm.pdf*** on the CMS Web site, as well as at several medical society Web sites.

Expedited Review Process

There is an expedited review process that CMS has outlined to ensure that drug plans can move an appeal quickly, i.e., within a 24-hour turnaround time, to provide medicines to patients with an immediate need. Beyond this expedited review process, the standard appeals process to challenge a plan's coverage determination has five levels:

- Redetermination by the plan;
- Reconsideration by a Medicare drug coverage qualified independent contractor (QIC);
- An Administrative Law Judge (ALJ) hearing;
- Review by the Medicare Appeals Council; and
- Review by federal district court.

Visit ***www.cms.hhs.gov/PrescriptionDrugCovGenIn/04_Formulary.asp*** for a list of plan contacts you can use to query your patient's plan should you need to pursue an appeal or require clarification on an issue.

Part B Drugs vs. Drugs Covered under Medicare Prescription Drug Coverage (Part D)

A previous Medlearn Matters article explains the difference between drugs covered under Part B versus those covered under Part D. This article can be found at ***www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0570.pdf*** on the CMS Web site. Additionally, a chart explaining specific drugs can be found at ***www.cms.hhs.gov/pharmacy/downloads/partsbdcoverageissues.pdf*** on the CMS Web site.

Verifying Beneficiary Enrollment in a Medicare Drug Plan

Office staff can use the Medicare Prescription Drug Plan Finder, located at ***www.medicare.gov***, to verify a beneficiary's enrollment in a Medicare drug plan. By entering all information provided on a beneficiary's Medicare card, the plan finder will identify the plan in which the beneficiary is enrolled.

Pharmacists have access to a new computer tool called "E1" that provides real-time enrollment and eligibility information. This tool provides both eligibility and billing information at the point of sale and is constantly updated by CMS.

Obtaining Prior Authorizations

A prior authorization can **only** be obtained by calling the drug plan directly. 1-800-MEDICARE **cannot** process a prior authorization.

Ensuring Coverage for a Dual Eligible Beneficiary Who Needs to be Enrolled in a Plan

CMS has ensured that people with Medicare and full Medicaid benefits (full dual) will have drug coverage by enabling customer service representatives at 1-800-MEDICARE to enroll these beneficiaries in WellPoint, a national plan. If these beneficiaries have **immediate prescription needs**, they should visit their local pharmacies. The pharmacist can enroll them in WellPoint at the pharmacy. To find out more about what happens with Medicare prescription drug coverage in certain situations, visit ***www.cms.hhs.gov/Pharmacy/Downloads/whatif.pdf*** on the CMS Web site.

Providing a 90-day Supply of Transitional Prescription Medication

CMS has instructed ***all*** Medicare-approved plans to extend the original 30-day transitional coverage period by an additional 60 days. This means that a Part D beneficiary will be able to get a 90-day supply of ***all*** of his or her medications when they enroll in Part D, even if some of the medications are **not** on formulary. This 90-day period will give the patient's doctor and pharmacist time to adjust the patient's drug regimen, or request exceptions to the plan's formulary, so that the next refill of medications will be consistent with the plan's coverage rules. Beneficiaries who enroll after March 31, 2006, will get a 30-day transitional fill so that they have time to adjust their medication regimen to the plan formulary.

Important Contact Information to Report Problems with Medicare Prescription Drug Coverage

Health Care Professionals: Email **prit@cms.hhs.gov** with problems and issues encountered. Please take advantage of CMS' regular conference call at 2:00 p.m. (EST) every Tuesday. This call gives health care professionals an opportunity to ask questions of CMS staff. Call 800-619-2457; Passcode: RBDML.

Pharmacists: Call 866-835-7595, a CMS-dedicated line designed to help answer questions regarding billing and beneficiary enrollment information.

Additional Information

Health care professionals can visit ***www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage*** on the CMS Web site. The redesigned Web page contains all the latest information on Medicare prescription drug coverage.

2006 Standard Medicare Prescription Drug Coverage: Understanding Costs to Beneficiaries

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The Twelfth in the Medlearn Matters Series on Drug Plans

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

Important Points to Remember

Key points to remember about the new Medicare prescription drug coverage include the following:

- Beneficiaries can join a Medicare Prescription Drug Plan that covers prescription drugs **only** and keep their original Medicare coverage. Or, they can join a Medicare Advantage Plan or other Medicare health plan that covers doctor and hospital care as well as prescriptions.
- Medicare prescription drug coverage is NOT automatic - people **must** join a plan to get coverage
- Your patients have an initial opportunity to join a Medicare drug plan now through May 15, 2006.
- Most people will have to pay a higher premium that includes a penalty if they wait to join a Medicare drug plan until after May 15, 2006, unless they have other coverage that, on average, is at least as good as Medicare prescription drug coverage.

Note: This penalty consists of an additional one percent (1%) of the base premium for every month the person went without coverage and is levied as long as the person is enrolled in a Medicare drug plan.

- People who do **not** join a Medicare drug plan by May 15, 2006, may also have to wait until November 15, 2006, for their next opportunity to join.

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

General Information

One of the issues that may be most important for your patients involves what Medicare prescription drug coverage means to them in terms of cost. This article focuses on the out-of-pocket expenses that your patients will incur under this new program and highlights the costs covered by a standard plan. Actual costs of the specific Medicare Prescription Drug Plans and the Medicare Advantage Plans or other Medicare health plans in each area are available in the "Medicare & You 2006" handbook and at ***www.medicare.gov*** on the Web.

Costs Covered by a Standard Plan

Costs for your patients who join a Medicare drug plan will vary depending on their financial situation and which Medicare drug plan they join. All Medicare drug plans will offer at least the standard level of coverage described below. Medicare drug plans may design their plans differently as long as what their plan offers is, on average, at least as good as the standard coverage. Some plans may offer more coverage for higher premiums. Patient costs under standard Medicare drug coverage as defined by the Medicare Modernization Act (MMA) for 2006 will include the following:

- A monthly premium (average of $32 in 2006);
- A $250 deductible;
- Person pays, on average, 25 percent of allowable drug expenses up to a coverage limit of $2,250 (plan pays the other 75 percent);
- After $2,250 in covered drug costs, person pays 100 percent of covered drug costs until $3,600 limit in true out-of-pocket spending is reached;
- About five (5) percent coinsurance for covered drug costs after $3,600 out-of-pocket limit is reached.

Individuals with standard coverage will pay the full cost of their prescriptions for drug spending between $2,250 and up to their true out-of-pocket limit of $3,600. However, plan enrollees will still be able to obtain their plan's discounted price for prescription drugs in this coverage gap.

Alternate Coverage

Plans are able to offer alternative coverage structures. For example, a plan can offer a deductible lower than $250 or use tiered copayments rather than coinsurance - provided that the alternative coverage structure meets certain tests of actuarial equivalence. Also, plans may offer additional drug coverage that supplements the standard coverage. Medicare payments to plans do **not** subsidize such supplemental coverage.

Costs for Patients With Medicare and Full Medicaid Benefits

Under Part D, starting in 2006, Medicare will provide primary drug coverage for individuals who are dually eligible for Medicare and Medicaid. Dually eligible individuals who earn incomes up to 100 percent of the federal poverty level will have Medicare prescription drug coverage with **no** deductibles, **no** premiums, nominal copays, and **no** coverage gap.

Beneficiaries who do **not** qualify for Medicaid, but whose incomes are below 150 percent of poverty and who meet an asset test, will qualify for extra help paying for Medicare prescription drug coverage. Beneficiaries who qualify for extra help can join a Medicare drug plan with full or partial coverage for premiums and cost-sharing and **no** coverage gap.

Specific Information on Out-of-Pocket Expenses

Medicare Drug Plan Premiums

Medicare drug plan monthly premiums vary, depending on the plan; however:

- All regions of the country have multiple plan options with premiums significantly below $30.
- There will be at least one prescription drug plan with a premium below $20 per month in every region of the country except Alaska.
- The average monthly beneficiary premium is $32.20, about $384 per year.

True Out-Of-Pocket Costs

The cost to beneficiaries with Medicare for Medicare prescription drug coverage over and above the monthly premium is often referred to as "true out-of-pocket expenses" or TrOOP. The TrOOP represents the

amount a beneficiary **must** spend on Part D covered drugs until catastrophic coverage begins. That catastrophic coverage begins when the beneficiary's out-of-pocket expenses reach $3,600 in a year. In addition to paying the base premium for their plan, Medicare beneficiaries will also pay TrOOP costs including the following:

- A deductible amount ($250) and coinsurance (25 percent of covered drug costs during the plan payment + coinsurance stage);
- All costs during the coverage gap stage; and
- Five percent of covered drug costs during the catastrophic coverage stage.

These additional TrOOP expenses are explained as follows:

Deductible (From $0 to $250: A net value of $250)
Under standard coverage, plan enrollees pay a $250 deductible each calendar year out of their own pockets for Part D covered drugs.

Plan Payments + Coinsurance (From $251 to $2250)
Once the annual ($250) deductible is met, standard coverage pays for 75 percent of the next $2,000 (or up to $1,500) for covered (allowable) drugs and biologicals. The remaining 25 percent (a maximum of $500) of the cost is covered by the beneficiary via coinsurance/copayments.

Coverage Gap (From $2,251 to $3,600 TrOOP limit)
Once covered drug costs have reached the plan payment + coinsurance + deductible limit of $2,250, the plan does **not** pay again until the plan enrollee has reached the $3,600 limit in out-of-pocket spending. The beneficiary pays ***all*** covered drug costs incurred in this "gap." The total out-of-pocket cost (not including premiums) to this point (deductible + plan payments + coinsurance + coverage gap) is $3,600 for coverage through the full "gap" (see TrOOP discussion below.)

Catastrophic Coverage (Costs over $3,600 TrOOP limit)
Once the individual's true out-of-pocket spending reaches $3,600, costs for necessary covered drugs are covered as follows:

- Reinsurance - 80 percent of covered drug-related costs are covered by Medicare;
- Plan payments - 15 percent of covered drug-related costs are covered by the drug plan;
- Coinsurance - 5 percent of covered drug-related costs are covered by the individual.

What Counts Toward True Out-of-Pocket (TrOOP) Costs?
Beneficiaries **must** adhere to their plan's formulary, prior authorization, and formulary exceptions processes in order for their out-of-pocket spending to count toward the $3,600 limit. The following types of spending count toward the $3,600 threshold:

- The beneficiary's own out-of-pocket spending;
- Spending by a family member or official charity, on behalf of the beneficiary;
- Supplemental drug coverage provided through qualifying state pharmacy assistance programs (SPAP) or Medicare's extra help; and
- Under the Centers for Medicare & Medicaid Services' (CMS') demonstration authority, supplemental drug coverage paid for with Medicare Advantage (MA) rebate dollars.

In summary, the amount that a beneficiary **must** spend on Part D-covered drugs until catastrophic coverage is reached, based on the 2006 standard coverage, is as follows:

$250 deductible
+ $500 plan enrollee coinsurance during initial coverage
+ $2,850 coverage gap
= $3,600 (plus the monthly premium, which averages $384/year)

Once this cost has been reached for covered drugs, catastrophic coverage begins.

Related Links

Health and Human Services (HHS) Secretary Mike Leavitt recently released a two-month progress report on Medicare Prescription Drug Coverage that takes a hard look at what is working and what needs to improve. To view the report, visit ***www.hhs.gov/medicare2final.pdf*** on the Web.

For more information about Medicare Prescription Drug Coverage for Providers, visit ***www.cms.hhs.gov/MedlearnProducts/23_DrugCoverage.asp#TopOfPage*** on the CMS Web site.

Important Message to All Medicare Participating Providers in Pennsylvania

As you may be aware, many Medicare beneficiaries who also have Medicaid coverage from the state of Pennsylvania (also known as "full benefit dual eligibles," or "dual eligibles") have been enrolled into Medicare "Special Needs Plans" (SNPs) and coverage began January 1, 2006. These Medicare SNPs (shown in the below List of Medicare Special Needs Plans) are managed care plans operated by the same organization that provided these beneficiaries' Medicaid managed care coverage and are specifically designed to provide coordinated care (including Medicare prescription drug coverage) for the dually eligible population.

You may or may not participate in any or all of these plans' networks. **Regardless, please do *not* let this stop you from seeing your Medicare patients.** Here's why:

1) For the first 90 days of this year (through March 31, 2006), you may provide Medicare-covered services to these individuals and submit a claim to your patient's Medicare SNP even though you do **not** participate in its network. The SNP is required to pay you the Medicare fee-for-service (FFS) rate or billed charge, whichever is lower, for any Medicare-covered services provided during the period beginning January 1, 2006, and ending on March 31, 2006.
2) You may sign up to be a participating provider with the plan, should you so desire. You should contact the plan for further details about becoming a participating provider.
3) Your dual eligible patients are allowed to disenroll from the SNP and return to Original (FFS) Medicare or choose a different Medicare managed care plan at any time.

The Centers for Medicare & Medicaid Services (CMS) has worked closely with the SNPs to clarify their obligations to continue to pay for services provided by out-of-network providers through March 31, 2006, and to ensure that these "transition policies" are appropriately disseminated throughout their organizations. These policies are further described in the Special Needs Plans' Attestation (see below), and each of the SNPs has signed this document, thereby attesting to their intent to implement these policies. If you have any questions about these policies, or encounter any difficulties receiving payment for care provided during this time period, please contact the appropriate plan in the List of Medicare Special Needs Plans. You may also contact CMS' Philadelphia Regional Office if you encounter problems with this process.

All affected beneficiaries received notice of the prospective enrollment into an SNP earlier in the fall, including an explanation of their ability to disenroll from the plan and choose Original Medicare or another Medicare managed care plan. This notice also explained the changes in the way they would be able to access their benefits, including the need to generally obtain services from network providers. They will soon receive another notice explaining their enrollment options and clarifying plan transition policies. That is, these beneficiaries may disenroll from their SNP by calling the plan directly at the number included above, or by calling 1-800-MEDICARE (1-800-633-4227). TYY users should call 1-877-486-2048. Staff at 1-800-MEDICARE will also help them to enroll in a Medicare Prescription Drug Plan, to make sure that they retain Medicare prescription drug coverage.

List of Medicare Special Needs Plans

AmeriHealth 65
Member Services: 1-800-645-3965
Provider Services: 1-888-850-9200

Gateway Health Plan
Member Services: 1-800-685-5209
Provider Services: 1-800-685-5205

Health Partners
Member Services General: 1-800-553-0784
Medicare Specific: 1-888-667-7367
Provider Services: 1-888-991-9023

Keystone 65 Complete
Member Services: 1-800-645-3965
Provider Services: 1-888-850-9200

Unison Health Plan
Member Services: 1-800-290-4009
Provider Services: 1-800-600-9007

UPMC Health Plan
Members and Providers: 1-800-606-8648

Special Needs Plans' Attestation

[Insert Name of Plan] (the "Plan") has established a transition plan for the first 90 days of 2006, up to and including March 31, 2006, for all dual eligible beneficiaries who were enrolled in the Plan as part of the passive enrollment process. As part of the transition plan, covered services furnished by out-of-network providers will be covered for these "passive enrollees" for 90 days without the need for referrals, prior authorization, or similar restrictions that would prevent access to an out-of-network provider. The Plan will pay the out-of-network provider the Medicare fee-for-service rate, or billed charges, whichever is less.

With regard to Part D prescription drugs, the Plan will honor prescriptions for Part D covered drugs for its passive enrollees from all appropriately licensed providers, regardless of whether those providers are in the Plan's network. The Plan will comply with CMS formulary transition policies, as set forth most recently in CMS' January 6 and January 13, 2006, memoranda to all Part D Plans. In short, while transition policies are not intended to cover excluded drugs or to preclude drug utilization review edits for safety, delaying, or denying the filling of initial prescriptions at point of sale because of prior authorization/edit requirements is not acceptable. Thus, a passive enrollee's Part D-covered maintenance drugs that were available under the Medicaid managed care plan will remain available to the enrollee through the Plan during the transition period.

Hurricanes Katrina and Rita – Transportation of Evacuees with Medical Needs

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The following information affects physicians, suppliers, and providers billing Medicare carriers, including durable medical equipment regional carriers (DMERCs), and/or fiscal intermediaries (FIs), including regional home health intermediaries (RHHIs), for transportation services provided to evacuees of Hurricanes Katrina and Rita.

Provider Action Needed

Impact to You

This Special Edition article provides a summary of the Department of Health and Human Services (DHHS) Fact Sheet regarding the transportation of Hurricanes Katrina and Rita evacuees with medical needs.

What You Need to Know

If you made your own medical transportation arrangements, prior to or after the DHHS established the HHS Medical Travel Center services contract, then the normal Medicare coverage rules apply.

What You Need to Do

As you receive inquiries from providers or beneficiaries seeking to discharge a patient (or to help those patients return home), you should provide them with the information contained in this Special Edition article. Please review the questions and answers at the end of this Special Edition article and take appropriate action to use the instructions in your claims submissions.

Background

The Centers for Medicare & Medicaid Services (CMS) is providing this Special Edition article to give you important information regarding the transportation of Hurricanes Katrina and Rita evacuees with medical needs. This Special Edition article:

- Explains the HHS Medical Travel Center services;
- Defines which individuals are eligible for medical transportation;
- Provides information for beneficiaries;
- Defines the role of the discharge planner;
- Describes the different types of transfers; and
- Provides a list of transportation-related questions and answers directed to patients, providers, Medicare carriers and FIs, and discharge planners.

Hurricane Evacuation

Because of Hurricanes Katrina and Rita, many people were forced to evacuate their homes and healthcare facilities in Texas, Mississippi, and Louisiana. Evacuees included many Medicare beneficiaries, including some with serious and/or ongoing medical needs, and assisting these evacuees has included dealing with significant difficulties and has raised questions regarding:

- The logistics of transporting the patients back to their home states, and

- The costs and billing for these medical transportation services.

In response to these and many more questions, DHHS created a Fact Sheet to provide information and answer frequently asked questions regarding certain issues resulting from Hurricanes Katrina and Rita. The DHHS Fact Sheet provides instructions and answers questions pertaining to the provision of transportation for evacuees from Texas, Louisiana, and Mississippi who:

- Are currently patients in healthcare facilities,
- Have outpatient/ongoing medical needs, or
- Were evacuated by air-lift out of their home state.

Note: The DHHS Fact Sheet may be viewed at ***www.hhs.gov/katrina/factsheet.html*** on the DHHS Web site.

In many counties and parishes in Texas, Mississippi, and Louisiana, the healthcare infrastructure will **not** support the return of evacuees with medical needs. Evacuees may need to continue to shelter in their host state or travel to an interim location to be closer to friends and family until Texas, Mississippi, and Louisiana can support their return.

Texas is currently accepting the return of patients and those evacuees with ongoing medical needs to select counties in Texas.

Mississippi is currently accepting the return of patients and those evacuees with ongoing medical needs to select counties in Mississippi.

Louisiana is:

- Accepting the return of evacuees who are currently patients in healthcare facilities on a case-by-case basis **only**. All healthcare facilities in Louisiana are responsible for gaining approval from the Louisiana Department of Health and Hospitals before accepting the transfer of evacuees into the state. If there is **not** a receiving facility available, the evacuee may access transportation to an interim location in another state where family and friends may reside.
- NOT accepting the return of evacuees with medical needs who are **not** patients at healthcare facilities. When Louisiana determines it is able to support the return of evacuees with outpatient/ongoing medical needs, additional guidance will be disseminated.

HHS Medical Travel Center

The DHHS established a transportation program to support the return of evacuees with medical needs from Texas, Mississippi, and Louisiana. The HHS Medical Travel Center is under contract with HHS to arrange transportation for evacuees who require enroute medical care and/or medical transport to include a nonmedical attendant to an institution or to a private residence, as appropriate.

If the evacuee's originating medical facility is **not** available in their home state or if their residence and community medical infrastructure is **not** suitable, evacuees will be allowed to travel to an interim location in the continental United States. The HHS Medical Travel Center will then return the evacuee to their home of record when a medical facility there is available or they can return to a safe community/home environment. The HHS Medical Travel Center provides transportation services without cost to providers. Providers (and patients) who use the HHS Medical Travel Center services will **not** incur any charge, and they should ***not*** bill Medicare. The HHS Medical Travel Center will be paid directly by HHS as per its contract.

The HHS Medical Travel Center can be reached at 866-753-9344. The telephone lines are open everyday 7:00 a.m. to 5:00 p.m., Central Daylight Time (CDT).

Note: Before contacting the HHS Medical Travel Center or their home state, all medical evacuees **must** register with the Federal Emergency Management Agency (FEMA) and obtain a Disaster Registration Number from the FEMA Registration Center at 800-621-FEMA. This telephone line is operational 24 hours a day, 7 days a week.

Important Information for Discharge Planners

For evacuees in healthcare facilities or special needs shelters with a discharge planner, the discharge planners are responsible for:

- Determining if an evacuee must be transferred to a receiving facility or can be discharged to a private residence;
- Identifying a receiving facility/residence in the evacuee's home state or an interim state if necessary;
- Determining the evacuee's medical requirements during transport; and
- Arranging for a FEMA registration number for the evacuee and any nonmedical assistants.

Facility to Facility Transfer
Once the discharge planner has completed these tasks, they may contact the HHS Medical Travel Center to arrange for medical transportation. In order to complete the transportation process, discharge planners **must** complete and submit a Documentation of Medical Necessity form provided by the HHS Medical Travel Center. This form will be provided to discharge planners when they call the HHS Medical Travel Center, and it is available at ***www.hhs.gov/katrina*** on the HHS Web site.

Facility to Non-Facility Transfer
If the discharge planner determines that the evacuee can be discharged to a residence, the discharge planner **must** call the evacuee's home state, which will be acting as a receiving point of contact. Please see below for information on how to contact the evacuee's home state.

Evacuees in a Shelter, Hotel, or Private Home
Evacuees should call their home state to access transportation if they:

- Have medical needs, and
- Are sheltering in a hotel, private residence, or other facility that **cannot provide discharge planning**.

Guidance from the Home State
The evacuee's home state will determine if the evacuee can ride commercial transportation and if their state medical system can support their ongoing medical needs. If the state medical system **cannot** support the evacuee's ongoing medical needs, the home state will help the evacuee find an interim location in another state, if appropriate.

Texas
Texas evacuees with medical needs may contact the 2-1-1 telephone service (if calling within Texas) or 888-312-4567 (if out-of-state) to initiate access to appropriate transportation and receive an evaluation of the community medical infrastructure to support the return. The Texas telephone lines are open everyday 8:00 a.m. to 5:00 p.m., CDT.

Mississippi Department of Health
Mississippi evacuees with medical needs may contact the Mississippi State Health Department at 601-576-7300 to initiate access to appropriate transportation. The Mississippi telephone lines are open Monday to Friday 8:00 a.m. to 5:00 p.m., CDT.

Louisiana Department of Health and Hospitals
Louisiana is **not** currently accepting the return of evacuees with outpatient and/or ongoing medical needs. Evacuees from Louisiana with medical needs sheltering in a hotel, residence, or other facility that **cannot** provide discharge planning ***must*** have their current medical attendant or family member contact the HHS Medical Travel Center to initiate access to appropriate transportation.

The evacuee's medical attendant **must** complete and submit a Documentation of Medical Necessity form provided by the HHS Medical Travel Center to complete the transportation process. This form will be provided for the evacuee's medical attendant when they call the HHS Medical Travel Center or is available online at ***www.hhs.gov/katrina*** on the HHS Web site. If a family member is completing this form for the patient, it **must** be signed by the patient's current local healthcare provider.

Questions and Answers (Q&As)

Below are frequently asked questions about the transportation of Hurricanes Katrina and Rita evacuees. CMS will be posting these Q & As at ***www.cms.hhs.gov/hki*** on the CMS Web site:

Q1. What is the first step in the process no matter what category of evacuee I am?

A1. Register for Disaster Assistance and obtain a FEMA Disaster Registration number via 800-621-FEMA.

Q2. What if the evacuee or patient I am arranging care for doesn't have a FEMA Disaster Registration number?

A2. Call the FEMA Registration Center at 800-621-FEMA to register for Disaster Assistance and obtain a FEMA Disaster Registration number.

Q3. Will this travel system arrange transportation for National Disaster Medical System (NDMS) patients as well as those persons who became patients in similar facilities after evacuating?

A3. Yes, the HHS Medical Travel Center will arrange transportation for all evacuees that currently require enroute medical care and/or medical transport back to their home state or to an interim state. Discharge planners at medical facilities/shelters should contact the HHS Medical Travel Center to arrange for transportation of their evacuees.

Evacuees from Texas and Mississippi with medical needs who do **not** have a discharge planner should contact their home state. Evacuees from Louisiana with medical needs who do **not** have a discharge planner should contact the HHS Medical Travel Center and will need their healthcare provider to complete the forms.

Q4. Will evacuees or medical facilities incur any transportation costs using this travel system?

A4. The HHS Medical Travel Center covers all transportation costs; **there will be neither bills nor co-pays and no insurance forms will be necessary**. Evacuees who can travel via commercial transportation **must** make their own arrangements to the airport or station.

Q5. Can a healthcare facility be reimbursed by the HHS Medical Travel Center for transportation arrangements already made? Can a healthcare facility make transportation arrangements for evacuees in the future and be reimbursed by the HHS Medical Travel Center?

A5. No. The HHS Medical Travel Center will **not** reimburse facilities or states that have already made transportation arrangements for evacuees. All future transportation arrangements for evacuees should be made through the HHS Medical Travel Center or appropriate state system.

Q6. What are the criteria for deciding if an evacuee needs enroute medical care and/or medical transportation, and who makes this determination?

A6. If the evacuee is currently a patient at a medical facility and has a discharge planner coordinating their transportation, the healthcare facility discharge planner will determine if the evacuee requires medical transportation.

If the evacuee is **not** sheltering at a facility with discharge planning, the evacuee's home state or, in the case of Louisiana, the evacuee's medical attendant or accompanying family member, will determine if the evacuee is able to travel via commercial air or ground transportation.

Commercial airlines are very flexible in accepting people with such medical needs as oxygen and wheelchairs. If that is all that is required, a routine commercial flight will be arranged by FEMA for the evacuee and their family members if the evacuee meets the necessary qualifications.

Q7. Will the HHS Medical Travel Center perform discharge planning or provide clinical validation of evacuees?

A7. No. The discharge planners in the healthcare facilities and/or the evacuee's home state will provide that function PRIOR to movement. The HHS Medical Travel Center will provide safe, efficient, and effective medical transport enroute.

Q8. Who arranges for the discharge planning of evacuees, including destination, special medical equipment required, or other relevant transportation concerns?

A8. The discharge planners of the healthcare facility in which the evacuee resides should coordinate all arrangements for the evacuee with the receiving institution. This includes working with the evacuee's home state, hospital, and/or nursing home to identify a receiving institution if the originating facility is **not** able to receive patients. Evacuees without discharge planners will need to contact their home state for assistance.

Q9. What if an evacuee requires enroute medical care and/or medical transport and has multiple accompanying family members (who are also evacuees) who must return with the evacuee?

A9. The HHS Medical Travel Center will provide a medical attendant to support enroute medical care if required. The HHS Medical Travel Center will make all reasonable efforts to accommodate at least one family member during medical transport. If the HHS Medical Travel Center is unable to do so, a separate transportation program will attempt to ensure family members will travel to the destination along a similar schedule. Both of these systems require all travelers to have a FEMA Disaster Registration number.

Q10. If an evacuee is living in a hotel or a home (and therefore does not have a discharge planner) and has medical needs (e.g., requires oxygen or stabilized transport), how does the evacuee arrange for travel home?

A10. With the exception of Louisiana citizens, evacuees can call their home state to access travel arrangements. Their home state will act as their discharge planner and will determine if the evacuee can travel via commercial air or ground transportation and work with the evacuee to ensure that the medical infrastructure in their home community is ready to accept them. If the evacuee's home state determines that they can travel via commercial means, a separate transportation program will arrange their transportation. If the evacuee **cannot** travel by commercial means, the HHS Medical Travel Center will arrange for their transportation.

If the evacuee is a citizen of Louisiana and is living in a hotel or a home in a host state, he or she will **not** be able to return to Louisiana at this time. If their medical attendant or a family member determines that they can travel via commercial means, a separate transportation program will arrange their travel to an interim state. If the evacuee **cannot** travel by commercial means, the HHS Medical Travel Center will arrange for their transportation to an interim state, and the evacuee's medical attendant should complete the necessary paperwork for the travel.

Q11. What if the evacuee wants to return to his or her original healthcare facility and that facility is not able to receive patients?

A11. There are three potential options if the originating facility is **not** able to receive patients:

- The evacuee's discharge planner can identify another facility within the evacuee's home state. Transportation will be provided to another suitable facility within the home state with final transportation to the originating facility to be arranged by the HHS Medical Travel Center when the originating facility is able to receive patients;
- The evacuee's discharge planner can identify a facility in an interim state where family members or other relatives or relations of the evacuee reside. The HHS Medical Travel Center will provide transportation to the interim state facility with final transportation to the originating facility to be arranged when it is able to receive patients; or
- The evacuee must continue to be cared for by the current host state with final transportation to the originating facility to be arranged by the HHS Medical Travel Center when the originating facility is able to receive patients.

Q12. As a discharge planner, do I have to arrange for transportation from my healthcare facility to the airfield (if aeromedical transportation is being used)?

A12. No, the HHS Medical Travel Center provides door-to-door service. See question Q4.

Q13. As a discharge planner, do I need to fill out and submit a particular discharge planning form when making travel arrangements for my patient evacuee?

A13. Yes. The HHS Medical Travel Center will fax or email you a Documentation of Medical Necessity form to complete. The information you provide on this form will help the HHS Medical Travel Center provide the necessary medical care enroute for your evacuee. This form is also available at ***www.hhs.gov/katrina*** on the HHS Web site.

Q14. What if a discharge planner needs to move an evacuee within the state? Do these travel systems arrange that transportation?

A14. Yes, all of these travel systems arrange for intra- and inter-state transportation.

Q15. How will hospitals and other providers be reimbursed for the medical care they provided to evacuees?

A15. Remember, with the use of the HHS Medical Travel System, there are **no** transportation costs associated with the return of evacuees to their home state or an interim state. However, there are many ways for providers to be reimbursed for services provided to evacuees:

Existing Health Care Insurance

Many evacuees have existing health insurance coverage. Providers should bill an evacuee's private health insurer, if one exists.

Medicare

Many evacuees are covered under the Medicare program. Providers should contact their local Medicare carrier or fiscal intermediary if they have questions regarding Medicare reimbursement for evacuee health care.

On January 1, 2006, the Medicare prescription drug benefit begins. CMS will work closely with evacuees and those who provide insurance counseling to the elderly to ensure that those evacuees who want to enroll in a drug plan will be able to do so. We [CMS] are also taking steps to let those elderly evacuees who qualify for extra help in paying for their drug costs know about the availability of this program.

National Disaster Medical System (NDMS)

Some evacuees received medical treatment via the NDMS. At the request of FEMA, CMS and DHHS is developing payment mechanisms for those patients who entered NDMS hospitals via the Federal Coordinating Centers as part of the NDMS evacuation. Specifics about how to submit claims for these patients will be made available on the CMS Web site (***www.cms.hhs.gov***).

Medicaid

Many evacuees will qualify for Medicaid, either because they were eligible in their home state or because they are now eligible because of a loss of income and/or resources. CMS has approved Medicaid waivers for many states. Under these waivers, effective retroactively to August 24, 2005, evacuees who have been displaced from their home as a result of Hurricane Katrina will be provided the opportunity to enroll through a streamlined process to receive services under the Medicaid or State Children Health Insurance Program (SCHIP) programs in whatever state they are now physically present.

Medicaid and SCHIP providers should work with their states to submit claims and receive payment. States are putting in place modifications to their current claims processing systems to accept such claims, and all payments for Medicaid and SCHIP eligible persons will be handled through the states.

Uncompensated Care

Through the waiver process mentioned above, CMS is working with states with large numbers of evacuees to put in place processes for handling those claims which would otherwise have been uncompensated. Providers should contact their state for information on how those claims will be submitted and how payments will be processed.

CMS will be providing information on these payment mechanisms on the CMS Web site (***www.cms.hhs.gov/emergency/***). CMS will also be sharing information with provider and patient-based national and state trade and professional associations and the states via the state Emergency Operations Centers.

Note: All HHS press releases, fact sheets, and other press materials are available at ***www.hhs.gov/news*** on the HHS Web site.

Additional Information

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

News from DMERC A…

Change in Call Center Hours of Operation

The Region A Durable Medical Equipment Regional Carrier (DMERC A) supplier and beneficiary toll-free telephone lines (866-419-9458 and 1-800-MEDICARE, respectively) are available from 8:00 a.m. until 4:00 p.m. (Eastern Standard Time) Monday through Friday (unless otherwise stated). Please note, this is a change in the DMERC A call center hours of operation from previously published information.

Program Inquiries

News from CMS…

Changes to Chapter 29 - General Appeals Process in Initial Determinations

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

Note: This article was revised on November 18, 2005, to clarify the entry in section 4 of the chart, under the "Steps in the Appeals Process: Overview" subsection of the "Key Points" section, to show that appeals to the Departmental Appeals Board are **only** to be made to the Board and **not** to the Administrative Law Judge (ALJ) hearing office.

The following information affects physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service (FFS) claims to Medicare.

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. It is different from the previous first level of appeal for Part A claims performed by fiscal intermediaries (FIs). Reconsiderations will be processed by Qualified Independent Contractors (QICs). Change Request (CR) 4019 focuses on the general appeals process in initial determinations. CR 4019 contains a considerable amount of information that is pertinent to the entire process of Medicare claims appeals and focuses specifically on the additions of Sections 200 to 260 to Chapter 29 of the Medicare Claims Processing Manual.

Key Points

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

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

Minor Errors and Omissions

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

Who May Appeal

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

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

Provider or Supplier Appeals When the Beneficiary Is Deceased

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

Parties to an Appeal

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

Steps in the Appeals Process: Overview

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

The Medicare Fee-for-Service Appeals Process

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

*Where to Appeal - Part A includes Part B claims filed with the FI.

** In accordance with the appropriate manual section and the Joint Operating Agreement (JOA).

***Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy (AIC) requirement will increase by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is **not** a multiple of $10 will be rounded to the nearest multiple of $10.

Where to Appeal

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

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

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

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

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

Amount in Controversy (AIC) Requirements

The AIC requirements apply **only** to the ALJ and Federal Court levels. The chart above indicates the AIC, as well as the method of calculating the AIC, for the Medicare appeals process.

Additional Information

The official instruction issued to your FI or carrier regarding this change may be found by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 4019 in the CR NUM column on the right and click on the file for that CR. All of the new sections of Chapter 29 of the Medicare Claims Processing Manual are attached to CR 4019. These sections provide excellent detail that explains the revised appeals process.

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

Changes to Chapter 29 - Appeals of Claims Decisions:

Redeterminations and Reconsiderations (Implementation Date May 1, 2005)

Medlearn Matters Number: MM3942
Related Change Request (CR) #: 3942
Related CR Release Date: October 7, 2005 **Revised**
Related CR Transmittal #: 697
Effective Date: May 1, 2005
Implementation Date: January 9, 2006
Note: This article was revised on February 21, 2006, to update the language regarding the appeals process. In addition, the article now contains Web addresses that conform to the new Centers for Medicare & Medicaid Services (CMS) Web site.

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

Provider Action Needed

The new second level in the administrative appeals process is called a "reconsideration." Reconsiderations are processed by Qualified Independent Contractors (QICs).

Background

The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, now requires a new second level in the administrative appeals process called a reconsideration. Requests for reconsideration of appeal decisions (redeterminations) should go either to the QIC, or the hearing officer (HO), when the redetermination was issued by a carrier **prior** to January 1, 2006.

Time Limit for Filing a Request for Reconsideration

A request for reconsideration **must** be filed within 180 days of the date of receipt of the notice of redetermination. For requests filed in writing - the date received is defined as the date received by the QIC in the corporate mailroom. Please refer to the following table for clarification.

Appeal Rights for Requests for Reconsideration
The Second Level of Appeal

Medicare Claims	Medicare Contractor Issuing Redetermination	Date Redetermination Issued and Mailed	Where to Appeal the Redetermination*
Part A/ Part B	Fiscal Intermediary (FI)	On or after May 1, 2005	QIC

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

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

Additional Information

Medicare Claims Processing Manual, Chapter 29 - Appeals of Claims Decisions, 310.2, 310.3, can be found at ***www.cms.hhs.gov/manuals/downloads/clm104c29.pdf*** on the CMS Web site. Medlearn Matters article MM3530 - "MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries **Revised: 4/12/2005**" (Change Request (CR) Title - Appeals Transition - BIPA 521 Appeals), can be found at ***www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM3530.pdf*** on the CMS Web site. CR 3530 "Revisions to Medicare Appeals Process for Fiscal Intermediaries **Revised: 4/12/2005**" (CR Title-Appeals Transition – BIPA 521 Appeals), can be found at ***www.cms.hhs.gov/Transmittals/downloads/ R146OTN.pdf*** on the CMS Web site. The official instruction issued to your FI, durable medical equipment regional carrier (DMERC), or carrier regarding this change may be found by going to ***www.cms.hhs.gov/Transmittals/downloads/R697CP.pdf*** on the CMS Web site. The new sections of Chapter 29 of the Medicare Claims Processing Manual are attached to CR 3942.

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

Appeals of Claims Decisions: Redeterminations and Reconsiderations

Medlearn Matters Number: MM3944
Related Change Request (CR) #: 3944
Related CR Release Date: September 23, 2005
Related CR Transmittal #: 688
Effective Date: May 1, 2005, for appeals of claims submitted to Medicare intermediaries and January 1, 2006, for appeals of claims submitted to carriers
Implementation Date: December 16, 2005, for Medicare intermediaries and January 1, 2006, for Medicare carriers

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

Provider Action Needed

Medicare providers who appeal claims decisions made by Medicare carriers and fiscal intermediaries (FIs), including durable medical equipment regional carriers (DMERCs) and regional home health intermediaries (RHHIs), need to be aware of the new appeals processes.

Background

The purpose of Change Request (CR) 3944 is to notify Medicare contractors (FIs or carriers, including DMERCs) and Medicare providers about the upcoming transition to the new second level of the appeals process. The "redetermination" is the first level of appeal. It is a second look at the Part A or B claim and supporting documentation by an employee of the contractor (Medicare carrier or intermediary) who was **not** involved in the initial claim determination. In performing a redetermination of the services requested by the appellant, Medicare contractor personnel **must** examine all issues in the claim.

The Medicare claims appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process, called a "reconsideration." This new "reconsideration" is different from the previous first level of appeal for Part A claims performed by FIs. These appeals are processed by Qualified Independent Contractors (QICs).

Additional Information

Rather than repeat the extensive details of CR 3944 in this article, the Centers for Medicare & Medicaid Services (CMS) encourages physicians, providers, and suppliers who wish to appeal an initial determination of a Medicare claim made by a Medicare carrier or FI to review CR 3944. The new/revised manual sections of Chapter 29 of the Medicare Claims Processing Manual that are attached to CR 3944 contain many important

details for those wishing to file claims determination appeals. You can find CR 3944 by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 3944 in the CR NUM column on the right and click on the file for that CR.

If you bill a Medicare FI, you may also wish to review Medlearn Matters article MM3530 and/or CR 3530. They are available as follows:

- Medlearn Matters article MM3530 MMA, "Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title - Appeals Transition - BIPA 521 Appeals), is available at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3530.pdf*** on the CMS Web site.
- CR 3530, "Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title - Appeals Transition - BIPA 521 Appeals), is available at ***www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf*** on the CMS Web site.

In addition, if your request for a redetermination is dismissed by the Medicare contractor, you may wish to understand your appeal rights with regard to that dismissal. These rights are discussed in CR 3939, which can also be found at ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. Once at that page, look for CR 3944 in the CR NUM column on the right and click on the file for that CR.

Please refer to your local FI, carrier, or DMERC if you have questions on this issue. To find their toll-free telephone numbers, go to ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Appeals of Claims Decisions: Redeterminations and Reconsiderations and Appeals Rights for Dismissals

Medlearn Matters Number: MM3939
Related Change Request (CR) #: 3939
Related CR Release Date: October 21, 2005
Related CR Transmittal #: 724
Effective Date: January 1, 2006, for appeals of initial determination of claims by Medicare carriers; May 1, 2005, for initial claim determinations by Medicare fiscal intermediaries (FIs)
Implementation Date: December 16, 2005, for FIs and January 1, 2006, for carriers

The following information affects physicians, providers, and suppliers who appeal initial claims determinations by Medicare.

Provider Action Needed

The purpose of Change Request (CR) 3939 is to notify Medicare contractors (FIs or carriers, including durable medical equipment regional carriers (DMERCs)) and Medicare providers about the upcoming transition to the new second level of the appeals process. The Medicare claim appeals process was amended by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process, called a "reconsideration." This new "reconsideration" is different from the previous first level of appeal for Part A claims performed by FIs. Reconsiderations will be processed by Qualified Independent Contractors (QICs).

Rather than repeat the extensive details of CR 3939 in this article, the Centers for Medicare & Medicaid Services (CMS) encourages physicians, providers, and suppliers who wish to appeal an initial determination of a Medicare claim made by a Medicare carrier or FI to review CR 3939. The new/revised manual sections of Chapter 29 of the Medicare Claims Processing Manual that are attached to CR 3939 contain many important details for those wishing to file claims determination appeals. You can find CR 3939 by going to ***www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp*** on the CMS Web site. From that Web page, look for CR 3939 in the CR NUM column on the right and click on the file for that CR. The key new or revised sections contained in CR 3939 include information on:

- Filing a request for redetermination;
- Appeal rights for dismissals of redetermination requests, including sample dismissal letters and notices;
- Filing requests for reconsiderations, the second level of appeal;
- Time limits for filing reconsideration requests; and
- How reconsideration decisions are effectuated.

If you bill a Medicare FI, you may also wish to review Medlearn Matters article MM3530 and/or CR 3530. They are available as follows:

- Medlearn Matters article MM3530, "MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries"

(CR Title - "Appeals Transition - BIPA 521 Appeals") is available at ***www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3530.pdf*** on the CMS Web site.

- CR 3530, "Revisions to Medicare Appeals Process for Fiscal Intermediaries" (CR Title -"Appeals Transition - BIPA 521 Appeals") is available at ***www.cms.hhs.gov/manuals/pm_trans/R146OTN.pdf*** on the CMS Web site.

Please refer to your local FI, carrier, or DMERC if you have questions on this issue. To find their toll-free telephone numbers, go to ***www.cms.hhs.gov/medlearn/tollnums.asp*** on the CMS Web site.

Notes from DMERC A…

As a result of the changes to the appeals process, the Region A Durable Medical Equipment Regional Carrier (DMERC A) is no longer sending Fair Hearing acknowledgement letters to the requestors of the hearings. Also, if you receive a Reconsideration Request form, which is part of the Redetermination letter, **please complete the form** and mail it to the address on the form in order to avoid delays in processing your request.

In addition, the hours of operation for the DMERC A Telephone Redeterminations Line (866-420-6906) have changed to 9:00 a.m.-11:00 a.m. and 1:00 p.m.-3:00 p.m. (Eastern Standard Time) Monday through Friday. Please note these important changes.

Program Education & Training

Claim Submission Errors for the First Quarter of Fiscal Year 2006

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 October 1, 2005, through December 31, 2005, are provided in the following chart. The total number of ANSI errors for this period was **227,078**.

ANSI Error Number - Narrative (Total Errors)	Reason for Error
1) 40068 - Invalid/Unnecessary Certificate of Medical Necessity (CMN) Question (31,680 errors)	The question number entered is **not** valid for the DMERC CMN you are sending.
2) 40022 - Procedure Code/Modifier Invalid (30,375 errors)	The procedure code and/or modifier used on this line is invalid.
3) 20269 - Pointer 1 Diagnosis Invalid (23,152 errors)	Diagnosis pointer is invalid.
4) 20270 - Pointer 2 Diagnosis Invalid (12,529 errors)	Diagnosis pointer is invalid.
5) 20011 - Billing Provider Secondary ID Invalid (10,232 errors)	Secondary provider ID is invalid.
6) 40073 - Dates of Service Invalid with Procedure Code (7,748 errors)	The procedure code used is **not** valid for the dates of service used.
7) 20143 - Ordering Provider Secondary ID Invalid (6,472 errors)	The provider number or Unique Physician Identification Number (UPIN) is invalid.
8) 20025 - Subscriber ID Code Invalid (6,244 errors)	The qualifier identifying the subscriber is invalid.
9) 20271 - Pointer 3 Diagnosis Invalid (5,661 errors)	Diagnosis pointer is invalid.
10) 40067- Invalid/Unnecessary CMN Version Submitted (5,028 errors)	The DMERC CMN version number entered is **not** valid for the Health-care Common Procedure Coding System (HCPCS) code submitted.

In an effort to reduce other initial claim denials, the below information represents the top ten return/reject denials for the first quarter of fiscal year 2006. Claims denied in this manner are considered to be unprocessable and **have *no* appeal rights**. An unprocessable claim is any claim with incomplete or missing, required information, or any claim that contains complete and necessary information, however, the information provided is invalid. Such information may either be required for all claims or required conditionally. Please refer to Chapter 1, Section 80.3.1, of Pub. 100-4, Medicare Claims Processing Manual.

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form Entry Requirement
1) CO 16 M51 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid procedure code(s) and/or rates. (7,862 claims)	Item # - **24D**
2) CO 16 M78 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid HCPCS modifier. (5,794 claims)	Item # - **24D**
3) CO 16 MA83 Claim/service lacks information which is needed for adjudication. Did **not** indicate whether we are the primary or secondary payer. (5,685 claims)	Item # - **11**

Denial Code - Narrative (Total Claims Denied)	CMS-1500 Form 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 telephone number. (3,917 claims)	Item # - **33**
5) CO 16 MA102 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/ supervising provider. (3,717 claims)	Item # - **17**
6) CO 16 N64 Claim/service lacks information which is needed for adjudication. The "from" and "to" dates **must** be different. (2,832 claims)	Item # - **24A**
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. (2,724 claims)	Item # - **21**
8) CO 16 MA114 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid information on where the services were furnished. (518 claims)	Item # - **32**
9) CO 16 M77 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid place of service. (374 claims)	Item # - **24B**
10) CO 16 M79 Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid charge. (236 claims)	Item # - **24F**

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

Spring 2006 Seminars

The Region A Durable Medical Equipment Regional Carrier (DMERC A) announces the spring 2006 continuing education seminars and workshops. 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 - Getting It Right the First Time. The seminars are being offered as two-day sessions; however, you may attend any session(s) you wish. Please visit the DMERC A Web site at ***www.umd.nycpic.com*** for more information and details on what will be covered in each session.

Dates and Locations

Date	Location	Address	Telephone
April 18-19, 2006	Wyndham Harrisburg-Hershey	4650 Lindle Road Harrisburg, PA	717-564-5511
April 26-27, 2006	Holiday Inn Boardwalk	Chelsea Avenue & The Boardwalk Atlantic City, NJ	609-348-2200
May 3-4, 2006	Sheraton Station Square	300 West Station Square Drive Pittsburgh, PA	412-261-2000
May 16-17, 2006	Sheraton Springfield	One Monarch Place Springfield, MA	413-781-1010

Note: 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. **You may now submit your registration online.** The registration form is available on 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. Attendees are limited to three (3) registrants **per company**; this is **not** per session. 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. 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 570-255-9666 and select option 1.

If you do **not** have Internet access, please call 570-255-9666, option 1, and **leave your name, company name, telephone number, and fax number**, and a registration form will be sent to you.

New Online Tutorials Available

The Region A Durable Medical Equipment Regional Carrier (DMERC A) has educational tutorials available seven (7) days a week, 24 hours a day. These are great sessions to train new employees or refresh your

knowledge on basic DMERC topics. The following new tutorials are currently available: CMS-1500 Form Completion, Commodes and Bathroom Aids, External Breast Prosthesis, and Life of an ANSI Claim. To access the tutorials, please visit the "Education-Tutorials" section of the DMERC A Web site at ***www.umd.nycpic.com/dme-eduonline.html***.

In addition, be sure to check the "Events" section at ***www.umd.nycpic.com/dmprovcaln.html*** for our available live online sessions. These sessions are Web-based seminars or workshops, which enable you to participate via computer from the comfort of your office, meeting room, or home.

Provider Communications (PCOM) Advisory Group

The second quarterly Provider Communications (PCOM) Advisory Group meeting for fiscal year 2006 was held via teleconference on February 8, 2006. Participants included representatives from the Centers for Medicare & Medicaid Services (CMS), supplier billing services, state provider associations, and individual provider organizations. Also represented was the new Durable Medical Equipment Medicare Administrative Contractor (DME MAC), National Heritage Insurance Company (NHIC). Topics addressed at the meeting included:

- Transition to the DME MAC, effective July 1, 2006
- DMERC bulletins and Web site enhancements
- Medicare Contractor Provider Satisfaction Survey (MCPSS)
- Outreach Initiatives
  - Educational opportunities and plans
  - WebEx online seminars
- Data analysis
- Nebulizer dispensing fees and billing issues
- Medicare Part B versus Part D coverage issues
- Appeals process changes

Presentations on the transition to the DME MAC were given by Amy Capece, HealthNow Program Education & Training Manager, and Karen Grasso, NHIC Supplier Communications Lead for the transition. HealthNow and NHIC used this opportunity to introduce NHIC as the new DME MAC and to start the supplier communications and outreach transition process. Both HealthNow and NHIC provided general DME MAC updates in relation to supplier communications and outreach, followed by an open question and answer period. Additional details on this, as well as all other topics discussed, are included in the minutes for this meeting, located on the "PCOM Advisory Group" section of the HealthNow Region A Durable Medical Equipment Regional Carrier (DMERC A) Web site at ***www.umd.nycpic.com/dmerc_PCOM.html***.

The next PCOM Advisory Group meeting is scheduled for May 10, 2006, in Harrisburg, PA.

DMERC A Participation at Several Events

The Region A Durable Medical Equipment Regional Carrier (DMERC A) 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:

- **New England Medical Equipment Dealers (NEMED) Association Membership Meeting** - March 16, 2006, Nashua, NH
- **Medtrade Spring 2006 Exposition & Conference** - March 22-23, 2006, Las Vegas, NV - Booth #534
- **New York Medical Equipment Providers (NYMEP) Annual Meeting** - April 25, 2006, Tarrytown, NY
- **Upstate Medicare Division (UMD) Spring 2006 Medicare Part B Conference** - May 8-9, 2006, Turning Stone Resort, Verona, NY
- **Pennsylvania Association of Medical Suppliers (PAMS) Annual Meeting** - May 21-23, 2006, Harrisburg, PA
- **NEMED Annual Meeting** - June 19-21, 2006, Groton, CT

For more information about these events, please visit the "Events" section of the DMERC A Web site at: ***www.umd.nycpic.com/dmprovcaln.html***

Supplier Manual News

The 2003 edition of the Region A Durable Medical Equipment Regional Carrier (DMERC A) supplier manual was reprinted in September 2005. The *DMERC A Supplier Manual* is available via the "Publications" section of our Web site at

www.umd.nycpic.com/dmprovpublcopy.html. After accepting the CPT License Agreement, suppliers can access the entire manual, including revised chapters and archived revisions. The 2005 reprint is available to current suppliers via the DMERC A Web site, and newly-enrolled suppliers will receive their initial manuals on CD-ROM. The option to request additional copies **for a fee** is also available via the DMERC A Web site.

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

Revision 2005-03 (March 2006)

- Chapter 1 (Contact Information) - updated for changes related to the hours of operation for toll-free telephone lines
- Chapter 10 (Program Safeguard Contractor) - updated to reflect current changes to medical policy information and the new Centers for Medicare & Medicaid Services (CMS) Web addresses

  (**Note**: The table of contents was also updated to reflect the new CMS Web addresses.)

Suppliers who maintain hard copy manuals at their place of business need to discard the previously published pages and replace them with the revised ones. Be sure to follow the download instructions to print the revised pages.

Web Site Resources

News from CMS…

What is the MCPSS?

The Medicare Contractor Provider Satisfaction Survey (MCPSS) is funded by the Centers for Medicare & Medicaid Services (CMS). The purpose of the MCPSS is to garner quantifiable data on provider satisfaction with the performance of Medicare Fee-for-Service (FFS) contractors, including the Region A Durable Medical Equipment Regional Carrier (DMERC A).

To learn more about the MCPSS, please review the following documents:

- **MCPSS Fact Sheet (October 2005)** - available via the CMS Web site at: ***www.cms.hhs.gov/MCPSS/downloads/factsheet.pdf***
- **MCPSS Frequently Asked Questions** - accessible via the CMS Web site at: ***www.cms.hhs.gov/MCPSS/01_overview.asp***

For more information, or to access the survey, go to ***www.mcpsstudy.org*** (**Note**: This is a secure Web site). Selected providers/suppliers are strongly encouraged to participate in this important CMS initiative.

Drug Coverage Materials for Health Care Professionals

NEW! Visit ***www.cms.hhs.gov/center/provider.asp*** and scroll down to "Part D Tools for Health Care Professionals" for a comprehensive list of links to agency-wide resources for providers on Medicare Rx coverage. These resources can help providers and office staff access direct telephone numbers to a Medicare drug plan's coverage determination staff, as well as obtain model forms that will help speed the process.

Additionally, a new fact sheet, as well as other educational products for the fee-for-service (FFS) community, is now available at ***www.cms.hhs.gov/medlearn/drugcoverage.asp*** [Note: this redirects to ***www.cms.hhs.gov/MedlearnProducts/23_drugcoverage.asp***] on the Centers for Medicare & Medicaid Services (CMS) Web site.

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/QuarterlyProviderUpdates/01_Overview.asp***. 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 CMS-QPU ListServe at: ***https://list.nih.gov/cgi-bin/wa?SUBED1=cms-qpu&A=1***

News from DMERC A…

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 winter 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.)

Region A DMERC and PSC Affiliate Web Sites

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

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

Reminder

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

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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)
EDI Services Help Desk	866-861-7348
Program Education & Training	570-255-9666
Program Inquiries	
Telephone Redeterminations Line	866-420-6906
FAX Numbers	
Check Control/MSP	570-255-9594
Electronic Data Interchange	570-255-9510
Extra Documentation/ADMC	570-255-9402
Program Education & Training	570-255-9442
Program Inquiries (Redeterminations & Hearings)	570-255-9599
National Supplier Clearinghouse	866-238-9652
SADMERC	877-735-1326
Web Sites	www.umd.nycpic.com www.tricenturion.com www.cms.hhs.gov

Addresses

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

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

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

General Correspondence
P.O. Box 5303
Binghamton, NY 13902-5303
[*for Written Inquiries, Freedom of Information Act (FOIA) Requests*]

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

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

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

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

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

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

MEDICARE

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

A CMS Contracted Carrier